Systems of Care and the Integrative Clinician: A Look Into the Future of Psychotherapy

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The widespread implementation of systems of care represents an important opportunity to integrate behavioral, cognitive, milieu, client-centered, group, solution-focused, systems, multicultural, and ecological approaches to child and family therapy. This integrated approach is described and illustrated, and systems of care principles are considered to be a useful foundation for effective therapeutic practices for difficult problems of children, families, and adults.

Most recent attempts to integrate different therapeutic perspectives have focused on systems of psychotherapy for adults (e.g., Norcross & Goldfried, 1992). However, child therapy methods are typically more integrative, including work with other family members and commonly involving a combination of systemic, behavioral, and dynamic approaches simultaneously. A child therapist will often examine the role a child plays in a family system, provide parenting education based in behavioral methods, and work through play on dynamic aspects of the child's difficulties (Fauber & Kendall, 1992; Feldman & Powell, 1992; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Wachtel, 1992). Fauber and Kendall (1992) argued for the necessity of integrating child psychotherapy with family systems approaches, overcoming a tendency by therapists to locate problems in either the child or the family system more or less exclusively. Wachtel (1992) advocated an integration of behavioral, psychodynamic, and systems theory in child psychotherapy. But in these approaches to integration, the psychotherapist remains the primary change

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agent. In contrast, we will describe an approach used with children and adolescents that introduces a much broader perspective on agents of change.

In this article, we describe the system of care (SOC; Stroul & Friedman, 1986) approach to helping emotionally troubled children and their families. It is based on specific principles and practices that produce an integrated treatment approach that extends beyond most previous attempts to develop broader systems of influence. We will briefly review the history of the SOC approach, the principles on which it is based, its connection with traditional schools of psychotherapy, and its utilization of change agents in ways that go beyond what is seen in traditional practice. We will illustrate that just as SOC principles expand the practice for child psychotherapy, they provide a framework of general principles of good practice that are applicable to a wide range of ages and disabling conditions.

One reason to continue to develop truly integrative psychotherapy approaches is the changing demographics in psychotherapy practice in the United States. Clinicians are seeing an increasing number of people from southeast Asia, the Middle East, Central and South America, and Eastern Europe, often with traumatic histories (Grizenko & Azima, 2002; Huang & Gibbs, 2003; Wohl & Aponte, 2000). These immigrants, as well as many people of other minority populations in the United States, are often underserved, underinsured, and more likely to receive inpatient care that is very expensive and has not been found to be highly effective (American Psychological Association Office of Ethnic Minority Affairs, 1993; Kiesler, 2000; Valdez, 2000). New responses are needed to meet the needs of people from different cultural and ethnic groups and address the documented disparities in services and outcomes (U.S. Department of Health & Human Services [DHHS], 1999). The creation of SOCs is one mechanism for responding to these demographic changes, allowing for access to psychological treatment among persons who are unfamiliar or uncomfortable with it. It is an approach that respects and utilizes the contributions of various professionals, community members, and clients and their families to behavior change. Furthermore, it can also be a force in community efforts to develop informal supports to help address the psychological needs of its members.

A BRIEF HISTORY OF SOCs

In 1984, the National Institute of Mental Health initiated the Child and Adolescent Service System Program (CASSP) to support the development

of SOCs to improve the delivery of services for children with severe emotional disturbances and their families. A SOC has been defined by Stroul and Friedman (1986) as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families" (Stroul & Friedman, 1986, p. xxii). The CASSP initiative provided funding to states to change fragmented services from multiple agencies into more coherent SOCs. More recently, starting in 1992, the Center for Mental Health Services, through its Comprehensive Community Mental Health Services for Children and Their Families Program, has provided funding for 92 communities in 47 states to develop SOCs. Family advocacy groups throughout the country have also adopted the key values and principles of SOCs, and have worked to ensure that these principles are part of state and local mental health systems.

