2nd EDITION

Building Systems of Care

A Primer

BY

Sheila A. Pires

Human Service Collaborative

Washington, DC

FOR

National Technical Assistance Center for Children's Mental Health

GEORGETOWN UNIVERSITY CENTER FOR CHILD AND HUMAN DEVELOPMENT

SUPPORTED BY

Child, Adolescent and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
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Acknowledgments to the First Edition

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Acknowledgments to the Second Edition

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Introduction

"The world that we have made as a result of the level of thinking we have done thus far creates problems that we cannot solve at the same level at which we created them."

– ALBERT EINSTEIN –

A Word About the Second Edition

In the eight years since the first edition of *Building Systems of Care: A Primer*, there has been considerable growth in the system of care movement, with more states, tribes, territories, and communities understanding system of care concepts and embarking on or expanding system of care development. This is partly due to federal leadership and grant making. Communities in every state have had federal system of care grants through the federal Center for Mental Health Services or the Children's Bureau. Growth also is due to a concomitant strengthening of the family movement and the burgeoning growth of the youth movement, with strong family-run and, increasingly, youth-run organizations supporting system of care development. System of care development also has benefited from expansion of evidence-based and effective practices that reinforce family-driven, youth-guided, and home and community-based system of care concepts. Growth also is the result of the natural progression of system change efforts. It has been said that it takes an average of 17 years for an effective practice in the health care field to "take hold." It has been a little over 20 years since the system of care movement began. At this moment in time, we are seeing system of care values, principles, and concepts taking hold across child-serving systems at federal, state, and local levels in ways that were not seen in earlier years. Increasingly, the system of care framework is being applied to many different populations of children, youth, and families, from birth to 3-year-olds to transition-age youth and even to adult populations. New technologies have emerged for implementing system of care concepts, some of which draw on related fields such as managed care and public health. All this is by way of saying that an update to the original *Primer* is in order—to capture the sense of growth, new technologies, and expanded applications of the system of care concept.

Strategic Framework

Building systems of care is inherently a strategic process. *Webster's Dictionary* defines strategic planning as *"the science and art of mobilizing all forces—political, economic, financial, psychological—to obtain goals and objectives."* This terminology comes out of warfare! It assumes that there is clarity about goals and objectives. Creating that clarity and mobilizing "all forces" are key roles that system builders play. This document provides a strategic framework to support system builders in these roles by:

- Reviewing the history, values, principles, and operational characteristics of systems of care to create a context for system building;
- Exploring many of the functions that require structure in systems of care;
- Discussing examples and the pros and cons of various structural arrangements to promote improved outcomes for children, youth, and families involved, or at risk for involvement, in multiple systems; and
- Describing and providing examples of effective system-building processes.

System Builders

The *Primer* refers to those involved in developing, implementing, and sustaining systems of care as "system builders." The term "system builders" is meant to encompass all key stakeholders at national, state, tribal, and local levels—families, youth, providers, line staff, supervisors, administrators, judges, policy makers, evaluators, and broader community partners—recognizing that effective system building entails collaboration, consensus building, and partnership across these stakeholder groups and across national, state, tribal, regional, county, city, and neighborhood levels.

Purpose and Organization of the *Primer*

The *Primer* offers a roadmap for those involved in building systems of care for populations of children, youth, and families who are involved, or at risk for involvement, in multiple systems. In recognition of the many possible routes to take in a journey, the *Primer* is not meant to be prescriptive but rather to offer a framework for system builders at state, tribal, and local levels. The *Primer* uses examples from actual systems of care to illuminate the framework, drawing on the author's experience and the experience of many other national, state, tribal, and local system builders over more than two decades with the system of care movement. The *Primer* is intended to be useful—as a roadmap, a reference, and a workbook—to family members, youth, local communities, cities, counties, tribes, states, and others who may wish to use it, in whole or in part, depending on their own needs and circumstances.

The *Primer* is organized into four main sections. It begins with the *Introduction*, which discusses the history of the system of care movement, the system of care concept and philosophy, and current trends in system reform. This section also describes the values and principles that guide system building. This initial section is an important context-setting piece for those new to systems of care and for those wanting to understand the development of the system of care concept over time. Section I, *Family Partnership, Youth Partnership, and Cultural and Linguistic Competence: Non-Negotiable Elements of Effective System-Building Processes and Structures*, describes as essential the integration of family and youth partnerships and cultural and linguistic competence in all system of care structures and processes. These elements are integrated throughout the *Primer* as intrinsic to effective system of care structures and processes, rather than as stand-alone elements. However, Section I provides an important introductory discussion of why these elements—family and youth partnerships and cultural and linguistic competence—are non-negotiable characteristics of systems of care. Section II, *Structuring Systems of Care*, describes the role that structure plays in systems of care and the functions that require structure. It explores the pros and cons of different structural arrangements for key functions in systems of care. Section III, *The System-Building Process*, examines critical process considerations in system-building efforts.

The sections on *Structure* and *Process* provide a brief, explanatory overview of each structural element and process consideration. This narrative overview typically is followed by an example or examples borrowed from actual systems of care (although they may not be identified by name). Suggested resource materials or Websites are incorporated into each section. The *Primer* is organized in a workbook-like format, with key questions posed to promote thinking about the reader's specific system-building effort and space to make notes. The author hopes that this format also will encourage additions and modifications to the *Primer* over time as knowledge about systems of care continues to grow.

A Bit of History About the System of Care Movement

Over the past 20 years, there have been concerted national efforts to help states, tribes, and localities build **systems of care** for children and adolescents and families who require services and supports from multiple providers and systems. Those involved in building systems of care today are not operating in a vacuum. There is a considerable and rich history to systems of care. Twenty years ago, the concept of systems of care was applied initially to children and youth with serious emotional disorders and their families. It has evolved over time as a concept that can be applied to any designated population of children, youth, and families who require an array of services and supports from multiple entities.

A review of the history of systems of care provides current system builders with an important context for their efforts. A brief retrospective of the system of care movement highlights the following national efforts:

- In 1983, with a mandate and funding from Congress, the National Institute of Mental Health initiated the *Child and Adolescent Service System Program (CASSP)*, which provided funds and technical assistance to all 50 states, several U.S. territories, and a number of local jurisdictions to plan and begin to develop systems of care for children with *serious* emotional disturbance. CASSP recognized that children with serious disorders often are involved in multiple public systems, such as education, child welfare, juvenile justice, and mental health, and that planning more effective services for these children requires **interagency collaboration**.

- In the mid-1980s, a burgeoning family movement began to gather strength, and a national, **organized, family voice emerged**, with creation of the Federation of Families for Children's Mental Health in 1989 and the growth of the National Alliance for the Mentally Ill Child and Adolescent Network (NAMI CAN). The family movement has been strengthened over time with the growth of state, tribal, and local family-run organizations and federal support through the Statewide Family Network Grant program.

- In 1986, Congress passed the *State Comprehensive Mental Health Services Plan Act*, which required all states to develop and implement plans to create community-based service systems for persons with serious mental illness, including adults and children, and mandated participation of family members and consumers in the development of state plans. This legislation reinforced the premise that most states would need to **redirect funds from hospital and institutional care to build community-based systems of care.**

- In 1989, the Robert Wood Johnson Foundation launched the *Mental Health Services Program for Youth*, which funded 12 states and cities, and in 1992 provided replication monies to fund 15 more states and localities. Among other contributions, this initiative introduced the use of **managed care technologies and one accountable Care Management Entity** to the development of systems of care.

- In 1992, Congress passed legislation creating the *Comprehensive Community Mental Health Services for Children and Their Families Program*, which has funded over 140 communities in all states, as well as tribal communities and several territories, to build systems of care. It is the current major national source of funding for state and local system of care development. At the core of this program is the goal of developing a comprehensive array of community-based services and supports guided by a system of care philosophy with an emphasis on **individualized, strengths-based services planning, intensive care management, partnerships with families and with youth, and cultural and linguistic competence**.

- In 1993, the Anne E. Casey Foundation began the *Mental Health Initiative for Urban Children*, which focused system-building efforts at the **neighborhood level** in inner cities, advancing the use of **family resource centers as hubs for services and supports**, use of **natural helpers** as partners in service delivery, and inclusion of **parents and neighborhood residents as equal partners in the governance** of systems of care. Another contribution of the Casey program was to reframe the focus of system building from one of treating serious disorders only to that of **promoting emotional well-being in all children** and their families, including those children with serious disorders.

- In the mid-1990s, **youth development principles** and approaches advocated at a national level from youth service arenas, such as youth employment, began to gather strength within systems of care, emphasizing the importance of youth leadership and involvement. With federal support, *YouthMove* was launched, which today includes a growing number of state and local chapters and members from around the country who have mobilized to build and grow a **youth movement** and ensure that the voice of youth guides the development and implementation of systems of care.

- In 1999, the Supreme Court issued the *Olmstead* decision, which affirmed the right of individuals with disabilities, including children with serious behavioral health disorders, to live in the community rather than in institutions. The decision provided further impetus to system of care efforts to promote the most **appropriate, least restrictive, home and community-based services.**

- In 2003, the *President's New Freedom Commission on Mental Health* issued its report on transforming mental health care in America, which reinforced such system of care principles as family and youth partnerships, cultural and linguistic competence, individualized services, and early intervention. The report also introduced the application of a **public health approach** to children's systems of care.
- In 2003, the federal Children's Bureau funded nine states and local communities to build systems of care for children, youth, and families involved in the child welfare system. In 2008, the Children's Bureau funded regional technical assistance centers to work intensively with states to **reform child welfare systems through application of system of care concepts**.
- In 2006, the federal Center for Mental Health Services launched the *Building Bridges Initiative* to **engage residential treatment providers as partners** in promoting system of care principles and concepts.

Complementing these national efforts are numerous initiatives sponsored by states, tribes, counties, cities, communities, and family organizations to build systems of care for children and adolescents and their families.

It is useful to review this history because the system of care movement is not static. Over time, system of care efforts have broadened to encompass not only children with serious emotional disorders, as originally envisioned by CASSP, but also other populations of children, youth, and families involved, or at risk for involvement, in multiple systems. The system of care concept has been increasingly embraced, not only by the children's mental health field, which initiated the movement, but by other systems, such as child welfare and adolescent substance abuse treatment, with national support from federal agencies and foundations.

Avoiding "Categorical Systems of Care"

The commonality of a system of care focus across major federal programs is encouraging, but there is a danger now in states and localities building "categorical systems of care," depending on which federal or foundation initiative may be leading the way. One of the major opportunities that a system of care approach provides is to bring together related reform efforts and reduce a "siloed" approach to serving children, youth, and families. Those who have multiple system of care grants, for example, or related reform agendas underway, need to conceptualize these as part of the same cloth when they are focused on common populations of children, youth, and families.

System of Care Definitions

The system of care values and principles initially articulated by Stroul and Friedman for the federal CASSP program were developed with the population of children with serious disorders in mind. Increasingly, these values are being applied in all system of care building, that is, regardless of whether the focus is on only children with serious disorders, on those who also are at risk for serious disorders, or on a total eligible population (e.g., all Medicaid-eligible children, within which there will be children with serious disorders and those at risk). Indeed, one of the challenges in large-scale reforms focused on total eligible populations of children—for example, large-scale Medicaid managed care reforms—is incorporating and operationalizing system of care values and principles that were developed initially for populations of children with serious disorders but which are equally applicable to systems of care for all children. There are growing examples of states' embedding system of care values and principles into large-scale systems focusing on total populations, such as **Arizona's** and **New Jersey's** behavioral health managed care systems. These systems encompass all children in need of behavioral health services, not only those with serious disorders. **North Carolina's** child welfare system also incorporates system of care values and applies them to all children and families involved, or at risk for involvement, in child welfare, not just to those with the most serious challenges.

The definition of a system of care for children with serious emotional disorders was first published in 1986:

> *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 their families.*
>
> Stroul, B., and Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev. ed.). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. (Reprinted by permission)

The *Primer* modifies this definition in recognition that the system of care concept has evolved to be applicable to any population of children, youth, and their families who are involved, or at high risk for involvement, with multiple services and systems. (One might also argue that the system of care approach is equally applicable to adult populations with multi-system involvement, such as frail elders or adults with co-occurring mental illness, substance abuse, and physical health problems.)

The *Primer* defines a system of care as:

> ***"a broad flexible array of effective services and supports for a defined multi-system involved population, which is organized into a coordinated network, integrates care planning and care management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and with youth at service delivery, management and policy levels, has supportive management and policy infrastructure, and is data-driven."***

This definition incorporates the elements that are essential in a system of care. Specifically, the definition includes both formal services and informal supports. It maintains that services and supports must be effective (informed by evidence or experience) for the population or populations who are the focus of the system of care and that the system must identify a defined population or populations. Services and supports must be comprehensive and flexible and organized into a coordinated network. The definition also addresses the importance of service planning and care coordination that is integrated across programs and systems so that families and youth do not end up with multiple plans of care and care managers. It asserts that the system must be culturally and linguistically competent and that meaningful partnerships with families and with youth at all levels are essential. The definition specifies that management and policy infrastructure that supports the system of care is necessary, and that the system must use data to inform decision making, continuously improve quality, be accountable, and build support.

Organizing Framework Supported by Core Values

As Stroul has noted, the system of care concept provides an organizing framework, a philosophy, and a values base for systemic change, which can be applied to any population that requires services and supports across multiple providers or systems.

System of care core values originated over 20 years ago and include *child/youth centered and family focused; community based; and culturally and linguistically competent*. They developed, initially, out of a children's mental health movement at a time when many mental health systems were adult focused and hospital based. Hence, values of "child and youth centered and family focused" were in direct response to concerns that children were being treated as "little adults" and not within the context of their families. The value of "community based" was in direct response to the lack of home and community services for children and families and the bias at the time to hospitalize children and youth with serious disorders. The value of "cultural and linguistic competence" was in response to concerns over the disparity in access to services experienced by racially and ethnically diverse children and families and their disproportional representation in restrictive services. These core values have evolved in meaning over time as multiple systems serving children, youth, and families have embraced a system of care approach.

Box A presents the values and principles for the system of care as initially articulated by Stroul and Friedman.

A Original Values and Principles for the System of Care

Core Values

1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult services system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev. ed.). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. (Reprinted by permission)

One can see these values reflected in how the federal Substance Abuse and Mental Health Services Administration (SAMHSA) describes systems of care (see Box B).

B SAMHSA Description of System of Care

A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth, and families function better at home, in school, in the community, and throughout life.

Family and youth leaders have expanded the concept of family and youth partnerships to assert as basic principles that systems of care must be *family driven* and *youth guided* (see Box C).

C Family Driven and Youth Guided

Family-driven means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their communities, states, tribes, territories, and nation. This includes:

- Choosing supports, services, and providers
- Setting goals
- Designing and implementing programs
- Monitoring outcomes
- Partnering in funding decisions
- Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

Osher, T., Penn, M., & Spencer, S. Partnerships with families for family-driven systems of care. In B. Stroul and G. Blau (Eds.), 2008 *The system of care handbook*. Baltimore: Paul H. Brookes Publishing.

Youth-guided means young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives as well as the policies and procedures governing the care of all youth in the community, state, and nation.

YouthMove, 2006, Technical Assistance Partnership, American Institutes for Research, Washington, DC.

The *Primer* summarizes system of care values and principles applied to any defined population of children, youth, and families as:

- **Family driven and youth guided;**
- **Home and community based;**
- **Strengths based and individualized;**
- **Culturally and linguistically competent;**
- **Coordinated across systems and services;**
- **Connected to natural helping networks; and**
- **Data driven and outcome oriented.**

One finds complementary values and principles in the family support movement that emanated from child welfare (see Box D) and in the field of youth development and youth services (see Box E).

D Principles of Family Support Practice

1. Staff and families work together in relationships based on equality and respect.
2. Staff enhances families' capacity to support the growth and development of all family members—adults, youth, and children.
3. Families are resources to their own members, to other families, to programs, and to communities.
4. Programs affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society.
5. Programs are embedded in their communities and contribute to the community building.
6. Programs advocate with families for services and systems that are fair, responsive, and accountable to the families served.
7. Practitioners work with families to mobilize formal and informal resources to support family development.
8. Programs are flexible and continually responsive to emerging family and community issues.
9. Principles of family support are modeled in all program activities, including planning, governance, and administration.

Family Support America. (2001). *Principles of family support practice*. Chicago: Author.

E Youth Development Principles

1. **Adolescent Centered:** Adapts services to the adolescent rather than expecting the adolescent to adapt to the services.
2. **Community Based:** Provides local, integrated, and coordinated services.
3. **Comprehensive:** Recognizes the multiple needs of youth, and ensures comprehensive services and holistic care.
4. **Collaborative:** Draws on the resources of a community, or works in coordination with other programs to provide a range of services, in-house or through interagency agreements.
5. **Egalitarian:** Provides services in an environment and a manner that enhances the self-worth and dignity of adolescents; respects their wishes and individual goals.
6. **Empowering:** Maximizes opportunities for youth involvement and self-determination in the planning and delivery of services, and fosters a sense of personal efficacy that encourages youth to want to effect changes in their lives.
7. **Inclusive:** Serves all youth, or provides and tracks referrals for those youth whom the system is unable to serve.
8. **Visible, Accessible, and Engaging:** Provides services that attract youth.
9. **Flexible:** Incorporates flexibility in service provision and funding to support individualized services.
10. **Culturally Sensitive:** Works to provide culturally competent services.
11. **Family Focused:** Recognizes the pivotal role that families play in the lives of high-risk adolescents.
12. **Affirming:** Targets strengths, not deficits, of youth and their families.

Pires, S., & Silber, J. (1991). *On their own: Runaway and homeless youth and programs that serve them*. Washington, DC: Georgetown University Child Development Center.

System of care values also resonate closely with the principles that underpin the federal Child and Family Services Review (CFSR) process in child welfare, which mandates reforms in child welfare. CFSR principles include *family-centered practice; community-based services; strengthening the capacity of families; and individualizing services*. More information about the principles embedded in CFSR can be found at: www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm.

EXAMPLE A

Alabama is an example of one of the first states to undertake reform of its child welfare system utilizing system of care principles and values, adding to them and adapting them for the child welfare system, and anticipating by several years CFSR principles in the process. For more information, read: *Making Child Welfare Work: How the R.C. Lawsuit Forged New Partnerships To Protect Children and Sustain Families*, Judge David L. Bazelon Center for Mental Health Law, Washington, DC, May 1998. (**www.bazelon.org**)

EXAMPLE B

Nevada, Kansas, North Carolina, Oregon, and **North Dakota** are examples of state child welfare systems that more recently adopted system of care values and principles to guide their child welfare reform activities.

Shared system of care values are what guide a system-building process. Achieving consensus on values across diverse stakeholder groups is a first step in system building. We all come to this work with values that we have integrated into our lives from our cultures, families, work environments, neighborhoods, and the like. These values are tested over time and shaped as system building proceeds. System builders need to create an environment in which it is safe for stakeholders to express their values, and system builders need to provide leadership in developing sufficient common ground for system building to advance. The most successful and sustaining system-building efforts have been those that establish their values early, use them to guide their decisions, and revisit them often to ensure they still hold.

Operational Characteristics of Systems of Care

From a philosophy and values standpoint, there is far more synergy today among all the systems that serve children, youth, and families than there was 20 years ago when the system of care movement began. There are greater understanding and more examples of how to apply a system of care approach to different populations of children, youth, and families (and not just to children with serious emotional challenges as was the case 20 years ago when the movement began). There also is more shared understanding today across systems about the operational characteristics of systems of care.

Box F describes operational characteristics of a system of care as a customized approach to service delivery for children and youth with multiple system needs and their families.

F Operational Characteristics of Systems of Care

- Collaboration across agencies;
- Partnerships with families and youth, including with family- and youth-run organizations;
- Cultural and linguistic competence;
- Blended, braided, or coordinated funding;
- Shared governance (and liability) across systems and with families and youth;
- Shared outcomes across systems;
- Organized pathway to services and supports;
- Staff, supervisors, providers, and families trained and mentored in a common practice model based on system of care values;
- Child and family service-planning and service-monitoring teams across agencies;
- Single plan of services and supports;
- One accountable care manager;
- Cross-agency service coordination and care management;
- Individualized services and supports "wrapped" around children, youth, and families;
- Home and community-based alternatives;
- Broad, flexible array of services and supports;
- Integration of formal services and natural supports and linkage to community resources;
- Integration of evidence-based and promising practices; and
- Data-driven systems supported by cross-system management information systems and focused on continuous quality improvement.

The concept of systems of care developed and has taken root over time as an approach to address long-standing problems with traditional systems, many of which persist today (see Box G).

G Entrenched System Problems

- Lack of home and community-based services and supports both for children and youth and for families;
- Patterns of utilization—that is, the ways in which children and families use services and supports—in which relatively small percentages of children and families with the most serious and complex issues use a very large percentage of the service dollars because, for example, children are placed for too long or repeatedly in restrictive levels of care and because financing streams may create incentives to place children;
- High costs associated with these patterns of utilization;
- Racial and ethnic disparities in access to community services and disproportional representation in restrictive services;
- Administrative inefficiencies when multiple systems serving children and families create parallel delivery systems serving many of the same children and families;
- Knowledge, attitudes, and skills of key stakeholders (e.g., staff, supervisors, providers, clinicians, families, and youth) that do not embrace or know how to implement family-driven, youth-guided, culturally and linguistically competent, strengths-based, and individualized services and supports;
- A history of poor outcomes;
- Rigid financing structures; and
- Deficit models with limited types of interventions that do not lend themselves to a strengths-based, individualized approach.

A fundamental challenge to multiple system involvement in the lives of children, youth, and families is that no one system controls everything, and every system controls something. Systems of care represent a way to address this basic challenge of multiple system involvement in the lives of families and fractured accountability. Better outcomes are more likely to be achieved through the effective collaboration called for in systems of care.

Systems of Care as System Reform or Transformation Efforts

Systems of care fundamentally are about reforming or *transforming* systems. Box H highlights the shifts that systems of care are trying to achieve as *system reform* or *transformation efforts*.

H **Characteristics of Systems of Care as System Reform/Transformation Initiatives**

FROM	TO
Fragmented service delivery	Coordinated service delivery
Categorical programs/funding	Multidisciplinary teams and blended resources
Limited services	Comprehensive service array
Reactive, crisis-oriented approach	Focus on prevention/early intervention
Focus on "deep end," restrictive settings	Least restrictive settings
Children out-of-home	Children within families
Centralized authority	Community-based ownership
Creation of "dependency"	Creation of "self-help" and active participation
Child-or youth-only focus	Family as focus
Needs/deficits assessments	Strengths-based assessments
Families as "problems"	Families as "partners" and therapeutic allies
Youth as "problems"	Youth as partners
Cultural blindness	Cultural and linguistic competence
Highly professionalized	Coordination with informal and natural supports
Child and family must "fit" services	Individualized/wraparound approach
Input-focused accountability	Outcome/results-oriented accountability
Funding tied to programs	Funding tied to populations

Pires, S. (1996). *Characteristics of systems of care as systems reform initiatives*. Washington, DC: Human Service Collaborative.

System reform involves both system-level and frontline practice change. Box I illustrates shifts required at a practice level.

I Frontline Practice Shifts

Given power imbalance	→	Acknowledgment of power imbalance with family and that their fears and concerns are real
"I'm in charge" attitude	→	Positive engagement
Controlling	→	Collaborative
Law enforcement approach	→	Helping/social worker approach
Multiple case managers	→	One service manager
Multiple service plans for child	→	Single plan for child and family
Family blaming	→	Family partnerships
Deficit based	→	Strengths focused
Mono cultural	→	Sensitivity to culture/linguistics and family ritual

System reform not only involves changes in the way that staff and providers interact with families and youth but changes as well in the roles and expectations of families and youth themselves, as Box J illustrates.

J Shifts in Roles and Expectations of Families and Youth

Being a recipient of service plan information and service requirements	→	participating in service planning	→	being a service-planning team leader;
Being an unheard voice in program evaluation	→	participating in evaluation	→	being a partner in developing and conducting program evaluations
Being a recipient of services and supports	→	partnering in planning and developing services/supports	→	being a services/supports provider
Being uninvited to training activities	→	participating in training	→	partnering in developing training and being trainers
Being angry and resistant to what may feel like coercion	→	self-advocacy and peer support	→	system-level advocacy and expanded capacity to provide peer support

Just as staff and providers need training and supports to make the shifts called for in systems of care, so, too, do family and youth partners and community partners.

In summary, systems of care as system reform efforts entail changes at multiple levels: policy level, management level, frontline practice level, and community level, exemplified in Box K.

K **System Change/Transformation Focuses on:**

- Policy Level (e.g., system design, financing, regulations, and rates);
- Management Level (e.g., data systems, quality improvement, and human resource development);
- Frontline Practice Level (e.g., assessment, care planning, care management, and services and supports); and
- Community Level (e.g., partnership with families, youth, and natural helpers, and community buy-in).

A Non-Categorical Approach

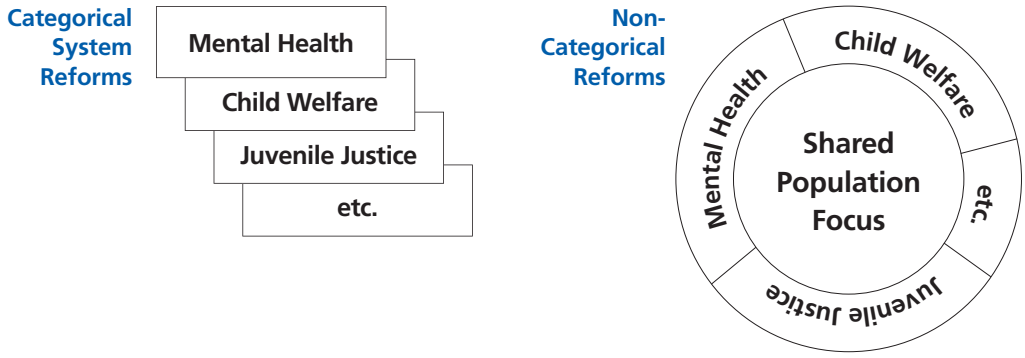
A system of care, by definition, is non-categorical; that is, it crosses agency and program boundaries and approaches the service and support requirements of families and youth holistically. It adopts a population focus across systems.

A non-categorical approach is quite different from one that focuses on reform of a particular system, such as a "mental health reform" or a "child welfare reform," although a non-categorical approach also entails reform of those systems. While interagency players and cross-system stakeholders may be involved in a mental health reform or a child welfare reform just as they would be in an effort to build a system of care, there is a fundamental difference between the two, as shown in Illustration A. *One is a categorical system reform; the other is a non-categorical approach to improving outcomes for a population of children and families. Effective system builders recognize the difference between the two.*

There have been many categorical system reform efforts over the past two decades in children's services—privatization in child welfare, for example, deinstitutionalization in juvenile justice and in mental health, inclusion in special education, and the like. A challenge for system builders is to identify the features of these categorical reform initiatives that can be incorporated into more holistic systems of care for populations of children, youth, and families involved in more than one of these systems.

ILLUSTRATION A

Categorical vs. Non-Categorical System Reforms



Pires, S. (2001). *Categorical vs. non-categorical system reforms.* Washington, DC: Human Service Collaborative.

A Shared Population Focus

An essential early focus of system builders needs to be on understanding the populations of children, youth, and families that are involved, or are at risk for involvement, in multiple systems and determining the populations of focus for the developing system of care, which may be the total population or subsets of the total. Several ways of thinking about subsets is by:

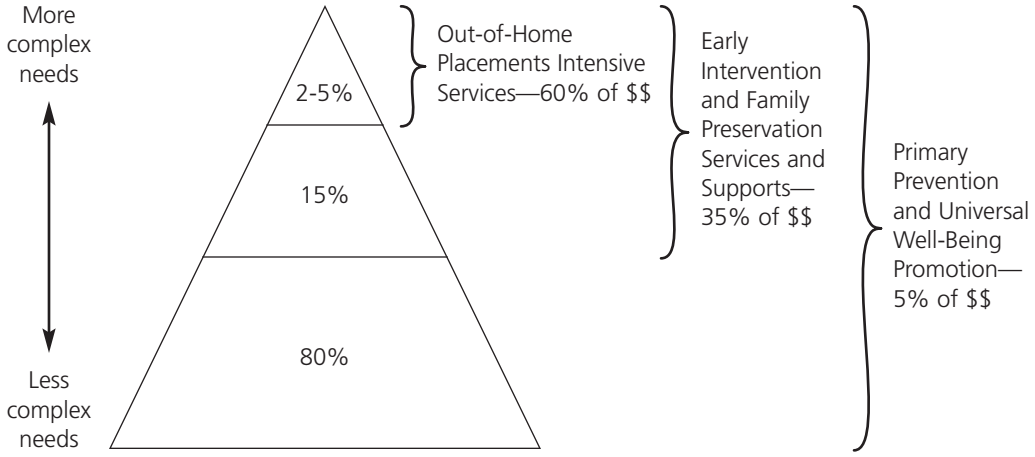
- **Demographics**, for example, Infants and toddlers? Transition-age youth? Racially and ethnically diverse children and youth experiencing disparities in access to services or disproportional representation in restrictive services?
- **Intensity of system involvement**, for example, children and youth in out-of-home placements, such as residential treatment centers or group homes
- **At-risk characteristics**, for example, children with birth families at risk of child welfare involvement, children in permanent placements at risk for disruption, families in which methamphetamine abuse is occurring, teen mothers under severe stress; and
- **Level of clinical/functional impairment**, for example, children with serious emotional disorders, children with serious physical health conditions, children with developmental disabilities, children and youth with co-occurring disorders, such as mental health and developmental challenges, and mental health and substance abuse problems.

System builders need to ask themselves, "Who are the populations of children, youth, and families that we are especially concerned about because they are experiencing poor outcomes and/or high costs in our current service systems or are at very high risk of experiencing poor outcomes and/or high costs if we do nothing?"

Understanding the prevalence of problems and current utilization—that is, the way that children and families use services and supports—also is essential. Visually, think of a triangle representing prevalence and service utilization among all children and families in a given state, tribe, territory, or community for problems that may lead to involvement with public systems (see Illustration B).

ILLUSTRATION B

Prevalence and Utilization



At the top of the triangle is the relatively small percentage of children, youth, and families with serious and complex problems who may be using a large percentage of the dollars; these are typically children and youth in out-of-home placements. In the middle of the triangle are various at-risk populations of children and families who need services and supports but where there may be few resources available (because a large percentage of the dollars is going to the top of the triangle). This middle tier includes families at risk for child welfare involvement, for example, or youth at high risk for juvenile justice involvement. At the bottom of the triangle are most children and families, who do not need specialized services and supports but where health and mental health promotion and primary prevention are imperative. In most states, however, very few resources are available for promotion and prevention (because the dollars are being spent on the rest of the triangle).

A Population-Driven Systems Approach

The strengths and needs of the populations of focus must drive the types of services, supports, and strategies that will be required in the system of care, the financing streams that need to be accessed, the stakeholders that need to be involved, and so on. For example, if the system is focusing initially on infants and young children and their families, it must partner with early intervention programs like Head Start and child care, and primary care practices are especially critical. If it is focusing on transition-age youth, as displayed in Box L, another set of players, funding streams, services, supports, and community resources comes into play.

L Example: Transition-Age Youth

What outcomes *(e.g., connection to caring adults, employment, education, and independence)* do we want to see for this population?
What will our system look like for this population?

POLICY LEVEL
- What systems *(e.g., housing, vocational rehabilitation, employment services, mental health and substance abuse, Medicaid, schools, community colleges/universities, physical health, juvenile justice, and child welfare)* need to be involved?
- What dollars/resources do they control?

MANAGEMENT LEVEL
- How do we create a locus of system management accountability for this population *(e.g., in-house, lead community agency)*?

FRONTLINE PRACTICE LEVEL
- Are there evidence-based/promising approaches *(e.g., Family Finding)* targeted to this population?
- What training do we need to provide, and for whom, to create desired attitudes, knowledge, and skills about this population?
- What providers *(e.g., culturally diverse providers)* know this population best in our community?

COMMUNITY LEVEL
- What are the partnerships we need to build with youth and families?
- How can natural helpers in the community play a role?
- How do we create larger community buy-in?
- What can we put in place to provide opportunities for youth to contribute and feel part of the larger community?

Resonance With a Public Health Approach

Over the past decade, systems of care have moved closer to a public health framework, focusing not only on treatment for individual children with serious conditions but also encompassing promotion, prevention, early intervention, and education to improve outcomes and health, and developmental and behavioral health status for identified populations of children and youth. For example, early childhood systems of care, such as those in **Colorado** and **Vermont**, have created effective partnerships with early childhood settings, such as child care and Head Start programs, and with primary care to promote developmental and emotional well-being in young children. Other systems of care, such as those in **Rhode Island**, are partnering with the schools to implement universal, school-wide behavioral health promotion approaches, such as Positive Behavioral Interventions and Supports, to change school climate, reduce stigma, and promote emotional well-being, at the same time, linking youth with serious challenges to appropriate services. The President's *New Freedom Mental Health Commission Report* stressed a number of important public health-related goals for a transformed behavioral health system, including education to reduce stigma, early screening, assessment and treatment, and reduction of disparities experienced by racially and ethnically diverse populations and those in rural communities.

The Importance of State, Tribal, and Local Partnership in System Building

The system of care concept emphasizes the importance of local control and ownership of the system. The more "local" a system is, the more likely it will reflect community strengths, needs, values, and day-to-day realities. However, system building at local levels cannot sustain itself without state-level commitment; indeed, systems of care at local levels may not even be able to get off the ground without state-level involvement, much less sustain themselves over time. For better or worse, state-level policies and practices have an impact on local systems of care. In addition, for states and communities with tribal populations, partnerships with tribes are essential. Tribes operate as sovereign nations, with their own rights and laws. Tribes have the right to intervene in situations that involve children and families who are tribal members, and tribal children and families often are involved in services and supports provided both through the tribes and by state and local systems.

Effective system building requires a partnership between state, tribal, and local stakeholders to clarify and address the ways in which state policies and practices (e.g., regulations, funding, and reporting requirements) can be strengthened or altered to support local and tribal systems of care. When the partnership is effective, system builders at all levels view themselves as part of the same system-building team. This partnership does not mean that there will not be tensions between state, tribal, and local levels; such tensions are inevitable if only because there are different, and sometimes competing, constraints, demands, and resources at each level. However, tensions are more likely to be resolved when there is an effective partnership in place rather than a "we-they" operating mentality. *This* Primer *is intended for both state-tribal and local-level system builders and treats them as part of the same system-building team.*

A Multifaceted Approach

Historically, systems of care have focused on the organization and financing of services to improve access to and availability of services and to reduce service and funding fragmentation. In addition, systems of care have focused on frontline practice, that is, on the skills, knowledge, and attitudes of service providers. Systems of care are concerned about "treatment efficacy," ensuring effective therapeutic interactions between practitioners and children in care and their families.

Systems of care have been influenced over the past decade by the movement toward evidence-based and promising practices in child and family services—and vice versa. **Evidence-based practices** *"show evidence of effectiveness through carefully controlled scientific studies, including random clinical trials"*; these are practices that have had the benefit of research dollars. **Promising approaches** (also referred to as "practice-based evidence") *"show evidence of effectiveness through the experience of key stakeholders—*

for example, families and youth, providers, and administrators—and outcome data." Systems of care need both evidence-based practices and promising approaches (see Box M).

