Access, Voice and Ownership
Examining Service Effectiveness from the Family's Perspective

by Patricia Miles and John Franz

How can we tell if our systems of care are effective? A traditional strategy would look solely at outcomes: are children remaining at home or at least in the community, are they progressing from grade to grade in school, being kept free from harm caused by abuse and neglect, and not harming or abusing others? This is the ideal. If we could monitor outcomes, find out what works and do more of it, we would be constantly improving our services. (As long as we can all agree on a common definition of "good outcomes.") However, there is a practical limitation on this strategy: our current ability to collect, maintain and analyze concrete outcome data across a community-wide collection of systems of care is very limited, and even when small amounts of outcome data are available, it is often difficult to link them directly to questions of system redesign. This article explores another option which may be more workable.

Linking Positive Outcomes to System Characteristics

The alternative is to determine whether good service outcomes can be linked with certain system attributes that are easier to monitor. This second tack was taken by Washington State under the leadership of Dr. John Whitbeck, who is the director of research for the state's Mental Health Division. He began his study with a large sample of individual cases from a variety of human service disciplines which were identified as having good outcomes. He then assembled teams which did in-depth analyses of these successful interventions to determine whether any common elements could be identified. The initial results were then rechecked through follow up investigations.

What the Washington State team discovered was that positive service situations nearly always had three key clusters of attributes. Participants described them in a variety of ways, but what they boiled down to was that successful outcomes were highly correlated with strategies that provided clients with feelings of access, voice and ownership in the development and implementation of their service plans. These qualities seemed essential to good results, regardless of the type of service being offered, the technique being used or even the specific presenting problems of the individual or family receiving help. Whitbeck's group defined each of these attributes in the following way:

Access occurred when clients (parents, children, individuals receiving services) were offered valid opportunities for inclusion in the process of deciding what sort of services would be provided and how they would be delivered. In other words, family members had a seat at the table when the real work of planning was taking place.

Voice was present in those situations in which clients not only had a seat at the table, but actually had an opportunity to present their perspectives and to be heard during the planning process.

Ownership existed when clients felt a sense of commitment to the course of action which was developed through the planning process, identified with it and believed it to be worth while.

The concepts of access, voice and ownership have a ring of common sense about them. Any of us are more likely to agree with, participate in and benefit from a course of intervention that we feel we are a part of than one which we feel is being done to us. We respond better when we are treated like people than we do when we are manipulated like objects.

Process elements that support access, voice and ownership

In looking at their data, the team found a second set of process components that appeared to have a high likelihood of supporting or producing conditions in which the qualities of access, voice and ownership could emerge. These components were:

1. *Holistic reframing* which meant that successful outcomes seemed to be linked to planning approaches in which a broad-based course of support and intervention was constructed by operationalizing normal and appropriate outcomes in the context of each of the major domains of the individual or family's life, instead of limiting care and treatment to narrow categories defined more by the provider's structure than the family's needs. (Life domains include areas such as a place to live, a family or surrogate family to live with, a social life including friends and other social contacts, educational or vocational activities, medical concerns, psychological and emotional needs, legal issues, safety issues, and the impact of the person or family's ethnic, cultural, geographic and spiritual needs and values.) In addition, service plans fitting within this cluster were built on the strengths and needs of the participants, rather than limiting the focus to a family's clinically-defined deficits and diagnoses.

2. The second element consisted of various types of *flexible planning processes* that bundled the outcomes from the reframing into operational, client-based, in-depth strategies which dealt objectively with real-life contingencies and which focused on actions designed to address the primary needs standing as barriers to positive outcomes for families regardless of the domains in which those needs occurred.

3. The final factor was the need for some form of *team-based approach* for developing and implementing the plan of care which actively included the family as well as any natural and system-based support persons who were necessary to design and implement the plan. The team members also had to be hands-on participants who were both willing and able to do the work or commit the resources necessary to carry out the aspect of the plan for which they were responsible.

As is implied by these findings, communities in which the various systems of care have a high degree of integration are more likely to generate the process elements that lead to access, voice and ownership. Similarly, the more a community's programs remain highly categorical and avoid pooled planning and service delivery, the more difficult it becomes to introduce positive attributes.

Measuring the elements of access, voice and ownership

For system redesign based on access, voice and ownership to be effective, a feedback mechanism must be established for measuring the presence of those attributes as well as the process components which are their precursors. Dr. Whitbeck and his associates are developing a nationally validated tool which does just that, but in the meantime staff and associates with the Community Partnerships Group have prepared some ad hoc scales based on Dr. Whitbeck's work that are designed to assist system planners for individual communities to at least get a feel for the level of family inclusion in the current operations of their systems of care.