Beginning in 1994, the Center for Mental Health Services (CMHS) has supported an evaluation of the outcomes of the Comprehensive Community Mental Health Services for Children and Their Families Program (Center for Mental Health Services [CMHS], 1997, 1998; U. S. Department of Health & Human Services, 2003; Holden et al., 2003). Based on a sample of over 9000 participants, the national evaluation of this initiative has found that children enrolled in SOCs, most of whom have multiple risk factors and involvement with many different agencies, improve in their overall functioning, school performance and attendance, decrease their levels of symptomatology and contact with law enforcement officials, and experience an increase in the stability of their living arrangements (U.S. Department of Health & Human Services, 2003). When children in SOCs were compared with similar children in a matched community who were provided with "standard" services, the SOC children had fewer juvenile justice charges, less need for special education, fewer suspensions, and better prosocial peer affiliation over a 24-month period (Holden et al., 2003). Other investigations of SOCs have raised serious questions about the fidelity of the implementation of the SOC model and the degree to which treatments provided within them are effective (Bickman, Heflinger, Lambert, & Summerfelt, 1996; Bickman, Noser, & Summerfelt, 1999; Bickman, Summerfelt, Firth, & Douglas, 1997). While SOCs are becoming more widespread throughout the country, with a growing level of empirical support, additional research is needed to determine the specific mechanisms of SOCs that have the greatest impact (Cook & Kilmer, 2004).

Children and families targeted in the federal CMHS-funded efforts have a variety of risk factors and significant problems that can present great challenges to clinicians and can be difficult to successfully address in treatment. The targeted children in these programs have *DSM–IV* diag-

noses, significant functional impairment and clear risk of out-of-home placement. Over half have a history of substance use and more than 25% have histories of psychiatric hospitalization, abuse, and/or running away from home. In addition, almost 70% of the families live in poverty, and over half of the children have a secondary diagnosis. Overall, two thirds of the families have a history of parental substance abuse, and approximately half have histories of mental illness, domestic violence, and felony convictions. Twenty-one percent of the families reported two of these family risk factors and an additional 40% indicated three or more risk factors (U.S. Department of Health & Human Services, 2003). Clearly these children and families tend to have multiple needs that can benefit from integrative approaches to treatment.

SOC Principles

Stroul and Friedman (1986) have articulated three "core values" of the SOC approach: (1) child and family needs dictate and drive services; (2) management, service, and decision-making rest at the community level; and (3) services must reflect and be consistent with the cultural experiences of clients. In addition to these three core values, another 10 principles have been specified, as summarized in Table 1. Neither these principles and values nor the CMHS initiative specify a particular detailed method of service delivery. Rather, local communities are expected to develop services that meet the specific needs of that community. However, the "wraparound" approach advocated by VanDenBerg and others (VanDenBerg, 1993; VanDenBerg & Grealish, 1996; Burchard & Clarke, 1990; Burns & Goldman, 1999) has become the model of service delivery most commonly advocated by proponents of SOC. The wraparound approach emphasizes

Table 1. Guiding Principles of SOC Based on Stroul and Freidman (1986)

1. Provide access to comprehensive services to address physical, emotional, social, and educational needs.
2. Develop an individualized service plan in accordance with child's unique needs and potentials.
3. Provide services in least restrictive, most normative environment.
4. Design service planning and delivery process so that families and surrogate families are full participants.
5. Link programs that plan, develop, coordinate, and provide services.
6. Provide case management to ensure coordination of services in accordance with changing needs.
7. Provide early identification and intervention.
8. Provide smooth transition to adult services at maturity.
9. Protect child's rights.
10. Be responsive to cultural differences and special needs.

the strengths of the child and family, using a "child and family team" to develop a service plan that builds upon those strengths. The clinician can be a key player in a team that includes not only appropriate professionals such as therapists, juvenile justice and social service workers, school counselors, and medical personnel, but also important natural support persons in the child's life such as clergy, neighbors, coaches, teachers, and extended family members. The family is an integral part of the team that plans and evaluates services, selects the majority of the members of the team, and utilizes professional service providers in supportive roles. In this model, the clinician and the team are challenged to listen carefully to the variety of perspectives and pieces of information provided, to help define commonly supported goals for change, and to encourage a process that is truly collaborative and focused on the strengths of the child and family.

The Child and Family Team

In a child and family team meeting, a specific agenda is prescribed (VanDenBerg & Grealish, 1996). First, the strengths of the child are described and written for all to see. Second, priorities for change are determined in one or two life domains (e.g., health, school conduct, relationships with siblings), with the team setting goals for each that build upon the child's and family's strengths. Next, needs are assessed for each goal, and the group identifies ways that the collective resources of the team can work to meet those needs. A backup crisis or safety plan is then created, in case the primary plan does not have the desired effect. Finally, those who are responsible for implementing various aspects of the overall plan are clearly identified, the specifics of their tasks are articulated, and a time frame for accomplishing the tasks and reviewing progress is delineated.