M Evidence-Based Practices and Promising Approaches

Evidence-Based Practices
Show evidence of effectiveness through carefully controlled scientific studies, including randomized clinical trials

Promising Approaches/Practice-Based Evidence
Show evidence of effectiveness through experience of key stakeholders (e.g., families, youth, providers, and administrators) and outcome data

Systems of care also increasingly recognize the importance of quality of life issues such as safety and opportunities for recreation in neighborhoods and communities that affect the well-being of children and families.

Successful system builders recognize that all the above are needed to improve outcomes for children and families, in addition to strengthening the capacity of youth and families themselves to guard and enhance their own, and their children's, well-being. If frontline practice changes but families do not know how to access services, or services are not available, or the delivery system remains fragmented, then only a few families lucky enough to reach "effective services" will benefit. Conversely, if systems of care are built that improve access, availability, and coordination of care but frontline practice remains ineffectual, then systems of care will improve access but not outcomes. Similarly, if larger neighborhood conditions remain damaging, then, even though families get better services, they will continue to live within "risk conditions."

Building systems of care is a multifaceted, multilevel process. It involves making changes at state, tribal, local, and even neighborhood levels. It entails changes at policy and service delivery levels. Effective system builders are multidimensional, strategic thinkers. They recognize the complexities of system building and tend to be stimulated rather than discouraged by the process. They also are realistic. They recognize that system building takes time, is developmental, and proceeds in both linear and circular fashion. They weigh strategically which aspects of system building to tackle at which developmental stage and guard against exhausting themselves by trying to take on "everything at once." They also constantly are looking for allies to engage in system building to spread the workload and maximize the resources.

Over time, some basic tenets to guide system builders have become more clearly articulated (see Box N).

N Basic Tenets about Systems of Care

- The system of care concept is a framework and a guide, not a prescription. The concept of a system of care was never intended to be a "model" to be "replicated"; rather, it was intended as an organizing framework and a value base. Flexibility to implement the system of care concept and philosophy in a way that fits the particular state and community was emphasized from the beginning. Different communities have implemented systems of care in different ways—no two are exactly alike. It is the philosophy, the value base, that is the constant.
- Systems of care change and evolve over time. The policies, organizational arrangements, service delivery approaches, and treatments change and adapt to changing needs, opportunities, and environmental circumstances in states and communities, in both positive and negative fashion.
- Since a system of care is not a discrete model, it is difficult to say definitively or precisely that one community has one and another does not. It is more appropriate to define the level of development. Building systems of care is a developmental process. Most communities throughout the country have some elements of the system of care philosophy and services in place, even if they are not all far along the developmental pathway.

Stroul, B. (2002). *Systems of care: A framework for system reform in children's mental health* [Issue brief]. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

As the structures and processes required to build systems of care are discussed throughout this *Primer*, it is important to acknowledge that there is no one correct way to structure the functions or to organize the processes involved in system building. The system of care concept and philosophy offer an organizing framework and a value base that system builders may use as a starting point. Decisions about which structural approaches to implement and precisely how to organize the system-building process depend on the needs, strengths, characteristics, and context (political, economic, and social) of each state, tribe, territory, and locality.

The Role of Process and Structure in System Building

Building anything involves *processes* and *structures*. As defined for this *Primer*, *process* fundamentally has to do with who is involved in a system-building effort; the roles, rights, and responsibilities each is accorded or assumes; and how these various players communicate, negotiate, and collaborate with one another. Process also has to do with being strategic (or failing to be). *Structure* refers to those functions that become organized in certain defined arrangements—for example, how children enter the system, how services and supports are individualized, how care is managed, how quality is monitored, how services are financed, and the like.

Because much has been written already about the processes involved in building systems of care, the *Primer* devotes more attention to the structural aspects of system building, specifically, the role that structure plays, the functions that require structure, and the challenges and opportunities posed by different structural arrangements for key system of care functions. In no way is this skewing meant to suggest that process is less

important than structure. Indeed, breakdowns in process are arguably more harmful to building systems of care and more difficult to repair than are structural breakdowns. Having said that, however, structure—how functions are organized—can undermine even the most effective system-building processes.

WEB RESOURCES

Substance Abuse and Mental Health Services Administration Systems of Care Section at: **www.systemsofcare.samhsa.gov**

Children's Mental Health Initiative Digital Library at: **www.cmhi-library.org**

National Technical Assistance Center for Children's Mental Health at: **http://gucchdtacenter.georgetown.edu**

Technical Assistance Partnership for Child and Family Mental Health at: **www.tapartnership.org**

Child Welfare Information Gateway Service Improvement Section at: **http://www.childwelfare.gov/systemwide/service**

System of Care Alumni Network: **www.systemofcarealumni.org**

Building Systems of Care: A Primer for Child Welfare Web-Based Training Powerpoint at the National Child Welfare Resource Center for Organizational Development: **http://muskie.usm.maine.edu/helpkids/telefiles/060308tele/Primer%20Hands%20On%20Child%20Welfare.ppt**

I Family Partnership, Youth Partnership, and Cultural and Linguistic Competence

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I. Families, Youth and Culture

Overview

To be effective, system-building processes and structures need to support the ability to operate in cross-cultural situations and to partner effectively with families and with youth. Family and youth partnerships and cultural and linguistic competence are not stand-alone characteristics, but are woven throughout the fabric of system of care processes and structures (as are the characteristics of cross-agency collaboration and state, local, and tribal partnership noted earlier). Family and youth partnership and attention to diversity, along with a cross-agency perspective and state, local, and tribal partnership, are non-negotiable characteristics of effective system-building processes and structures. *Building Systems of Care: A Primer* integrates concepts and examples of family and youth partnership and cultural competence throughout its discussion of system of care processes and functions requiring structure, rather than having just a stand-alone section on these intrinsic characteristics of effective systems of care.

Family Partnership, Support, and Development at All Levels

(i.e., Policy Level, Management Level, and Service Level)

Family partnership works in our system because support and development are structured at all levels of the system.

In effective systems of care, families are partners at policy making, management, and service levels of the system with other key stakeholders. Effective systems do not simply invite families to be part of the process—although *asking* families whether and how they want to be involved is a critical first step. They also actively support and engage families in a number of ways, for example, by providing tangible supports such as transportation, translation, and child care assistance; by recognizing and drawing on the knowledge and skills that parents bring to the table (e.g., utilizing parents as trainers of other stakeholders); by providing capacity-building support, such as training and peer and non-peer mentoring, that gives families the information, skills, and confidence to partner; and by asking families how they would like to be involved. Effective system builders recognize that families are diverse—racially, ethnically, linguistically, socioeconomically, and in family composition; thus, they utilize multiple strategies and structures for family involvement and support.

There are increasing examples of how systems of care are structuring family involvement at the various levels of the system (see Illustration 1.1). At the *policy level*, for example, families may comprise the majority vote on governance bodies; they may be part of the team that drafts legislation; they may participate on system design workgroups and on system advisory bodies. At the management level, families may be actively involved in developing and implementing quality improvement processes, in evaluating system performance, in helping to recruit and select personnel, in framing

Requests for Proposals, and in training activities, and they may be managers in systems. At the *service level*, in addition to the role that families play with respect to their own children, they may be service providers, care managers, family support workers, peer mentors, system navigators for other families, and advocates on behalf of other families.

ILLUSTRATION 1.1

How Systems of Care Are Structuring Family Involvement at Various Levels of the System

LEVEL	STRUCTURE
Policy	At least 51% vote on governing bodies As members of teams to draft legislation As members of system design workgroups and advisory boards
Management	As part of quality improvement processes As evaluators of system performance As trainers in training activities As advisors to selecting personnel As co-drafters of Requests for Proposals As administrators
Services	As members of team for own children As family support workers, care managers, peer mentors, and system navigators for other families

Family partnership is a fundamental practice shift, which requires capacity building to change attitudes, build knowledge about how to partner, and teach and coach partnering skills. Concerns may arise about partnering with families—such as families lacking expertise about policy issues or families having too many personal crises to be reliable, System builders need to strategize ways to address these issues, such as training, orientation, and coaching (for families and other system partners) and connecting families to family organizations for supports. It is important for system partners to acknowledge that families may have experienced a system "culture" that fostered feelings of fear, anxiety, hopelessness, and powerlessness. As a result, families may feel anger, shame, and distrust, making them reluctant to partner. Again, system builders need to work in partnership to develop strategies to address these issues, such as supporting family organizations to work with families about practice change goals and with system partners to change the practice culture in agencies so that families do feel respected and sought after as partners.

Some systems of care fund family organizations to play various roles in the system of care; some hire family liaisons who work within the system. Some systems form alliances (unpaid) with family organizations and utilize paid family advocates within the system. There are pros and cons to whatever structure is developed for the involvement of families, depending on the particular locale and perspectives of different stakeholders. For example, families involved in some systems of care believe strongly that to be hired or paid by the system leads to co-optation, whereas families in other systems of care feel just as strongly that the system's hiring of families allows for greater equalization of parent-professional status in the system and ensures that families get "inside" information directly from a family member (i.e., not filtered through non-family staff).

EXAMPLE 1.1

The **Parent Support Network of Rhode Island (PSN)** worked with the Rhode Island Coalition for Family Support and Involvement to develop a self-assessment tool for system builders, called *Family-Centered Practice: How are we doing?* The tool incorporates a family-centered rating scale that supports families, policy makers, administrators, service providers, and the like, to examine how programs, supports, or services are family centered. Examining the key areas supports system builders in identifying strengths and areas that need improvement. These key areas include: focus on the strengths of the child and family; support relationship building and community membership; foster mutual trust and respect between families and program staff and/or administration; promote family choice and control; offer families good information and access to information; and include families in policy decisions and program planning. (**www.psnri.org**)

The points being made here are threefold:

- Family involvement, support, and development at all levels of the system must be structured, that is, deliberately organized and not left to happenstance, and multiple strategies are necessary to engage the diversity of families affected by systems of care.
- Whatever structures are put in place will have advantages and disadvantages to them, depending on local circumstances and stakeholder perspectives.
- It is incumbent upon system builders including families to be thoughtful about the pros and cons of different structures in order to understand how they will affect different stakeholders' experiences, level of involvement, and attainment of system goals.

In the following example, family involvement is the building block on which all other structures of the system of care are based.

EXAMPLE 1.2

In a rural county in a northeastern state, family members took the lead in designing the system of care. They first prioritized services and supports needed, which included: respite; an advocate to help families navigate; information and referral; parent and sibling support; a family center; community supports such as after school activities, crisis services, and concrete assistance. They developed specific recommendations, which became the basis for system of care policies. For example:

- All committees, including the board and steering committee, should have at least 50 percent parent representation.
- Preference for all staff positions should be given to parents of children with special needs.
- Parents should participate as trainers in the training of all staff and volunteers.
- Parents should establish criteria for family-friendly agencies and award those that meet the criteria a "Family Friendly Seal of Approval."
- Families should interview and "hire" those professionals and service providers working with them. Participants and service providers should have an agreement for a trial period after which either can decide to discontinue the contract. There should be scheduled periodic evaluations as part of every agreement to see if the match is successful and if the service suits the provider and the family.
- Families First should stress the importance of sensitivity to language that is respectful and inclusive of parents. Specifically, families should be referred to as "multi-stressed," never "dysfunctional." People using Families First services are "participants," not "clients." The term "advocate" should be used rather than "case manager."

Tannen, N. (1996). A family designed system of care: Families First in Essex County, New York. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society*. Baltimore: Paul H. Brookes Publishing.

WEB RESOURCES

National Federation of Families for Children's Mental Health at: **www.ffcmh.org**

System of Care Development website at:
http://mentalhealth.samhsa.gov/publications/allpubs/CB-E198/chp4pg2.asp

YouthMove National at: **www.youthmove.us**

Youth Involvement in Systems of Care: A Guide to Empowerment. 2005.
Matarese, M., McGinnis, L., Mora, M, at:
www.systemsofcare.samhsa.gov/headermenus/docsHM/youthguidedlink.pdf

National Alliance on Mental Illness Child and Adolescent Action Center at: **www.nami.org/caac**

Closing the Quality Chasm in Child Abuse Treatment, Volume II: Partnering with Youth and Families in Mental Health Treatment for Child Abuse at:
www.chadwickcenter.org/Documents/Best%20Practices%20for%20Youth%20and%20Families.pdf

National Directory of Family-Run and Youth-Guided Organizations for Children's Mental Health at:
http://familyorgdirectory.fmhi.usf.edu

New Jersey Youth Development Council Guiding Document at:
www.state.nj.us/dcf/behavioral/YCguidingdoc10_28_09.pdf

Key Questions: Family Partnership, Support and Development

- What are our structures for partnering with families at policy, management, and service delivery levels?
- What are the pros and cons to the structures we have for family involvement?
- Have we provided families with the necessary resources to partner effectively?
- Do we have strategies for building and growing a family-run organization to support family voice over time?
- How do our structures for family involvement and support promote or limit the participation of diverse families?

NOTES

Youth Partnership, Support, and Development at All Levels

(i.e., Policy Level, Management Level, and Service Level)

Many of the same points made about family involvement pertain to youth involvement as well. That is, partnerships with youth need to be structured at all levels of the system and not left to happenstance. This is particularly the case with youth partnerships because systems historically have been even slower to build meaningful partnerships with youth than with families.

Systems of care have begun to recognize the value of and embrace a "youth development" approach, that is, engaging youth as partners in program design and implementation, affirming and drawing on the strengths of youth, and involving youth in service delivery. Box 1.1 presents the principles articulated for a youth-guided system.

1.1 Principles of a Youth-Guided System

- Youth have rights
- Youth are utilized as resources
- Youth have an equal voice and are engaged in developing and sustaining the policies and systems that serve and support them
- Youth are active partners in creating their individual support plans
- Youth have access to information that is pertinent
- Youth are valued as experts in system transformation
- Youths' strengths and interests are focused on and utilized
- Adults and youth respect and value youth culture and all forms of diversity
- Youth are supported in a way that is developmentally targeted to their individual needs

YouthMove, 2006, Technical Assistance Partnership, American Institutes for Research, Washington, DC

As youth voice has grown in systems of care, youth themselves have conceptualized systems as needing to support youth, at individual, community, and policy levels, to move along a continuum from youth guided, to youth directed, to youth driven, as the following schematic, Illustration 1.2, developed by YouthMove shows.

ILLUSTRATION 1.2

YOUTH GUIDED

Young people have the right to be empowered, educated, and given a decision making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state, and nation. This includes giving young people a sustainable voice, and the focus should be toward creating a safe environment enabling a young person to gain self-sustainability in accordance with their culture and beliefs. Through the eyes of a youth-guided approach, we are aware that there is a continuum of power and choice that young people should have based on their understanding and maturity in this strength-based change process. Youth guided also means that this process should be fun and worthwhile.

YOUTH DRIVEN

Youth initiated, planned, and executed in partnership with others
Youth advocate for other young people
Expert level of understanding

YOUTH DIRECTED

Continuing with youth-guided process
Increased knowledge of services and resources
In a safe place (not in continual crisis)
Taking a more active decision making role in treatment and in the system of care (policy, etc.)
Deeper understanding of system

YOUTH GUIDED

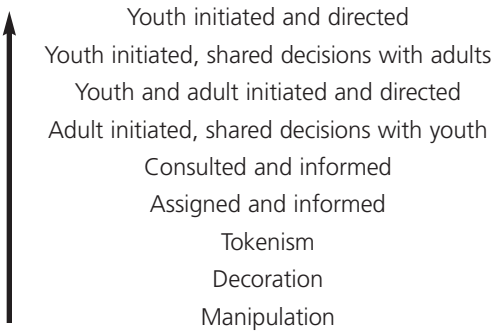
Knowledge of services
Voice in identifying needs and supports
Beginning to research and ask questions about resources
Learning how to self advocate
Beginning to understand the process of system and services
Articulate experience and what helps and what harms

Education foundation **Awareness** foundation
Resources foundation **Support** foundation **Philosophies**

Youth also have conceptualized the shifts to a youth-guided system as a "ladder" symbolized by Illustration 1.3.

ILLUSTRATION 1.3

LADDER OF YOUNG PEOPLE'S PARTICIPATION



There is a valuable body of youth development research and practice, which can inform the efforts of system of care builders. The Center for Youth Development and Policy Research, for example, has articulated a Youth Development Perspective, displayed in Box 1.2.

1.2 A Youth Development Perspective

- Engages and involves youth as active participants in the planning, implementing, monitoring, and evaluating of programs and projects that are designed to serve them
- Creates and strengthens the infrastructures that support positive development of all young people working through local citizens and with local partners
- Ensures young people have the skills and opportunities for voice, value and visibility in communities, schools, government and larger society
- Provides pathways and skills for emerging leaders to advocate for social justice and lead work of the social sector
- Encourages and empowers young people to adopt healthy lifestyles
- Supports young people to gain workforce skills and link them to meaningful employment
- Helps youth to develop the skills to avoid or mitigate conflict

YOUTH ARE CURRENT RESOURCES, NOT FUTURE ASSETS

Academy for Educational Development. (2009). *A youth development structural perspective*. Washington, DC: The Center for Youth Development and Policy Research.

The Center for Youth Development and Policy Research also articulated barriers to youth development as perceived by adults and as perceived by youth. Although there is some overlap in perceptions, there also are unique perspectives that youth have that are different from those of adults. For example, while both groups identify racism as a barrier, youth also identify ageism, sexism, stereotyping by appearance, and homophobia as barriers. Box 1.3 shows the importance of the youth perspective in a strategic system-building process.

1.3 Barriers to Youth Participation

AS IDENTIFIED BY ADULTS	AS IDENTIFIED BY YOUTH
Time	Ageism/Adultism
Funding	Money
Staffing	Racism, sexism, homophobia
Access to youth	Stereotyping by appearance
Lack of training (in how to work with youth)	Time
Politics	Transportation
Parents	Language
Adult staff not empowered	Lack of access to information
Program evaluation requirements	Lack of access to opportunities
Weak leadership	Lack of support from adults
Racism	Few role models
	Lack of motivation

Academy for Educational Development. (1996). *Barriers to youth participation*. Washington, DC: The Center for Youth Development and Policy Research.

Initiating and continuing a dialogue with youth is a first step in all parties thinking strategically about how to break down barriers. There are many different roles for youth in systems of care (see Box 1.4).

1.4 Roles for Youth: Infusing Youth Voice at all Levels

- Engage youth in planning and implementation
- Create youth advisory boards
- Develop youth-run organizations
- Train and utilize youth as peer mentors
- Involve youth as educators/trainers/evaluators

Adapted from Matarese, M. Technical Assistance Partnership for Child and Family Mental Health and National Child Welfare Resource Center for Youth Development.

It has been fairly common for youth movements in systems of care to be launched by family organizations. This approach can provide a stable home for a developing youth movement, though a potential drawback is that youth may feel they lack sufficient autonomy. Open and respectful discussion between youth and family organization stakeholders can lead to effective strategies for utilizing the strengths of an existing family organization to nurture a youth movement while supporting independence as the movement matures.

EXAMPLE 1.3

Parent Support Network of Rhode Island, the statewide family organization, brought youth together to launch a youth-driven empowerment, support, and advocacy group. This group became *Youth Speaking Out*, which emphasizes leadership development, community/civic service, and peer-to-peer support activities for youth with a wide range of mental health challenges, youth living in high-risk situations, and youth who have parents with substance abuse challenges or who are incarcerated. Youth from *Youth Speaking Out* have presented at local, state, and national conferences. They meet weekly; determine their own activities; participate in a broad range of community service activities, such as restoring shelters; and provide peer supports to one another. Staff from Parent Support Network, including a Youth Coordinator, offer support, guidance, and resources to help the youth achieve individual and group goals. (**www.psnri.org**)

WEB RESOURCES

National Federation of Families for Children's Mental Health at: **www.ffcmh.org**

System of Care Development website at:
http://mentalhealth.samhsa.gov/publications/allpubs/CB-E198/chp4pg2.asp

YouthMove National at: **www.youthmove.us**

Youth Involvement in Systems of Care: A Guide to Empowerment. 2005.
Matarese, M., McGinnis, L., Mora, M, at:
www.systemsofcare.samhsa.gov/headermenus/docsHM/youthguidedlink.pdf

National Alliance on Mental Illness Child and Adolescent Action Center at: **www.nami.org/caac**

Closing the Quality Chasm in Child Abuse Treatment, Volume II: Partnering with Youth and Families in Mental Health Treatment for Child Abuse at:
www.chadwickcenter.org/Documents/Best%20Practices%20for%20Youth%20and%20Families.pdf

National Directory of Family-Run and Youth-Guided Organizations for Children's Mental Health at:
http://familyorgdirectory.fmhi.usf.edu

New Jersey Youth Development Council Guiding Document at:
www.state.nj.us/dcf/behavioral/YCguidingdoc10_28_09.pdf

Key Questions: Youth Involvement, Support and Development

- How does our system of care incorporate a youth development framework?
- What are our structures that support youth involvement at policy, management, and service delivery levels?
- Have we provided youth with the necessary resources (funding, training, information, etc.) to partner effectively?
- What are our strategies for building and growing youth voice in our system of care?

NOTES

The Important Role of Family- and Youth-Directed Organizations

Organizing family and youth networks through the work of a family- or youth-directed organization is a key strategy in systems of care to support family and youth involvement. Strategies include both partnering with existing family and youth associations/organizations and supporting the development of new ones where none exists. These associations or organizations can start as informal networks of support and can grow over time.

Some of the considerations in *establishing a new family- or youth-directed organization* include:

- Identifying and supporting natural family and youth leaders in the community;
- Providing adequate funding;
- Delineating relationships;
- Letting families and youth decide the mission, goals, structure, and activities of the new organization; and
- Partnering with families and youth in strategic planning for sustainability.

Key elements in *contracting with existing family or youth organizations* include ensuring that the organization has the following:

- Representation from the culturally and linguistically diverse families and youth involved in the system;
- Strong ties to the community and linkages with other family and youth groups, both locally and nationally;
- Clear expectations of what is required;
- Performance criteria and evaluation procedures; and
- Fair compensation for the work to be performed.

A family or youth organization can help to ensure a higher level of accountability from the system of care than individuals working on their own might be able to create, to ensure that families and youth receive the necessary services and supports and that they are involved in meaningful ways as system partners (see Box 1.5).

1.5 Role of Family- and Youth-Directed Organizations

- Mobilize family and youth voice.
- Provide a structure for implementing family and youth partnerships with the system of care.
- Engage and support families and youth, including families and youth who may feel disenfranchised from or distrustful of the system.
- Create ties to the larger community and to other family and youth organizations.

Through its capacity to develop family or youth leadership and mobilize a family and youth "voice," an organization can strengthen the strategic approach to family and youth partnership building within the system of care. Family and youth organizations also can play an effective role in creating a safe space for families and youth to air concerns and obtain support to become involved in system change. Family and youth organizations that have viable partnerships with system partners, such as state, tribal, and local agencies, including access to resources (dollars, training, etc.), are in a position to build capacity to embed family and youth voice into all levels of the system. The strength of the relationships between these system partners and family- and youth-run organizations is a key factor in the sustainability and growth of family and youth voice in systems of care. The Family Involvement Center in **Maricopa County, Arizona (Phoenix)**, provides one example from many of a family organization that through effective partnerships with state and local agencies, including access to resources, has meaningful and substantive involvement in the system of care at all levels (see Example 1.4).

EXAMPLE 1.4

FAMILY INVOLVEMENT CENTER FUNCTIONS

Under State Mental Health Contract:
- Policy and system management involvement
- Payment of stipends, transportation, child care to support family and youth partnership at policy/system management levels
- Training of families, providers, staff on AZ system of care principles and family and youth partnership
- In partnership with MIKid, development of a Latino family organization
- Building of family and youth movement

Under Administrative Contract with Maricopa County Regional Behavioral Health Authority:
- Staff and participate on Children's Advisory Council
- Recruit and train family partners for variety of roles
- Recruit, train, and support family peer mentors
- Organize open education opportunities
- Provide information and referral
- Co-facilitate administrative meetings
- Train and provide technical assistance to providers on family and youth partnership

Under Contract as a Direct Service Provider to Provide:
- Peer mentoring
- Respite
- Behavioral coaching
- Skills training
- Health promotion
- Family support and education
- Personal aide services
- Case management

Under Contract with State Child Welfare System:
- Provide peer support for families at risk of child welfare involvement through a Family-to-Family approach

See: www.familyinvolvementcenter.org

Cultural and Linguistic Competence

Effective systems of care respect and make every effort to understand and be responsive to cultural and linguistic differences. Typically, systems of care are serving children, youth, and families from diverse racial, ethnic, and socioeconomic backgrounds. The recognition of this diversity undergirds the system of care principle and practice of individualizing services and supports.

As noted in the *Overview*, cultural and linguistic competence are not stand-alone functions but, rather, need to be infused within every structure that is built in systems of care and within the system-building process. The *Primer* tries to model the integration of cultural and linguistic competence into all aspects of system building by addressing relevant issues and strategies within each section in II. *Structuring Systems of Care* and by addressing cultural and linguistic competence as a core element of III. *The System-Building Process*. For example, within Section II, Subsection 2.20 of the *Primer*, *Quality Management, Continuous Quality Improvement (CQI), and Evaluation*, attention is paid to the disparities in data collection, analysis, and reporting that historically have been the case with respect to diverse populations and the importance of structuring quality improvement and evaluation approaches that are culturally and linguistically competent. In Section II, Section 2.13 of the *Primer*, *Purchasing and Contracting*, there is discussion of how certain types of contracting arrangements may disadvantage small, non-traditional, or indigenous providers serving diverse communities and the importance of structuring purchasing and contracting mechanisms that intentionally reach out to and include those providers. These are examples of how the *Primer* integrates cultural and linguistic competence throughout structural and process considerations rather than having just a free-standing section on the topic.

Although the *Primer* treats cultural and linguistic competence as an intrinsic element of every system of care function, it also is essential that system builders create structures that pay attention to cultural and linguistic competence *across* functions and within the ongoing system-building process. For example, some states and localities create planning and implementation teams or workgroups whose role is to assess cultural and linguistic competence issues and needs within system of care structures and processes and to develop and oversee appropriate responses and strategies *on an ongoing basis*.

In recognition that different terminology may be used across stakeholders and communities, the following definitions are offered for cultural and linguistic competence (see Box 1.6).

1.6 Cultural and Linguistic Competence: Definitions

Culture
A broad concept that reflects an integrated pattern of a wide range of beliefs, values, practices, customs, rituals, and attitudes that make up an individual.

Cultural Competence
Accepting and respecting diversity and difference in a continuous process of self assessment and reflection on one's personal (and organizational) perceptions of the dynamics of culture.

Linguistic Competence
The capacity of an organization and its personnel to communicate effectively and convey information in a way that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.

Adapted from Youth Involvement in Systems of Care: A Guide to Empowerment (2006) and Goode & Jones (modified 2004). National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

Culture matters because culture affects:

- Attitudes and beliefs about services;
- Parenting and child rearing;
- Expression of symptoms;
- Coping strategies;
- Help-seeking behaviors as well as helping behaviors;
- Utilization of services and social supports; and
- Appropriateness of services and supports.

Valuing diversity is a key principle of systems of care. It should also be noted that federal law, Title VI of the Civil Rights Act of 1964, prohibits discrimination on the basis of race and national origin and also applies to cases in which individuals with limited English-speaking ability have trouble accessing services because of language barriers.

In addition to recognizing that all children and families bring a unique cultural background with them, effective systems of care also acknowledge and address proactively the disparities in access and treatment that historically have been the experience of diverse families in traditional systems. One would be hard pressed to find a state or locality in the country in which ethnically, racially, and linguistically diverse children and families are not overrepresented in the most restrictive, "deep end" services and underrepresented in quality community-based services. This finding tends to be the case even in states and communities with relatively few racial and ethnic minority families.

Numerous studies, as well as the U.S. Surgeon General in 2001, have documented that racial and ethnic minority children tend to have less access to services, receive poorer quality services, and are more likely to be placed into care. The first round of Child and Family Services Reviews in child welfare found that White children achieve permanency outcomes at a higher rate than children of color. Disparities include not only children, but families. For example, African American families are investigated for child abuse and neglect twice as often as White families.

A key aspect of a culturally competent approach is to understand the racial and ethnic disparities and disproportionality issues in one's particular system. A system may also experience geographic disparities and disproportionality with, for example, rural areas being under- or overrepresented in the system, and certain populations beyond those that are racially and ethnically diverse may experience stigma and disparity in access to services, such as youth who are lesbian, bisexual, gay, transgender, or questioning (that is, youth who are sometimes referred to as "sexual minority youth").

In a study conducted by the Congressional Research Service, child welfare administrators, supervisors, and workers offered their theories on why there is racial and ethnic disproportionality in child welfare, including: poverty and related issues, such as homelessness; lack of community resources to address a range of issues, such as substance abuse and domestic violence; greater visibility of minority families for reporting of child maltreatment; a lack of experience (among those working in systems) with other cultures and lack of familiarity regarding what constitutes abusive behavior across these cultures; and media pressure to remove children (Congressional Research Service, August 2005. *Race/Ethnicity and Child Welfare*).

Each of these potential reasons for the racial and ethnic disproportionality in child welfare lends itself to particular collaborative strategies for change. For example, combining resources across systems and partnering with natural helping networks might help to make more services and supports available. Training and coaching across systems and partnering with families and youth might help to increase cultural awareness and reduce biased decision making. Social marketing strategies might help to alleviate media pressure to remove children. The point is that cultural and linguistic competence, like all aspects of system building, must be approached strategically.

EXAMPLE 1.5

South Dakota's Collaborative Circle for the Well-Being of South Dakota's Native Children was established because Native American children were so disproportionally represented in South Dakota's child welfare system. Key stakeholders came together in 2005 and committed themselves to partnering to reduce the number of Native children in child welfare and to achieve better outcomes for Native children and families. The partners are (1) the nine Sioux Tribes; (2) the State Division of Child Protection Services; (3) birth parents, family caregivers, and youth; (4) and the provider community. Together, they created the Collaborative Circle, and since its creation, there reportedly has been a 10% reduction in Native disproportionality in child welfare. For more information, contact: **http://dss.sd.gov/cps/icwa/index.asp**.

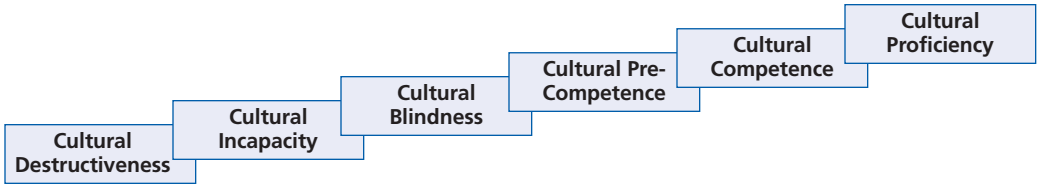
EXAMPLE 1.6

In **Wake County, North Carolina**, African American children make up 25% of the child population but are 60% of the child welfare population. In the past 5 years, Wake County has implemented several strategies to reduce racial disparity and improve child welfare outcomes. The county's initiatives included a Family-to-Family Initiative, the implementation of a Racial Disparities Workgroup, a Believe in the Children Campaign, a Child Welfare Faith Based Partnership, and the establishment of a small fund to help kinship caregivers purchase legal services to establish custody. The county has reported that the percentage of African American children entering foster care in Wake County and the overall percentage of Wake County's African American foster children have both decreased. For more information, contact: **www.casey.org/Resources/Publications/PlacesToWatch.htm**.

Some years ago, Terry Cross of the National Indian Child Welfare Association and colleagues identified a "cultural competence continuum," which still has relevance (see Illustration 1.4). The continuum moves from cultural destructiveness, to cultural incapacity, to cultural blindness, to cultural pre-competence, to cultural competence, to cultural proficiency. This construct provides one useful tool for assessing the cultural strengths and weaknesses of the system of care.

ILLUSTRATION 1.4

CULTURAL COMPETENCE CONTINUUM



Cultural competence is a developmental process that evolves over an extended period. Individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (NCCC adapted from Cross et al., 1989)

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care* (Vol. 1). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Systems of care fundamentally are concerned about organizational cultural competence. The following criteria are useful to identify culturally competent organizations; they are adapted from the monograph cited above, *Toward a Culturally Competent System of Care*.

"Cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally
- Have the capacity to value diversity, conduct self assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery, and involve systematically consumers, key stakeholders, and communities."

Leaders in the area of cultural and linguistic competence also have identified core elements of a culturally competent system of care (see Box 1.7).

1.7 Core Elements of a Culturally and Linguistically Competent System of Care

- Commitment from top leadership
- Organizational self-assessment
- Needs assessment and data collection relevant to diverse constituencies
- Identification and involvement of key diverse persons
- Mission statements, definitions, policies and procedures reflecting the value of cultural and linguistic competence
- A strategic plan for cultural and linguistic competence
- Recruitment and retention of diverse staff
- Training and skill development in cultural competence
- Certification, licensing and contract standards that reflect cultural competence goals
- Targeted service delivery strategies
- Internal capacity to monitor the cultural competence implementation process
- Evaluation and research activities that provide ongoing feedback about progress, needs, modifications, and next steps
- Commitment of agency resources (human and financial) to cultural competence quality improvement

Isaacs, M., Benjamin, M., et al. (1989(1998). *Towards a culturally competent system of care* (Vols. 1(3). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Using these and similar parameters, system builders can assess the cultural competence of their systems and develop strategies to address areas needing improvement.

WEB RESOURCES

The ***National Center for Cultural Competence (NCCC)*** at the Georgetown University Center for Child and Human Development maintains many online resources and tools addressing cultural and linguistic competence in systems of care, including:

- Conceptual frameworks/models, and guiding values and principles;
- Definitions of cultural and linguistic competence;
- Policies to advance and sustain cultural and linguistic competence; and
- Tools and processes for organizational or system self-assessment.

The NCCC also has a searchable database listing a wide range of resources on cultural and linguistic competence.

- National Center for Cultural Competence at: **http://nccc.georgetown.edu**

The Technical Assistance Partnership for Child and Family Mental Health at the American Institutes for Research supports a Cultural and Linguistic Competence Community of Practice and a Cultural Competence Action Team.

- Cultural and Linguistic Competence Community of Practice at: **www.tapartnership.org/COP/CLC/default.php**
- National Network to Eliminate Disparities in Behavioral Health at: **www.nned.net**

Key Questions: Cultural and Linguistic Competence

- How are we ensuring that cultural and linguistic competence is built into all system of care structures and processes?
- What are our examples of culturally and linguistically competent approaches at service delivery, management, and policy levels?

NOTES

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II. Structuring Systems of Care

The Role of Structure

This *Primer* is based on a number of premises with regard to the important role that structure plays in systems of care. Specifically:

- **PREMISE 1:** ***Certain functions must be organized to implement systems of care successfully; that is, they cannot be left to happenstance.*** For example, if there is no structure—that is, no defined arrangement—for how care is to be managed, then it is unlikely that care will be managed.

- **PREMISE 2:** ***The structures that are created send a message about values, either undermining or reinforcing the values and principles that have been adopted.*** For example, individualized, flexible service provision is a key principle of systems of care. However, if the financing structure attaches dollars only to programs, the principle of individualizing care will be undermined—not that it is impossible to incorporate individualized service provision within this structure, but it is more difficult. The structure in this instance sends a message about how much the system truly values an individualized, *Wraparound* approach.