These scales are meant to be used in a positive way. They are not constructed to show what's wrong with a community's system of care, but to enable folks to measure how far they have moved toward their goals for system change. Because these scales have not yet been validated, they cannot be linked definitively to an accurate measure of access, voice and ownership and the supporting process components in a system. On the other hand, within limitations, the scales do provide a framework community groups can use to clarify their own values and determine how well their systems of care put those values into action.

For example, charts such as the one below have been used as the basis for system surveys in several communities. In those situations, some of the most interesting and helpful results have not be the absolute scores that have been achieved, but the differences in scores reported by participants from various segments of the community. For example, if direct service providers generally give responses indicating that they feel that parents have a high degree of participation in service planning, but parents report otherwise, some important discussions need to take place.

Surveys like this are most useful when they include participants from a wide variety of community roles. It is not unusual for social workers, teachers, youth participating in service programs, parents, youth who are not involved in special programs, law enforcement officers, judges, district attorneys, public defenders, private therapists, foster parents, school principles, agency administrators, sports coaches, siblings of youth in special programs, etc., to all have different opinions, but combining those disparate responses often produces the most accurate topography of a community's systems of care.

To help illustrate how these scales operate, we have selected ten examples which focus on the degree to which a community's systems of care might come together to support families with children who have severe emotional disabilities. In practice, surveys being developed for specific communities would use items more clearly tied to the nature and needs of the area involved, and break them down into more discrete segments. However, the general pattern would be the same: a basic value or goal for the system is stated and a series of examples are given describing levels of development which might occur as the system matures. We've offered three stages of implementation for each of our ten values; a working survey using 5 levels would provide more room for discrimination by respondents. A point score can be given to each level to provide a way of measuring change over time.

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Ten Values for Responsive Systems of Care

Basic value	Levels of implementation
1. **Access**. Families identified as having significant service needs are provided meaningful access to the decision-making process.	a. The community's systems of care give parents at least two weeks lead time prior to routine planning meetings and give parents both written and phone or face to face notice of the meetings.
	b. The systems of care have the capacity to schedule meetings outside the usual 9-5 work day, and are observed to occasionally rearrange meetings around parents' work schedules and choose alternative sites more convenient to parents.
	c. All meetings which include important decision-making are automatically built around parents' schedules and preferences for location.

2. **Voice**. Parents have an active voice in the development of service plans.	a. Parents are present during planning meetings and are given an opportunity to respond to proposals made by potential service providers and to select from available options. b. A staff person meets with parents before key decision-making meetings to explain the structure and purpose of the meeting and to determine the concerns and needs of the parent. c. Parents are given the opportunity and support to be the agenda-setters for meetings, including making choices about the structure and membership of the meeting and selecting the key issues to be determined.
3. **Ownership**. Family members feel a thorough sense of ownership with the plans of care which are developed.	a. In most systems of care within the community, families are generally perceived as being given the opportunity to receive needed services. b. Families are viewed as active partners with professionals in selecting plans of care most likely to achieve good outcomes. c. Families take a lead role in guiding the service development and implementation process, including configuring the planning team, helping to select or design service options and identifying key outcome indicators.
4. **Effective parent support.** The community's systems of care have specific structures in place which support parent participation and empowerment.	a. Parents are referred to support groups which provide companionship and emotional support from other parents in similar situations. b. One or more formal, parent-run organizations are available in the community to provide advocacy and system orientation services for parents, generally in the form of other parents who volunteer to provide this support. c. Each parent who comes into a community system of care is put in contact with a parent-run project that includes the availability of paid parent-partners who are able to function as formal advocates or system-conductors for new parents, if the parents choose to use them.
5. **Flexible access.** Families are able to draw from a full range of integrated services and support through any of a variety of access points within the community	a. Each primary service provider within a community (i.e. schools, social services, juvenile justice, mental health) has formal, or regularly-used informal, channels of communication with other providers which allow for the development of coordinated plans of care. b. For at least one target population, a mechanism exists which allows all of the service providers offering components of the full range of support needed by a family to join together to develop a single plan of care using pooled resources. Leadership for joint planning is usually housed in a one or more specialized agencies. c. Each primary service provider in the community has the ability to respond in a flexible, integrated manner to assist families who present complex, multi-categorical needs, including tapping into other system resources when needed. Leadership for supporting the development of an integrated plan of care can be in a variety of sites, based on the needs and concerns of each family, but families with complex needs are seen as the responsibility of the community as a whole.