Child and family teams, as specified in SOCs (VanDenBerg & Grealish, 1996), have some surface similarity to a number of other multi and interdisciplinary teams designed to meet the needs of children and families. In particular, since 1975, with passage of the Education for All Handicapped Children Act (PL 94–142), Individualized Educational Programs (IEPs) have been mandated for all children with disabilities. More recently, the Individuals with Disabilities Education Acts (IDEA) of 1990 and 1997 have revised the requirements for engaging parents and school personnel in the development of IEPs. In some states, interdisciplinary teams (sometimes called Child Study Teams [CSTs] or Student Study Teams), including psychologists, social workers and speech/language specialists, work with the family, teacher and school administrator to develop the IEP. Departments of social services may also create multidisciplinary

teams to address the needs of children who are abused or neglected. While there is some similarity between these different multidisciplinary teams and CFTs, these other teams tend to be much more circumscribed in their intended purposes (e.g., focusing on the educational needs or the protection of the child), with more restricted team membership (often involving parents with a range of professionals, but not as likely to involve informal supports such as neighbors or friends), and a more limited role for the parent (often parents are less in control of the process than is espoused for CFTs).

SOC IN PRACTICE

A typical family served by SOCs is now described, along with a description of the principles underlying a SOC approach and the ways that those principles can be utilized by clinicians serving a family. We are not describing this as a "case," as is commonplace in therapy parlance, because in SOCs, children, and families are not to be viewed as cases, but as equal and respected partners in the process of effecting change. Certainly most therapeutic approaches value family contributions, but the emphasis on families as full partners in the process of developing and implementing a plan to address the child's and family's needs is clearly different from most therapeutic approaches.

An Example: Mary J.

Mary J. is a 12-year-old girl who lives with her mother and two younger siblings. Ever since Mary witnessed her older sister's murder, she has been sullen and prone to a quick temper. She has done poorly in school and has been increasingly disruptive in the classroom. She has been in several fights and seems to have few real friends. She claims that other children in her class tease her about the way she dresses. After her grandfather, with whom she was very close, died, her behavior deteriorated even more, alternating between being quiet, passive, and almost noncommunicative, to fits of rage in which windows have been broken and furniture demolished.

Mary's mother, Ann J., works in a textile mill. Mary's father is not involved with the family. Ann has had occasional boyfriends since her divorce 4 years ago, but no stable relationships. She has two sisters in town, both of whom are married and have children. She also has an elderly aunt who is raising a grandson. Both of Ann's parents are deceased. Mary's clinician suspects that Ann has a problem with alcohol abuse, but Ann

denies this. The most recent boyfriend (whom Ann occasionally sees) abuses alcohol and other drugs.

SOC With Mary J.

A child and family team meeting was called in response to a recent crisis. In one of Mary's outbursts of rage, a fellow student was hurt by a book that Mary threw. Mary's school wants her removed from the classroom and placed in a therapeutic residence in a town 25 miles away. Mary's mother Ann appeared acquiescent, stating that she was "at the end of her rope" and did not know how to deal with Mary's problems. The clinician suggested to Ann that a team meeting might be helpful, and Ann agreed. She was asked to indicate the people she thought would have constructive input about how to best deal with this situation. She invited her aunt, her sisters, her minister, and a neighbor who is the mother of one of Mary's friends. In addition, a social worker from the Department of Social Services, the school counselor, the assistant principal, and Mary's home room teacher are also present at the meeting. Mary is not present at this meeting. Consistent with the key value that the process should be family driven, Ann was not only asked to identify a group of people to be at the meeting, but was asked if there were a place to hold the meeting where she and the other participants would be comfortable and able to attend. The team meeting was held in a room at the church the family attends, which is close to her home and not far from where Ann's aunt and sisters live. Also, Ann is quite religious and close to her minister and members of the congregation. Consistent with the SOC value of cultural competence, the minister was invited to open the meeting with a prayer.