- **PREMISE 3:** ***The structures that are created have very much to do with how power and responsibility are distributed.*** For example, a goal of systems of care is to invest families and youth with shared decision-making power and responsibility at the services and system (i.e., policy, management, and monitoring) levels. A system-level structure that involves one parent or one youth on an advisory committee obviously distributes less power and responsibility than a structure that requires and strengthens the capacity of families and youth to participate in all aspects of system-level decision making. This latter structure, in turn, distributes less power and responsibility than one that mandates majority representation of families and youth on decision-making or governance bodies and provides funding and support to implement the mandate.

- **PREMISE 4:** ***The structures that are created affect the subjective experiences of stakeholders, that is, how families, youth, providers, staff, administrators, and others feel about the system.*** In the example given above of the lone parent or youth on a system-level advisory committee, families and youth are likely to feel that the system, no matter how innovative certain aspects of it are, is being tokenistic.

- **PREMISE 5:** ***Structure affects practice and outcomes.*** If for no other reason than that structure affects how people feel, it will affect practice and outcomes. For many reasons, the structures that are created can get in the way of or support intended practice and attainment of desired outcomes to lesser or greater degrees. The financing structure noted above, for example, that attaches dollars only to programs, is likely to hinder (though not necessarily defeat entirely) the practice of individualizing services. This structure, in turn, could frustrate (though, again, not necessarily defeat) attainment of the goal of improving clinical and functional outcomes. Another desired outcome may be reduction in inappropriate use of residential treatment. If the

Medicaid benefit structure (i.e., the services and supports that are allowable) and the provider network structure do not encompass home and community-based alternatives, then it is highly unlikely that residential treatment utilization will be reduced—at least not without affecting other desired outcomes, such as improvement in clinical and functional status of children or reduced recidivism.

- **PREMISE 6:** ***Structures need to be evaluated and modified, if necessary, over time.*** Because system building is occurring in an ever-changing environment and is by its nature not a finite activity, the structures that are created today may not be what are needed tomorrow.

- **PREMISE 7:** ***New structures replace existing ones; some existing ones may be worth keeping, and some are more difficult to replace than others.*** This is an admonition not to throw the baby out with the bathwater because there are existing structural strengths in every system that are worth preserving in whole or in part. And, it is an admonition to be strategic about how much precious time and energy are spent and at what juncture (since timing is [almost] everything), in trying to replace intractable structures.

- **PREMISE 8:** ***There are no perfect or "correct" structures.*** Sometimes, the most desirable structures for the attainment of system goals are ones that for political, financial, technical, or other reasons cannot be created at the time. Sometimes, there is no agreement among stakeholders or even clarity about what the most desirable structures are. The most desirable structures in one community may be very different from the most desirable structures in another. *What is important is that all stakeholders in a given community who are involved in system building take the time to analyze, acknowledge the strengths and weaknesses of, and plan contingencies in response to, the structures that are created (or left standing)*. This reflection needs to consider how the structures that are created reflect values, distribute power and responsibility across different stakeholder groups, affect the subjective experiences of different stakeholder groups, and affect goal attainment.

ILLUSTRATIONS 2A&B

To illustrate the role that structure plays, consider the examples provided by Illustrations 2.A and 2.B, which describe the organizational structures of two state departments of mental health. Both state departments have system of care-like mission statements and expressed values to create a comprehensive continuum of care for children with emotional disorders and their families.

In the department whose organizational structure is described in Illustration 2.A, responsibility for children's services is fragmented across three divisions—the Division of Institutions, which has budgetary and operational responsibility for both adult and child and adolescent inpatient and residential treatment facilities; the Division of Community Programs, which has jurisdiction over community mental health centers that provide both adult and child and adolescent outpatient services; and the Division of Special Populations, which includes the children's director, who has responsibility for special projects related to children, such as grant-funded programs and demonstration projects, which tend to include home and community-based and *Wraparound* services. The children's director is relatively buried within this organizational structure and lacks line

authority over most services and most dollars related to children. This director must negotiate with three division directors, two of whom control the lion's share of the resources needed to create a continuum of care and who are probably more focused on issues related to adults in the system. In this example, there is a State Mental Health Advisory Council focusing on all populations (children, adults, and elders), which has a children's subcommittee with a family member as chair. However, there are no resources committed to building family and youth voice except those provided by a demonstration grant at a local level.

Although it is not impossible to create a family-driven, youth-guided continuum of care within the structure described in Illustration 2.A, it is certainly more difficult than it is within the structure described in Illustration 2.B, where there is a children's division with line budget and operational responsibility over the entire continuum of care. The division provides funds to the statewide family organization to build family voice and organizational capacity across localities. The structure in Illustration 2.A sends a message about the extent to which the state truly values an integrated continuum of care, is likely to create frustrations for the children's director and key stakeholders concerned about the system, and creates confusion for families and providers. In spite of both states having similar values and goals, the structure in Illustration 2.A is less likely to support achievement of those goals than that in Illustration 2.B.

ILLUSTRATION 2.A: State Mental Health Department

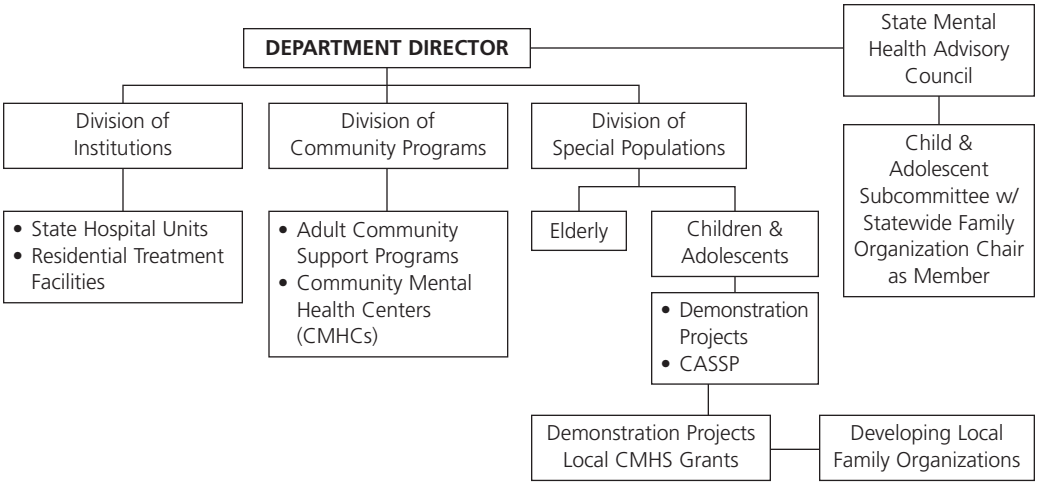
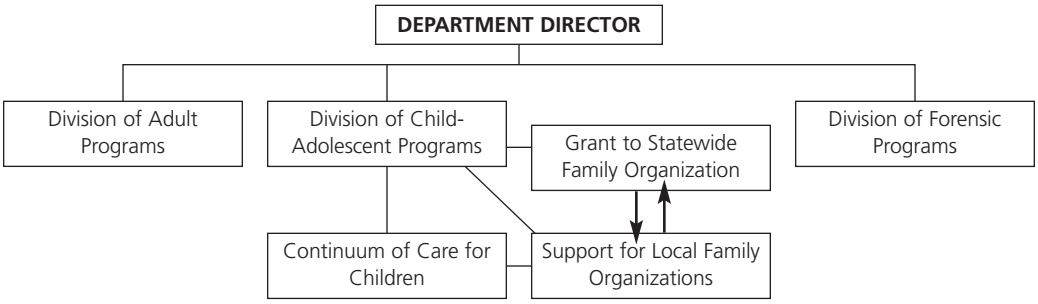


ILLUSTRATION 2.B: State Mental Health Department



Pires, S. (2009). *"Primer hands on" for family organizations.* Washington, DC: Human Service Collaborative.

Key Questions: The Role of Structure

- Are we paying enough attention to the types of structures we need to operate effectively?
- How do the structures that are in place make sense, given our values and goals?
- Which structures tend to create frustration for stakeholders? Which stakeholders? Why?
- What are the challenges and opportunities for changing structures that contradict our values and goals?

NOTES

System of Care Functions Requiring Structure

There are certain functions within systems of care that need to be structured, that is, organized in some defined arrangement and not left to happenstance. Many functions require structure at both state and local levels, as well as at tribal levels. The list of functions that follows provides a good starting point that system builders can add to and adapt, based on their own experiences:

- Planning (The planning process itself needs structure)
- Decision Making and Oversight at the Policy Level (also referred to as "Governance")
- System Management (day-to-day management decisions)
- Outreach, Engagement, and Referral
- System Entry/Access (also referred to as "Intake"; how children, youth, and their families enter the system and what happens when they get there)
- Screening, Assessment, Evaluation, and Service Planning (separate functions but are important to link)
- Care Management and Service Coordination, Including Use of Care Management Entities
- Crisis Management at the Service Delivery and System Levels
- Benefit Design/Service Array (There needs to be a definition of the types of services and supports that are allowable and under what conditions within the system of care)
- Evidence-Based and Effective Practice
- Prevention and Early Intervention
- Provider Network (network of services and supports)
- Purchasing and Contracting
- Provider Payment Rates
- Billing and Claims Processing
- Utilization Management
- Financing
- Human Resource Development
- External and Internal Communication and Social Marketing
- Quality Management, Continuous Quality Improvement, and Evaluation
- Information and Communications Technology
- Protecting Privacy
- Ensuring Rights
- Transportation

- System Exit (how families leave the system; what happens when they leave)
- Technical Assistance and Consultation

In this section of the *Primer*, each of these functions will be addressed, with examples to illustrate different approaches to structuring these functions and key questions for system builders to consider about the structures they have put in place or are contemplating. As discussed previously, the types of structures that are created send a message about values, distribute power and responsibility, influence the subjective experience of stakeholders, and affect practice and outcomes (see the box below). System builders need to continually examine the structures they have built in this context.

As discussed in the *Introduction*, to be effective, system builders need to ensure that every structure they build encompasses four fundamental characteristics:

- Cultural and linguistic competence, that is, structures that support capacity to function in culturally and linguistically effective ways;
- Meaningful partnerships with families and with youth in structural decision making, design, and implementation;
- A cross-agency, cross-system perspective, that is, structures that operate in a non-categorical fashion; and
- State, tribal, and local partnership.

Reference to these characteristics is woven throughout the discussions of each function requiring structure in this section of the *Primer*.

Not every function that needs to be structured within systems of care can be tackled at once. As system builders consider the functions that require structure and weigh the pros and cons of different structural arrangements, they also must think operationally and strategically about which functions to address at which stage in the system-building process. Typically, system builders begin by structuring a planning process, which is the first function discussed in this section of the *Primer*.

Structure

"Something Arranged in a Definite Pattern of Organization"

I. Distributes
- Power
- Responsibility

II. Shapes and is shaped by
- Values

III. Affects
- Practice and outcomes
- Subjective experiences (i.e., how participants feel)

Pires, S. (1995). *Structure.* Washington, DC: Human Service Collaborative.

Key Questions: System of Care Functions Requiring Structure

- What are the functions we need to structure in our system of care?
- What are the pros and cons of the structures in place or contemplated?
- Are our structures characterized by cultural competence? Partnership with families and youth? A cross-agency perspective? State, tribal, and local partnership?
- What are the functions that we need to address quickly? Which require more time or the involvement of other stakeholders before they can be structured effectively?

NOTES

2.1 Planning

Issues for Structuring Planning

Because system of care building is a dynamic process occurring in an ever-changing environment, "planning" is an ongoing process that requires structure—perhaps different structures at different times and more or less structure at different times, but structure nonetheless. Typically, building systems of care involves structuring planning by launching or reinvigorating a planning process (or bringing related planning efforts together). The planning process itself needs to be structured; it cannot be left to happenstance. In time, *the planning process must lead to a clear system design for the population or populations of focus*, and the process may then become a planning and implementation oversight process. Planning, in effect, does not really end; it is part of a cycle in a Continuous Quality Improvement framework, which includes: planning, implementing, evaluating, and changing as needed (which usually involves additional planning).

A number of structural issues need to be considered related to structuring (or restructuring) the planning process (see Box 2.1A).

2.1A Examples of Issues for Structuring Planning

- Who is taking leadership for the planning process?
- How will the process be staffed?
- When and where will meetings be held?
- How and which stakeholders will be involved?
- How will diverse and disenfranchised stakeholders be reached and involved?
- What structures are needed to involve families and youth?
- Will the structure use committees, workgroups, and focus groups?
- How will communication and information dissemination be structured?
- How will the system-building process link to related reform initiatives?
- Who has resources to support the planning process and what resources will be used?

Staffing is an element of structure, and effective planning processes need to be staffed. The time and place of meetings, the roles and responsibilities of those involved, how work gets done (e.g., through committees or workgroups), how information is communicated, and to whom—all have structural considerations in planning processes. The location and time of meetings may discourage some stakeholders from attending or alternatively make it possible for them to participate. Whether meetings are organized or not sends signals about the importance of the process. How information is imparted can value or de-value participants. For example, if all information about planning meetings is conveyed electronically, constituencies that do not have computers are left outside the loop.

Structures for planning may be initiated at the local or tribal level and then draw in state-level stakeholders. Or, the state may create a structure for planning and engage local-level and tribal stakeholders. The important point is that the structure needs to allow for the involvement of stakeholders at all levels.

A number of elements of effective planning processes have been identified over the years in system of care efforts (see Box 2.1B).

2.1B Elements of Effective Planning Processes

- Effective planning processes are staffed.
- Effective processes involve key stakeholders.
- Effective planning involves families and youth early in the process and in ways that are meaningful.
- Effective planning processes ensure meaningful representation of racially and ethnically diverse families and youth.
- Effective planning processes develop and maintain a multiagency, cross-system focus.
- Effective processes build on and incorporate related programmatic and planning initiatives.
- Effective planning processes continually seek ways to build constituencies, interest, and investment.

Adapted from Pires, S. (1991). *State child mental health planning*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

The wrong kind of structure can be as detrimental as no structure at all. For example, a structure that is highly rigid can stifle creativity and the inclusion of key stakeholder groups who may be uncomfortable with highly structured processes such as youth. On the other hand, a very loose structure may be frustrating to others, for example, agency directors, whose input also is needed. *In reality, effective planning processes create a variety of different structures to support system building*. This variety also is important to respond to the racial, ethnic, linguistic, and cultural diversity across stakeholder groups.

Strategies for Involving Families and Youth in Planning

Effective system builders typically structure planning processes in ways that create a variety of mechanisms for meaningful involvement of families and youth (see Box 2.1C). In some communities with a strong family organization, families may structure their own planning process, which is formally linked to the system-building process. There may be a youth council that serves a similar purpose. These mechanisms allow for a broader family and youth voice to influence system-building planning than representation on one planning body alone might allow.

Other communities may have one planning body with multiple subcommittees or workgroups to facilitate the involvement of a large number of people. The subcommittees or workgroups may be time limited and typically establish their own guidelines for meeting schedules and places. The point is that meaningful involvement of

families and youth requires a planning process structure that is flexible and informed by the needs of families and youth.

The family preservation literature in child welfare, now over a decade old, describes a number of still very relevant strategies that can be adapted for involving families and youth in planning processes.

2.1C Strategies for Involving Families and Youth in Planning

- Provide special orientation and training as well as ongoing assistance to parents and youth who may need a better understanding of administrative, budgetary, and other issues that play a role in planning. This support should also include consulting with families and youth prior to a meeting to highlight what they might expect to be covered.
- Have more than token representation of parents and youth at meetings.
- Contract with community-based family- and youth-run organizations to develop and direct a process that ensures sustained and thoughtful family and youth participation in planning.
- Work through Head Start parent advisory groups, Parents Anonymous, and other parent and youth organizations (*such as the Federation of Families for Children's Mental Health, the National Alliance for the Mentally Ill Child and Adolescent Network, and YouthMove*).
- Ask agencies that work with families and with youth to recommend families and youth to participate in planning bodies.
- Pay a stipend to parents and youth who participate in planning sessions, provide or pay for transportation and child care, and have food at meetings.
- Hold planning meetings at various times, for example, in the evenings or on weekends, in communities across the state, and in diverse locations such as schools, community centers, and other settings that may be more familiar and comfortable to parents and to youth than state or local office buildings.
- Use a variety of methods, such as focus groups and surveys, to elicit the views of families and of youth.
- Utilize parents or youth who work regularly with parents or youth to conduct focus groups who probe the views of selected groups of parents and youth such as teenage parents, single parents, grandparents raising children, foster parents, adoptive parents, youth in foster care, and youth involved with juvenile justice systems.
- Work with family and youth support programs to tap into informal networks such as parent or youth support groups or parents or youth who routinely visit a neighborhood drop-in center.
- Work with home-visiting programs, health clinics, schools, and others to involve parents and youth who may be otherwise hard to reach.
- Work with successful programs to identify and involve families and youth who have benefited from these services.
- Conduct sessions for planning group members, administrators, and staff led by an experienced facilitator to explore attitudes and stereotypes about different ethnic, racial, and religious groups, and about parents and youth.
- Publicly acknowledge the contributions and strengths of family members and of youth.

Adapted from Emig, C., Farrow, F., & Allen, M. (1994). *A guide for planning: Making strategic use of the family preservation and support services program*. Washington, DC: Center for the Study of Social Policy and Children's Defense Fund.

Cultural and Linguistic Competence in Planning

Particularly because of issues of disparities and disproportionality, attention needs to be paid to cultural and linguistic competence in the planning process. Numerous examples of strategies in planning for cultural competence have been described (see Box 2.1D).

2.1D Strategies in Planning for Cultural Competence

- Conduct periodic assessments of the cultural and linguistic competence of existing systems serving children, youth, and families.
- Build support for the changes in knowledge, skills, and attitudes needed for the system to be culturally and linguistically competent.
- Identify, acknowledge, engage, and partner with formal and informal leadership in culturally diverse communities.
- Identify resources and leadership capacity to enhance cultural and linguistic competence for the planning process.
- Conduct sessions for planning group members with trained facilitators to explore attitudes about culture and diversity.
- Articulate values and set goals with respect to cultural and linguistic competence.
- Plan action steps in partnership with families, youth, and culturally diverse communities.
- Determine best strategies for formally sanctioning and mandating, if necessary, the incorporation of cultural knowledge into policy making, system management, and frontline practice.

Adapted from Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care* (Vol. 1). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Families, youth, and culturally diverse constituencies are critical to the planning process. The planning structure needs to create a safe environment in which these key stakeholders can share their points of view without fear of retribution. Often, effective planning structures utilize family leaders or youth to co-facilitate or co-lead the planning process and provide ongoing support to families and youth during planning meetings. Effective family, youth, and cultural leaders can help to set the tone with all stakeholders to raise the level of sensitivity to issues of family and youth partnership and of cultural and linguistic diversity. Family organizations may play a key role in reaching out to families from diverse communities to be involved in planning and other system of care functions. The system's capacity to provide basic support to families and youth, such as transportation, child care, stipends, and food, has a major bearing on success in partnering with families and youth.

The planning process structure must encompass mechanisms to build capacity among all stakeholders, recognizing that different stakeholders have different capacities for participation both with respect to information, knowledge, and skills and with regard to practicalities such as availability of transportation and child care, ability to leave work or school to attend meetings, ability to communicate in the English language when English is not one's primary language, and the like. This is true of all stakeholders, not just parents and youth; however, other stakeholders often have more resources available to them to obtain information that is lacking or to accommodate a meeting schedule than do parents and youth.

EXAMPLE 2.1A

In a neighborhood-based system of care in the Southeast, system builders engage in an ongoing strategic planning process tied to the budget development process that is structured to ensure organized input from major stakeholder partners. These partners are families, youth, staff/providers, and the governing board comprised of neighborhood residents (in the majority), state and local officials, and business and community leaders. The planning process is structured so that, initially, the neighborhood's family council (representing many families in the neighborhood), the staff and providers involved in delivering services, the youth group, and the governing body each conduct their own annual process. In this process, they each reflect on and celebrate system-building achievements, identify major unmet challenges, and prioritize goals and objectives for the upcoming year. Each individual partner group structures its own planning process as it wishes, to accommodate the needs and capacities of its members, but the individual processes are linked one to the other and fit within the overall timetable for the system-building planning process. In addition to structuring where and when they meet, individual partner groups also obtain facilitation and technical support for their processes, based on what each needs. For example, the family council utilizes a facilitator trained in working with parent organizations and engages technical assistance in areas such as budget and fund development. The governing body obtains technical assistance on strategic planning and financing.

Results of these individual planning processes are circulated among all the partners so that discrepancies and differences can be identified. All partners then come together for a daylong retreat to resolve any outstanding differences and to finalize consensus on goals for the future. This planning structure produces a strategic plan for the year.

AGENDA OF DAY LONG RETREAT

- Opening
  - Introductions and welcome
  - Review purpose of retreat and consensus-building process to date
- Accomplishments during the past year
  - Identify major accomplishments in the past year, based on consensus among partners
- Lessons learned (What factors facilitated accomplishments in the past year?)
- Unmet challenges in the past year
  - Identify major unmet challenges in the past year, based on consensus among partners
- Lessons learned (What factors contributed to unmet challenges?)
- Priorities for new fiscal year
  - Identify major priorities for the year ahead, based on consensus among partners
- Strategic Plan
  - Analyze and discuss strengths, needs, and resources related to new fiscal year priorities
  - Identify and prioritize strategies to be implemented
  - Assign responsibilities

Stages of Planning

One way to think about planning is in stages related to articulating and implementing a "theory" or theories about system change. A "theory of change" assumes that "if certain things change, certain outcomes will be achieved." The theory of change methodology tests these assumptions by implementing them (or trying to) and revising them as needed based on an evaluation of whether they are working to achieve intended outcomes. Researchers have articulated various stages of planning to support a theory of change approach to building systems of care.

2.1E Stages of Planning for Systems of Care

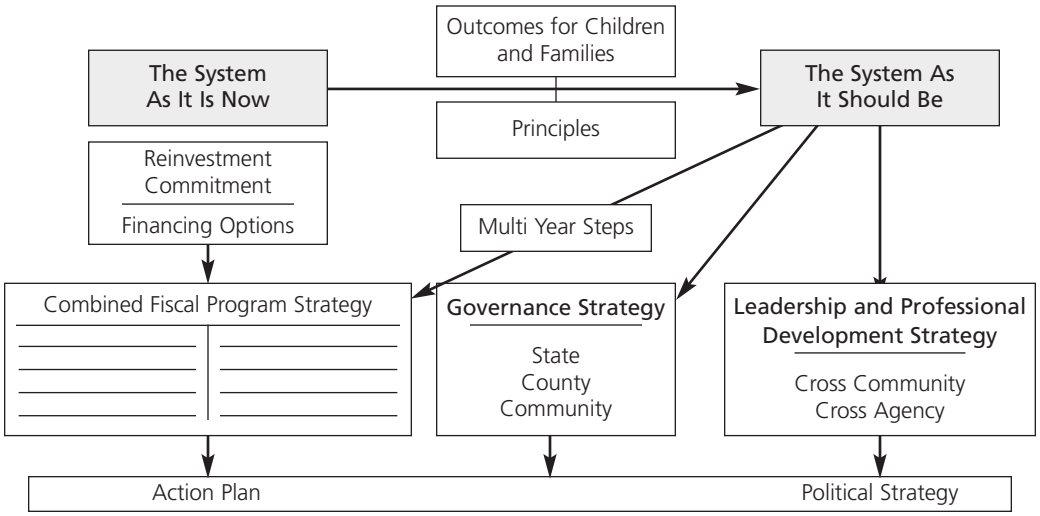
Stage 1:	Form workgroup
Stage 2:	Articulate mission
State 3:	Identify goals and guiding principles
Stage 4:	Develop the population context
Stage 5:	Map resources and assets
Stage 6:	Assess system flow
Stage 7:	Identify outcomes and measurement parameters
Stage 8:	Define strategies
Stage 9:	Create and fine-tune the framework
Stage 10:	Elicit feedback
Stage 11:	Use framework to inform, plan evaluation, and technical assistance
Stage 12:	Use framework to track progress and revise theory of change

Adapted from Hernandez, M., & Hodges, S. (2003). *Crafting logic models for systems of care: Ideas into action*. Tampa, FL: University of South Florida.

In addition to conceptualizing planning in stages related to a theory of change, creating a graphic representation of a planning process for child and family service system reform also can be an effective tool in planning. This graphic, Illustration 2.1A, was developed by Mark Friedman for the Center for the Study of Social Policy. It provides a schematic picture of how to structure the content of a planning process for reforming services for children and families, beginning with an understanding of the current system and moving to a vision of what the system should be, based on values, principles, and desired outcomes. The vision of what the system should be becomes operationalized through a number of strategies, which this diagram organizes as fiscal, governance, leadership, and professional development strategies. These strategies are guided by an action plan and a political strategy.

ILLUSTRATION 2.1A

A Planning Process for Family and Children's Service Reform



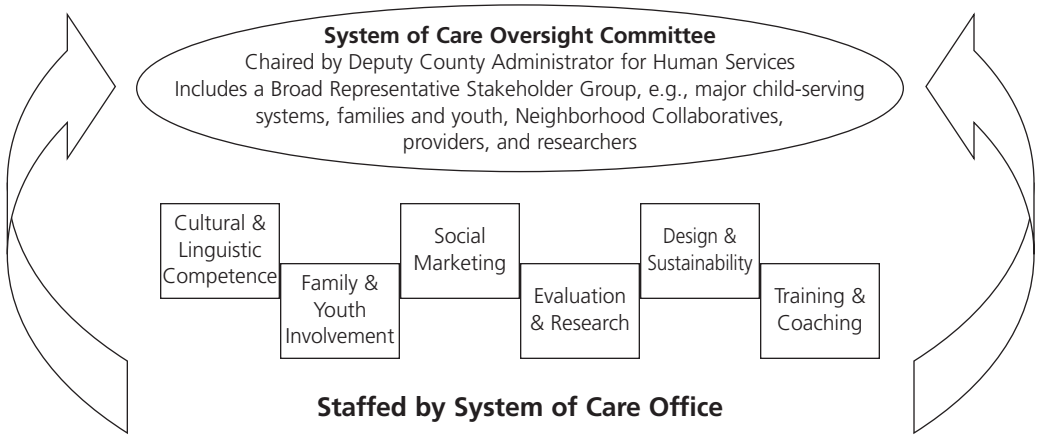
Friedman, M. (1994). *A planning process for family and children's service reform*. Washington, DC: Center for the Study of Social Policy.

The following is an example of a planning process structure for a system of care.

EXAMPLE 2.1B

Cuyahoga County, Ohio (Cleveland), offers an example of a structured planning process. There is a System of Care (SOC) Oversight Committee, chaired by the Deputy County Administrator for Human Services, which includes a broad representative stakeholder group, for example, the major child-serving systems, families and youth representing Family-to-Family Neighborhood Collaboratives, providers, university partners, and the like, with six overarching system of care subcommittees, including design and sustainability, cultural and linguistic competence, evaluation and research, family and youth involvement, social marketing, and training and coaching. This structure for planning and implementation oversight brings together several related reform initiatives into one coordinated planning and implementation approach (e.g., two system of care grants focusing on different but cross-cutting populations as well as child welfare reform). It is staffed by a "system of care office" that reports to the Deputy County Administrator. (**www.cuyahogatapestry.org**)

Cuyahoga County Planning Process Structure



Key Areas of Focus in Planning

Box 2.1F identifies key areas that must be addressed in a system-building planning process; effective planning structures achieve consensus on each of these so that implementation can proceed.

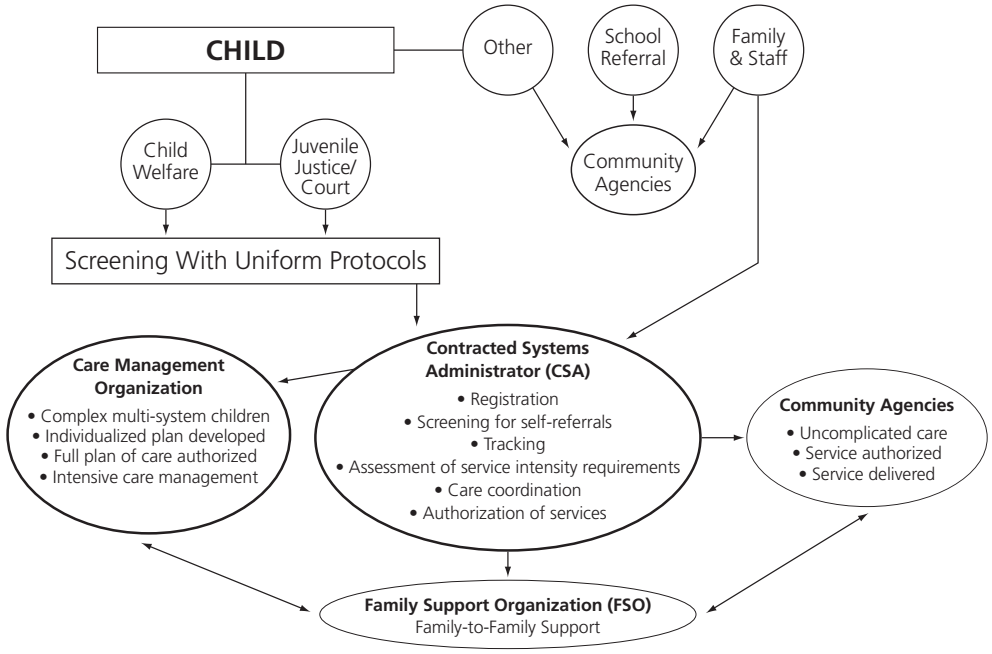
2.1F Key Areas of Focus in System of Care Planning

1. Identify the population or populations of focus—who are the populations of children, youth, and families that are the focus of the system of care?
2. Agree on outcomes to be achieved, informed by consensus on values—what do you want to achieve on behalf of the population or populations of focus?
3. Identify the services and supports that are needed and the practice model (e.g., a family-centered or *Wraparound* practice model) to achieve desired outcomes.
4. Identify how services and supports will be organized into a coordinated system—*what is the system design?*
5. Identify the administrative and other infrastructure needed to support the delivery system (e.g., data systems, quality improvement structure, structures for sustaining and growing family and youth voice, etc.).
6. Identify training, coaching, and capacity-building requirements.
7. Cost out the system of care.
8. Identify financing and sustainability strategies.

The planning process must begin with stakeholders agreeing on the population or populations of focus because it is the strengths and needs of the identified populations that will drive system design. Section III of the *Primer, The System-Building Process*, also discusses issues relating to the population of focus. The planning process also must define how the delivery system will be organized or reorganized, that is, what the system design will look like so that all stakeholders actually can draw the design. **By definition, systems of care are modifying existing delivery systems in some fashion. Planners must be able to illustrate those modifications and create a clear picture of the reformed system.** Illustration 2.1B below is a picture of the New Jersey system of care, whose population focus is all children and youth in the state with behavioral health challenges and their families who are involved with public systems.

ILLUSTRATION 2.1B

New Jersey System of Care Design



Adapted from NJ System of Care

The New Jersey planners created a picture that illustrates how families can access the system through one pathway—a statewide Contracted Systems Administrator—and how children with complex behavioral health challenges have access to specialized Care Management Organizations that work in partnership with Family Support (i.e. family-run) Organizations.

WEB RESOURCES

Planning for Sustainability at: **www.tapartnership.org/SOC/SOCsustainabilityPlanning.php**

Merging System of Care Principles with Civil Rights Law: Olmstead Planning for Children with Serious Emotional Disturbance at:
www.bazelon.org/issues/children/publications/mergingsystems/index.htm

Children's Systems of Care: A Guide for Mental Health Planning and Advisory Councils at:
www.namhpac.org/PDFs/childrens_systems.pdf

Key Questions: Planning

- How is planning structured? Is it an ongoing activity of system building or a one-time event?
- How do the structures we have for planning facilitate the involvement of parents and caregivers? Youth? Diverse communities? Other key stakeholders?
- Does the way we conduct planning create frustration for certain stakeholders? Which ones? Why?
- What have been our most successful planning process structures? How have our structures for planning evolved over time?
- What strategies can we implement to improve our planning process structure?
- Has our planning process led to consensus on the population or populations of focus and on a design for the system of care guided by a consensus on values and a practice model?

NOTES

2.2 Governance: Decision Making and Oversight at the Policy Level

Definition of Governance

Governance—policy-level decision making and oversight—should not be confused with system management (discussed separately). These are two distinct functions. Governance has to do with policy making and oversight. System management has to do with day-to-day operational decision making. In some communities, the same entities may be involved in both governance and system management, but in many communities, the players are different—and in either event, these are two separate functions. This is an important distinction to make because some entities may be appropriate for one function but not the other, and if the two functions are confused, the roles of potential stakeholders cannot be clarified. For example, a lead agency may be an appropriate entity to carry out the function of system management, but the agency's management cannot serve as the governance—that is, policy-making—structure for the system of care because system of care governance, by definition, must involve other systems and families and youth. A state-level interagency body with appropriate stakeholder representation can be an appropriate structure for a governance entity, but it cannot serve as a management entity if it lacks the technical and staffing capabilities.

2.2A Definition of Governance

Decision making at a policy level that has legitimacy, authority, and accountability.

Pires, S. (1995). *Definition of governance.* Washington, DC: Human Service Collaborative.

2.2B Key Issues for Governing Entities

- Has authority to govern
- Is clear about what it is governing
- Is representative
- Has the capacity to govern
- Has the credibility to govern
- Assumes shared liability across systems for the populations of focus

Pires, S. (2000). *Key issues for governing bodies.* Washington, DC: Human Service Collaborative.

Governing bodies for systems of care exist at the state level, at tribal levels, at the local or neighborhood levels, and in some places at all levels for the same system of care. Some are created by legislation, some by executive order, some by memoranda of agreement, and some by community will. Some are governmental or quasi-governmental bodies, and some are 501(c)(3) (private, not-for-profit) entities.

However they look, there are some basic questions to be asked about governance structures. Those listed below are far more important questions to answer initially with respect to governance structures than whether the structure should be a 501(c)(3) or a quasi-governmental or governmental entity or some other arrangement. There are pros and cons to each of these types of governance structures, depending very much on the particular circumstances in a given locality.

Basic Governance Questions

From where does the governance body get its *authority* to govern the system of care? From legislation? executive order? regulation? contractual obligation? interagency memorandum? community will (as expressed through some defined, credible process)? System of care governance structures need to derive their authority from something or someone that has the authority to give it or risk being viewed as tangential.

Is there *clarity* about what the governance body is responsible for governing? For example, in some states, there is more than one governance structure for the same system of care—one at the state level, one at the tribal level, and one at the local level. Are the roles and responsibilities of each clear and non-redundant? Even where there is only one governance structure, system builders need to be very clear about what it is governing, or there will be confusion, dashed expectations, and resentment among stakeholders.