6. **Outcome-focused planning**. Service providers throughout the community consistently use a planning process which focuses on the individual strengths and needs of the family and their natural supports in order to overcome the primary barriers to positive outcomes.	a. Staff of most community agencies are trained to provide blame-free service planning, although some families are still primarily assessed in terms of their problems and diagnoses. b. Family members served by any of the primary service providers are viewed as people with strengths as well as deficits. Families throughout the community report feeling that they are in an environment in which they can take responsibility for helping to develop solutions for their problems. c. Staff at all primary providers are trained to view families members as resources with skills, abilities and strengths. Supports and interventions are provided based on needs identified throughout the major life domains of the families. Ongoing adjustments are made to facilitate the transition of families from professionally-provided to naturally-occurring supports.
7. **Strength-based, need-driven services**. Supports and interventions are developed individually, respond to the specific strengths and needs of the family, and focus on producing successful long term outcomes.	a. Family members receive services from various community agencies in the context of a coordinated plan of care. b. Family members not only receive pre-existing services from community agencies, but also receive unique, individualized services developed by a specialized agency using flexible funds. Cooperating agencies are willing to adjust their categorical programs to some extent in order to meet specific family needs. c. Each service plan is individually developed based on the strengths and needs of the family members and their natural supports. Fiscal flexibility as well as programmatic resource realignment are controlled by the agency with primary responsibility for serving the family. Services are continually evaluated and adjusted based on progress toward identified outcomes.

8. **Flexible, integrated service delivery.** Traditional primary service providers adapt their family support strategies to permit flexible, multi-categorical responses.	a. Families in a specific target population are made the responsibility of a certain agency. Staff of that agency are viewed as primarily assigned to a specific system of care and function as case managers for a designated caseload. Each case manager then attempts to help her or his clients access other system resources, while also often providing direct services for families.
	b. Community agencies take joint responsibility for families with complex needs. Staff of a specialized agency with leadership responsibility for a particular family may facilitate the development of a plan of care, and provide technical assistance and backup, but primary services are likely to come from a variety of sources throughout the community, based on the family's combination of strengths and needs.
	c. A family with complex needs is able to access a full array of community services through the primary service agency with whom they have the most comfort and contact. Lead facilitation may come from a variety of sources, including generic staff who are provided sufficient backup to adjust their roles to provide special care for a family during a crisis or while a plan of care is being developed. Staff of specialized agencies are community-owned and may be drawn in for technical assistance and support by any primary service agency.
9. **Community-based care.** Service environments are community-based and maintained through an unconditional commitment to meet the needs of the family in as normalized a process as possible.	a. When children are placed out of the community for care, their return is viewed as a reward for improved behavior or progress toward treatment goals in the restrictive setting.
	b. Leadership agencies focus on providing unconditional care across domains and strive to provide or develop community-based services regardless of the severity of a child's needs. Use of out-of-community, restrictive treatment options is viewed as a system weakness to be overcome, rather than a failure by the family or the child.
	c. All system agencies operate under a presumption that a plan of care can be developed to meet any client's needs in a community environment. Mutual support from each agency greatly increases the likelihood that even children with exceptional treatment needs can live successfully in the community. Services change with needs, and crises are managed with most children experiencing minimal or no moves in placement.

10. **Consistent interagency coordination.** A community-wide group with broad representation and clearly delegated authority provides consistent vision, support and conflict management to insure the delivery of integrated services.	a. A voluntary committee of representatives from primary care agencies, the courts, community leaders and citizen representatives meets regularly to suggest better ways of improving system operation.
	b. Each primary service agency has made a specific and measurable commitment of resources to an integrated system of care. A formal community organization exists that has the power to direct resources to address unmet or unexpected system needs, to resolve conflicts among service providers and to provide vision and leadership for further improvements in the community's systems of care.
	c. A formal process for objectively resolving conflicts in values is in place and directly linked to the integrated system of care. Mechanisms and strategies for dealing with issues of coercion and consequences that arise when children and family members refuse or are unable to meet the community's minimum standards of conduct are in place and their operation is understood by staff throughout the systems of care and clearly explained to families.

Operationalizing value-driven system redesign

As noted above, these are only sample value statements and descriptions of implementation. The actual values that would be surveyed in a specific community would be better defined and more complete. However, a group attempting to develop an integrated system of care in a particular community might find this scale useful as part of an exercise during an initial planning process.

First, take time at a meeting to consider each of the values. Do people agree with it, or disagree with it. Can the group reach consensus on a specific value statement that roughly corresponds to each of the categories in the list above? Are there additional value statements your group would add?

Second, look at the implementation examples. Can your group make the examples more applicable to your community's situation? Then, take a few minutes and allow each member of the group to individually score their opinion of the community's current level of practice. Compare your results. Where there is divergence, have each proponent discuss the evidence that she or he feels supports their evaluation.

Using at tool like this one, even while we wait for Dr. Whitbeck and his colleagues to complete their effort at national validation, gives us a far more structured way to put our values into action and form a more objective picture of our communities' strengths and needs.