The SOC clinician encouraged the engagement of the family and community supports as crucial elements in the development and implementation of an intervention plan for the family. Following the prescribed order for the team meeting, the clinician invited each person present to introduce him or herself and describe their role in Mary's life. The tone for the meeting was set as the clinician asked participants to describe Mary's strengths and preferences. Based on this, a description of Mary emerged: she had a close relationship with her grandfather, likes music and feels confident in her singing, is respectful with her music teacher, is very protective of her family— her mother and younger brothers, visits her sister's grave often, likes to write poetry about her sister, is interested in the criminal justice system and what will happen to her sister's murderer, is gentle with animals, and is sensitive to what others think and say about her. Some of these statements represent "reframings" of Mary's behavior as

strengths. For example, the last item was derived from reports of the circumstances surrounding Mary's conflicts with peers.

The SOC clinician encouraged the people attending the meeting to develop a goal that was important and attainable for Mary, and one that could be clearly observed and measured, so that later, it would be clear to all how much progress had been made. There was broad agreement in the child and family team meeting that school success was an important life domain for Mary. It was further agreed that managing her anger was a goal that Mary could address to help her be more successful in school. The assistant principal and Mary's teacher stated that they thought it would be in everyone's best interests if Mary attended a residential program, where she could learn how to control herself, and then returned to school. However, Mary's aunts strongly opposed taking her out of school and the home. They promised to provide more support to Mary and her mother. One aunt offered for Mary to come live with her temporarily, speaking out forcefully against the idea of a therapeutic home.

The conflict among the participants presented a challenge for the SOC clinician, who favored a least restrictive, normative environment for Mary. While acknowledging the concerns of the school personnel, the clinician capitalized on the fact that the majority of the team seemed to agree that placement outside the home was not the preferred approach. Consequently, the focus shifted to finding ways that Mary could bring her behavior under control while at school. At this point, the clinician found it necessary to structure the rather free-wheeling discussion, so that the team members could focus on Mary's needs and her goals, and then discuss the strategies for meeting the goals, and the assignment of team members to tasks. Because anger management seemed to be a key issue, the clinician proffered anger management skill training (assuming a more traditional clinical role) to help Mary meet a goal of better behavior at school. However, concern was expressed that events at school might trigger additional outbursts. The team struggled to find a way for someone to talk with Mary each morning at the start of school to help her plan for potential difficulties and acceptable ways to deal with them, and to coordinate this with the clinician. But it was unclear who could be available to perform such a task.

The assistant principal and the teacher still felt that Mary was a danger to other students, and that parents of the children in her class would not tolerate her remaining there. They were especially concerned about the parents of the injured student, since that family had threatened a lawsuit if their child were not properly protected. The assistant principal agreed that he would be more comfortable with the emerging plan if the parents of the injured student were willing to give this a try, and that there was a plan for Mary to be taken out of class if she became unruly. Here, the SOC clinician

acted as an arbitrator of sorts, attempting to demonstrate that there was common ground in the concerns expressed by the members of the team, despite the fact that school administration seemed to favor keeping Mary out of school, and the family wanted to keep her in. The common ground was that everyone would want Mary to be a successful and nondisruptive student. This allowed the discussion to become more solution-focused. It was pointed out by the teacher that Mary's fights with other students had occurred either on the school bus or at the front of school before the day started. Mary's aunt offered to drive her to school to help avoid conflicts on the bus, and it was suggested that she might be able to help Mary plan for potentially difficult encounters. The clinician offered to talk with the aunt and Mary about using the time in the car to the best advantage. However, a plan was still needed to manage the problems on school grounds.

The teacher noted Mary's interest in music and wondered if the music teacher could be included on the child and family team, and perhaps be the person Mary checked in with first thing in the morning at school in order to help face her day constructively. She might also get Mary started in a choral group to help her develop a positive peer group. But for this to happen, Mary would need transportation home from school, and her aunt had to work at this time during the day. It remained unclear whether the music teacher's involvement and the transportation problem could be worked out.

The SOC clinician sought a broader involvement of the community resource people included on the team, asking the minister for ideas. The minister said he would try to find a person or persons in the congregation who could help with transportation. He also pointed out that he thought that Mary still needed help with her grief about her sister's murder. He offered to contact a girl in her late teens who is a member of the congregation who had also had a sibling murdered several years ago, and see if this young woman would spend some time with Mary. The school counselor agreed to talk with the music teacher and with the parents of the injured student when the plan was finalized.