Are those who sit on the governance body *representative* of the stakeholders who have an interest in the system of care? Does it include families and youth; state, tribal, local, and community representatives; providers; and other representatives? (If there is some stakeholder group who cannot by consensus among system builders sit on the governing body because of potential conflict of interest, in what other, more appropriate ways can this group have input into the governing body? This issue has arisen in some communities, for example, with respect to providers and in some communities has been resolved by creation of a formalized *providers forum*, which meets periodically with the governance body to offer input and feedback.) If the governance body is not representative, it will be viewed with skepticism, its decisions questioned, and its effectiveness compromised.

Does the governing body have the *capacity* to govern the system of care? That is, does it have the talent, time, staff, data management, and other resources to operate? Many times, system of care governance structures get created that are not staffed, have no dedicated resources for their own operations, and whose members have other full-time responsibilities. This is a recipe for failure. Systems of care cannot be governed out of hip pockets. Lack of capacity to govern obviously affects outcomes, builds resentment among stakeholders, unfairly assigns responsibility without providing capacity, and

sends a message that system of care governance is not valued. In some communities, the system management entity discussed below, in effect, staffs the governance body because governance and system management are subsets of the same entity. In other localities, governance and system management may be lodged within two discrete entities. The governance body may be overseeing the system management structure in a contractual relationship, for example, and in this instance needs its own staff and management information capability.

Does the governance structure have *credibility* among key stakeholder groups to govern the system of care? The answer to this question has to do not only with the answers to the questions above but also with how effective the governance body is in communicating to key stakeholders regarding its functions. A governance body may be doing a terrific job, but if key stakeholders do not know about it, it might as well be doing no job.

Does the governance structure embrace the concept of *shared liability* among partners? Systems of care serve populations of children, youth, and families for whom different agencies have legal responsibilities, for example, children involved in the child welfare, juvenile justice, and special education systems. If the system of care governance structure does not assume shared liability to meet these legal responsibilities, system builders are creating a situation of "double jeopardy" for partner agencies that have legal mandates and that have committed resources for the population to be served by the system of care. The principle of unconditional care, which is so important to the integrity of the system of care, begins with the governing body's embracing the concept of shared liability. Without it, governing bodies in effect leave themselves "outs" that are inherently suspect to partners with legal mandates and to families who are tired of having to navigate multiple systems.

Involving Families and Youth and Culturally Diverse Stakeholders in Governance

To have legitimacy, authority, and accountability, governance structures for systems of care are by necessity interagency bodies. In addition, the most effective governance structures also legitimize the voice of family and youth consumers by including them in governance mechanisms.

Families and youth and culturally diverse constituencies need to have meaningful representation on governing bodies. Some governance structures that are particularly effective involve families and youth with at least 51% representation. They also involve families or youth as co-leaders of governance processes. System of care policies are more likely to be embraced by those who are being served if there is high-level commitment to their representation on policy-making bodies. Some systems of care contract with family organizations to reach out to families and diverse communities to ensure full representation in governance functions. Some governance structures may include key family or youth members who represent larger constituencies, such as the head of the statewide family network, foster family association, organizations of current and former

foster youth, and other youth forum representatives. A similar strategy can be employed to ensure representation from culturally and linguistically diverse communities by reaching out to the leaders in those communities to be involved in governance. (See Box 2.2C for a description of culturally and linguistically competent governance activities.) Individuals representing specific populations on governance structures must have credibility with those populations for the governing body to be sanctioned by the community and garner grass-roots support.

2.2C Culturally and Linguistically Competent Governance Activities

- Identify and recruit members for the governing body that reflect the population or populations of focus.
- Create/revise policies to affirm support for a culturally and linguistically competent perspective.
- Conduct an annual demographic analysis and needs assessment.
- Allocate adequate funds.
- Develop formal partnerships with cultural community agencies (e.g., faith-based entities and traditional cultural providers).
- Develop strategies to support and retain diverse board members (e.g., identification of key leaders, mentoring, and partnering).
- Develop a policy for timely provision of interpretation services and allocation of bilingual staff.
- Develop a policy for reimbursement of services provided by youth and families who serve on boards and committees, provide outreach services, and engage in other system-building activities.

Types of Governance Structures

The key issues for governing bodies must be settled first before determining the *type* of governance structure. As noted above, there are several different types of governance structures, such as state/local interagency bodies, tribal authorities, quasi-governmental entities, and non-profit boards. The type of structure and membership on it also is inherently driven by the population focus. For example, if the focus is on the early childhood population, there may be an existing Early Intervention governance structure in the state or community. It might make more sense to undertake reform efforts under the auspices of this body, with appropriate changes as necessary in its policy focus and membership, rather than to create yet another governance body. Also, the membership of a governance structure focusing on the birth to three population will look different from one focusing on, say, transition-age youth.

EXAMPLE 2.2

In **Cuyahoga County, Ohio**, the governance structure is the *System of Care Oversight Committee*, which operates under the auspices of the County Deputy Administrator for Human Services. This governance structure has a very broad representation because it is focusing on many different high-risk populations of children, youth, and families involved, or at risk for involvement, in multiple systems. (**www.cuyahogatapestry.org**)

Example of an Evolving Governance Structure

Governance structures typically evolve over time as they wrestle with and resolve the key issues described above, as illustrated by the following example of a county-level governance entity.

ILLUSTRATIONS 2.2A&B

Illustrations 2.2A and 2.2B describe the evolving governance structure in a county in which the state enacted legislation requiring counties to reduce the number of children in out-of-county residential placements. This county lodged its system of care initiative to meet this goal in a lead public agency—the child welfare agency (DSS), which had the greatest number of children in out-of-county residential treatment, although the county envisioned this as an interagency reform. In Illustration 2.2A, it is not clear from whom the governing body derives its authority. It also is unclear what the governing body oversees since it appears as if DSS actually is in charge. (Indeed, when asked to whom the SOC Supervisor reports, both the DSS Director and board members responded, "To me/us.") Although the board includes representation from a statewide family organization, it does not include representation from families and youth actually served by the system. Providers seem to have no voice in this structure. The structure seems to suggest that service coordinators "belong to" DSS. There are no feedback loops between the board and staff and families. Those closest to the ground, who often know the most about what is happening—i.e., care coordinators, families, and youth—seemed to be most removed from the board. It does not appear as if the board shares liability for outcomes; it would appear as if DSS is solely liable.

Over time, this governing body restructured, as shown in Illustration 2.2B. The County Executive drew up an Executive Order to give the board its authority and cited the state legislation. The DSS Director's role became the same as that of other board members (even though the project remains "housed" in DSS for operational and management purposes). The SOC Supervisor reports to the board and meets with the board monthly. In addition to representation from the statewide family organization, the board changed its bylaws to increase family and youth membership and ensure representation from families and youth actually being served by the project. The board decided against including providers on the board, citing concerns about potential conflict of interest, but instead created a *providers forum*, which meets quarterly with the board. Communication and feedback loops are shown in Illustration 2.2B by two-way arrows, indicating that care managers now have direct input to the board on a periodic basis, in addition to providing input through the SOC Supervisor, who functions as staff to the board. Families and youth served by the system, but not actually serving on the board, meet quarterly with the board. The Executive Order and the board's bylaws make it clear that the board is sharing liability for outcomes.

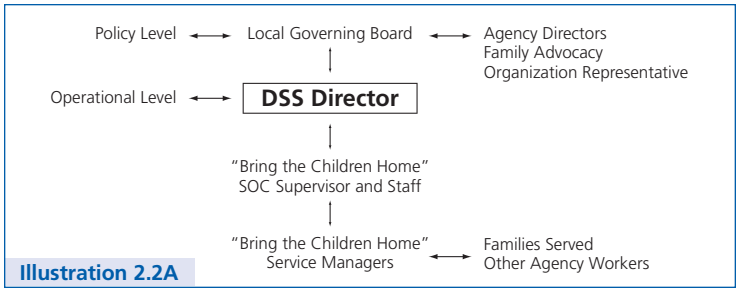


Illustration 2.2A

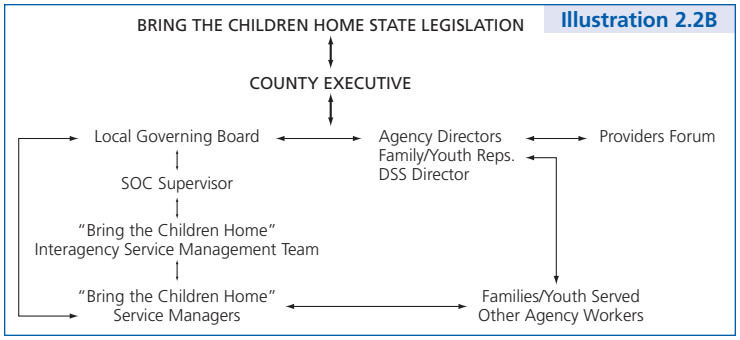


Illustration 2.2B

Adapted from Pires, S. (1996). *Evolving governance structure*. Washington, DC: Human Service Collaborative.

WEB RESOURCES

Cultural Competence Considerations in Governance at:
www.chadwickcenter.org/Documents/WALS/Adaptation Guidelines - Organizational Competence Priority Area.pdf

Key Questions: Governance

- What is the governance structure for our system of care?
- How does our governance structure incorporate partnership with families and with youth, and what makes the structure culturally competent?
- Does our governance entity have the authority, capacity, and credibility to govern effectively?
- Has it assumed shared liability for the identified population or populations?

NOTES

2.3 System Management

Issues for System Management Structures

System management has to do with *day-to-day operational decision making*. A number of key issues must be addressed for system management entities, as described in Box 2.3 below.

2.3 Key Issues for System Management Entities

- Is the reporting relationship to the governance structure clear?
- Are expectations and outcomes to be achieved clear?
- Does the system management entity have sufficient technical and staff capacity?
- Does the system management entity have credibility with key stakeholders?

As with governance structures, before determining what type of management structure makes sense, system builders need to be able to answer a number of questions:

- Is the **reporting relationship** clear; that is, is it clear to whom the system management structure reports?
- Are **expectations** clear about what the system management structure is managing and what information it is expected to provide to the governing body?
- Does the system management structure have the **capacity** to manage, that is, with qualified staff, data management capability, leadership, and so on?
- Does the system management structure have **credibility** with key stakeholders, or can it create such credibility? For example, let us say that the system management function is being contracted to a commercial company that lacks credibility with certain key stakeholder groups because it is a profit-making entity and/or because it lacks familiarity with the population. With orientation and training, communication, targeted strategies to build relationships with stakeholders, limits set on profits, and the like, in addition to effective performance, is it possible to create credibility? If not, no matter how effective the performance, there is likely to be a constant "energy drain" from system-building efforts caused by the negative perceptions and resistance of key stakeholders.

Types of System Management Structures

System management may be lodged with a lead state or local agency, an interagency body at either level, a tribal agency, a quasi-governmental entity, a private, nonprofit lead agency, or a commercial company, such as a managed care organization. System management might be lodged with one entity or co-shared, for example, between a family organization and a lead provider agency or between a commercial company and a state agency or between a commercial company and a coalition of nonprofit providers. When system management is co-shared, clarity as to the roles and responsibilities of each party is critical.

There is no one right or wrong type of structure, but system builders need to weigh strategically the pros and cons of different structures to determine what is the best fit for their particular system of care. In some localities, for example, particularly where there are many 501(c)(3) organizations, creation of a new 501(c)(3) may be viewed as "creating yet another private nonprofit that will compete for funds." In other localities, designation of an existing private nonprofit agency to serve as system manager might not be viable for political or technical reasons (i.e., there may simply be no existing organization with the capacity to perform system management functions). In some states or localities, because of long histories of contention and mistrust across child-serving agencies or because the internal management capability does not exist, it may not be possible to designate a lead government agency as system manager. In still other circumstances, it may not be possible to use a commercial company because of stakeholder resistance to use of profit-making entities or stakeholder beliefs (and, perhaps, the reality) that commercial companies lack adequate knowledge of populations that rely on public systems of care.

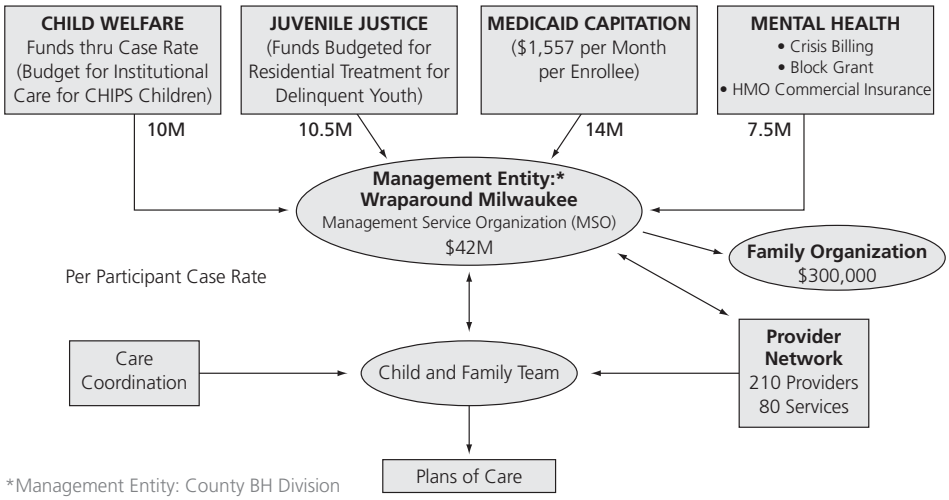
Locus of Management Accountability for Populations of Focus

An important concept in systems of care is the creation of a *locus of management accountability* for the populations that are the focus of the system of care. As already discussed under governance, accountability and liability at a policy level need to be shared. However, if system management is spread across many systems, it is unlikely the system will be well managed as an integrated delivery system, even with shared governance. Indeed, that is basically the structure we have had historically, with multiple systems managing different pieces of the system for the same families. When every system is responsible, in effect, no one ultimately is accountable. A system of care approach seeks to create one locus of management accountability for the identified populations, which is managing as many relevant pieces of the system as possible and is deliberately coordinating around the pieces that need to remain with any given system.

EXAMPLE 2.3A

Example of a Lead Public Agency Management Structure

In **Milwaukee County, Wisconsin**, Wraparound Milwaukee manages virtually everything related to children in or at risk for residential treatment, including placements, behavioral health services, and basic supports for families, like transportation; for the pieces it does not manage directly, including physical health care and treatment services for adult family members, it intentionally seeks to coordinate with those systems. The management entity is a lead public agency, the county children's behavioral health division. (**www.milwaukeecounty.org**)

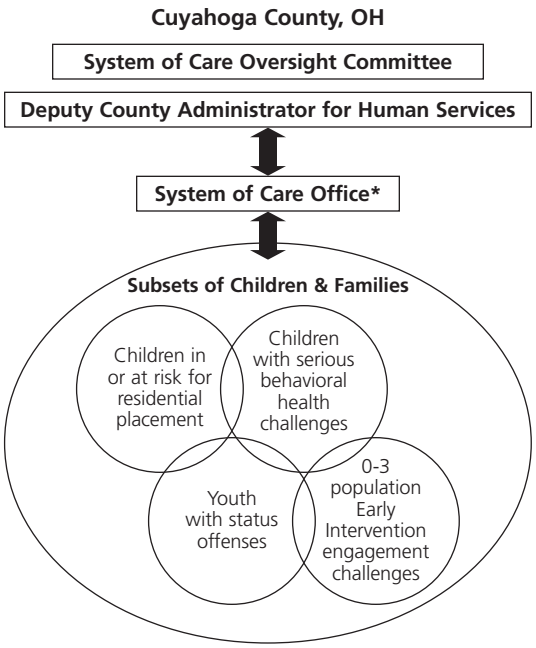


Adapted from Wraparound Milwaukee, 2008, Milwaukee County, Milwaukee, WI.

EXAMPLE 2.3B

Example of In-House Management Structure

In **Cuyahoga County, Ohio**, the county System of Care Office reporting to the Deputy Administrator for Human Services serves as the locus of management accountability for subsets of children and families involved in multiple systems or at high risk for involvement, including children and youth in or at risk for residential placement, youth who have status offenses, children with serious behavioral health problems, and a subset of the 0-3 population whose families the Early Intervention Program is having difficulty engaging. (**www.cuyahogatapestry.org**)



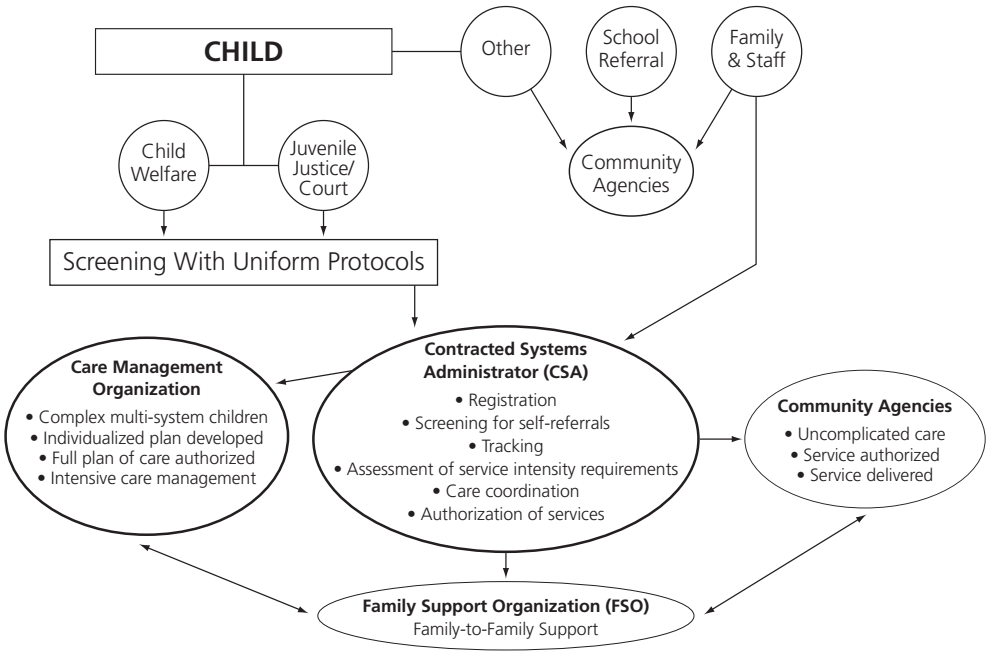
*Functions as an Administrative Services Organization

EXAMPLE 2.3C

Example of a Contracted Management Structure

In the **New Jersey** system of care for children with behavioral health challenges and their families, management accountability is shared between a statewide Administrative Services Organization (a contracted commercial behavioral health managed care organization) and locally based Care Management Organizations (private, nonprofit agencies), which are accountable for the subset of youth with serious and complex behavioral health challenges and which work in partnership with family-run organizations.

Management Shared Between a Commercial Managed Care Organization Operating as an Administrative Services Organization Statewide and Locally Based Lead Nonprofit Organizations



Adapted from NJ System of Care

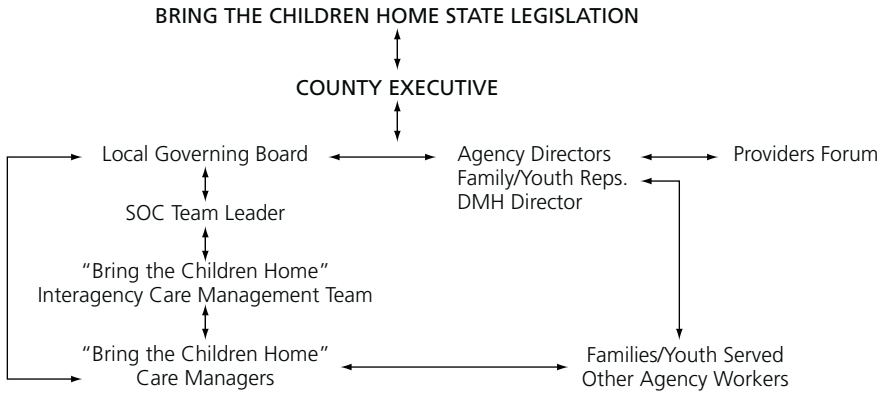
Relationship Between Governance and System Management Structures

There needs to be a clear relationship between governance and system management structures. Illustrations 2.3A and 2.3B are different illustrations of system management structures that also show the relationship to the governance structure.

Although both of these structures are quite different, they each clarify the reporting relationship to the governing body and the expectations about what is to be managed. Each invests capacity within the system management structure to manage the system of care.

ILLUSTRATION 2.3A

In Illustration 2.3A, the governance structure is an interagency body created by executive order; the management structure is an in-house management team with system management and clinical/care management staff. In this example, the system of care team leader reports directly to the interagency governance board (even though the project is "housed" within the Department of Mental Health), and the system of care team leader staffs the governing board (similar to an executive director in a nonprofit organization staffing a board of directors).

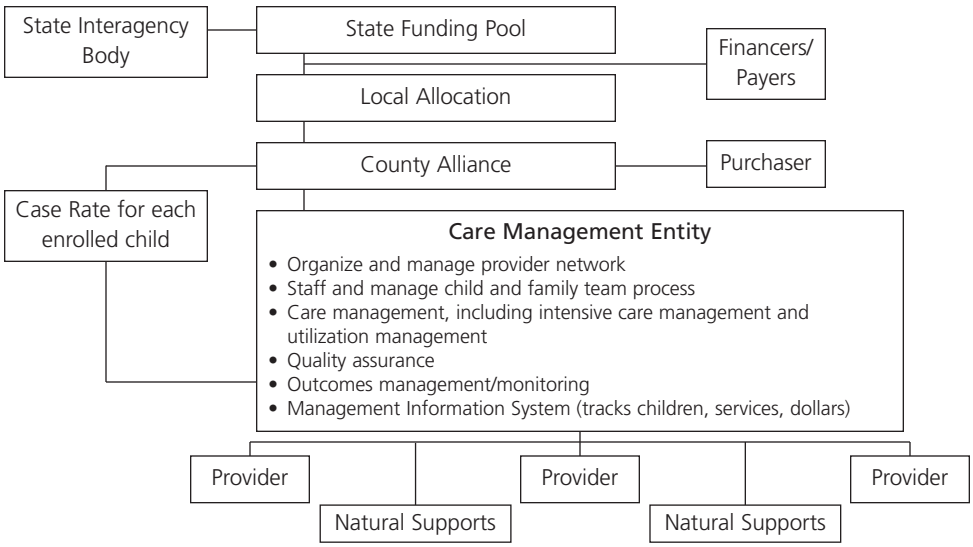


Pires, S. (1996). *In-house system management structure.* Washington, DC: Human Service Collaborative.

ILLUSTRATION 2.3B

In Illustration 2.3B, the governing bodies are a statewide interagency body and a countywide purchasing alliance or cooperative that has taken the form of a new quasi-governmental governing body. The system manager is a commercial managed care company that has partnered with a lead nonprofit provider in the county. The system manager is contractually accountable to the county purchasing alliance. The county purchasing alliance has its own monitoring and quality assurance staff.

Example of Governance/Management Structure



Adapted from Pires, S. (1996). *Contracted system management structure.* Washington, DC: Human Service Collaborative.

System Management Accountability for High-Utilizing Populations—Care Management Entities

When systems of care are managing "total populations," for example, all children and youth in a given county or statewide who need behavioral health services, there needs to be built into the system customized management accountability for subpopulations of children with serious and complex issues and their families. For example, in the **New Jersey** system of care, which is focusing on all children in the state involved in public systems who need behavioral health services, there is a statewide systems administrator for the system as a whole. In addition, at a local level, there are locally based Care Management Organizations that have responsibility to serve as a more customized management entity for children with serious and complex issues and their families.

In **Maryland**, under the auspices of the Governor's Children's Cabinet, the state has created regional Care Management Entities to serve as customized management entities for various subpopulations of children and youth who historically have high and/or inappropriate service utilization, including children in or at risk for psychiatric residential treatment, youth who can be diverted from detention, and children younger than 12 who are involved in child welfare and can be diverted from group home placements.

In **Massachusetts**, the system of care for all Medicaid-eligible children who need behavioral health services and their families has created locally based Community Service Agencies (i.e., Care Management Entities) to serve as the accountable entities for children with serious emotional disorders and their families who were part of a class action lawsuit (*Rosie D.*) and found to receive an inadequate array of services and intensive care management under more traditional Medicaid approaches.

Section II, Subsection 2.7 of the *Primer, Care Management and Service Coordination, Including Use of Care Management Entities*, discusses the critical role of intensive care management, Care Management Entities, and a *Wraparound* approach within these customized system management structures for populations of children and youth with high needs.

When Managed Care Is a Factor

For states in which managed care is the primary system management structure for certain populations of children and families and certain services—for example, Medicaid managed care systems—system of care values, principles, and operational elements can be built into the larger system. **Arizona** is an example of a state whose behavioral health managed care system in the public sector incorporates system of care values and practices. Providers in the system are mandated to use a child and family team (i.e., *Wraparound*) approach to service planning and management and to utilize family and youth peer mentors. Family-run organizations provide key services in the system such as respite, peer support, and family education and support. The system tracks progress in use of home and community-based alternatives to more restrictive services and covers a

wide range of services and supports. It builds in outreach to and culturally appropriate services to diverse children and families such as Native American and Hispanic children and youth.

New Jersey provides another example of a behavioral health managed care system serving a total (statewide) population that incorporates system of care values and technologies, including customized Care Management Entities for children with serious and complex issues and meaningful (i.e., funded) partnerships with family-run organizations.

Involving Families and Youth in System Management

Examples of how system management structures can involve families and youth and diverse constituencies include their providing input/evaluation regarding:

- Key management positions;
- The quality of services and the overall functioning of the system of care;
- Resource allocation decisions;
- Service planning and implementation;
- Management policies and procedures; and
- Grievance and resolution procedures.

Families and youth may be involved in management advisory capacities, in management oversight, such as quality improvement (QI) processes, and in management operations, such as reviewing bid proposals and personnel selection. Families and youth also increasingly are hired within management structures in key staff and leadership positions.

Culturally and Linguistically Competent System Management Structures

System management structures may become more culturally and linguistically competent through such strategies as:

- Implementing policies to hire from racially, ethnically, and socioeconomically diverse communities;
- Modifying job descriptions to require development of cultural knowledge and cross-cultural practice skills;
- Incorporating QI measures that reflect the issues facing diverse communities;
- Undertaking concerted outreach to and relationship building with diverse communities;
- Conducting cultural "self-assessments" to ensure that management operations are culturally and linguistically competent; and
- Organizing a cultural and linguistic competence committee and giving it authority to monitor service delivery and provide guidance to management.

WEB RESOURCES

The Arizona Vision at: **www.azdhs.gov/bhs/principles**

Wraparound Milwaukee as a unique managed care entity at:
www.milwaukeecounty.org/router.asp?docid=7890

Key Questions: System Management

- What does our system management structure currently look like?
- Do we have a customized management structure for subpopulations of children and youth with high needs and their families?
- Is the reporting relationship to the governing body clear?
- Is it clear what is to be managed?
- What capacity does the system management structure have to manage effectively?
- What have we done to ensure that the system management structure has the credibility to manage?
- How have we incorporated families, youth, and cultural and linguistic competence into our management structure or structures?

NOTES

2.4 Outreach, Engagement, and Referral

Outreach and Engagement Issues

A goal of systems of care is to improve access to appropriate services and supports for children and their families within the population of focus. If for no other reason than that system building creates significant changes in existing systems, system builders need to structure outreach and referral mechanisms to ensure appropriate access. In addition, most systems of care are trying to reach populations of children, youth, and families who have been underserved or inappropriately served in the past, such as ethnically and racially diverse children and those in rural areas and inner cities. Failure to structure effective outreach approaches to these populations sends a message about the seriousness of system builders to improve access.

System builders need to think strategically about the question, "Who is it we are trying to reach?" This question encompasses a number of outreach and engagement issues, including: How are we going to structure outreach activities to the population or populations of focus? How are we going to reach out to culturally diverse communities and partner with these communities and with parents and youth in outreach efforts? How are we going to engage needed system partners? For example, if the population of focus is transition-age youth, strategies are needed to reach out to and engage the youth themselves, as well as resources in the community, such as community colleges and housing agencies.

How outreach is structured will affect access. For example, relying either on written materials sent by mail or on telephone outreach makes little sense for populations who may not or cannot read the material or who may not have phones. In some communities, there is deep distrust of formal delivery systems; therefore, the most effective outreach involves use of natural helpers "reaching out" to families in their natural settings, such as supermarkets, places of worship, and the like.

EXAMPLE 2.4A

In a city in the South, "walkers and talkers," who are residents from the community, knock door to door in a housing development to sign up children for the State Children's Health Insurance Program and explain the benefits to parents, as part of an Annie E. Casey Foundation-sponsored outreach effort that recognizes "the importance of the messenger."

See *AdvoCasey,* 2(1) (2000, Spring/Summer) Baltimore, MD: Annie E. Casey Foundation.

Roles for Families and Youth in Outreach and Engagement

Families and youth are critical partners in helping to develop and implement plans for effective outreach. They are effective spokespersons to share information with other families and youth and to advocate for their involvement in system building (see Box 2.4).

2.4 Potential Roles for Families and Youth in Outreach and Engagement Activities

- Family and youth peer helpers can be present and available to families at strategic points in the system, such as child protective services offices, family court, and mental health clinics.
- Families and youth can help build formal and informal environments of trust, such as focus groups, education forums, social events, and support groups.
- Family- and youth-run organizations can be contracted with to provide outreach and engagement and to help systems understand population needs and diverse cultures.
- Systems of care can support families and youth to share information with one another, such as phone trees, chat rooms, and other ways.
- Systems of care and families and youth can co-sponsor conferences and design workshops to create bridges of trust between systems and communities.

Culturally Competent Community Engagement

Many families and youth, and especially those from diverse cultures, will not comply with mandated service requirements, initiate service involvement, or remain in services if the pathway to services is inaccessible or insensitive to family and cultural issues. Principles of culturally competent community engagement include: the process of working with natural, informal supports and helping networks within culturally diverse communities; the concept of communities determining their own strengths and needs; partnership in decision making; meaningful benefit from collaboration; and a reciprocal transfer of knowledge and skills among partners.

EXAMPLE 2.4B

The Everglades Health Center in **Dade County, Florida**, employs a number of culturally competent outreach and engagement strategies, including: signs in several languages; literacy programs; audio cassettes in multiple languages; and use of mini soap operas on the radio on critical community issues, such as substance abuse and domestic violence, with follow-up from health care outreach workers. (**http:/nccc.georgetown.edu**)

Referral Issues

In addition to outreach and engagement strategies, referral needs to be structured—who can refer? can families and youth self-refer? where are referrals made? The issue of how to structure referral is sometimes cast as a debate between polar opposites—a narrow referral base in which, for example, only partner agencies can refer versus an open referral process in which anyone can refer, including families and youth self-referring. In reality, there is a legitimate tension between the goal of having an "open" system for the identified population and that of managing access so that the system is not overwhelmed, with mounting waiting lists and discouraged stakeholders as a result. Families *will* use a quality system (the "if you build it, we will come" phenomenon), and in virtually every community there is significant pent up demand for services—which argues for an open system. On the other hand, nothing can torpedo a developing system faster than growing waiting lists and uncontrolled costs—which argues for a narrower referral base. Many systems of care structure staged referrals, in which the referral base expands as system capacity develops.

If you build it, we will come.

There is no one correct answer on how to structure referrals, which depends, in any event, on such factors as system capacity, resources, extent of pent-up demand, political implications, and the like. What is important is for system builders to analyze such factors, recognize the pros and cons of whatever referral structure is established, and communicate to stakeholders the rationale for the structure that is put in place.

Decisions about the structure of outreach and referral mechanisms are a concern of both state- and local-level system builders. State-level stakeholders, for example, may be making referrals to a local system of care through state-run child welfare systems or mental health facilities; and states control resources such as Medicaid and Temporary Assistance to Needy Families (TANF) dollars that can help to support outreach. In addition, information gathered during outreach and referral processes usually has to be submitted in some fashion back to states for reporting and other purposes. Localities and tribal communities, on the other hand, typically are in the best position to design outreach and referral mechanisms that address the particular needs and strengths in the community.

WEB RESOURCE

Family and Youth Engagement at: **www.childwelfare.gov**

Key Questions: Outreach, Engagement, and Referral

- What are our current mechanisms for outreach? How are we reaching out to historically underserved groups in our community, including ethnically and racially diverse families and those isolated in rural areas or inner cities?
- How do our outreach and engagement strategies incorporate partnerships with families with youth, and with cultural leaders?
- What is the structure of our current referral system?
- What is working with our current referral system? What is not?
- Have we explained to stakeholders how and why our current referral system operates as it does?

NOTES

2.5 System Entry/Access (Intake)

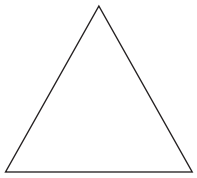
Organizing a Pathway to Services and Supports

A goal of systems of care is to provide a more organized pathway to services and supports for the population or populations of focus, in contrast to the multiple, typically confusing paths to services posed by the traditional, fragmented delivery systems. Families under stress, with complex issues going on, are unlikely to have their service needs met or themselves meet service requirements if the pathway to services and supports is confusing or difficult to manage. System builders sometimes refer to a "centralized intake" or a "system gatekeeper" within systems of care, but that terminology can be off-putting to families and other stakeholders and can convey a bureaucratic rigidity that is not necessarily intended. This author prefers to use the terminology, *an organized pathway to care*.

An organized pathway to care, depicted in Illustration 2.5A, does not necessarily mean there is just one place to go to enter the system of care (although it might). System builders must make strategic decisions about whether to create multiple entry points or a single access point, and there are pros and cons to each. Some systems of care decentralize entry to the system of care with multiple entry points with the goal of making the system more accessible for youth and families. The potential downside to this arrangement is loss of control over system entry, including loss of quality control, since it can be more difficult to monitor the quality of multiple entry points. Other systems of care centralize the entry to care with, literally, one access point, with the goal of making the system less confusing to families and exerting more control over access. The potential downside to this arrangement is that system entry may be perceived as or may actually be inaccessible to families and too controlling.

ILLUSTRATION 2.5A

Organized Pathway to Care

Multiple Entry Points		One Access Point
+ more accessible		+ less confusing
- loss of entry control		+ more entry control
- loss of quality control		- inaccessible
+		-
-		-

Can create virtual single pathway through an integrated Management Information System (MIS)

System builders need to weigh the pros and cons of various approaches within the context of the goals they are trying to achieve and recognize that different approaches have differing effects on system stakeholders. In one community, for example, youth and families might like multiple system entry points, whereas in another community families would find that arrangement confusing. *What also is important to note is that, regardless of the approach taken, intake can be "centralized"—by investing with the systemwide manager (rather than with multiple decentralized offices) the responsibility for organizing and managing system entry and by effectively using management information systems (MIS) to centralize intake data.*

We like having all these places to find out about services.

Creating an organized pathway to care—whether through one entrance point in a community or through multiple entryways—is essential for many reasons, among them the following:

Having one, central place is so much easier for us.

- Children, youth, and families with or at high risk for complex challenges typically are involved in, or at risk for involvement in, multiple systems (such as education, child welfare, juvenile justice, mental health, and substance abuse). **An organized pathway to services provides a mechanism to ensure that all of these systems are "at the table" when care planning is done, so that families do not have to navigate multiple systems to obtain care.**
- The services and supports needs for youth and their families do not remain stagnant. They change, often frequently, over time. **An organized pathway to care that leads to care planning, management, and monitoring ensures that families do not have to renavigate systems every time service and support requirements change.**
- Care for children, youth, and families with complex challenges who are involved in multiple systems needs to be managed—from both a cost and a quality standpoint. **An organized pathway to care facilitates the ability of the system to know who is in care; how much service is being utilized, which services, and how many; and what is the cost of care.**
- Through an organized pathway to care, the delivery system can more readily convey systemwide values and link youth and families to systemwide supports, such as family and youth peer mentors and system navigators.

Box 2.5 offers some elements of an organized pathway to care and their purpose.

2.5 An Organized Pathway to Care

ELEMENT	PURPOSE
Systemwide Manager	To organize and manage system entry To effectively use information technology to "centralize" intake and care management data
Multiple System Representation	To ensure all systems are "at the table" To keep families from having to navigate multiple systems
Care Planning, Management, and Monitoring	To ensure that families do not have to re-navigate systems for every service and support requirement change
Cost and Quality Management	To know who is in care To know how much service is being utilized, which services, and how many To know the cost of care
Family and Youth Centered, User Friendly, and Culturally Competent	To provide linkage to peer supports To operate from a strengths-based approach To convey system values and goals

Pires, S. (2009). *An organized pathway to care.* Washington, DC: Human Service Collaborative.

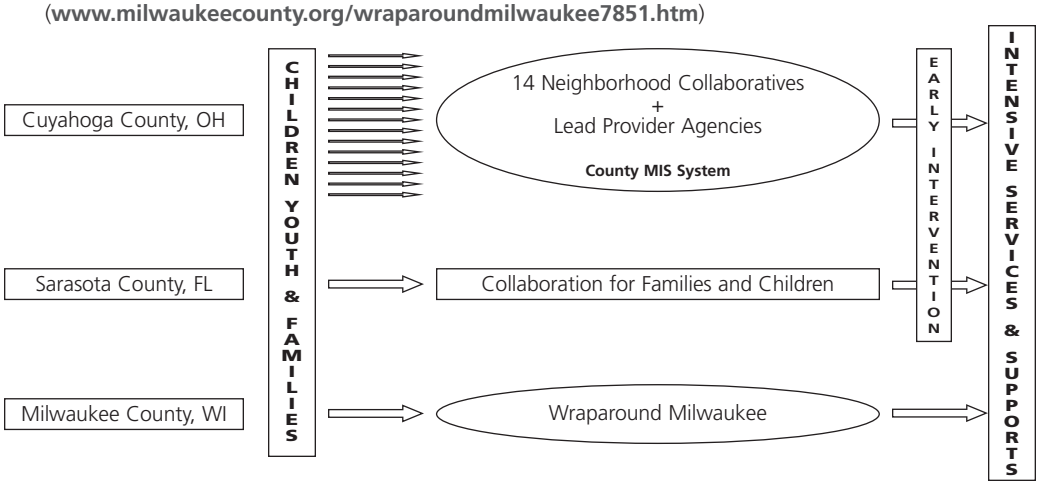
EXAMPLE 2.5A,B&C

Examples of Organized Pathways to Services

A. In **Cuyahoga County, Ohio**, 14 Neighborhood Collaboratives serve as identifiable pathways to services and supports for families at risk for involvement in child welfare. The county is partnering the Collaboratives with lead provider agencies to extend the pathway to families already involved in the system, indeed in multiple systems, who need intensive services and supports and care management. Through the county's MIS system, system managers will be able to track activity at all entry points, and system managers can ensure that the same family-centered, Wraparound practice model, supported by training and coaching, is utilized at all sites. This is an organized pathway with multiple entry points. (**www.fcfc.cuyahogacounty.us/services.htm**)

B. In **Sarasota County, Florida**, the Collaboration for Families and Children serves as the single organized pathway to services and supports for all children referred by child protective service investigators, including both children and families at risk and in placement. (**http://aspe.hhs.gov/hsp/CW-financing03/ch1.htm**)

C. In **Milwaukee County, Wisconsin**, Wraparound Milwaukee serves as the single organized pathway to services and supports for all children and families referred by the court for intensive services and supports. In the past, these children and families would have been placed in residential treatment. (**www.milwaukeecounty.org/wraparoundmilwaukee7851.htm**)

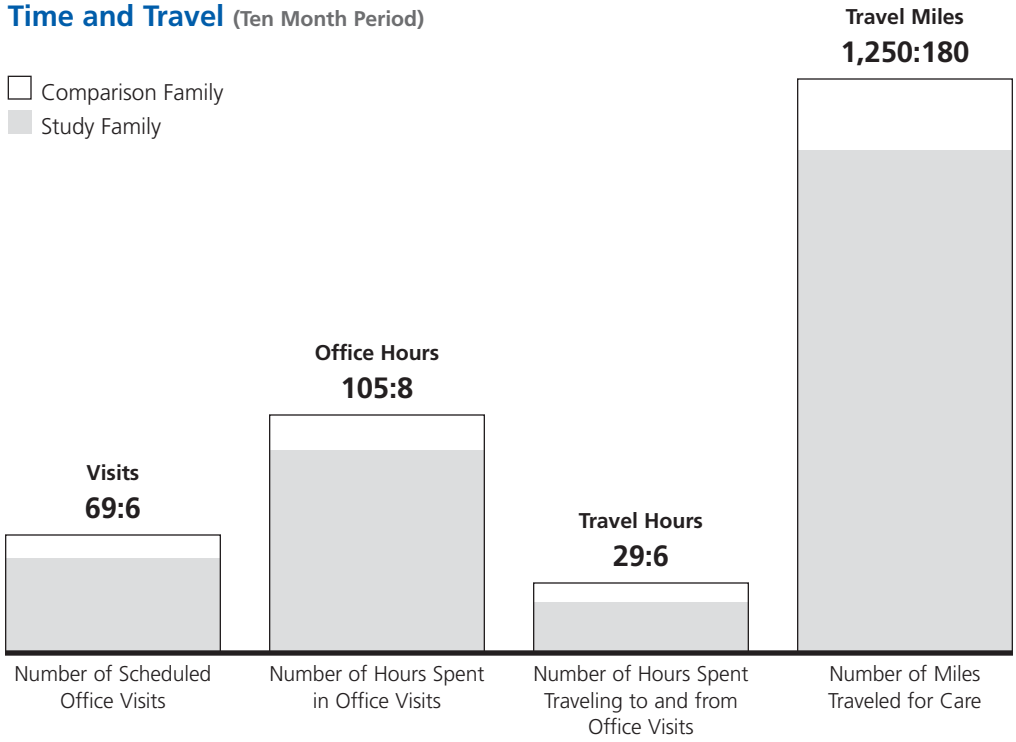


Unburdening Families

Navigating traditional service pathways that are disconnected and fragmented is time consuming and stressful for families who have complex needs to try to obtain services and supports. Illustration 2.5B shows the results of a study in Florida that examined the amount of time spent by a family with a child with serious emotional problems to access services, compared with a family whose child of the same age and race did not have serious behavioral health needs. The family who had a child with a serious behavioral health challenge had over ten times the number of office visits and spent nearly five times the number of hours traveling to appointments as the family who did not have a child with special needs. At the time of this study, the family of the child with serious behavioral health challenges (the mother, father, and three children) was living together and was not involved with child welfare. However, the stress of their situation affected their family. The mother reported that she feared losing her children to "the system" as she was beginning divorce proceedings and was afraid she would be "living out of her car in the not so far off future." Imagine the number of additional hours the family would have spent with a caseworker if the family were also involved with child welfare. Understanding the burden on families of trying to access services and supports when there is no organized pathway, and developing strategies to make the pathway less stressful, is a critical step for system builders.

ILLUSTRATION 2.5B

Time and Travel (Ten Month Period)



Lazear, K. (2003). *Family experience of the mental health system*. Tampa, FL: Research and Training Center for Children's Mental Health.

Family- and Youth-Centered, Culturally and Linguistically Competent System Entry

An important part of structuring the pathway to services and supports has to do with how families and youth and culturally diverse constituencies will be received when they enter the system, training for intake workers in system of care principles, the types of forms families must complete, whether entry is culturally and linguistically competent, and whether there are partnership roles for families, youth, or natural helpers in system access. *All of these aspects of first encounters with the system of care send a powerful message regarding system values and goals*. Systems of care increasingly are hiring parent partners to support families when they enter the system and are linking youth to youth peer support groups. Some make sure that paperwork is simplified to every extent possible. Effective systems of care strive to develop a point of access to services and supports that is understandable to families and youth, is non-stigmatizing, and links them to information, strong assessment capacity, and a range of services and supports, including peer support.

EXAMPLE 2.5D

Maryland is an example of a state that is engaged in a reform initiative spearheaded by the Governor's Office for Children to create "single points of access" in localities for families in need of services and supports that are also embedded in a system of care practice model (i.e., strengths based, family centered, individualized, culturally competent, and cross-agency). Many of the Maryland counties are developing structures that connect families to family or system navigators. (**www.goc.state.md.us**)

A Story From the Newspaper

The following is from an editorial in *The Washington Post* by Jeff Katz, founder of the Listening to Parents project (www.listeningtoparents.org). It is an illustration of how outcomes are affected by the way in which "system entry" is structured, in this case, entry to becoming an adoptive parent in the public system.

"Contrast two of the locations we studied for a 2005 report: In San Jose, everyone calling to inquire about adoption was invited to a meeting designed to inform prospective parents about the children available and to get parents into the training program. In Miami, everyone calling to inquire about adoption was required to fill out a two-page questionnaire, over the phone, that included sensitive personal and financial information. Those who 'passed' the call were invited to an information meeting that began with an announcement that all attendees would be fingerprinted at the front of the room. Is it any wonder that a prospective parent in San Jose was 12 times more likely to adopt than a prospective parent in Miami?"

WEB RESOURCE

Community Ideas for Improving Access at: **www.aap.org/commpeds/schip/comm_idea.html**

Key Questions: System Entry/Access (Intake)

- How is our entry to the system of care structured?
- How do families actually enter the system and what is their experience with the process?
- How are we using an organized pathway to services as a mechanism to support greater accountability and quality improvement?
- How do our pathways to care incorporate partnerships with families and with youth, and what makes the pathway culturally and linguistically competent?

NOTES

2.6 Screening, Assessment, Evaluation, and Service Planning—Changing Practice

Overview

Screening, assessment, evaluation, and service planning are three distinct functions that are closely linked, one building on the other to generate a deeper understanding of the strengths, resources, and needs of individual children and their families. These functions need to be linked in a continuous process and by a common practice model, that is, one that embodies the characteristics of being individualized, strengths based, culturally and linguistically competent, coordinated across agencies, and carried out in partnership with families and with youth, not "done to them." In systems of care, this practice model often is referred to as a "*Wraparound* approach." Sometimes, states or localities may refer to this practice model as a *family-centered practice approach*. Together, when linked by a common practice model, these functions enable development of effective, individualized, and common (across agencies) plans of care.

Definitions

Screening is usually the first step of an ongoing process to determine a child's need for services. It serves a triage function to ensure children reach an appropriate level of assessment. In the field of early intervention, that is, services for children ages birth to three, screening takes on the added concept of identifying at an early stage children who have a high probability of exhibiting delayed or atypical development. Screening for purposes of early intervention need not be confined to young children, however. Risk factors are well documented for children and adolescents throughout the age continuum. Early intervention also encompasses the notion of intervening early, regardless of age, before problems reach crisis or intractability stages. This concept of early intervention is a tenet of systems of care for children and adolescents of all ages. Screenings such as those required under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) of Medicaid take place on a periodic basis. Some states and localities are implementing targeted screening initiatives, not just for young children but for other populations as well, for example, children and adolescents in residential treatment, as an avenue to home and community-based services. Often, these screening mechanisms are implemented using EPSDT dollars.

Assessment is a process of gathering data from multiple sources to create a comprehensive picture of children who need services, with the purpose of identifying strengths and needs in order to plan specific services and supports.

EXAMPLES 2.6A&B

A. Screening Children and Youth Involved in Child Welfare and Juvenile Justice

An urgent response system is built into the **Arizona** behavioral health managed care system to ensure that children coming to the attention of child welfare who are removed from home receive a behavioral health screening within 24 hours. In addition, within 48 hours of a youth's entering detention, the juvenile justice system administers the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2), to identify the need for behavioral health services.

B. Partnering With Primary Care Using EPSDT

Vermont co-locates community mental health personnel jointly trained in mental health and substance abuse in primary care offices (pediatricians and family practitioners) to screen children and youth, refer them as appropriate, coordinate services and supports with the behavioral health system, and provide staff consultation.

Evaluation often is discipline specific (e.g., psychological testing or a neurological exam) and is conducted by individuals trained and certified in the relevant discipline. It encompasses closer, more intensive study in a particular area to provide additional data and recommendations to the assessment and care planning process.

Service planning (also referred to as "care planning") is the process for making decisions about which services and supports are provided to individual children and their families. The process is informed by screening, assessment, and evaluation data and, in systems of care, a *child and family team approach*. A child and family team approach means that families and youth are at the table, partnering in making decisions about which services and supports, including natural supports, might help to address identified needs and build on family and youth strengths and resources.

Although different staff or entities may be carrying out screening, assessment, evaluation, and care-planning functions, conceptually successful system builders recognize all of these functions as linked in one continuous process. These functions need to embody the same characteristics of being individualized, comprehensive, and coordinated across child-serving systems, culturally appropriate, and carried out in partnership with youth and their families.

Screening, assessment, evaluation, and service planning may involve state as well as tribal and local stakeholders. For example, state-level stakeholders may be involved for purposes of determining eligibility and referral for certain types of services, such as hospitalization or residential treatment. Tribal and local stakeholders need to be involved because they are best positioned to gather a comprehensive, culturally competent picture of the strengths and needs of children and families and have knowledge about community resources that may be helpful.

The *Wraparound* or Family-Centered Practice Approach: Comprehensive, Strengths-Based Principles

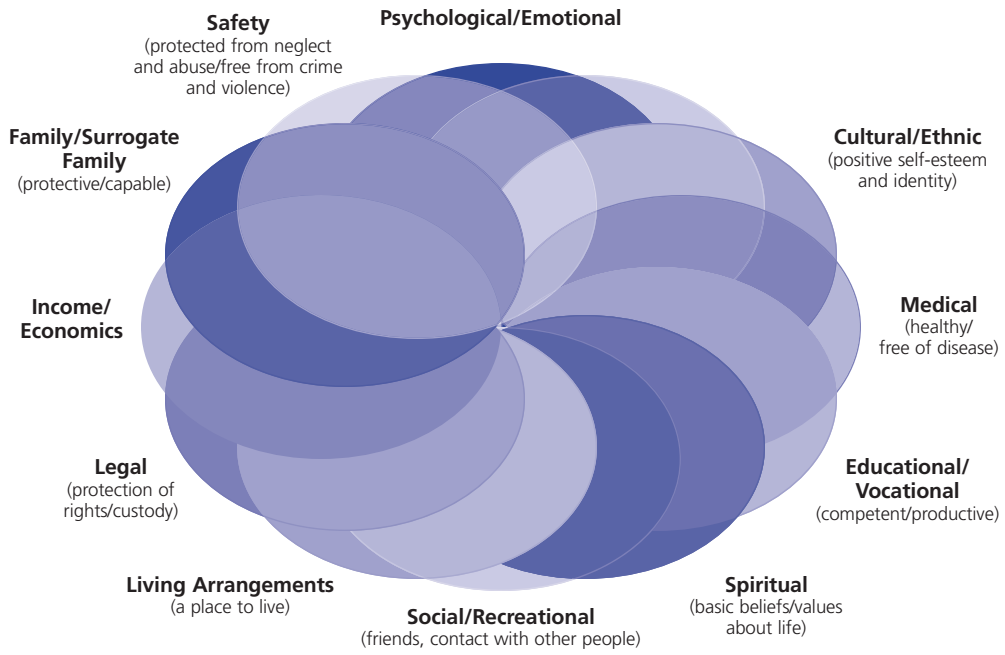
A key principle of systems of care is that screening, assessment, evaluation, and service planning must be strengths and resources based and not just "needs driven," as is typically the case in traditional service delivery, and that they take into account *both* the child/youth and his or her family's strengths, resources, and needs. Another key principle is that there should be an integrated, coordinated assessment across child-serving systems so that families do not have to undergo multiple assessment processes, retelling their stories repeatedly. In addition, system of care principles call for assessments to be comprehensive—encompassing an ecological perspective across life domains—individualized, and culturally appropriate. An ecological perspective focuses on the relationships between children, youth, and families and their larger environments, for example, relationships with schools, with their communities, and with peers.

This is the 6th time I've told my story this week.

Illustration 2.6A provides a picture of the multiple life domains that have relevance in a holistic assessment and service-planning process.

ILLUSTRATION 2.6A

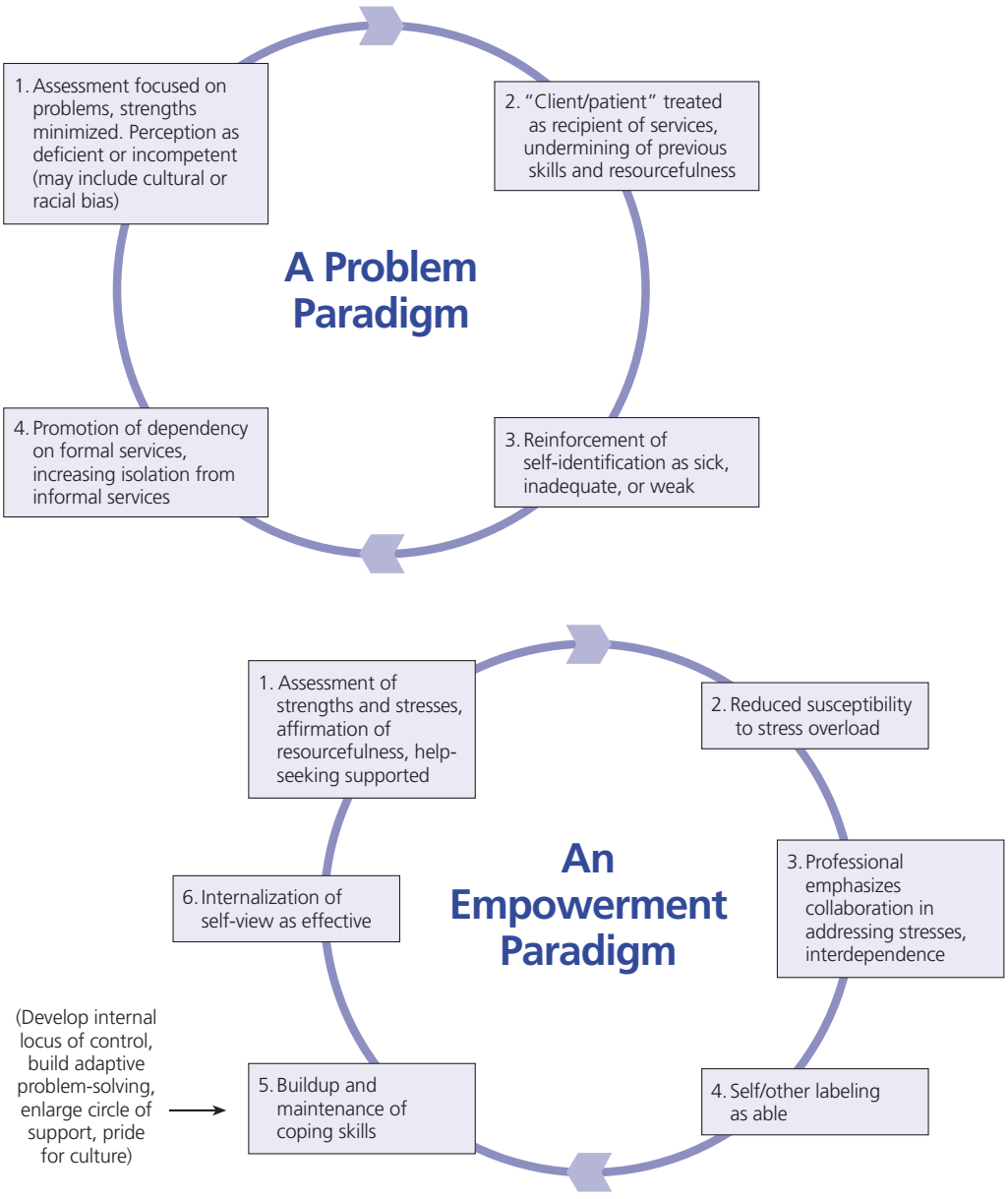
Life Domains



Adapted from Dennis, K., VanDenBerg, J., & Burchard, J. (1990). *Life domain areas.* Chicago: Kaleidoscope.

System of care principles have implications for how screening, assessment, evaluation, and service planning are structured in systems of care. They underscore that screening, assessment, evaluation, and care planning are not done *to* children and families but *with* them as equal partners who have an enormous amount to contribute to a sound analysis of the issues in their lives and potential strategies for addressing them. Focusing on strengths and assets in families and youth also helps to build resiliency, a

ILLUSTRATION 2.6B



Models developed by Ted Bowman, Associate Director, Community Care Resources, A Program of the Wilder Foundation, St. Paul, MN. In *Guide to developing neighborhood family centers.* (1993).Cleveland, OH: Federation for Community Planning.

key principle in systems of care. Illustration 2.6B describes the shift from a problem-oriented to a strengths-based approach in screening, assessment, evaluation, and service-planning processes.

EXAMPLE 2.6C

Mississippi Division of Family and Children Services provides a Family Centered Strengths and Risk Assessment Guidebook to guide caseworkers in their initial assessment conversation with families, youth, and children in ways that focus on family strengths and successes. This division also seeks to employ principles of family-centered practice in planning services and supports from the entire system of care that can help parents improve their ability to care for their children **www.hunter.cuny.edu/socwork/nrcfcpp/downloads/MS_ASSESSMENT_GUIDEBOOK.pdf.**

Defining the *Wraparound* Approach

2.6A ***Wraparound* is …**

Wraparound is a "definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes."

Chamberlain, P. (2002). Treatment foster care. In B. J. Burns & K. Hoagwood (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (pp. 117(138). New York: Oxford University Press.

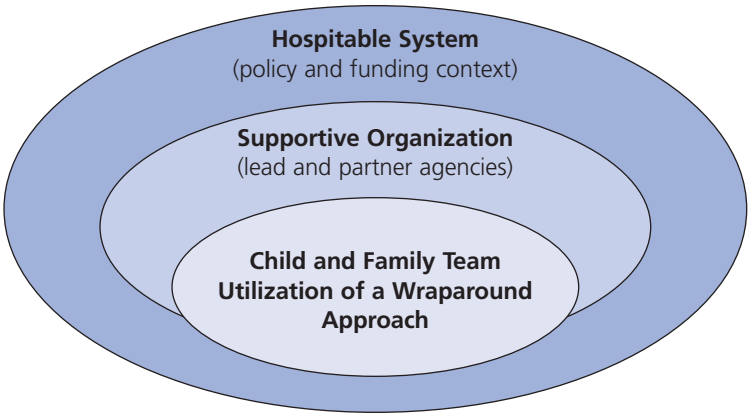
Wraparound puts system of care values into practice for the development and implementation of individualized care plans. It is a collaborative, team-based approach that is grounded in 10 key principles:

- Family and youth voice and choice;
- Team based;
- Use of natural supports as well as formal services;
- Collaboration across providers, natural helpers, systems, families, and youth;
- Community based;
- Culturally and linguistically competent;
- Individualized;
- Strengths based;
- Persistence; and
- Outcome based.

***Wraparound* is not equivalent to a system of care.** It is the practice approach within a system of care. This is an important distinction. Systems of care have supportive policy and administrative infrastructure (e.g., governance, system management, data systems, and training capacity), as depicted in Illustration 2.6C, to ensure successful implementation of *Wraparound* at frontline practice levels.

ILLUSTRATION 2.6C

Supportive Environment for Effective Wraparound in a System of Care



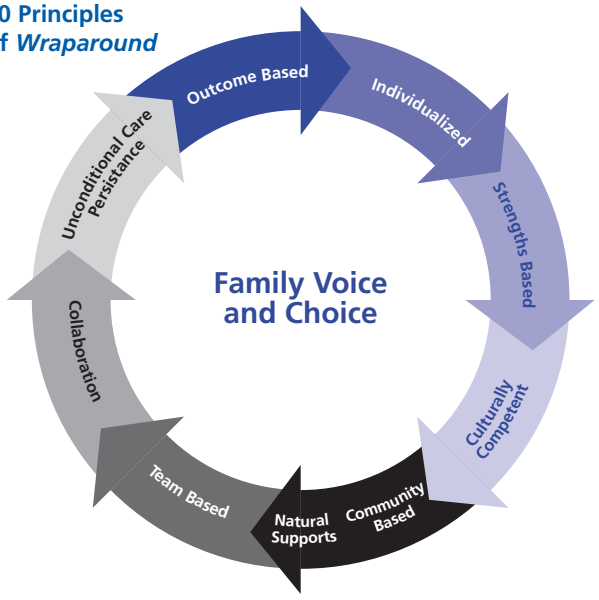
Applying *Wraparound* to Various Populations

Although *Wraparound* initially was utilized for populations of children and families with complex needs, a *Wraparound* approach can be used for any population, as shown in Illustration 2.6D. For example, children with acute, short-term mental health service needs can still benefit from an individual clinician's applying *Wraparound* principles and pulling together a team approach to service planning, though the team may be smaller than for a child and family with a range of complex issues who are involved in multiple systems. Adult populations also can benefit from a *Wraparound* approach, for example, adults with substance abuse problems or elders with chronic care needs.

ILLUSTRATION 2.6D

Wraparound is a practice approach for the planning and provision of services and supports that can be applied to any population of children and families with or at risk for intensive service needs—not just to those with the most serious and complex problems.

10 Principles of *Wraparound*



Integrating Dedicated Care Managers in a *Wraparound* Approach

When *Wraparound* is utilized for populations of children with complex issues who are involved in multiple systems, the practice approach also incorporates a dedicated, full-time care coordinator, who works with the youth and family to pull together a child and family team, ensures that the plan of care continues to be effective for youth and families, continues to reconvene the team as needed, is available to families on a 24-hour, 7-day-a-week basis, provides intensive care management, and functions as *the* accountable care manager across systems. For example, the *Wraparound* care manager accompanies youth and families to court, working closely with child welfare workers and juvenile court staff when youth and families are involved in those systems. The care manager in this application of *Wraparound* works with small numbers of families, no more than 8 to 10, has strong clinical coaching and support, and the child and family team has access to a broad range of services and supports. Care management is discussed more fully in Section II, Subsection 2.7 *Care Management and Service Coordination, Including Use of Care Management Entities*.

Care Managers and Wrap Facilitators

Sometimes, *Wraparound* approaches that are utilizing dedicated full-time care managers refer to them as "wrap facilitators." However, in other applications of *Wraparound*, wrap facilitators who are not full-time care managers are used. In this use of *Wraparound*, wrap facilitators are responsible for convening child and family teams and for providing a basic level of case management for families, but they are not *the* accountable care manager working intensively with small numbers of youth and families as does an intensive care manager. The use of the term "wrap facilitator" in these different applications of a *Wraparound* approach has led to some confusion. As is discussed more fully in Section II, Subsection 2.7, *Care Management and Service Coordination, Including Use of Care Management Entities*, children and youth with complex issues who are involved, or at very high risk for involvement, in multiple systems require use of a *Wraparound* approach that integrates a full-time, dedicated intensive care manager.

The Team Approach

Family-centered or *Wraparound* practice requires a team approach, both with families and youth and with other system partners. In *Wraparound*, the team is often referred to as the "child and family team." Being part of a team means:

- Appreciating strengths and cultures of families and youth;
- Being creative and thinking beyond traditional services;
- Listening;
- Being honest and empathetic;
- Being comfortable taking risks and working with traditional and non-traditional providers;

- Being confident and persistent;
- Having a positive and goal-oriented philosophy; and
- Finding solutions, rather than seeing problems as barriers that cannot be overcome.

It also means working with families and youth to create choice and explore possibilities and not simply telling families and youth what to do. Working in a team requires training, coaching, and practice. The diverse perspectives brought to the team by the different formal and informal service and support providers can lead to holistic, comprehensive, family-driven, and youth-guided service and support plans. It is important to clearly acknowledge the roles and expectations of each team member.

Phases and Activities of a *Wraparound* Approach

The National Wraparound Initiative (www.rtc.pdx.edu/nwi) has articulated the phases and activities of the *Wraparound* practice approach (see Box 2.6B).

2.6B Phases and Activities of the *Wraparound* Process

Phase 1: Engagement and team preparation

1.1 Orient the family and youth to *Wraparound*, and address legal and ethical issues.
1.2 Stabilize crises; elicit information from family members, agency representatives, and potential team members about immediate crises or potential crises, and prepare a response.
1.3 Explore strengths, needs, culture, and vision during conversations with child/youth and family, and prepare a summary document.
1.4 Engage and orient other team members.
1.5 Make necessary meeting arrangements.

Phase 2: Initial plan development

2.1 Develop an initial plan of care: Determine ground rules, describe and document strengths, create the team mission, describe and prioritize needs and goals, determine outcomes and indicators for each goal, select strategies, and assign action steps.
2.2 Create a crisis/safety plan to ameliorate risk and respond to potential emergencies.
2.3 Complete necessary documentation and logistics.

Phase 3: Implementation

3.1 Implement action steps for each strategy of the *Wraparound* plan, track progress on action steps, evaluate success of strategies, and celebrate successes.
3.2 Revisit and update the plan, considering new strategies as necessary.
3.3 Maintain/build team cohesiveness and trust by maintaining awareness of team members' satisfaction and buy-in and by addressing disagreements or conflict.
3.4 Complete necessary documentation and logistics.

Phase 4: Transition

4.1 Plan for cessation of formal *Wraparound*: Create a transition plan and a post-transition crisis management plan, and modify the *Wraparound* process to reflect transition.
4.2 Create a "commencement" by documenting the team's work and by celebrating success.
4.3 Follow up with the family.

Adapted from Walker, J. S., et al. (2004). *Phases and activities of the wraparound process*. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health, National Wraparound Initiative.

Box 2.6C provides the characteristics of effective Wraparound plans:

2.6C Characteristics of a Wraparound Plan

- Strengths and culture discovery;
- Crisis/safety plan;
- Vision (family's, youth's, and system partners');
- Family narrative;
- Needs statement;
- Strategies (who, what, when, and how) based on strengths (including transition out of formal services);
- Tells the family and youth story in a way you would want your own story told;
- Is written from a strengths perspective;
- Uses family- and youth-friendly language;
- Reflects what was actually said in the service-planning meeting;
- Is specific and concise; and
- Addresses mandates while staying family focused.

Adapted from Meyers, M. J. Wraparound Milwaukee, Milwaukee County Behavioral Health Division.

EXAMPLE 2.6D

Example of Building on Strengths and Addressing Needs in a Wraparound Plan for a Sexual Minority Youth Struggling With Behavioral Health, Family, and School Truancy Issues

Culture and Strengths
- John is a good artist
- Claire (his mother) likes to help others
- Claire has strong spiritual beliefs
- Family is close
- Probation officer has strong community connections (including a youth-directed, church-affiliated community center)
- School guidance counselor is committed to working with John

Needs
- John needs to learn to get along with others; increase self-esteem and self-confidence; John needs to feel safe at school; John needs to attend all of his classes for the next four months to graduate
- Claire needs to feel that she is not alone; accept John for who he is
- School needs help with changing school climate

Strategies
- John works with other youth to design logos and posters for the community center
- School art teacher will introduce John to famous gay artists, such as Keith Haring
- Claire will attend Parents and Friends of Lesbians and Gays (PFLAG) and join the Federation of Families for Children's Mental Health meetings
- John and Claire will participate in family counseling
- School will provide in-service training to school staff to understand lesbian, gay, bisexual, and transgender issues and provide support and intervention in the event of bullying

Family vision: To get along better; John, to graduate and get a good job.

Lazear, K. (2008). *Primer hands on*. Washington, DC: Human Service Collaborative.

Others have written persuasively about the need for individualized plans of care to include **crisis and safety plans** (see Box 2.6D). In a *Wraparound* approach, a crisis/safety plan is *a prioritized written list, using the youth's and family's own words, of pre-determined strategies and sources of support that youth and families can use during or preceding a crisis*.

2.6D The Importance of Individualized Crisis Plans

Tannen (1991) warned that setbacks and crises are likely to occur during the course of implementing an individualized care plan. To prepare for this eventuality the plan must include agreed-on approaches for handling crises. The inherent flexibility of individualized service approaches allows support to youngsters and caregivers to be quickly increased or decreased in response to changing needs. For example, an aide may be brought into the home or classroom during a crisis or particularly difficult period. Furthermore, based on the underlying value of unconditional care, individualized services are provided to children and families for as long as they are needed, regardless of youngsters' behavior or the challenges and complexities presented by their needs.

Lourie, I., Katz-Leavy, J., & Stroul, B. (1996). Individualized services in a system of care. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society*. Baltimore: Paul H. Brookes Publishing.

Box 2.6E provides examples of cultural factors that affect safety plans.

2.6E Examples of Cultural Factors Having a Bearing on Safety Plans

- A youth experiencing bullying and violence in school because of his sexual orientation;
- An African American youth who feels that he cannot talk to anyone about his suicidal ideations because of the stigma he sees in his community about seeking mental health services;
- A youth in a rural community whose nearest neighbors are 25 miles away; and
- A youth whose family's religious beliefs dictate conversing with the spiritual leader, rather than a mental health professional, about depression and suicidal thoughts.

Team Access to a Range of Services and Supports

To develop individualized plans of care, child and family teams need access to a broad, flexible range of services and supports, including formal services and natural supports, and the ability to provide one-time supports, such as payment of a utility bill. Wraparound Milwaukee, for example, has more than 200 providers in its network offering over 80 different types of services and supports. Section II, Subsection 2.12, of the *Primer, Provider Network (Network of Services and Supports)*, discusses this issue more fully.

Box 2.6F provides examples of services and supports provided through a *Wraparound* approach.

2.6F Examples of Services and Supports Provided Through a *Wraparound* Approach

- **Family support and sustenance:** providing emergency assistance for the child, paying for utilities, paying for repair of a car engine, paying for a telephone, paying for participation in Weight Watchers, and so on.
- **Therapeutic services:** providing individual/family/group counseling, substance abuse services, a bilingual therapist, a therapist of color, respite care in- or out-of-home, and so on.
- **School-related services:** providing school consultation or an academic coach, utilizing behavioral aides or classroom companions at school, paying for school insurance for a classroom companion, buying a chemistry set for Christmas, and so on.
- **Medical services:** providing a needed medical evaluation, providing medical or dental care, paying for tattoo removal, teaching sex education, teaching birth control, teaching medication management, and so on.
- **Crisis services:** hiring a family member or friend to provide crisis support, utilizing a behavioral aide in the child's home or therapeutic foster home, teaching crisis management skills, and so on.
- **Independent living services:** helping to locate and rent an apartment, assisting a youth to obtain Supplemental Security Income, hiring a professional roommate/mentor, providing a weekly allowance, teaching money management and budgeting, providing driving lessons, teaching meal preparation, teaching parenting skills, teaching housekeeping skills, and so on.
- **Interpersonal and recreational skills development:** hiring a friend or finding a "big brother," teaching social skills and problem-solving skills, purchasing a membership in an exercise gym, a YMCA membership, horseback riding lessons, art or music lessons, summer camp registration, class trip, fishing license, bicycle, and so on.
- **Vocational services:** providing job training, teaching good work skills, providing a job coach, finding an apprenticeship, providing a mentor at an apprenticeship or other program, paying someone to hire the youth for a job, conducting a vocational skills assessment, and so on.
- **Additional reinforcers:** purchasing items such as a radio, makeup, clothing, punching bag, skateboard, trips, activities, photographs for teen magazine, and so on.