A timeframe was set for transportation and in-school support to be established, so that Mary could return to school. It was decided that the assistant principal, minister, clinician, and Mary's mother would act as an on-call crisis team until a clearer plan could be worked out at a subsequent meeting. This gave various players with somewhat differing concerns a stake in shepherding the process toward success. The time for the next meeting was planned for four days later, and discussion about whether Mary should attend led to a decision to put that off until Mary and the clinician discussed this possibility. There was general agreement that Mary's involvement would be a positive development, showing her investment in the process.

Application of SOC Principles

As can be seen in this example, the clinician who uses SOC principles in practice acts not simply as a traditional psychotherapist, but intervenes with other key people in the life of the client in more active ways. By pulling together a team meeting for Mary, the clinician focused on creating consensus and commitment among persons who have a crucial ongoing role in Mary's life. True to SOC practice, the clinician in this example must keep the focus on a possible positive outcome for the child, especially since school personnel often are under pressure to exclude children with problem behaviors. There is potential for major disagreement, and it is important to find some common ground. In this case, the clinician focused on an issue that addressed concerns of all present—Mary's disruptive and dangerous behavior—while at the same time concentrating on Mary's strengths and how they could be used to the best advantage for Mary. It should be noted that this emphasis on strengths, a key element of wraparound practice, does not deny or negate the problems that Mary is experiencing. On the contrary, consistent with the growing interest in a "positive psychology," a focus on helping patients build upon and develop a variety of strengths is viewed as a viable means of preventing subsequent problems (Seligman, 1998; Seligman & Csikszentmihalyi, 2000; Cowen & Kilmer, 2004; Yates & Masten, 2004). In addition, focusing on an issue that can involve all members of the team in the solution and that can have measurable results allows each member of the team to perform helpful tasks. These are also tasks that they publicly commit to, while making it clear that the child's behavior regularly will be examined to see if change occurs. Each team member has a stake in the success of the intervention.

Engaging family members as active participants can be challenging. In this situation, the support offered to the family was gratifying, but the clinician noticed that Mary's mother generally played a passive role during the meeting. Therefore, the clinician frequently encouraged the mother to express her views about any suggestions that were made, to ensure that the meeting remained family driven. The clinician attempted to relinquish as much of the responsibility of the meeting as possible and place the mother in a central role. Since Mary's mother continued to have difficulty expressing herself assertively, the clinician encouraged her to talk with a family advocate who could accompany her to future meetings if she liked. In Mary's community, the local Mental Health Association provides such advocates. The clinician also decided that addressing Ann's boyfriend or possible drinking problem might be counterproductive in a first team meeting since a major goal of this first meeting was to engage Ann and empower her as much as possible. These issues could be addressed at a

later time, when Ann became ready. The SOC approach allows the team members, including the clinician, to develop strong relationships with the family, increasing the likelihood that the family will be open to different suggestions and changes in the future, when the family is ready.

In child and family team meetings, the clinician can play an important role in helping team members interpret the child's behaviors in a way that can change the focus from retribution and protection to understanding and problem-solving. For example, the clinician asked for a detailed accounting of the circumstances leading up to Mary's outbursts. Based on this, it was observed that Mary never seemed to want to hurt anyone, and her anger served the purpose of keeping people from hurting her with teasing ("to shut them up") or in the case of the object thrown in the classroom, out of shear frustration, not aimed at anyone. This "reframing" enabled the team members to view the behavior as self-protective rather than malicious.

Overall, the clinician can play an important role by keeping the process positive, keeping it focused, making sure it is family driven, and making sure that a useful result occurs within the period of time that the team meets. In doing so, the clinician is also introducing a way that community members can approach other problems, recognizing the strengths they possess, and how powerful they can become by pooling these strengths in a process that emphasizes mutual respect and accountability. When the clinician encourages professionals to act as part of a family driven team, they are also seen by members of the community as more trustworthy. These professionals may end up being more positive, powerful forces in the community by relinquishing their usual directive stance.

THE SOC CLINICIAN

While individual outpatient therapy is provided to most children (75%) in SOCs (DHHS, 2003), the clinician or therapist is much less often involved in child and family teams, and rarely assumes a key role in them. We believe, though, that greater involvement in SOCs can provide important opportunities for clinicians to use their skills to impact both the child and the family. The role suggested here for the clinician in an SOC may seem odd and uncomfortable to traditional child therapists at first, but there are many ways in which this role provides significant opportunities for therapeutic gain, representing the best practices in child therapy and integrating well-known perspectives of traditional schools of therapy. This approach encourages clinicians to play a role that requires a combination of systemic, ecological, behavioral, solution-focused, humanistic, cognitive, and multicultural perspectives, among others, together with family and

group therapy skills. In the discussion that follows, we will clarify the qualities of good practice that characterize the integrative approach of the SOC clinician and mention how these qualities represent connections with these other familiar approaches to clinical work.