Lourie, I., Katz-Leavy, J., & Stroul, B. (1996). Individualized services in a system of care. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society*. Baltimore: Paul H. Brookes Publishing.

In summary, *Wraparound* puts system of care values and principles into practice, but it does not, in and of itself, constitute a system of care. Illustration 2.6E shows a list of examples of what *Wraparound* is not.

ILLUSTRATION 2.6E

What Wraparound is Not

- A system of care
- A new funding source
- A "service"
- A way to get "stuff"—e.g., services that are not typically reimbursable
- Only for a small group of children
- Case management
- A specific treatment intervention or program, though the approach itself has therapeutic value
- A categorical approach where services reflect what's available rather than what's really needed

Wraparound and Family-Centered Approaches in Child Welfare

Although *Wraparound* initially developed out of the children's mental health arena, increasingly, both a *Wraparound* approach and various related practice approaches, such as family group conferencing and team decision making, are being used in child welfare and other systems serving children, youth, and families (see Box 2.6G). From a values standpoint, they are very similar. Burns and Hoagwood (2002) describe *Wraparound* as "*…a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes.*" The National Child Welfare Resource Center for Family-Centered Practice describes Family Group Decision Making (FGDM) as "*…a non-adversarial process in which families, in partnership with child welfare and other community resources, develop plans and make decisions to address issues of safety, permanence and well-being…Reflecting the principles of family-centered practice, FGDM is strengths-oriented, culturally adapted, and community-based.*" Individual states and communities may have their own definitions as well. The point is that there is commonality in the values base that informs these practices and, therefore, opportunity to coordinate across systems on a common practice approach. Indeed, the **Arizona** Department of Health Services conducted an analysis of similarities among various individualized, strengths-based, culturally competent service-planning approaches, including Family Group Decision Making, *Wraparound*, and person-centered planning, and concluded that they were "not that different." (See Rider, F., 2005, *A Comparison of Six Practice Models*, Arizona Department of Health Services.)

2.6G Essential Elements of Wraparound, Family Group Conferencing, and Related Approaches

- Family and youth voice and choice;
- Team driven (i.e., not single-agency or single-provider driven);
- Community based;
- Individualized;
- Strengths based and focused across life domains;
- Culturally competent;
- Flexible approaches, flexible funding;
- Informal family and community supports;
- Unconditional commitment (or persistence);
- Interagency, community-based collaboration; and
- Outcome based.

EXAMPLE 2.6E

Kansas is an example of a state child welfare system that is using both Family Group Decision Making and *Wraparound* in its system of care. *Wraparound* is conceptualized in Kansas as being tied to intensive service management and utilized for children and families with the most intensive service needs, whereas Family Group Decision Making is used throughout the child welfare system for all families coming into contact with the system. A family may experience both Family Group Decision Making and *Wraparound* in the Kansas system, depending on the family's strengths and needs. Both come under what Kansas calls family-centered practice within a family-centered system of care. (**www.srskansas.org/CFS/programservices.htm#Family%20Centered%20Systems%20of%20Care**)

Role of Supervision and Coaching to Change Practice Approach

Supervisors can play a key role as practice change agents, or they can stifle change among frontline staff and clinicians. Effective systems of care engage supervisors early in practice change initiatives and ensure that they are involved in trainings and workshops that reflect new approaches and philosophies. Sometimes, supervisors are trained as trainers (through a "training of trainers" approach). Frontline workers and clinicians engaged in practice change need access to coaches to reinforce skills, attitudes, and knowledge and simply for support because fundamental practice shifts are challenging both professionally and personally. Sometimes, supervisors can play the role of coaches, but often they, too, need access to coaches. Typically, systems of care utilize a combination of external and internal change agents and coaches.

Box 2.6H offers requirements for effectively supervising family-centered practice.

2.6H Supervising Family-Centered Practice

- Experienced supervisors comment that supervising family-centered practice requires a different, disciplined approach to coaching workers.
- The goal is deepening the worker's empathy for the child, youth, family, and foster family.
- It takes time to reflect with workers and coach them on engaging families more effectively.
- Workers' strengths at developing collaborative relationships with families must be appreciated.
- One must help workers to have the patience to help families over time to get a better understanding of their child's needs and to see how they can build on their strengths.
- Workers need encouragement to help families design interventions that are most likely to meet their needs, rather than being limited to programs that already exist.

Adapted from Englander, B. (2007). *Oregon manual for system of care*. State of Oregon: Oregon Department of Human Services.

Use of Strengths-Based Screening and Assessment Tools: Movement Away From "Leveling" Decisions

Traditionally, many children's systems have used a kind of "leveling" process to determine what services a child would receive, typically using either standardized assessment tools or state or local guidelines. For example, if a child scored above a certain threshold on a standardized instrument or demonstrated certain variables on state guidelines, he or she would "qualify" for a certain level of care, such as residential treatment. This type of leveling approach to service decision making assumes that the intensity of a child's needs equates to a more restrictive service, such as residential treatment. Systems of care using a *Wraparound* or similar family-centered, strengths-based, and individualized service-planning approach have made it clear that many children with very intensive, serious challenges can be served effectively in home and community-based services. As one example, Wraparound Milwaukee effectively serves at home and in the community over a hundred youth with sex offenses, among others.

System builders cannot assume that clinicians, child welfare staff, juvenile court staff, and others involved in screening, assessment, and evaluation processes know how to conduct strengths-based assessments that are culturally competent or that they know how to work in partnership with families and youth. Those involved in such processes need training, supervision, and quality monitoring. Protocols among child-serving systems have to be structured to ensure that there is buy-in to a coordinated assessment process, including development and use of common screening and assessment tools. If the tools used are strengths based and support communication and decision making across stakeholder groups, they can be helpful in supporting a consistent practice approach, such as *Wraparound* or team decision making. Such tools also can document service-planning decisions for judges and others and can allow a state or county to collect state or county-wide service outcome data. However, if the tools are deficit based or used rigidly by those doing screens, assessments, and service planning, they can frustrate an individualized approach to care.

EXAMPLE 2.6F

New Jersey is an example of a state using common strengths-based screening and assessment instruments in its system of care. New Jersey uses the Child and Adolescent Needs and Strengths (CANS) tools (**www.praedfoundation.org/Comments.html**). The state mandates use of the CANS by its Mobile Response and Stabilization Teams, its statewide Contracted Systems Administrator (i.e., its Administrative Services Organization), and system partners such as child welfare workers, providers, Care Management Organizations, and residential treatment facilities. The CANS is a strengths-based, decision support tool used to guide the process of care. New Jersey has in place a Web-based certification process to support use of the CANS statewide.

States and localities that are using standardized screening and assessment protocols or guidelines have shared several "lessons learned":

- Select protocols that are meaningful to stakeholders, including clinicians and other staff, local management entities, provider agencies, families, and youth, and make protocols transparent to these stakeholders. Involve these stakeholders in the selection or development of protocols or guidelines and in implementation strategies.
- Select or develop and utilize protocols and guidelines within a values-based and systemic context. In other words, know what values, principles, and goals you are trying to promote in your system, and be clear that the protocols you have chosen or developed will support these values and goals.
- Provide adequate staffing and resources at state and local levels to implement a protocol-based system. Very much related to this is the recommendation to create an adequate infrastructure for training, retraining, and coaching in the use of the protocols.
- In budgeting for a protocol-based system, include resources for data collection and analysis.
- Integrate use of the protocols into everyday documentation requirements and everyday practice, rather than implementing them as an "add-on"; make them part of the culture of the system.
- Keep open lines of communication with those using and affected by use of the protocols, that is, families and youth, clinicians, provider agencies, and other child-serving systems, such as child welfare, education, and juvenile justice.
- Establish quality control in the use of protocols, which requires attention to data collection and analysis at both service and system levels, and attention to use of the data to inform quality efforts.
- Use data to improve quality, including providing technical assistance, consultation, and coaching to providers and clinicians.
- Utilize data generated by the use of clinical protocols to document results, which will help to shed light on system strengths and accomplishments, service gaps, and resource needs, which, in turn, promotes sustainability.
- *The use of standardized instruments works best for children and families when it is embedded into a system that is strengths based, family driven, culturally competent, and committed to the principle of individualized care. Clinicians, staff, and providers that embrace and are skilled in this practice model tend to make the most appropriate use of standardized protocols.*

For further information, see Pires, S. & Grimes, K. (2006). *Health care reform tracking project: Promising approaches for behavioral health services to children and adolescents and their families in managed care systems-8: Clinical decision making approaches* at: http://rtckids.fmhi.usf.edu.

Family and Youth Partnerships and Cultural Competence in Screening, Assessment, Evaluation, and Service Planning

Screening, assessment, evaluation, and service-planning functions are among the most critical for partnering with families and youth as resources and for ensuring cultural proficiency. There are many examples of structures that incorporate family partnerships in screening, assessment, and service planning. For example, families may be involved, often on a paid basis, in providing peer support to families involved in service-planning processes, and parents and youth may play a role in the screening process as system "navigators" who also help put families at ease. Some screening and assessment processes link families to family organizations for peer support and link youth to youth-run organizations or support groups. Family and youth representatives on screening teams bring a unique perspective. Often, systems of care report higher levels of family engagement and satisfaction when a family peer support worker is available to families through the initial screening, assessment, and service-planning processes and when families can connect through these processes to a larger family organization. Sometimes, family members hired by systems of care, by working inside the system, can help to change the overall culture of the system.

Screening, assessing, evaluating, and individualized service planning require a comprehensive base of information regarding cultural background and history. Those conducting screening, assessment, evaluation, and service-planning functions play critical roles in ensuring a culturally sensitive system; they need to be self-reflective and sensitive to their own cultural norms and practices and how these may influence their cultural competence as screeners, assessors, evaluators, and service planners.

WEB RESOURCES

National Wraparound Initiative at: **www.rtc.pdx.edu/nwi**

National Center on Family Group Decision Making at: **www.americanhumane.org/protecting-children/programs/family-group-decision-making**

Clinical Decision Making Approaches for Child and Adolescent Behavioral Health Care in Public Sector Managed Care Systems at: **http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/toc_08.html**

Key Questions: Screening, Assessment, Evaluation, and Service Planning

- What are the structures we have in place for screening, assessment, evaluation, and service planning?
- How do our screening mechanisms serve to identify problems at an early stage before they reach crisis or intractability stages?
- How are our screening, assessment, evaluation, and service-planning structures strengths based, comprehensive, and culturally relevant?
- How have we built partnerships with families and with youth into screening, assessment, and service-planning functions?
- How have we built training, coaching, and oversight into our screening, assessment, evaluation, and service-planning structures?
- How are these functions coordinated across child-serving systems?

NOTES

2.7 Care Management and Service Coordination, Including Use of Care Management Entities

Care Management Versus Service Coordination

Children, youth, and families who have multiple issues and stressors in their lives and involvement with multiple agencies often need and want support to manage and coordinate their involvement with many systems and providers. Some families may need just a basic level of support in managing and coordinating service requirements; other families may require far more intensive service coordination or "care management" support.

We make a distinction between **service coordination** and **care management**. The *Primer* defines service coordination as assisting families with basic to intermediate needs to coordinate services, where the *service coordinator* has other responsibilities or is responsible for relatively large numbers of families—for example, a clinician who is providing therapy and a basic level of service coordination, or a managed care service coordinator, or a child welfare worker with fairly large caseloads who is providing service coordination along with other responsibilities. In contrast, the role of a *care manager* as used here is that of working with only a few families (e.g., on a 1:8 ratio), who have multiple, complex needs, where the care manager is closely involved with the family and youth and with the array of providers and natural helping networks to ensure that the family can access needed services and that the services and supports continue to be helpful. The care manager often controls flexible resources and has the authority to convene child and family (i.e., *Wraparound*) teams. The care manager also is available to the family on a 24-hour, 7-day-a-week basis and is not performing other functions, except that of full-time care manager.

Box 2.7A provides a definition of a service coordinator and a care manager.

2.7A Definition of Terms

Service Coordinator
Assists families with basic to intermediate needs to coordinate services and supports, usually has other responsibilities, and/or is assisting large numbers of families.

Care Manager
Is primarily the accountable care manager for families with serious and complex needs, works with small number of families (e.g., 8-10), has authority to convene child/family team as needed, and often has control over resources.

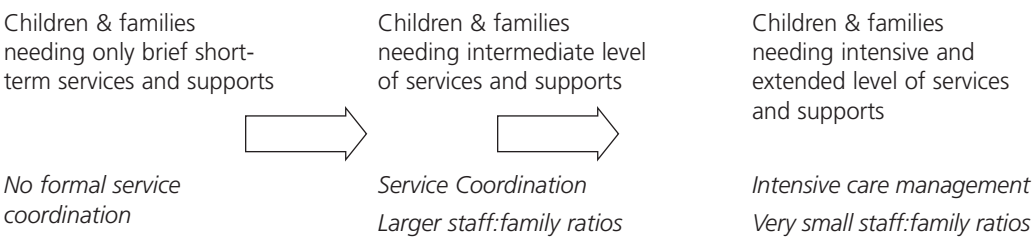
We intentionally do not use the term, "case management." Many families, youth, and other stakeholders find the term, "case management," off-putting since no one likes to be thought of as a "case." Thus, we use the terms, "care management" and "service coordination." System builders need to define what they, collectively, mean by service coordination or care management before they can implement effective service coordination and care management structures, and the characteristics and needs of the identified population or populations of focus will drive this definition.

A Continuum of Service Coordination and Care Management

Depending on the population focus, a system of care may incorporate both service coordination and care management structures (see Illustration 2.7A). For example, it may have an intensive care management structure for children and families with serious, complex problems and more of a service coordination structure for children and families using fewer services or services intermittently. Often, service coordination and care management structures include system navigation support as well, a role often played by family peer mentors in systems of care.

ILLUSTRATION 2.7A

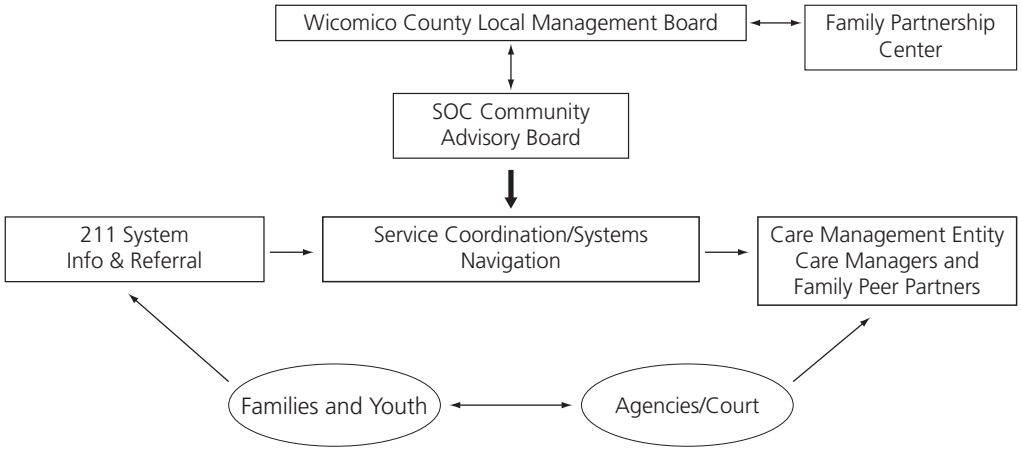
Service Coordination/Care Management Continuum



How care management and service coordination are structured depends on both the population being served and the goals of the system of care. Systems that are serving a total population of children (e.g., all Medicaid-eligible children) will include children who use none to a few services and children who use a lot of services. Such a system will include system navigation help and service coordination for children who use few or intermittent services and intensive care management for children with serious and/or complex needs using multiple services over time. Research has suggested that, for children with serious and complex issues, having the child's therapist or a child welfare worker perform care management, in addition to their other full-time roles and responsibilities, is no better than having no care management provided at all. These children fare better when a dedicated, full-time intensive care manager is available. (See, for example, Evans, M. and Armstrong, M. "What is case management?" In Burns and Hoagwood, 2002, Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders, New York: Oxford University Press.)

EXAMPLE 2.7

Wicomico County, Maryland, provides an example of a system of care focusing on a total population (i.e., all children and youth in the county who need behavioral health services) and has developed a continuum of information and referral, system navigation, service coordination, and intensive care management support.



The Use of Care Management Entities

In the Wicomico County example above, the county has contracted with a Care Management Entity (a nonprofit organization in this example) to serve as *the* locus of responsibility and accountability for managing care for children with serious and complex issues who are involved in multiple systems. Designation of one entity to be the accountable Care Management Entity recognizes that for children involved in multiple systems, when everyone is responsible, no one is responsible because there are too many places to shift responsibility. A Care Management Entity assumes responsibility for managing care across systems, working in close partnership with the other systems in which these children and youth are involved, such as with child welfare workers and juvenile probation officers.

Increasingly, systems of care are utilizing Care Management Entities to achieve better outcomes, particularly for populations of children and youth historically served in "deep-end" services, that is, in restrictive and expensive services, such as out-of-home placements. For example, **Maryland** has implemented regional Care Management Entities to manage care for various "high-utilizing" populations of children and youth who are involved in multiple systems and use multiple services and supports, including children and youth who can be diverted from restrictive and expensive services to home and community-based services and supports using a *Wraparound* approach. In Maryland, populations served by regional Care Management Entities include: youth in or at risk for placement in psychiatric residential treatment facilities, youth who can be diverted from detention, and children in child welfare who are younger than age 12 and in group homes. **New Jersey** has implemented county-based Care Management Entities

to serve as the locus of care management responsibility for children with serious behavioral health challenges, regardless of the other systems in which the children are involved. Wraparound Milwaukee is a Care Management Entity for youth with serious behavioral health problems who can be diverted from residential treatment, detention, and the state juvenile corrections facility. **Massachusetts** is implementing locally based Care Management Entities to serve as the locus of care management responsibility for all Medicaid-eligible children who have serious behavioral health challenges. **Georgia** is implementing regional Care Management Entities to serve youth who can be diverted from psychiatric residential treatment facilities and hopes to use the same care management infrastructure to manage other high-utilizing populations, such as youth in other types of group care. **Cuyahoga County, Ohio (Cleveland)**, has developed neighborhood-based Care Management Entities to manage several different populations for whom they felt they were experiencing poor outcomes and/or high costs, such as youth in or at risk for residential treatment, youth with status offenses at very high risk for more intensive juvenile justice involvement, and infants and toddlers whose families the county's Early Intervention system was having trouble engaging. These are just some examples of the use of Care Management Entities in systems of care.

In the examples above, the Care Management Entity might be a lead nonprofit agency (as in New Jersey), a lead public agency (as in Milwaukee), or a partnership (as in Cuyahoga County which partners lead nonprofit agencies and Neighborhood Collaboratives to form Care Coordination Partnerships). What type of entity performs the functions of a Care Management Entity will vary by state and community, depending on technical skill and capacity, politics, and the like. Regardless of who performs the functions, however, the functions have become fairly standard (see Box 2.7B). Maryland developed a concept paper on Care Management Entities that defines these functions (see Box 2.7C).

2.7B Functions of a Care Management Entity

- At the Youth and Family Level:
  - Child and Family Team Facilitation, using high-fidelity Wraparound
  - Care Management, using strengths-based assessment tools (e.g., CANS)
  - Care Monitoring and Review
  - Peer Support Partners
- At the System Level:
  - Information Management, using a Web-based, real-time data system
  - Provider Network Recruitment and Management, including broad use of natural supports and resources
  - Utilization Management
  - Evaluation, Outcomes Tracking, and Continuous Quality Improvement
- Financing Model
  - Case Rate

2.7C From the Maryland Concept Paper on Care Management Entities

"The Care Management Entity (CME) ensures accountability to an individual and his or her family and plan of care through individualized planning, utilization management, and coordination of services, resources and supports, with objective outcome measures mutually determined across multiple providers and systems in partnership with the youth and family. The CME is embedded into the community where the youth and family reside, providing more effective linkages to the natural and informal resources and supports that are available to participants with multi-system and complex needs. The CME is committed to cultural and linguistic competence and strives to reflect the diversity of the communities and populations it serves. The CME works closely with advocacy organizations to ensure that youth and families have access, voice and ownership in the development and implementation of their plans of care.

Youth with complex needs are at high risk for out-of-home placements. The CME approach typically is used by States and communities to organize a community-based alternative to divert youth from out-of-home placements and reduce lengths of stay. The CME approach is being used for various populations of youth and families, including those in or at-risk for residential treatment, detention, group home, and multiple foster home placements, among others. These are populations whose complex needs are not easily addressed through a single system and whose need for intensive care coordination is not readily met through the usual case management services and supports available through public child-family serving agencies." (**http://medschool.umaryland.edu/innovations**)

Care Management Principles

There is no one "correct" care management or service coordination structure, but there are principles, listed in Box 2.7D, that need to underpin these structures.

2.7D Care Management Principles

- Support one plan of services and supports, even when multiple agencies and systems are involved.
- Support the goals of continuity and coordination of services and supports over time and across systems.
- Encompass families and youth as partners in managing services and supports.
- Utilize a strengths-based focus that incorporates use of natural helpers and social support networks on which families rely and cultural and linguistic competence.

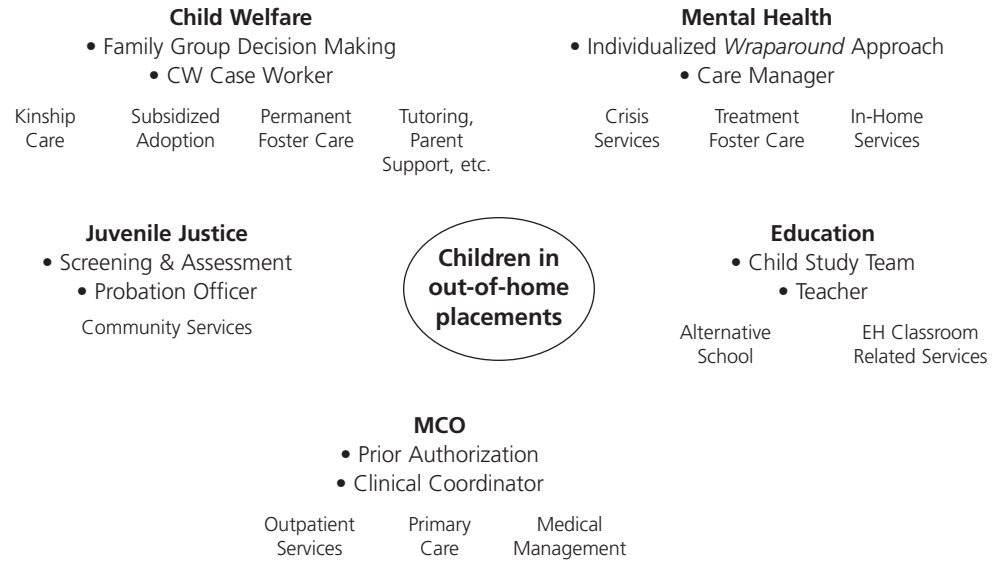
Importance of Structuring Care Management

If care management is not deliberately structured across systems for children and families involved in multiple systems but left to each agency to design its own, regardless of whether the system of care has a goal of "one plan of services and supports," the result is likely to be multiple plans and multiple service coordinators—with no one accountable "care manager" as the term is being used here. Illustration 2.7B highlights this point, showing multiple systems involved in developing plans of services and supports with no one accountable care manager.

ILLUSTRATION 2.7B

Multiple Care Management Structures
No One Accountable Structure

Intended Goal: One plan of services/supports; one care manager



Results: Multiple plans of services/supports; multiple service coordinators

Staffing Care Management Functions

There is wide variation in the type of staff systems of care hire as care managers—a decision that needs to be guided by whom the system is serving and system goals but is also affected by available resources, politics, and the like. Some systems of care utilize staff already working in public systems to perform care management functions. These workers may be reassigned to the system of care, or they may stay in their home agencies. Other systems of care hire a new, independent pool of care managers or contract for care managers, often through Care Management Entities. Some systems utilize parents as care managers. Some hire highly trained clinicians, others utilize paraprofessionals, and some use both.

Both state- and local-level stakeholders have an interest in the care management structure. State-level stakeholders, for example, may be involved in defining care management for purposes of ensuring reimbursement of care management services through Medicaid. They also may be reassigning current staff to undertake care management roles. Also, state-level stakeholders may need to be involved in decisions about how care managers in the system of care will interface with caseworkers in child welfare or eligibility determination workers in TANF offices. Local and tribal

ILLUSTRATION 2.7C

Illustration 2.7C depicts three different care management structures: one in which existing caseworkers stay within their home agencies, one in which existing caseworkers are assigned to the system of care, and one in which the system of care hires or contracts for new care managers. There are, as noted, other ways of structuring care management as well.

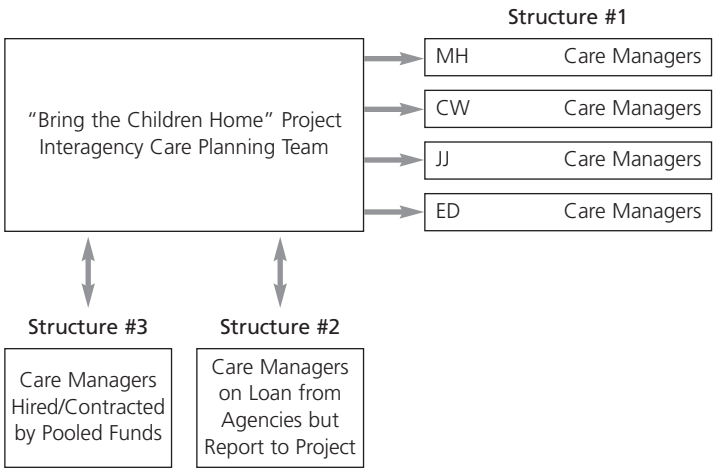
The pros and cons of the three approaches depicted in Illustration 2.7C will depend very much on each locality's circumstances. For example, the first arrangement (Structure #1), in which care managers stay within their home agencies, may be the easiest (or in some localities the *only* one possible) to implement, allowing for greater initial buy-in to the system of care because it does not entail home agencies having to "give up" staff. It might also allow for greater permeation of system of care values and principles throughout home agencies because those involved in the system of care are not in some other, "outside" location. It might encourage greater interest in the system of care on the part of supervisors, because they remain responsible for supervising staff involved in the system of care. It might create a higher comfort level for staff who, while involved in something new, can remain in their home agencies.

On the other hand, higher comfort levels are not necessarily what is needed in change initiatives like system of care building. Training and staff development are especially critical in an arrangement like that of Structure #1, where the larger culture still is operating in traditional ways and where each agency has its own approach to case management. Particularly if there is not strong buy-in from agency supervisors, these care managers may feel marginalized and de-valued in their home agencies. It may be very difficult to instill a unitary (i.e., across agencies) care management approach. There is the danger that caseworkers under such circumstances will revert to "old ways of doing business," which will affect system of care goal attainment. It also may be more difficult in this structure to involve families in care management roles, since this non-traditional approach has to fit within a traditional structure.

For the arrangement in which caseworkers from home agencies are reassigned to the system of care physically located outside the home agency and reporting to system of care administrators (Structure #2), care has to be taken to ensure that these staff members do not feel as if they have two masters (one in the system of care and one in their home agencies). Training also is needed, as is team building, to strengthen allegiances to the system of care and a new way of doing business. This arrangement may be or feel more tentative since staff that is on the payroll of a home agency can always be reassigned back to the agency in the event of staff shortages and the like. On the other hand, this arrangement enables the system of care to draw on the knowledge and connections of existing caseworkers while providing greater control over care management than the arrangement in Structure #1. It also might be easier than in the first arrangement to augment this care management staff with paraprofessionals and families in care management roles.

The third arrangement (Structure #3), in which the system of care uses pooled funds to hire (or contract out for) its own cadre of care managers, potentially allows for the most control over the care management function. On the other hand, the arrangement might serve to reinforce perceptions of the system of care as a "demonstration or special project" that has minimal impact on the functioning of traditional systems. Such an arrangement also may just not be possible to implement in some localities because of lack of new dollars and/or inability to redirect and "pool" existing dollars.

Examples of Care Management Structures



stakeholders obviously are critical to determining what care management structure will be most responsive to the strengths and needs of families in the community and "doable," given local capacity.

There are disadvantages and advantages to whatever care management structure or structures are developed, which will depend on system goals, capacity, and politics at both state and local levels; and whatever structure is chosen will affect distribution of power and responsibility, goal attainment, and the feelings of key stakeholders.

Readers of the *Primer* no doubt can think of many other pros and cons to the above arrangements as well as variations to the above structures and other approaches entirely—which is precisely the point. *There is no one "right" care management structure, but there are values and goals that systems of care are trying to achieve which have implications for care management, whatever structure is adopted*. Principles for care management in systems of care include:

- The care management structure needs to support a unitary care management approach even though multiple systems are involved, just as the care-planning structure needs to support development of one care plan.
- The care management structure needs to support the goals of continuity and coordination of care across multiple services and systems over time.
- The care management structure needs to encompass families and youth as partners in the process of managing care.
- The care management structure needs to incorporate the strengths of families and youth, including the natural and social support networks on which families rely.

WEB RESOURCES

Maryland's Care Management Entities Concept Paper at:
http://medschool.umaryland.edu/innovations

Research and Training Center on Service Coordination at:
www.uconnucedd.org/projects/rtc/rtc.html

Service Coordination Under IDEA at: **www.nectac.org/topics/scoord/scoord.asp**

Care Management Promising Approaches at: **http://rtckids.fmhi.usf.edu**

Key Questions: Care Management and Service Coordination

- How are care management and service coordination structured in our system of care?
- How does our structure support the principle of "one plan of services and supports and one care manager" for families involved in multiple systems?
- How does our structure support a unitary, or cross-agency, care management approach?
- How does our care management structure build on the strengths of families and youth and draw in natural supports?

NOTES

2.8 Crisis Management at the Service Delivery and System Levels

Effective Mobile Response Capability

Effective systems of care have in place crisis management structures; that is, they deliberately organize how the system will manage crises that occur at the level of children and their families (in addition to each child and family's having a crisis management plan as part of their individualized services plan, as discussed above). Building child- and family-focused crisis management structures is essential to ensure appropriate support for families at particularly critical times and to reduce reliance (and therefore costs) on inpatient hospitalization, emergency room use, and residential beds.

Effective crisis management structures in systems of care share certain characteristics:

- They ensure availability 24 hours a day, 7 days a week.
- They encompass mobile crisis capacity, that is, the capacity to go to children and families in their natural environments, for example, at home or in school.
- They include trained child and adolescent crisis workers and do not rely on predominantly adult-oriented crisis response workers.
- They teach crisis management skills to families, teachers, and other natural caregivers, building on natural support structures and reducing reliance (and therefore costs) on hospitals and formal crisis response systems.
- They provide practical information to families and follow-up services and supports, including transition to needed treatment services, and linkage to family peer support resources.

When effective crisis management structures are not in place at the service delivery level, there is an enormous cost both to families and to the system itself.

Wraparound Milwaukee in **Milwaukee County, Wisconsin, New Jersey**, and **King County, Washington (Seattle)**, are examples of systems of care that are employing newer crisis models, sometimes called *Mobile Response and Stabilization Services*, that utilize mobile crisis teams who work with children, youth, and families in natural settings (e.g., at home or in school). These services extend over a longer period of time than more traditional crisis services—for example, for up to 30 days—to not only provide stabilization but also education, service linkage, and coordination and ensure connection to ongoing supports. Use of this newer approach is not only reducing use of hospitals and residential treatment but helping to prevent placement disruptions in systems such as child welfare.

Capacity to Respond to Systemwide Crises

Effective systems also create crisis management structures for crises that impact the system as a whole, such as a major loss of funding, injury to children in care, severe staff shortages, and union strikes. Increasingly, we are reminded that systemwide crises also include community-wide tragedies such as school shootings and terrorist attacks. Effective systems try to anticipate the crises that may occur and make every effort to prevent them. However, they also recognize that crises will occur in spite of the best efforts to prevent them, so they develop protocols, procedures, and contingency plans to manage them if the need arises. Capacity to manage system-wide crises often requires establishing new kinds of partnerships at state and local levels, for example, with emergency preparedness officials and safety personnel.

EXAMPLE 2.8

A northeastern state has implemented an "early warning system" in connection with its managed care reform to track indicators that, if left unattended, could create potential crises systemwide. The system allows the state to obtain information rapidly on a limited set of indicators linked to stressors systemwide and, by early action in response to trouble areas, to avert crises.

WEB RESOURCES

New Jersey's Mobile Response and Stabilization Services at:
www.state.nj.us/dcf/behavioral/help/mobile.html and at:
http://ubhc.umdnj.edu/childrenfamily/CMRSS.htm

Milwaukee's Mobile Urgent Treatment Team at: at:
www.milwaukeecounty.org/router.asp?docid=10109

King County, Washington's Children's Crisis Outreach and Response System at:
www.kingcounty.gov

Key Questions: Crisis Management at the Service Delivery and System Levels

- What is our current crisis management structure at the service delivery level?
- How effective is our current crisis management structure at the service delivery level?
- How does our crisis management structure incorporate a strengths-based approach and one that links families to practical information and peer support as well as to formal services?
- Have we thought about how we will respond to crises that affect the system as a whole?
- Can we build "early warning and rapid response" structures into our system of care?

NOTES

2.9 Benefit Design/Service Array

Overview

"Benefit design" is a term borrowed from the insurance sector and from managed care. It refers to the types of services and supports that are allowable within the system and under what conditions. The benefit design or structure carries a powerful message about values, will certainly affect how key stakeholder groups (e.g., families and providers) feel about the system, and will definitely affect outcomes. A key principle of systems of care is that the benefit design needs to incorporate *a broad array of effective services and supports*, including both traditional and non-traditional services and supports and both clinical services and natural supports. (The following subsection, 2.10, *Evidence-Based and Effective Practices*, of Section II addresses the issue of *effective* services and practices in the service array.) Another key principle is that the benefit structure needs to allow for *individualized*, *flexible* service provision with attention to the cultural expectations of each child and family. State-level, tribal, and local-level stakeholders need to have a voice in structuring the benefit (i.e., defining the service array) because many services will be paid for by state funding sources, such as Medicaid, because tribal resources may be involved, and because the service array needs to reflect tribal and local strengths, needs, and capacity.

If the benefit structure arbitrarily limits the types of services and supports that are allowable or if it creates arbitrary day or visit limits on particular types of services, it is sending a clear message about the extent to which individualized, flexible care is valued. *Effective system builders do not try to manage costs and care by arbitrarily constraining the benefit (i.e., limiting the service array) but rather by incorporating care and utilization management capabilities, accountability mechanisms, and provider and family partnerships to reduce system dependency, building on strengths and natural supports.*

The Important Role of Medicaid

Medicaid is a primary source of physical and behavioral health care financing for children involved with public systems. It is imperative that Medicaid be a collaborative partner in system-building efforts. Although not every conceivable service in a system of care **can** be paid for by Medicaid, many can be paid for at least for Medicaid-eligible children (see Box 2.9A for such services in systems of care).

2.9A Types of Medicaid Services in Systems of Care

- Assessment and diagnosis
- Outpatient psychotherapy
- Medical management
- Home-based services
- Day treatment/partial hospitalization
- Mobile crisis services
- Behavioral aide services
- Therapeutic mentors
- Therapeutic foster care
- Therapeutic group homes
- Residential treatment centers
- Crisis residential services
- Inpatient hospital services
- Case management services
- Behavioral management skills training
- School-based health and behavioral health services
- Respite services
- *Wraparound*
- Family support/education
- Family and youth peer mentors
- Transportation
- Mental health consultation
- Early intervention and prevention services

The Importance of Medicaid Managed Care Organizations

As Medicaid dollars increasingly have moved into managed care arrangements, system builders also must become very familiar with the Medicaid managed care systems in their states and counties. Medicaid managed care organizations are critical partners. Partnerships are needed with managed care organizations that are managing primarily physical health care because they often also have responsibility for an acute care (short-term) behavioral health benefit and because of the need for coordination between physical and behavioral health care. Partnerships are also needed, of course, with behavioral health managed care organizations (BHOs) that are managing behavioral health services.

Arizona is one example of a state that has integrated system of care values and principles into its Medicaid managed care system for behavioral health services. Contracts with BHOs stipulate partnerships with families and youth at management and service levels, use of family peer mentors, and assurance that a *Wraparound* approach to care planning will be utilized and that the service delivery system is culturally and linguistically competent. (www.azdhs.gov/bhs).

System builders that fail to understand how Medicaid managed care is organized in their states and counties, and that fail to partner with Medicaid managed care organizations, are allowing a major aspect of their service delivery system—in some cases, the major aspect—to function outside of the system reform. In such a scenario, one would legitimately question how "real" the system reform is.

Use of Multiple Funding Streams to Support a Broad, Flexible Service Array

Use of multiple funding streams (as discussed more fully in Section II, Subsection 2.17, *Financing*) can support a benefit structure that covers a broad range of services and supports and individualized care provision. Sound care management, clinical leadership, family and youth partnerships, integration of natural supports, and strong accountability systems can prevent runaway costs, which are the fear associated with a "generous" benefit structure.

EXAMPLE 2.9

Example of a Broad Array of Services and Supports in a System of Care

The **Dawn Project** in **Marion County, Indiana**, utilizes a very broad array of services and supports. The system of care operates with a locus of management accountability for children in, or at risk for involvement in, multiple systems and their families. Dawn's service array spans a broad, flexible array of both formal services and informal supports and is made possible through collaborative funding across major systems serving children, youth, and families. Note that the array covers services and supports both to children and to families, including basic supports like transportation, food, and help with utility bills, as well as formal services to parents, such as parent skills training, as well as services and supports to children. (**www.choicesteam.org**)

Dawn Services and Supports

Behavior Health
- Behavior management
- Crisis intervention
- Day treatment
- Evaluation
- Family assessment
- Family preservation
- Family therapy
- Group therapy
- Individual therapy
- Parenting/family skills training
- Substance abuse therapy, individual and group
- Special therapy

Placement
- Acute hospitalization
- Foster care
- Therapeutic foster care
- Group home care
- Relative placement
- Residential treatment
- Shelter care
- Crisis residential
- Supported independent living

Psychiatric
- Assessment
- Medication follow-up/ psychiatric review
- Nursing services

Mentor
- Community case management/case aide
- Clinical mentor
- Educational mentor
- Life coach/independent living skills mentor
- Parent and family mentor
- Recreational/social mentor
- Supported work environment
- Tutor
- Community supervision

Respite
- Crisis respite
- Planned respite
- Residential respite

Service Coordination
- Case management
- Service coordination
- Intensive case management

Other
- Camp
- Team meeting
- Consultation with other professionals
- Guardian ad litem
- Transportation
- Interpretive services

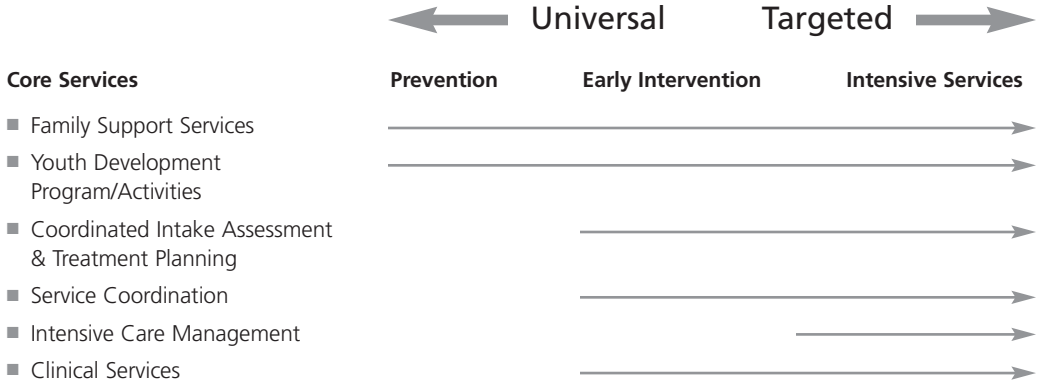
Discretionary
- Activities
- Automobile repair
- Childcare/supervision
- Clothing
- Educational expenses
- Furnishings/appliances
- Housing (rent, security deposits)
- Medical
- Monitoring equipment
- Paid roommate
- Supplies/groceries
- Utilities
- Incentive money

Universal Versus Targeted Services

Particularly if the system of care is focusing on a total population of children and families (e.g., all children and families in a county or all Medicaid-eligible children in a state), it needs to encompass both *universal* (i.e., geared to all children and families, including prevention and early intervention services) and *targeted* services and supports (i.e., geared to children and families identified with or at risk for serious problems, including early intervention and treatment services). Illustration 2.9 highlights this point by showing examples of a service array spanning universal through targeted interventions focused on a "total population." Section II, Subsection 2.11, *Prevention and Early Intervention*, focuses more on this topic.

ILLUSTRATION 2.9

Service Array Focused on a Total Population



Culturally Competent, Family- and Youth-Driven Service Array

Families and youth and culturally and linguistically diverse constituencies need to be involved in the design of the service array, and the services and supports need to reflect the priorities of these key stakeholders (see Box 2.9B). The availability of appropriate services and supports will send a powerful message about values and goals. If it is a narrow, inflexible array and fails to include non-traditional supports, then families, youth, and culturally diverse constituencies are likely to question the sincerity of system builders.

2.9B Developing a Family- and Youth-Driven, Culturally and Linguistically Competent Service Array

- Is it driven by family- and youth-preferred choices?
- Does it reflect the needs and help-seeking behaviors of the population or populations of youth and families who are the focus of the system of care?
- Does it reflect principles of equal access/non-discriminatory practices?
- Does it reflect cultural and linguistic competence regarding Evidence-Based Practices, Community-Defined and Practice-Based Evidence?
- Does it incorporate unique culturally relevant services and supports?

Strategies to Increase the Array of Home and Community-Based Services

A challenge facing system builders is that of increasing service capacity to accommodate increased demands in a new, more accessible system of care. Box 2.9C offers some strategies. Development of needed service capacity is a state-level and tribal-level, as well as local-level, issue. Most system builders face the reality that services for children, particularly home and community-based services, are underdeveloped. In most states and communities, there are shortages of particular types of providers (e.g., child psychiatrists) and service modalities (e.g., intensive in-home services). Development of service capacity is very much related to financing strategies, for example, redirecting or reinvesting resources in the development of new or more services or changing the State Medicaid Plan, as discussed in Section II, Subsection 2.17, *Financing*. It also is related to training and retraining of new and existing providers and to decisions about how to structure the provider network, for example whether to include new types of providers, as discussed in Section II, Subsection 2.12, *Provider Network*.

2.9C Strategies for Increasing Home and Community-Based Service Capacity

- Support family and youth movements so that families and youth can organize to advocate for services.
- Engage natural helpers and culturally diverse communities to identify and utilize informal supports.
- Implement a meaningful Rehabilitation Services Option under Medicaid.
- Collapse out-of-home and community-based budget structures so that savings in reduced out-of-home placements can be used to expand community services.
- Redirect dollars from "deep-end" spending, such as on out-of-home placements, to community services.
- Implement flexible rate structures, such as case rates.
- Implement capacity-building grants for providers.
- Implement performance-based contracts.
- Develop practice guidelines that support home and community-based service decision making.
- Orient key stakeholders, such as judges, families, and providers, to the effectiveness of home and community-based services and train these stakeholders in their use.
- Implement quality and utilization management practices that reinforce use of home and community-based services.
- Apply for federal system of care demonstration grants.
- Collect data on outcomes, on family and youth satisfaction, and on cost/ benefit of home and community-based services.
- Educate key policy makers, such as Governor's office staff and legislators.

WEB RESOURCES

Effective Strategies to Finance a Broad Service Array at:
http://cfs.fmhi.usf.edu/pub-details.cfm?pubID=194

Medicaid Coverage of a Broad Service Array at: **www.bazelon.org**

A Family Guide to Expanding Home and Community-Based Services at:
www.nami.org/Template.cfm?Section=Child_and_Teen_Support&template=/ContentManagement/ContentDisplay.cfm&ContentID=76200

Key Questions: Benefit Design/Service Array

- What types of services and supports do we offer?
- What are their limits?
- What services and supports do we need to offer that we are not?
- What are our strategies for building service capacity?

NOTES

2.10 Evidence-Based and Effective Practice

Overview

Historically, systems of care have been concerned about the quality and effectiveness of treatment interventions, that is, of frontline practice. As evidence grows regarding the efficacy of certain home and community-based clinical interventions and service modalities and the lack of efficacy of institutional treatment approaches, system builders have become more focused on building evidence-based practice into systems of care. In addition, there is increasing emphasis on building accountability at the treatment level into systems of care and recognition that systems of care cannot achieve desired outcomes without improving the quality of clinical interventions with children and families.

In the 2002 seminal work, *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders*,* Burns, Hoagwood, and Weisz define the term "evidence-based" as referring to *"a body of knowledge, obtained through carefully implemented scientific methods, about the prevalence, incidence, or risks for mental disorders, or about the impact of treatment or services on mental health problems."* They point out, *"Controlled studies of institutional care have found no evidence of benefit (e.g., a lack of positive outcomes) in such settings as psychiatric hospitals, residential treatment centers, and detention centers…. The current availability of evidence for effective home- and community-based interventions makes it possible for communities to redirect their approach to care—and many are beginning to do so."*

Burns, Hoagwood and Weisz also write, *"Perhaps it is the optimism that accompanies the beginning of a new century, but…much is now known about the effectiveness, impact, and outcomes of a range of treatments and services for children with severe emotional and behavioral disorders."* They identify a number of shared characteristics of the evidence-based interventions described in their book (see Box 2.10A).

In the same volume, Jensen writes, *"…the current need is…[for] building efficacious treatment interventions within effective, compassionate, and competent systems of care."*

*Hoagwood, K., Burns, B., & Weisz, J. *A profitable conjunction: From science to service in children's mental health*. In Burns, B., & Hoagwood, K. (Eds.). (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press. See also Marsenich, L. (2002). Evidence-based practices in mental health services for foster youth. Sacramento: California Institute for Mental Health.

2.10A Characteristics of Evidence-Based Interventions

- They function as service components in a system of care and adhere to system of care values (e.g., individualized, family-centered, strengths based (not pathology oriented), and culturally competent).
- They are provided in the community—homes, schools, and neighborhoods.
- With the exception of Multisystemic Therapy and sometimes case management, the direct-care providers (often) are not formally clinically trained. They are parents, volunteers, and counselors, although training and supervision are provided by traditionally trained mental health professionals.
- These interventions may operate under the auspices of any of the human service sectors (i.e., education, child welfare, or juvenile justice), not just mental health.
- Their external validity is greatly enhanced because they were developed and studied in the field with real-world child and family clients, in contrast to volunteers in university-based studies.
- When the full continuum of care in the community is in place, they are less expensive to provide than institutional care.

Burns, B., & Hoagwood, K. (Eds.). (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press.

Evidence-Based Versus Practice-Based or Community-Defined Evidence

Children's services—in child welfare, mental health and substance abuse, juvenile justice, education, early intervention, and other arenas—have benefited in the past decade from a growing research base on evidence-based practices. The field also is benefiting from a growing literature about promising approaches, which have not yet had the benefit of scientific research but which, experientially, are demonstrating effective outcomes. This is sometimes referred to as "practice-based evidence" or "community-defined evidence." Both evidence-based services and treatment approaches and those supported by practice-based or community-defined evidence are needed in systems of care (see Boxes 2.10B and 2.10C).

2.10B Practice-Based or Community-Defined Evidence

Show evidence of effectiveness through experience of key stakeholders (e.g., families, youth, providers, administrators) and outcomes data. Some examples include:

- Family Support and Education
- Wraparound Approach
- Mobile Response and Stabilization Services
- Family Group Conferencing
- Intensive In-Home Services
- Child and Youth Respite Services
- Mental Health Consultation Services
- Independent Living Skills and Supports
- Traditional Native Healing

2.10C Evidence-Based Practices

Show evidence of effectiveness through carefully controlled scientific studies, including random clinical trials. Some examples include:

- Multisystemic Therapy (MST)
- Multidimensional Treatment Foster Care (MDTFC)
- Functional Family Therapy (FFT)
- Cognitive Behavioral Therapy (various models)
- Parent-Child Interaction Therapy (PCIT)
- Trauma-Focused Therapies
- Intensive Care Management
- Integrated Co-occurring Treatment

In their review of evidence-based practices, Burns and Hoagwood found the following:

- **Most evidence of efficacy:** Intensive case management, in-home services, and therapeutic foster care
- **Less evidence** (*because not much research done*): Crisis services, respite, mentoring, and family education and support
- **Least evidence** (and lots of research): Inpatient, residential treatment, and therapeutic group home

Their findings suggest a compelling need for more research on such services as mobile crisis and stabilization, respite, and family and youth peer support, which families and youth often report as critical, which often are most missing in the service array, and on which there appears to be little research currently.

Examples of Non-Evidence-Based Practices

Services that do not tend to show up in the evidence-based practice literature as having sustainable outcomes for children, although they may be standard practice, include: residential treatment, group homes, traditional office-based "talk" therapy, and day treatment. These often are the services used most frequently for children with the most serious needs, and some carry very high costs.

Some states and researchers also have made advances in identifying not only effective practice but practices with harmful effects.

Hawaii provides us with an example of efforts to identify effective practices for children presenting with specific problems—for example, cognitive behavior therapy for children with anxiety—as well as practices that carry documented risks, such as group therapy for youth with delinquent behaviors.

EXAMPLE 2.10A

Example from Hawaii's List of Evidence Based Practices

Problem Area	Best Support	Good Support	Moderate Support
Anxious or Avoidant Behaviors	Cognitive Behavior Therapy (CBT); Exposure Modeling	CBT with Parents; Group CBT; CBT for Child and Parent; Educational Support	None
Depressive or Withdrawn Behaviors	CBT	CBT with Parents; Inter-Personal Tx. (Manualized); Relaxation	None
Disruptive and Oppositional Behaviors *Known Risks: Group Therapy*	Parent and Teacher Training; Parent Child Interaction Therapy	Anger Coping Therapy; Assertiveness Training; Problem Solving Skills Training; Rational Emotive Therapy, AC-SIT, PATHS & FAST Track Programs	Social Relations Training; Project Achieve
Youth with Sex Offenses	None	None	Multisystemic Therapy
Delinquency and Willful Misconduct Behavior *Known Risks: Group Therapy*	None	Multisystemic Therapy; Functional Family Therapy	Multi-Dimensional Treatment Foster Care; Wraparound Foster Care
Substance Use *Known Risks: Group Therapy*	CBT	Behavior Therapy; Purdue Brief Family Therapy	None

HA Department of Health, Child and Adolescent Division. (2005). Available from: http://hawaii.gov/health/mental-health/camhd/index.html.

See also research findings of Kenneth Dodge and colleagues in: Dodge, K., Dishion, T., & Lansford, J. (2006, January). *Deviant peer influences in intervention and public policy for youth* (Social Policy Report, Vol. XX, No. 1).

The Hawaii list of evidence-based practices is also instructive to illustrate the limitations of relying solely on evidence-based practices, rather than including practice-based and community-defined practices as well. For example, Hawaii, looking *only* at evidence-based practices, found that only Multisystemic Therapy has moderate support in being effective for youth with sex offenses. However, Wraparound Milwaukee is an example of a system of care that has experienced very good outcomes for youth with sex offenses, using high-fidelity *Wraparound*, close attention to safety plans, and strong clinical interventions. Their approach would not show up as an "evidence-based practice," but it is a good example of an approach with practice-based evidence.

Some states, for example, state Medicaid agencies, have implemented or considered policies to fund *only* evidence-based practices, which is problematic for several reasons. It dismisses community- or provider-generated practices that show evidence of effectiveness based on the experiences of families and administrators as well as on outcome data. Some of these community-defined practices may be more culturally relevant than evidence-based practices where there has been little research within unique racial and cultural contexts.

Challenges to and Strategies for Implementing Evidence-Based and Effective Practices

Building evidence-based and other effective practices into systems of care has very much to do with how system builders structure a whole range of policies and procedures, including benefit design, financing, reimbursement, credentialing, frontline practice protocols, training, and quality assurance mechanisms. Structural changes are needed to ensure the readiness of providers and clinicians to undertake and learn new ways of conducting frontline practice. Some of the challenges to implementing evidence-based and other effective practices within a system of care include:

- The need for training, consultation, and coaching;
- Provider capacity development;
- Fidelity monitoring;
- Outcomes tracking; and
- Policy and financing changes.

Strategies for addressing these challenges, which mirror system of care approaches, include: adopting a population focus across systems and identifying incentives to the various systems for collaborating.

EXAMPLE 2.10B

Contra Costa County, CA, provides an example of cross-system partnerships to implement evidence-based practices for children in child welfare and juvenile justice systems, for example, Multidimensional Treatment Foster Care. A federal grant from the National Institute of Mental Health to the California Institute of Mental Health pays for training, coaching, and fidelity monitoring; AFDC-FC (child welfare) funds pay for room and board; Medicaid (Medi-Cal in California) covers clinical costs, juvenile justice general revenue pays for children who are non-Medicaid eligible, and county mental health tracks outcomes. (**www.cchealth.org/services/mental_health/youth_families.php**)

Building evidence-based practices into systems of care requires effective partnerships with researchers, creating structures that include researchers as part of system-building teams. Some states and localities, for example, are creating "Centers for Excellence" as a key element of their system-building effort, such as the **Ohio Center for Innovative Practices** (www.cipohio.org), the **Maryland Innovations Institute** (www.medschool.umaryland.edu/innovations), and the **California Institute of Mental Health** (www.cimh.org). These centers provide a vehicle for the identification and dissemination of evidence-based practices to systems of care.

Implications for Residential Providers

Evidence-based research and practice-based evidence, combined with the high cost and generally poor outcomes associated with residential care, are moving state and county purchasers increasingly toward home and community-based services and supports. This trend has implications for how residential care is utilized within systems of care. Some children and youth still need out-of-home placements, but systems of care seek to move away from a "placement mentality" in which children remain in residential care for long periods to one in which a sense of urgency is created when a child is in out-of-home care to ensure that he or she can move home or to a more permanent, natural setting as quickly as possible. For example, in the Wraparound Milwaukee system of care, residential treatment is authorized for only 30 days at a time, and the average length of stay is less than three months for populations of children and youth with very serious and complex issues who, historically, have remained in residential care for 18 months or longer.

With federal leadership provided through the Center for Mental Health Services, systems of care are actively engaging residential providers in developing policies and principles that nest residential care within a system of care in which decisions are shared with families and with youth, treatment approaches are individualized, children in residential treatment remain connected to their communities and families/caregivers, and there is movement away from long lengths of stay (see Box 2.10D).

2.10D Implications of How Residential Care Is Utilized

- Movement away from "placement" orientation and long lengths of stay
- Residential as part of an integrated continuum, connected to community
- Shared decision making with families/youth and other providers and agencies
- Individualized treatment approaches through a child and family team process

For more information, go to Building Bridges Initiative: www.buildingbridges4youth.org

Tools to Guide Frontline Practice

As the body of knowledge about evidence-based and effective interventions continues to be developed, system builders may turn to a variety of tools to guide frontline practice. In Box 2.10E, Burns and Hoagwood describe six tools to "achieve more relevant and consistent clinical practice."

These tools provide a means for system builders to structure clinical leadership and direction to support effective frontline practice, based on evidence where it exists and on consensus derived from experience where more formal evidence does not yet exist.

2.10E Tools to Support Consistent Clinical Practice*

1. **Best practices** tend to set out fairly general statements about clinical practice. They may be consumer- or provider-developed, based on consensus, and may or may not be specific either to diagnosis or to specific interventions. An example is "Promising Practices in Wraparound for Children with Serious Emotional Disturbance and Their Families" (Burns & Goldman, 1999).
2. **Practice guidelines** for diagnosis-specific interventions are evidence based and may be consensus based as well. They are developed by clinicians and researchers to guide treatment for specific disorders. Those that have been developed for childhood disorders are identified as practice parameters and include attention-deficit/hyperactivity disorder (AACAP, 1991), conduct disorders (AACAP, 1992), anxiety disorders (AACAP, 1993), schizophrenia (McClellan & Werry, 1994), substance-use disorders (AACAP, 1997b), bipolar disorder (AACAP, 1997a), and mental retardation and comorbid mental disorders (AACAP, 1999).
3. **Clinical protocols/manuals** were historically designed to ensure adherence to highly specific types of treatment. Previously, rigid adherence to a verbal script was the approach taken, but manuals of today are more likely to expand on principles for implementing a specific intervention (e.g., Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998b, for MST; and VanDenBerg and Grealish, 1998, for wraparound).
4. **Quality monitoring**, usually developed by clinicians to monitor clinical practice, consists of general indicators to assess treatment such as criteria for admission, treatment continuation, or termination by level of care. They may also include performance indicators that are population-based such as rates of access to care. In the future we may expect to see quality indicators derived from practice guidelines for specific disorders—for example, the American Psychiatric Association Task Force on Quality Indicators for Children is developing a comprehensive set of quality indicators for children and adolescents across multiple clinical conditions.
5. **Fidelity/adherence** measures assess the extent to which a given intervention is provided as intended. Developed in research settings, to date these measures have been utilized in controlled and uncontrolled research but not (broadly) in clinical practice. Among the interventions for youth with severe emotional and behavior disorders, (at least) three have reasonably well-developed methods for assessing fidelity: multisystemic therapy (Henggeler et al., 1998b), treatment foster care (Foster Family-Based Treatment Association, 1995; Farmer, Burns, Chamberlain, & Dubs, 2001); and wraparound (Epstein et al., 1998).
6. **Regulations** are specified largely for licensure, accreditation, or reimbursement by regulatory agencies. They may include criteria for client eligibility for level of care, structural quality criteria (staff qualifications and institutional capability), and occasionally practice parameters (e.g., frequency of contact, availability, intensity, duration of care, and caseload ratios).

Burns, B., & Hoagwood, K. (Eds.). (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press.

*Note: All references cited in this box can be found in Community Treatment for Youth.

Trauma-Informed Practice

As part of the movement toward effective practice, systems of care also are embracing the concept of *trauma-informed care*, recognizing that many children, youth, and families who become involved with public systems have experienced personal or community violence and other trauma and that traditional systems too often end up retraumatizing them. A growing number of evidence-based trauma-specific interventions have developed. A trauma-informed approach, however, is concerned not only about implementing specific interventions but also about all organizations, programs, and services within the system of care transforming. Trauma-informed systems operate from an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, create a more supportive environment, and

avoid retraumatization. When a system of care takes the step to become trauma informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of a child, youth, and family seeking services.

EXAMPLE 2.10C

Maine is an example of a state in which the child behavioral health system is partnering with child welfare, providers, and families and youth to build a trauma-informed system of care. This approach recognizes "problem" behaviors as ways of either coping with or adapting to painful current circumstances or as stress related to past traumatic events. The initiative is providing training and coaching to build a cadre of trauma-informed organizations, as well as providers trained in specific trauma-informed interventions, including Trauma-Informed Cognitive Behavioral Therapy and Child Parent Psychotherapy for young children. Trainers and coaches work with staff, including receptionists and administrators, as well as clinicians, other community service providers, and youth and adult consumers, on trauma-informed interactions, assessment, and service delivery that is family driven, youth guided, and culturally and linguistically competent. (**http://thriveinitiative.org**)

As systems of care strive to incorporate evidence-based practices, it is important not to lose sight of the considerations noted in Box 2.10F.

2.10F Considerations Regarding Evidence-Based Practice

- The importance of considering and studying clinical interventions in the context of the service systems through which they are provided and with attention to the diversity and complexity of the populations served.
- The importance of using common sense and experience to make decisions about services where an evidence base has yet to be developed.
- The importance of identifying unique and creative practices within systems of care that are candidates for development of an evidence base.
- The importance of not allowing innovation to be stifled by the desire to use only proven interventions.
- The importance of incorporating evidence-based practices into systems of care where we do have data and supporting the use of effective clinical practices through training.
- The importance of broadening the concept of evidence-based interventions to include evidence-based processes that may cut across a number of clinical interventions such as relationship building or the wraparound approach to service delivery.
- The importance of defining what constitutes "evidence" and the research methods considered acceptable for providing evidence, more broadly to ensure their relevance to operating community-based service systems.
- The importance of not perpetuating a false dichotomy between the concepts of evidence-based interventions and systems of care—they go hand in glove.

Stroul, B. (2002). *Systems of care: A framework for system reform in children's mental health* [Issue Brief]. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

WEB RESOURCES

Findings from the Kaufman Foundation Best Practices Project at: **www.chadwickcenter.org**

Resource Guide for Promoting an Evidence-Based Culture in Children's Mental Health at: **www.systemsofcare.samhsa.gov/ResourceGuide/index.html**

Community-Defined Evidence Project at: **http://cfs.fmhi.usf.edu/project-details.cfm?projectID=399**

National Registry of Evidence-Based Programs and Practices at: **www.nrepp.samhsa.gov**

Addiction Technology Transfer Center Network at: **www.attcnetwork.org**

National Center for Trauma-Informed Care at: **http://mentalhealth.samhsa.gov/nctic**

National Child Traumatic Stress Network at: **www.nctsnet.org**

Key Questions: Evidence-Based and Effective Practice

- Have we read the literature and educated ourselves about evidence-based and effective practices?
- How do our structures support incorporation of evidence-based and effective practice into our system of care?
- What approaches are we using or should use to build leadership and direction into our system of care to support effective frontline practice?

NOTES

2.11 Prevention and Early Intervention

Overview

Just as systems of care are benefiting from a growth in evidence-based and effective practices in treatment and service modalities, they also can benefit from a growing body of effective prevention and early intervention approaches. As systems of care increasingly focus on broader populations than children with serious disorders, and as a public health approach is increasingly being used to inform systems of care, incorporation of effective prevention and early intervention approaches is critical (see Illustration 2.11).

The 2009 Institute of Medicine Report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (www.bocyf.org), indicates that mental, emotional, and behavioral disorders tend to appear first in childhood and adolescence and that "clear windows of opportunity" are available to prevent them. The report also notes that "opportunities are missed to use evidence-based approaches to prevent the occurrence of disorders, establish building blocks for healthy development in all young people, and limit the environmental exposures that increase risk." The report further notes that a range of policies and practices that target young people with specific risk factors (e.g., children in child welfare), promote emotional well-being, and build on family, school, and community resources "have proven to be effective" and "could potentially save billions of dollars by preventing or mitigating disorders that would otherwise require expensive treatment."

Proven Approaches

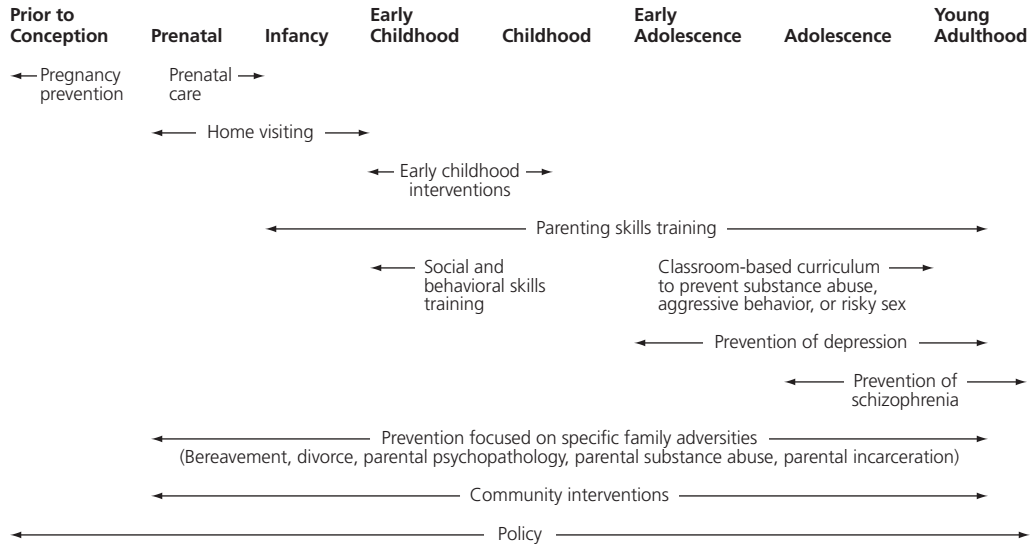
The Institute of Medicine report describes the following as proven approaches:

- **Strengthening families** by targeting problems such as substance use or aggressive behavior; teaching effective parenting skills; improving communication; and helping families deal with disruptions (such as divorce) or adversities (such as parental mental illness or poverty)
- **Strengthening individuals** by building resilience and skills and improving cognitive processes and behaviors
- **Preventing specific disorders,** such as anxiety or depression, by screening individuals at risk and offering cognitive training or other preventive interventions
- **Promoting mental health in schools** by offering support to children encountering serious stresses; modifying the school environment to promote prosocial behavior; developing students' skills at decision-making, self-awareness, and conducting relationships; and targeting violence, aggressive behavior, and substance use

- **Promoting mental health through health care and community programs** by promoting and supporting prosocial behavior, teaching coping skills, and targeting modifiable lifestyle factors that can affect behavior and emotional health, such as sleep, diet, activity and physical fitness, sunshine and light, and television viewing.

ILLUSTRATION 2.11

Interventions by Developmental Phase



Source: Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults, 2009.

The Importance of Partnerships

The Institute of Medicine report calls for the development of state and local systems involving partnerships among families, schools, courts, health care providers, and local programs to create coordinated approaches that support healthy development—an approach very familiar to those involved in building systems of care.

EXAMPLES 2.11A&B

In **Rhode Island**, the system of care for children with and at risk for serious emotional and behavioral health challenges is partnering with the schools to implement Positive Behavioral Interventions and Supports, a schoolwide prevention approach. In **Arizona**, through a partnership between the behavioral health and child welfare systems, the system of care for children with behavioral health needs has incorporated a 24-hour response system when a child enters child welfare placement, to ensure behavioral screening and linkage to appropriate services and supports for early intervention.

Relevance of Prevention and Early Intervention Approaches to Families, Youth, and Culturally Diverse Communities

The effectiveness of prevention and early intervention approaches is influenced by their relevance and acceptability to families, youth, and the community. System builders need to engage families, youth, and culturally diverse communities in developing or adapting appropriate strategies.

WEB RESOURCES

Institute of Medicine Report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* at: **www.bocyf.org**

Center for Prevention and Early Intervention at: **www.jhsph.edu/prevention/index.html**

Prevention and Early Intervention Literature review at:
www.community.nsw.gov.au/docswr/_assets/main/documents/eip_literature_review.pdf

Benefits and Costs of Prevention and Early Intervention Programs for Youth at:
new.vawnet.org/category/Documents.php?docid=1161

Key Questions: Prevention and Early Intervention

- Have we identified effective prevention and early intervention approaches for our population or populations of focus?
- What are our goals for creating a continuum from promotion, prevention, early intervention, and treatment?
- What are the partnerships we have created, for example, with public health and the schools, to develop and implement prevention and early intervention strategies?

NOTES

2.12 Provider Network (Network of Services and Supports)

Effective Provider Networks

"Provider network" has to do with who will provide the needed services and supports in the system of care. Will some services and supports be provided by in-house staff? Will some or all be contracted? To one main provider? To multiple providers? How will informal providers and parents and youth be included as providers?

Effective systems of care structure provider networks that have certain characteristics:

- **They are responsive to the population that is the focus of the system of care.** For example, systems of care include children involved in the child welfare system, which has implications for who needs to be in the provider network such as providers experienced in sexual abuse treatment, providers experienced with very young children, and clinicians well versed in providing trauma-informed care. Systems of care that are serving children with serious and complex disorders need to anticipate that the population will include an overrepresentation of children with dual diagnoses of emotional disorders and developmental disabilities and adolescents with both mental health and substance abuse treatment needs, and plan for inclusion of appropriate providers to serve those with dual diagnoses. Systems of care are serving racially, ethnically, and linguistically diverse populations, which has implications for the types of providers needed within networks. Systems of care that serve rural and frontier populations must include providers well versed in using technology to deliver services such as telepsychiatry.
- **They encompass both clinical treatment service providers and natural, social support resources, such as mentors, and they include both traditional and non-traditional, indigenous providers.** If a system of care is heavily reliant on a single provider agency, such as a community mental health center, it will need to build into the structure requirements for subcontracts with non-traditional, indigenous providers and the flexibility to purchase natural supports.
- **They include culturally and linguistically diverse providers.**
- **They include families and youth as providers of services and supports.**
- **They are flexible, structured in a way that allows for additions to and deletions from the network as system needs change over time.**
- **They are accountable, structured in a way that it is clear they have been organized to serve the needs of the system of care.** Some systems of care, particularly in early stages of development where they do not control major system dollars, must "beg, borrow, and steal" services and supports from providers who are under contract and primarily responsive to traditional systems. This structure makes it very difficult, if not impossible, to create provider accountability and really change the way services and supports are delivered. It requires strong relationship-building skills between the

system of care and the provider community, orientation and training, and augmentation of traditional services with whatever system of care dollars are available.

EXAMPLE 2.12A

Wraparound Milwaukee's system of care encompasses a broad, diverse provider network of over 200 agencies, programs, activities, and individuals. Rates have been established for each type of service and support within the network. Families who have a service and support plan of care can choose their providers from the system of care's provider list, which typically includes several providers offering the same type of service or support. For example, if the plan of care calls for respite services, a family can choose among a number of respite providers on the provider list.

In this way, families can "vote with their feet" on the providers they feel are responsive. This structure provides the system of care with a built-in mechanism for accountability, which surfaces issues regarding providers that consistently are not used by families. This structure also allows for a great deal of flexibility and inclusion of many different types of services and supports, including family-run programs and natural helpers.