The Flexible, Creative, Holistic Clinician

In a day when many clinicians are enamored with prepared packages of therapy intervention strategies, the SOC clinician tailors interventions closely to the needs of the child and family. These needs may include traditional mental health concerns which can be amenable to more singular types of child or family therapy, but are also likely to require attention to more mundane issues of the client's life that clinicians often overlook. Such needs (e.g., safety, transportation, companionship, housing) often act as barriers to services, hope, and change. Since the child and family are at the center of all decision making, the defined needs and the corresponding goals are theirs rather than the professionals'. In this way SOC is clearly consistent with "client-centered" or humanistic therapy, in that goals, therapy design, and participation are based on the child and family's needs as defined by them. As change occurs, the family may be ready to move on to other goals, and the clinician will need to be ready to work with these. Therapy therefore becomes an incremental, iterative process, rather than a linear progression of diagnosis, followed by a treatment plan and prescribed interventions. The clinician must be holistic, to see how various concerns of the family affect the mental health of the child; flexible, to respond to changes in concerns; and creative, to help the cast of characters on the child and family team design the individualized program. The inclusion of various nonprofessional members on the team, along with professionals and the clinician, can dramatically change the therapeutic goals and processes.

The design of the interventions, with a focus on clear, measurable results that can be agreed upon and observed by all, benefits from familiarity with behavioral interventions that also approach the assessment of change in this way. The SOC approach is also consistent with contemporary behavioral methods in that it emphasizes functional contextualism and generalizability (Follette & Hayes, 2000).

The Self-Restrained Clinician

To be effective, the SOC clinician needs skills commonly found in psychodynamic group therapy or humanistic therapy, that often require

restraint and a willingness to assume an active, but relatively unassuming role. The SOC clinician resists the temptation to control and to appear knowledgeable and masterful to clients and/or other professionals. In another context, we have described this as "expert companionship" (Tedeschi & Calhoun, 2004, 2006). A key role of the SOC clinician is to promote the collaborative process among all members of the team, finding out what makes them comfortable and willing to participate, trusting the group process to ultimately produce the best direction for the family, and recognizing the value in members who can say things that the clinician cannot. Since this is often a new way of interacting for family members and other informal supports, the clinician may need to encourage the team members to assume an active role to make sure that their perspective takes a central place in the discussions and is not drowned out by the professionals. This implies that the clinician plays much less of an expert, central role, and may act more as convenor and facilitator, not the primary figure in the meeting. This is different from the prescriptive role that many clinicians prefer. Furthermore, it is important to recognize that the child or family may be much more comfortable with another professional, for example, a nurse or a teacher, and the clinician must be able to support this person as convenor/facilitator without being threatened. Even when not facilitating the team meeting, the clinician can play an important supportive role. To do all this well, the SOC clinician should have a good sense of group process and skills. For example, Yalom (1995) has described good group therapists as social engineers as they organize groups and models for group members in their facilitation of group process. Good SOC clinicians certainly play these roles as they help to organize child and family teams and the subsystems of these teams, and help to facilitate the work of these groups.

The Clinician Who Knows the Community and Its Culture

The SOC clinician recognizes that the child and family function within their community, according to the norms and traditions found there. In practice, the primary concern of the SOC clinician is with the therapy relationship, but this relationship is not only with the child, but also with and among the family and the community figures important to the family. In strengthening all of these relationships, the SOC provides benefits for the child, the family, the community, and the network of professionals who collaborate in new, more respectful ways with each other.

In addition to the "usual suspects" who might be involved in a team addressing the needs of a child and family, informal supports, such as

neighbors, scout leaders, extended family members, coaches, friends, and ministers, should also be included. VanDenBerg and Grealish (1996) have suggested that at least half of the members of the team should be informal supports, and a deliberate part of the process should be a shift away from professional services toward a preponderance of informal community supports (Burns & Goldman, 1999). This requires that the clinician engage the family in a discussion of who is important, to help them include those people who might be helpful but not readily considered as part of their "community." Especially when dealing with children, most clinicians recognize that, unless they have the child in a residential treatment facility or hospital setting, they have very little control over the behavior of that child. Thus it is important to include critical components of the child's community, the people who have more impact than the clinician ever can, into the problem-solving loop. If the significant members of that family's community are involved in the problem-solving, it is more likely that they will become part of the solution. The inclusion of these community members also emphasizes to the child and family that they are clearly part of a community that affects them and is affected by them. Family and community members of the team are on equal footing with the professionals and take lead roles in determining how, when, and where the meetings are conducted. As a result, a clinician may find him or herself meeting in a family's home, or praying with the family before the meeting begins, if this is part of the cultural background of the family. Therefore, the SOC clinician by necessity operates from a multicultural perspective (e.g., Huang & Gibbs, 2003) and incorporates the concepts and many of the kinds of interventions found in the ecological and systems approaches to therapy (e.g., Dadds, 2002), especially Multisystemic Therapy (Henggeler, Schoenwald, Rowland, & Cunningham, 2002).

In time, the astute SOC clinician can become more culturally competent as he or she becomes more involved in the community, learning its ways of speaking and doing. A part of this is learning what resources are available in and acceptable to members of the community. The clinician needs to know about services in the community that are available to assist the child and the other members of the family, including not only traditional service providers, but also programs that provide family advocacy, recreation, transportation, and educational and financial assistance. In Mary's situation, family advocacy was an important resource for the mother. However, it is important for the clinician to be aware that some services, while potentially helpful, may be more or less consistent with the cultural mores of the family. For example, if the family is from a cultural group that places a high value on privacy, adding in an additional "stranger" (the parent advocate) may be more stressful than helpful.

Much of what is involved in the implementation of an SOC has roots

in principles of milieu therapy, which has been a tradition in residential and intensive outpatient therapies for many years. In SOCs, we do not create a new milieu; instead, we utilize an existing one to help the client. The advantage of this existing milieu, of course, is that it lasts beyond "treatment." In the language of a behavior therapist, this maximizes generalization or transfer of training effects to the "real world." The clinician does not have to wonder whether the new behaviors learned in the therapeutic setting will transfer to the home environment because that environment is actively engaged in the child and family teams and the program of change is integrated directly into the family's environment. Behavior therapists realize how much more powerful these community change agents can be, given their frequent contact with the child.

The Clinician Who Sees Strength and Potential

Although all clinicians would probably claim that they see potential in the children and families with which they work, many are practicing within a system that demands a focus on pathology from the first meeting. The diagnosis of "mental disorder" is a primary concern, and the "treatment plan" is linked to this diagnosis. Of course, many children seen for mental health services, particularly those children who are also involved with school programs or the juvenile justice system, have also developed reputations for being difficult. Not only do clinicians often adopt this frame of mind, the community members, teachers, the family, and even the child may come to define the child as a collection of problems and pathology. With this common mindset, it may become difficult for any or all of these people to see that the child has any strengths. In SOCs, the clinician must help focus initial discussions and ongoing emphases on the recognition of strengths of children rather than their weaknesses. This same emphasis applies to the other family members, who may, in other contexts, be viewed primarily in terms of their substance abuse or limitations as a parent. The SOC clinician must be mindful of the strengths and capacities of the parents and utilize them as part of a plan of action. By building on the recognized strengths, the clinician helps gain their support and helps enlist them as part of the solutions rather than blame them as causes of the problems.

The recognition of potential and strength is a hallmark of both humanistic and solution-focused therapies, as well as a key principle of SOC. This is not to say that problems are ignored. Moreover, the role of the clinician may be to "reframe" what are commonly viewed as deficiencies in ways that families and others can view them as strengths. Rather than

characterize a child as manipulative, the clinician might help the team view the child as "tuned into what goes on in the family so well that he can usually figure out how to get what he would like." Such reframing is of course commonplace in cognitive approaches as well.

Obstacles for the Clinician Who Wants to Utilize a SOC Model

There are certainly difficulties that clinicians may face as they attempt to integrate SOC principles into practice. One of the main problems has to do with the time that must be devoted to forming teams that include community members, and how to justify the time spent in organizing or meeting with the team. In many circumstances, these activities would not be billable or reimbursable hours, and as a result, administrators might not be supportive of them. Increasingly, however, wraparound is viewed as a "best practice" in providing services to children and families, and clinicians are expected to participate. Training in how to work effectively with families and community groups can facilitate the process of forming teams and working with diverse community members. Also, since there is a growing body of evidence that this approach can be quite effective, especially with families with multiple problems (who can be quite expensive to treat), a case can be made that the additional time is worth the effort. In addition, as SOCs become more common as a standard treatment approach for children, clinicians may find greater opportunities to engage in integrative practices. Although some states have adopted the SOC approach as the expected practice, funding for time spent in activities not traditionally viewed as billable treatment still lags behind the changes in policy.

An additional concern expressed by clinicians new to a SOC model is the potential for breaches in confidentiality when including a wide array of people in a team, including nonprofessionals and informal support persons. This is dealt with in a number of ways, most typically through the use of confidentiality statement signed by those not part of treatment/service agencies, and common consent forms across multiple agencies. Meeting summaries are sometimes covered by the common consent. If families truly have a major say in determining who are members of the child and family teams, confidentiality issues are generally not a concern for families. At the same time, clinicians who see family members in therapy and also participate in child and family teams would want to be sure that the individual in therapy had given consent prior to the therapist discussing any aspects of the treatment sessions.

Furthermore, the clinician may have trouble trusting that families can operate in positions of power and responsibility in their treatment, and it

will be tempting to remain somewhat paternalistic toward families "for their own good," especially if family members exhibit substance abuse or more extreme psychopathology. Clinicians may worry that, if they "sign off" on a treatment plan that is not of their liking, then they may be viewed as liable for its failure, if that should occur. When families do seem to make unfortunate decisions, it is tempting to return to the old models that place the clinician in a position of greater apparent control, rather than using the experience to help families become more empowered to assume responsibility for their own decision making. In reality, much of the apparent control that clinicians believe they have is illusory, since parents are generally much more in control than clinicians are. While a plan that is created by the clinician may appear to be better than a plan created and owned by the family, family ownership and buy-in may be a critical determinant of a family following through with the plan. Vander Stoep, Williams, Jones, Green, and Trupin (1999) have termed this "family empowerment" that is enhanced when family advocates are included on child and family teams. When this is done, children are better connected with their communities and function better in various domains of their lives (Vander Stoep, Green, Jones & Huffine, 2001).

Despite the challenges of developing clinical practice that incorporates SOC principles, clinicians, especially those who work with children, should keep in mind the conclusion of Fonagy, Target, Cottrell, Phillips, and Kurtz (2002) in a thorough review of treatments for children and adolescents. They found that "outcome studies increasingly demonstrate that the most effective places for treatment delivery may not be either inpatient or outpatient settings. [Places in the community] may be ideal contexts for intervention because of the unequivocal presence of the systemic pathogens in these environments. By the same token, the administrator of the intervention need not be the therapist. Administrators may be peers . . .teachers. . .parents. . .or foster parents" (p. 398).

SOC AS AN INTEGRATIVE INTERVENTION

While the language and implementation of a SOC may appear to be different, it has much in common with other therapeutic modalities. As has been shown, a SOC philosophy incorporates elements from therapeutic modalities that are familiar to many clinicians. Emphases on strengths, involvement of the family and other significant others, cultural competence, and community-based services are viewed by many as elements of good practice regardless of the type of problem or disability. Yet, it is the integration of these elements into a package that makes the notion of a

SOC different from standard practice. Evidence indicates that these principles and practices, when utilized together, have positive impacts on children, and families find them quite satisfying (CMHS, 1997; DHHS, 2003). In addition, there is a growing federal effort (and many states are adopting these principles as well) to promote these as "best practices" in the delivery of mental health services for children and families (Burns & Goldman, 1999). Consequently, it is important that clinicians not only become familiar with the concepts, but also identify ways that they can incorporate elements that are familiar to them into the broader framework.

Clinicians can study SOCs and glean valuable insights that can be incorporated into other therapeutic situations as well. How might marital or individual therapy benefit from attention to strengths, the cultural milieu with informal supports, a client-driven perspective, and clearly defined therapeutic tasks and responsibilities? For adults who have severe and persistent problems, a SOC approach suggests a new perspective that might produce greater success. We suggest that attention to SOC principles that integrate several well-established therapies into an innovative clinical perspective can also move the entire field of psychotherapy practice in new, more effective directions. Finally, the SOC represents a humane, respectful direction of practice that is in tune with changing demographics and needs.

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