Structuring the Provider Network

There are many ways of structuring the provider network, such as allowing any "willing provider" to provide services and supports within the system of care as long as the provider meets the system's standards and criteria, or designating a qualified provider pool, or creating a selective network for fixed service amounts through contracting arrangements. There are pros and cons to all of these arrangements (see Box 2.12A). For example, a selective network may allow for greater quality control over the network on the positive side, but it may disenfranchise some providers who do not get selected and may reduce the choice of providers available to families. An "any willing provider" pool may give families considerable choice on the positive side, but it may be difficult for the system of care to exercise sufficient quality control over providers. A "qualified provider pool," from which families and service planners may draw, provides flexibility and choice, but it may create management difficulties for some providers who do not get "chosen" frequently enough and face revenue losses, or for providers who are chosen too frequently and cannot sustain the volume. System builders need to engage in a strategic analysis of which provider network structures make sense for their particular circumstances.

2.12A Pros and Cons of Various Provider Network Arrangements

Selective Network (contracts)
- Allows for greater quality control over the network
- May disenfranchise some providers who do not get selected
- May reduce the choice of providers available to families

"Any Willing Provider" Pool (meets standards)
- May give families considerable choice of providers
- May be difficult for the system of care to exercise sufficient quality control over providers

Qualified Provider Pool (designated)
- May give families and service planners considerable choice of providers
- May be difficult for some providers to manage too much or too little service volume

Elements of Trauma-Informed Provider Networks

As discussed in the Section II, Subsection 2.10, *Evidence-Based and Effective Practices*, many children involved in multiple systems are exposed to multiple or complex traumas, such as abuse, neglect, and domestic or community violence. Children are often further traumatized by their involvement in the child-serving systems (i.e., child welfare, mental health, juvenile justice, etc.), because of insensitive interviews, repeated changes in treatment providers or placement, court testimony, and removal from home and loved ones. The National Child Traumatic Stress Network has begun to address this issue and identified eight essential elements of trauma-informed child welfare practice (see Box 2.12B). These principles can be applied to other populations of children and youth who have experienced trauma, not only those involved in child welfare.

2.12B Essential Elements of Trauma-Informed Child Welfare Practice and Provider Network

- Maximize the child's sense of safety.
- Connect children and youth with providers who can assist them in reducing overwhelming emotions.
- Connect children with providers who can help them integrate traumatic experiences and gain mastery over their experiences.
- Address ripple effects in the child's behavior, development, relationships, and survival strategies following a trauma.
- Provide support and guidance to the child's family.
- Ensure that caseworkers manage their own professional and personal stress.

Focal Point: Traumatic Stress/Child Welfare. Winter 2007. Research and Training Center on Family Support and Children's Mental Health, Portland, OR.

This list can be used to begin a discussion among system builders about the capacity of the provider network (including both in-house staff and contracted providers) in their respective communities to practice trauma-informed service provision.

Examples of Incentives to Providers to Change Practice

Effective system builders seek ways of creating incentives for providers to change practice. Provider payment rates obviously have a major bearing on the interest and quality of providers. However, system builders may not control the rate structure for all providers. For example, Medicaid providers will be in the network, and their rates may be controlled by the state Medicaid agency. In this case, system builders need to strategize how to provide other incentives to providers, such as allowing them greater flexibility and control, offering training and staff development, providing back-up support when especially difficult administrative or service challenges arise, providing more timely reimbursements, providing them with capacity development grants, reducing paperwork, and the like. System builders need to consider these provider incentive

strategies *across systems* because differences in approaches to providers among key child-serving systems serving the same populations aggravate the problem of fragmentation in children's services. Providers may abandon one system to obtain more decent rates or work within more favorable policies from another.

Importance of Natural Supports

Successful systems of care blend clinical and other formal services and natural supports, helping families to access and make use of both. Natural supports include people such as natural helpers, organizations such as faith-based organizations and parent associations, programs such as mentoring, and activities such as parent support and educational activities. Natural supports are those found within the neighborhoods in which families live and within the affinity groups with which they associate (or would associate if they existed). Natural helpers and social supports may be family members, youth, representatives from culturally diverse neighborhoods, and others who can provide a more "normalized" and enduring form of support to families and youth than can formal services. Natural helping networks may include groups such as faith-based organizations, neighborhood watch groups, or informal social groups, such as a neighborhood scrapbooking club.

Families and youth are the best definers of natural supports that make or could make a difference in their lives. They are a critical voice in defining the supports that need to be available systemically within the network of services and supports and those that need to be integrated within their own individualized plans of care. Use of natural supports is essential to achieve quality, efficacy, and cost outcomes, particularly for families who have children with serious disorders and for poor, inner city, and rural families who often feel isolated and for whom clinical services are especially in short supply. A connection to neighborhood resources and natural helpers also is critical to incorporate cultural competence into service delivery. Successful systems figure out ways to include natural supports within the financing, benefit design, provider network, and care-planning arrangements of local systems of care.

Roles for Natural Helpers

Examples of what natural helpers can provide include: skill building (e.g., a grandmother teaching a younger woman about child care); emotional support; resource acquisition (e.g., providing information about how to obtain housing or food assistance or linking families to support organizations); and concrete help, such as transportation (see Box 2.12C).

2.12C What Natural Helpers Can Provide

Natural helpers can provide many types of help. Arbitrarily, we have categorized this help into five areas: skill building, emotional support, community leadership and network, resource acquisition, and concrete help.

Some natural helpers (and some professionals) have assets in all five areas, but people who are strong in only one or two areas still can make important contributions. These examples are presented to help people think outside the box of traditional service delivery and to recognize the wealth of resources that can be drawn upon to help families help themselves.

Examples of Skills Building

- Helping others recognize their strengths, see a future, and set and reach measurable goals
- Helping others keep family members safe
- Helping others strengthen relationships
- Helping others learn to get and keep goods and services: transportation, housing, legal assistance, child care/babysitting, employment, food and clothing, financial aid, furniture and household goods, medical and dental services, toys, recreational equipment, and recreational opportunities
- Serving as a role model
- Helping others exercise their rights and responsibilities
- Teaching professionals how better to help

Examples of Providing Emotional Support

- Listening, being available, spending time
- Providing positive regard, without judgment
- Avoiding gossip and manipulation
- Addressing issues of isolation by being bridges and confidants

Resource Acquisition

- Providing information about where to find transportation and housing
- Providing help in dealing with landlords, installment sellers, and loan sharks
- Providing help in getting good deals on items: trading with junk dealers, hock shops, informal food and clothing banks, etc.

Concrete Help

- Babysitting
- Fixing things
- Cleaning up junk
- Gardening

Bruner, C., et al. (1999). *Wise counsel: Redefining the role of consumers, professionals and community workers in the helping process.* Des Moines, IA: Child and Family Policy Center.

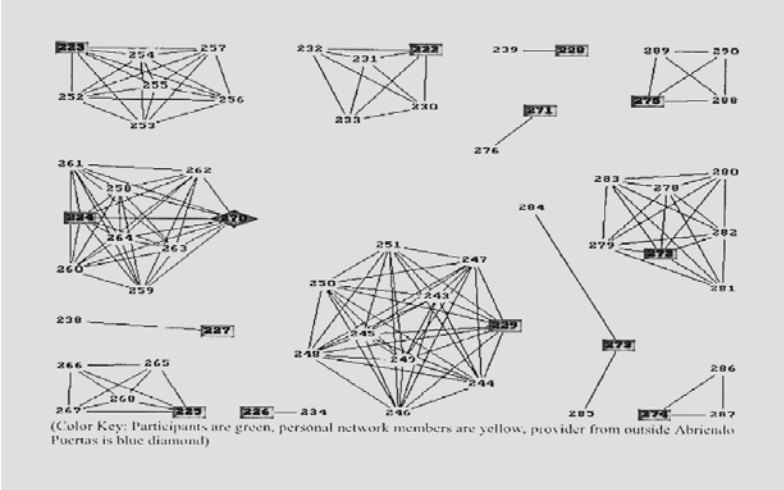
One of the most important and now recognized roles of the natural helper is that of "connector," helping to connect families to basic supports and resources, formal services, and informal support systems, as shown by the example of the Abriendo Puertas Family Center's "*Equipo* Network" in the following illustrations, 2.12A and 2.12B. *Equipo*, which means "team," was an initiative that trained natural helpers in a community, as well as formal service providers, to work in partnership to engage families at risk and implement family-centered practices. The illustrations below are from an evaluation of *Equipo* in the year before and year after its implementation.

The first illustration shows the connections that recently arrived immigrant families had to natural and formal helpers prior to development of the *Equipo* natural helpers initiative; the second depicts connections after the development and implementation of the natural helper network.

The pre-*Equipo* network shown below comprises 13 sets of largely disconnected families in the year prior to implementation of *Equipo*. The green blocks represent 13 families; the blue triangles represent formal providers; the yellow blocks represent natural supports (e.g., neighbors, faith-based organizations, and extended family). As can be seen, many of these families were very isolated even from natural helpers, and most had no connections to formal providers.

ILLUSTRATION 2.12A

Pre-Equipo Network

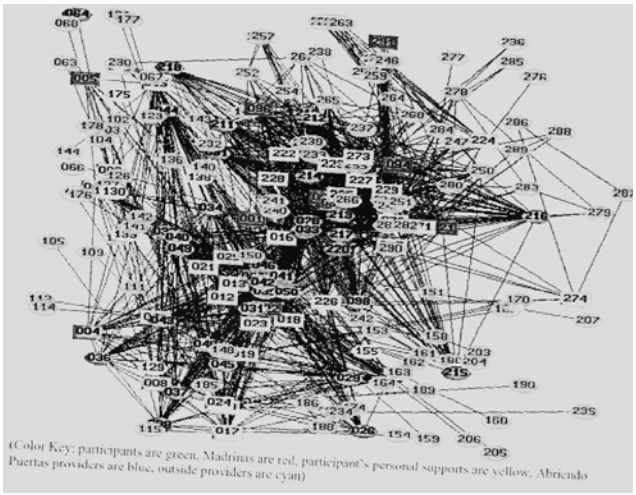


Guiterrez-Mayka, M., & Wolfe, A. (2001). EQUIPO Neighborhood Family Team: Final Evaluation Report.

The second illustration shows the connections for these 13 families one year after implementation of *Equipo*. In the post-*Equipo* network, there are many more relationships, so the network has a much higher density. There are no more clusters isolated from all the others. This decrease in isolation led to greater access to services. Decrease in isolation and improved access to services are also key variables in prevention and early intervention strategies.

ILLUSTRATION 2.12B

Post-Equipo Network



Guiterrez-Mayka, M., & Wolfe, A. (2001). EQUIPO Neighborhood Family Team: Final Evaluation Report.

Families and Youth as Both Formal and Informal Providers

Families and youth can play an important role as providers—both as formal providers and as informal helpers—if they are supported by systems that recognize their role as providers (see Box 2.12D).

2.12D Roles That Families and Youth Are Uniquely Positioned to Play

- Active outreach in the community;
- First to connect with family or youth upon intake;
- Respect for family's and youth's experience;
- Reflective of the families and youth to be served culturally, linguistically, and socioeconomically;
- Support for family and youth to have active voice and choice;
- Work collaboratively to connect families and youth to one another as a network of support;
- Work within or in partnership with family organizations (for both training and system reform);
- Building of trust and bridging relationships between families and youth and formal systems; and
- Co-location to create a family-driven working environment and culture.

Specific roles for families and youth as providers include: providing basic information to families about how various systems operate, such as mental health, child welfare, the courts, special education, and others; orienting families and youth to service-planning processes, such as *Wraparound*, and helping them think through strengths and needs; helping families locate resources; and helping families navigate systems. Families and youth may also provide specific services, such as respite and mentoring (see Box 2.12E).

Family organizations, state and county government, and local community provider agencies in systems of care increasingly are hiring family members and youth who have had experience with public agencies to be on the frontline. Their roles on the frontline are helping to establish trust with families and youth seeking services, diversifying the workforce, and increasing family and youth engagement in the delivery of services and supports. It is important, though, that as these new positions are created, there are clear job descriptions, supervision and support models, and training and coaching.

2.12E Where Families, Youth and Family and Youth Organizations Fit into the Service Array

As Technical Assistance Providers & Consultants

- Training
- Evaluation
- Research
- Quality Improvement
- Support
- Outreach/Dissemination
- Social Marketing

As Direct Service Providers

- Family Liaisons
- Care Coordinators
- Family Educators
- Specific Program Managers (respite, etc.)
- Youth Peers Mentors
- Family Peer Mentors
- System Navigators

Infrastructure to Support Families and Youth as Providers

It is not sufficient simply for systems of care to hire parents and youth; the system itself needs to be structured in ways that embrace family and youth partnership. For example, families will feel isolated if they are the lone family member working in the system and are not connected to a larger family movement. Families and youth need clear job descriptions and fair compensation. Agency policies may need to be changed to support more flexible working arrangements (which should then be changed for all employees, not just for family members and youth; otherwise, a two-tiered system is created). Systems of care can model partnerships, such as co-supervision and joint training.

EXAMPLE 2.12B

In **Arizona**, Medicaid created a new provider type, called Community Service Agency (CSA), to allow family organizations and other non-traditional providers to be Medicaid providers for certain rehabilitation services. *Family Involvement Center (FIC)* in Maricopa County (Phoenix) is a CSA and bills Medicaid for peer support, respite, skills training and development, health promotion, and behavioral coaching. FIC also, in time, became a fully licensed behavioral health organization so that it also could bill for case management. (**www.familyinvolvementcenter.org**)

Culturally and Linguistically Competent Provider Networks

Effective systems of care make concerted efforts to develop culturally and linguistically competent provider networks. They do not assume that the provider network that develops without this attention will be culturally competent. Structuring culturally and linguistically competent provider networks requires reaching out to culturally and racially diverse providers, non-traditional providers, and providers indigenous to the communities of focus. It also requires contracting policies that create requirements or incentives for inclusion of culturally and linguistically competent providers.

EXAMPLE 2.12C

System builders in a county in a midwestern state restructured provider contracts so that a piece of each agency's contract would have to be used to purchase services and supports from indigenous, non-traditional, and culturally relevant providers and natural helpers.

The federal Center for Mental Health Services has described areas in which managed care systems might consider standards for provider cultural competence (see Box 2.12F).

2.12F Cultural Competence Standards in Managed Mental Health Care

Provider Competencies

- Understanding of Consumer Populations' Backgrounds
- Clinical Issues and How to Provide Appropriate Treatment
- Agency/Provider Role
- Communicating Effectively Across Cultures
- Providing Quality Assessments
- Formulating and Implementing Quality Care and Treatment Plans
- Providing Quality Treatment
- Using One's Self and Knowledge in the Treatment Process
- Attitudes

Center for Mental Health Services. (2002). *Cultural competence standards in managed mental health care*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

WEB RESOURCES

Provider Network Plan for Community-Based Care Network of Brevard County, Florida, at:
www.brevardfp.org/docs/Provider_Network_Plan_-_12-08.pdf

Provider Services Network of Cuyahoga County, Ohio, System of Care at:
www.cuyahogatapestry.org/en-US/provider-faq.aspx

Key Questions: Provider Network (Network of Services and Supports)

- Do we have the right mix of providers in our network?
- Do we have clinical treatment and formal services as well as natural, social supports in our network and both traditional and non-traditional providers?
- What is our plan for addressing issues of cultural and linguistic competence in our provider network?
- How does our structure incorporate flexibility to add or remove providers as needed?

NOTES

2.13 Purchasing and Contracting

Considering Options

Once system builders determine the array of services and supports that is needed, as well as the types of providers (and/or in-house staff) to provide the services, they must decide which purchasing or contracting options to use. Systems of care typically have to contend with larger state and/or county procurement structures. Even within this context, however, it is usually possible to make choices about how to structure the procurement of services and supports for the system of care, and each of these choices has pros and cons associated with it, as the following discussion of four potential choices illustrates (and there are, obviously, other possible choices as well):

- **Pre-Approved Provider Lists:** Some systems of care pre-qualify providers as potential resources for the system of care and then draw on them as the need arises. These are cost-reimbursable structures in which providers get paid for services after they provide them. Such an arrangement gives the system enormous flexibility to individualize services and supports for children and families. However, it can create an overload on some providers; also, it may disadvantage small, indigenous providers who do not have the cash flow to exist viably within a cost-reimbursable structure. This structure may be particularly problematic for culturally and linguistically competent providers, who often are smaller and neighborhood based. (A possible tinkering with this structure would be to provide fixed price contracts [see below] for a certain amount of service for those providers whom the system absolutely wants and needs in the provider network but who cannot exist within a strictly cost-reimbursable structure.)

- **Fixed Price Contracts:** Some systems of care have in place (either intentionally or inherited) fixed price or fixed service contracts in which providers make available a designated amount of service (usually stated as number of service units or days) at a rate per service unit up to a specified amount. This arrangement creates predictability and a certain funding stability for providers; on the other hand, it is not particularly flexible and poses the risk of families' having to "fit what has been fixed."

- **Capitation or Case Rate Contracts:** Capitation contracts provide prospective, preset funding that is assigned on the basis of the number of persons in the designated population (i.e., covered by the system of care's benefit plan). Providers receive per capita funding, that is, funding for every person covered by and enrolled in the system, regardless of whether every person uses services or not. In return, the provider assumes the risk of serving everyone in the population who shows up for services within the total payment allocation. The capitated (per person) rate is determined by estimating how many persons can be expected to use services and the amount and type of service they can be expected to use and translating that use to a cost. It spreads the cost of serving those who do use services over a larger population.

Arguably, capitation makes sense only for systems of care that are serving a total eligible population (e.g., all children in a given community) and not for systems of care that are serving only "deep-end" populations or those at risk for deep-end services (i.e., children with or at risk for serious disorders), who can be expected to use services. For this latter population, **case rate** contracting structures may be more appropriate. Case rate contracts provide prospective, preset funding per actual user of service (as opposed to potential user), based typically on the child's meeting a certain diagnostic or level of functioning or service profile, such as children with serious disorders. Rates are determined by estimating the amount and type of services that these children can be expected to use. In this arrangement, the contractor is not at risk for the number of persons who use services but only for the amount and type of service that is used. In contrast, the contractor with a capitation contract is at risk for the number of children who use services as well as for the type and amount of services that are used. Capitation is obviously a riskier arrangement for the provider than is case rate contracting, though case rate contracting also carries risk.

- **Performance-Based Contracting:** Performance-based contracting ties provider payment to performance and can be built into virtually any contracting structure. The advantages to it are that it creates greater control for the system of care as purchaser over the quality of services and supports provided, and it can create greater clarity of expectations for providers. On the downside, particularly if performance measures are unclear or beyond the capacity of the provider to meet, this structure can lead to tensions between purchasers and providers that will ultimately affect system goal attainment.

Use of Risk-Based Contracting

Risk-based contracts using capitation or case rate financing have both advantages and disadvantages. They allow contractors a great deal of flexibility, which can be used to individualize services and supports for families in a *Wraparound* approach. They also allow systems of care as purchasers to integrate cost and quality of care considerations by tying flexibility at the provider level to accountability and adherence to outcomes and performance measures determined by the systems of care. They also by definition pose risk to both providers and purchasers (and thus to families). If the capitation rate paid to the contractor, for example, is too low, it creates an incentive for the contractor to under-serve by not reaching out to families who may need service and/or by providing insufficient service to those who do seek service. Conversely, a rate that is too high places the system of care in the position of overpaying for services.

Public child-serving systems, including systems of care, increasingly are using risk-based purchasing strategies. These strategies introduce the notion of financial "risk" into purchasing structures. Medicaid managed care systems often use *capitation*, whereas systems of care often use *case rates* if they are using risk-based purchasing strategies (see Box 2.13). In a capitated arrangement, a potential incentive is to prevent eligible users from becoming actual users. This goal can be accomplished through positive steps, such as prevention activities, or through negative steps, such as constraining access to services. In a case rate arrangement, there is no such incentive, although case rates do create an

incentive, like capitation, to control the type and amount of services provided. A case rate arrangement can be positive, for example, if it reduces unnecessary out-of-home placements, or it can be negative if it leads to under-service.

2.13 Capitation and Case Rate Distinctions

CAPITATION: Pays Managed Care Organizations (MCOs) or providers a fixed rate per *eligible* user

Incentive:
#1: Prevent eligible users from becoming actual users (e.g., make it difficult to access services; engage in prevention)
#2: Control the type and volume of services used

CASE RATE: Pays Managed Care Organizations (MCOs) or providers a fixed rate per *actual* user

Incentive:
#1: Control the type and volume of services used (e.g., reduce inappropriate use of out-of-home placements)

Case rates, rather than capitation, seem to be more appropriate for systems of care serving children, youth, and families with serious and complex issues. Because these children and families need to use services, it does not make sense to try to prevent them from using services (an incentive in capitated arrangements), but it *is* appropriate to try to manage the types and cost of service to prevent overutilization of restrictive settings and expensive services, such as out-of-home placements. A case rate gives the provider flexibility to provide different types of services and supports as needed in exchange for assuming a level of financial risk (i.e., all services have to be provided within the amount of the case rate or the provider loses money) and for meeting outcomes, such as reduced use of out-of-home placements and improvements in clinical and functional status. Outcome monitoring is essential to ensure that the provider is not providing a low level of services in order to save money.

Illustration 2.13A shows a risk-based contracting structure using both capitation and case rates.

ILLUSTRATION 2.13A

Risk-Based Contracting Arrangement

State—Capped Out of Home Placement Allocation

↓

County DHS acts as Managed Care Organization (contracting, monitoring, utilization review)

Child Welfare $$. Case rate contract with Child Placement Agency (CPA).		BH Tx $$ matched by Medicaid. Capitation contract with Behavioral Health Organization with risk-adjusted rates for child welfare-involved children.

Joint Service Planning Required

Child Placement Agencies (CPA)
Responsible for full range of Child Welfare services & ASFA (Adoption and Safe Families Act) related outcomes

Behavioral Health Organization
Responsible for full range of MH treatment services and clinical outcomes and management functions

Pires, S. (1999). *El paso county, colorado risk-based contracting arrangement.* Washington, DC: Human Service Collaborative.

Progression of Risk

From a financial standpoint, all purchasing and contracting structures carry some degree of risk for systems of care as purchasers, as well as for providers or lead agencies. Illustration 2.13B, borrowed from work done by Tony Broskowski for the Annie E. Casey Foundation, shows the progression of risks to systems of care as purchasers, compared with providers or lead agencies, based on the type of purchasing and contracting structure. It illustrates how risks to each operate in inverse proportion to one another. For example, the risk to the system of care as purchaser is highest in a grant structure because the system of care has little leverage over the provider once the grant has been made, but a grant carries the lowest risk to the provider or lead agency. Capitation, on the other hand, carries a low financial risk for the system of care as purchaser (because expenditures are capped) but a high risk for the provider or lead agency, which has to manage the dollars and achieve outcomes within the "cap" (or lose money if expenditures exceed the cap). Not surprisingly, case rates tend to cluster in an area where the "risk" is more balanced between purchaser and provider.

ILLUSTRATION 2.13B

Progression of Financial Risk by Contracting Arrangement

RISK TO SYSTEM OF CARE	RISK TO PROVIDER	TYPE OF CONTRACTING ARRANGEMENT
HIGHEST RISK	LOWEST RISK	• Grant
⇧	⇩	• Fee-for-Service
		• Case Rate
LOWEST RISK	HIGHEST RISK	• Capitation

Adapted from Broskowski, A. (1996). *Progression of provider's risks*. In *Managed care: Challenges for children and family services*. Baltimore, MD: Annie E. Casey Foundation.

Purchasing Quality Care

Because contracting is a powerful tool for achieving (or hindering) system of care goals, system builders need to be strategic in determining what mechanisms to employ. Families and culturally diverse constituencies need to be involved in decision making about contracting structures because they are directly affected by them. Contracting structures have a bearing on such factors as whether families will have choice of providers, whether there will be incentives for providers to under-serve, whether there will be performance incentives to provide quality home and community-based care, and the like.

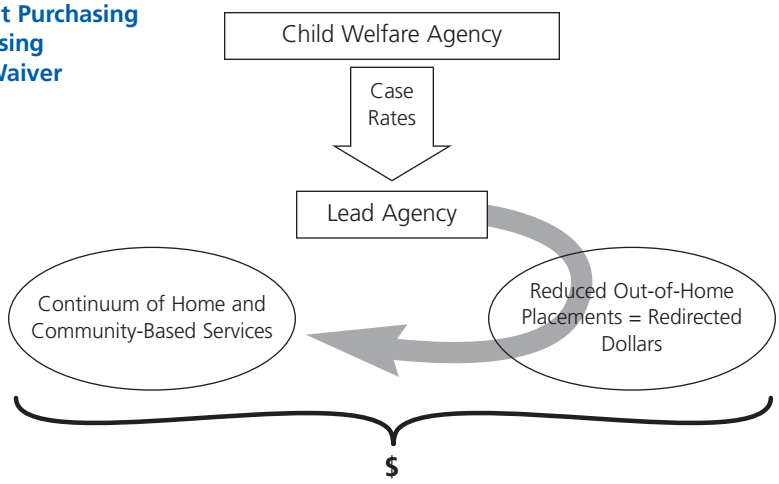
In addition, sponsoring or funding agencies that award contracts should have requirements concerning practice standards and training and staff preparation to address diverse needs and provide culturally competent services and supports. In systems of care,

system builders are moving from a mentality of "funding programs" to "purchasing quality care" and need to think about the purchasing and contracting strategies that will best support their goals.

EXAMPLE 2.13

Connecticut is an example of a state that changed its purchasing strategy, using a Title IV-E waiver. The child welfare agency provided case rates to lead service agencies to provide a continuum of home and community-based services, redirecting dollars from out-of-home placements. Evaluation of the waiver found that lengths of stay in restrictive placements were reduced; children returned to in-home placements sooner; use of care management, crisis stabilization, and family support services increased; the well-being of children improved; and costs were lower.

Connecticut Purchasing Strategy Using Title IV-E Waiver



FINDINGS FROM EVALUATION OF WAIVER

- Lengths of stay in restrictive placements reduced
- Children returned to in-home placements sooner
- Use of care management, crisis stabilization, and family support services increased
- Well-being of children improved
- Costs were lower

Adapted from Holden, W., et al. *Outcomes of a randomized trial of continuum of care services for children in a child welfare system*. ORC MACRO.

There is no one right or wrong contracting structure, but particular structures carry particular advantages and disadvantages. Because contracting is a powerful tool for helping to achieve (or hinder) system goals, system builders need to think carefully about what they are trying to achieve with their contracting arrangements.

WEB RESOURCE

Contracting for Child and Family Services: A Mission-Sensitive Guide at:
www.eric.ed.gov/ERICWebPortal/custom/portlets/recordDetails/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=ED450179&ERICExtSearch_SearchType_0=no&accno=ED450179

Key Questions: Purchasing and Contracting

- What contracting structures make sense to achieve our quality and cost goals?
- Have we considered use of risk-based approaches, such as case rates, to give providers more flexibility in return for meeting defined outcomes?

NOTES

2.14 Provider Payment Rates

Systems of care may or may not have control over provider rate structures, that is, how much providers will be paid for particular types of services and supports. The rate structure may be determined by another system, such as Medicaid. However, system builders need to understand that the adequacy and equity of the rate structure will have a significant effect on system of care goal attainment and, obviously, will influence how providers feel about the system.

The rate structure will affect the availability of services. If rates for particular services are too low, services may be in short supply; if rates are too high for certain services, those services may be oversupplied, potentially causing overuse. The rate structure carries its own incentives and disincentives for providers to develop or refuse to provide certain services and supports. Not only the sufficiency of the rate, but also the equity of the rate structure, is important. If there are unwarranted differentials within the rate structure, for example between providers of similar services, that will cause tension within the system and incentives to use certain providers over others.

EXAMPLE 2.14

A northeastern state mental health agency developed state-of-the-art standards for children's services within its system of care. However, the rates paid by Medicaid were too low to support the standards. This created frustration on the part of stakeholders and hindered attainment of quality care goals. Options being explored within the state to address the issue are advocacy to raise Medicaid rates, augmentation of the rates with general revenue, and stronger utilization management structures to alleviate Medicaid's concern over runaway costs if rates are raised.

Arizona established higher rates for out-of-office outpatient services than for in-office services to encourage therapists to provide services in homes and schools and not just in offices. The state also pays a tiered system of rates for out-of-home care, with rates decreasing with longer stays. Wraparound Milwaukee developed definitions and rates for over 85 specific services and supports for its system of care; it sets its own rates for all services except residential treatment, whose rates are set by the state.

If systems of care do not control the rate structure, they may need to strengthen other types of incentives to engage providers, for example, allowing providers greater flexibility and control, offering training and staff development opportunities, providing more timely reimbursements, and providing back-up supports for serving families with particularly difficult or complex situations. The important point for system builders is to analyze the incentives and disincentives created by the rate structure so that contingency steps can be taken, if necessary.

Some systems of care have experienced the problem of losing providers to other systems because rates paid by other systems for the same services are higher than those provided within the system of care. This situation aggravates fragmentation in children's

services and lack of service capacity within systems of care. *Effective system builders look at the issue of rates systemically across children's systems and try to create equity in rate structures.*

WEB RESOURCES

Payment Rates in Medicaid at: **www.cbpp.org/2-24-09health.htm**

Rate Issues in Early Care and Education Partnerships at:
www.ccf.edc.org/PDF/EDC_FinBrief2.pdf

Key Questions: Provider Payment Rates

- What is the impact of the rates we pay on service availability and utilization?
- Is there equity in the rates paid for the same services across children's systems?

NOTES

2.15 Billing and Claims Processing

It is not surprising to see even well-developed systems of care with billing and claims processing structures that thwart the goals of the system of care. For example, billing codes left over from a categorical system may make it virtually impossible to "code" flexible, individualized, *Wraparound* services. There may not be a billing code for important system functions such as interagency coordination or family support. Similarly, claims-processing systems may be structured in such a way that there are long delays in payments to providers, which may create unintended consequences of providers' withholding services.

Billing and claims-processing systems may be rigidly structured in an effort to control costs and create tighter accountability. However, too rigid systems can create incentives among providers to utilize service components, however restrictive or expensive, that are "easily billable," or as noted, to withhold service or refuse to participate in provider networks—all of which will frustrate system of care goal attainment. Lack of appropriate billing codes for services provided in the system of care, or lack of guidance to providers on how to code appropriately, leads to miscoding, which, in turn, can lead to audits and financial exposure for the system of care if irregularities are occurring. Effective system builders need to examine the support (or lack thereof) created for systems of care by billing and claims-processing structures.

Billing and claims-processing structures concern both state and local stakeholders. Certain types of billing and claims-processing data, such as those pertaining to Medicaid or Title IV-E, ultimately must be reconciled at state levels. Certainly in these areas, billing and claims-processing structures at the local level must be compatible with state systems and requirements. Local-level stakeholders, however, have to live with billing and claims-processing structures on a day-to-day basis, which has a bearing on access to and quality of services. They, too, must be closely involved in design or redesign decisions.

EXAMPLE 2.15

In **Milwaukee County, Wisconsin**, Wraparound Milwaukee uses a Web-based billing and claims-processing system that allows more than 200 providers in the provider network to bill for over 80 different services and supports. The system is able to reimburse providers within five days. Other system of care communities are adapting this system; for example, **Cuyahoga County, Ohio**, leases the Milwaukee system.

WEB RESOURCE

Billing and Claims Processing to Support a Wraparound Approach at: **www.rtc.pdx.edu/NWI-book/Chapters/Hale-5e.2-(databases).pdf**

Key Question: Billing and Claims Processing

- How do our billing and claims-processing structures support system of care goals?

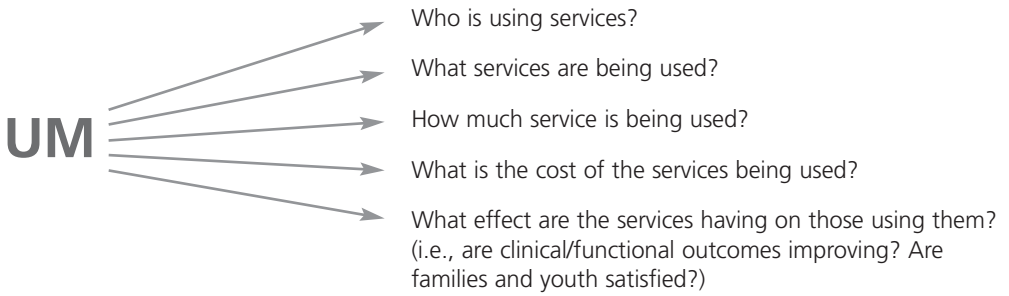
NOTES

2.16 Utilization Management

"Utilization management (UM)," a term borrowed from managed care, needs to be structured in systems of care whether or not they are "managed care" systems. Paying attention to how services are being used, how much service is being used, what services are being used, and the cost of those services is important from both a cost and quality standpoint (see Illustration 2.16). From a cost standpoint, dollars for systems of care are finite (and, typically, not sufficient for the need). *Every unnecessary dollar spent on one child deprives another of needed care*. From a quality standpoint, children and families can suffer just as much from "too much service" or the wrong service as from not enough service or no service. UM is a function that needs to be structured both at the system level and at the level of individual children and families.

ILLUSTRATION 2.16

Utilization Management (UM) Concerns



Some systems of care contract with commercial managed care companies to perform UM functions. Others perform UM functions in house or contract with a provider agency and/or family organization. There are pros and cons to all of these structures, again depending on the circumstances of the given locality. For example, commercial companies may have the technical capacity and data systems to hit the ground running in performing UM functions, whereas government, provider agencies, and family organizations may have a learning curve in this arena. On the other hand, commercial companies may only have UM expertise with acute care systems and commercial sector populations, whereas the system of care is providing longer-term care and serving children with serious disorders who historically have relied on the public sector. In this case, the commercial company's learning curve may be just as long as that of the government agency or local provider or family organizations.

However UM is structured in systems of care, there are certain key principles:

- **UM must be understood and embraced by all key stakeholders**—managers, providers, service-planning team members, care managers, families, and youth—which will necessitate training and orientation and involvement in the UM structure. If the UM

structure creates the perception and/or reality that UM is solely the purview of management, it will perpetuate a "we-they" attitude between providers, care managers, and families on the one hand and management on the other. UM will be perceived (and perhaps experienced) as a policing function instead of a means to support achievement of system of care quality and cost goals.

- **UM must concern itself with both the cost and quality of care.** As such, it must be structured so that key stakeholders are aware of UM cost and quality objectives. Clinicians, care managers, and families, for example, need to be as familiar with cost issues as are system administrators who, in turn, must be cognizant of quality care concerns. Effective UM structures tie together cost and quality issues at all levels of the system.
- **The UM structure needs to be tied to the quality improvement structure in the system,** that is, UM needs to inform quality improvement and vice versa.

UM is an important function at state and tribal as well as local levels. Local stakeholders often are best situated to perform UM functions at the level of individual children and families, ensuring that children receive the appropriate type, level, mix, and duration of treatment and making adjustments over time. This is particularly true in the case of children with serious and complex disorders, who tend to use a lot of services, often episodically, over time. Local-level stakeholders may need technical support from state-level stakeholders to perform the UM function. Local stakeholders also need to be concerned about UM, not just for individual children but also for the totality of children for whom they have responsibility, to ensure an efficient distribution of limited dollars. This also is true of stakeholders at the state and tribal levels, who need to pay attention to utilization patterns and implications statewide or within the tribal community.

Key UM Functions

Key UM functions include care authorization and care monitoring and review. **Care authorization** has to do with who or what structure has responsibility and what is the process for approving services and supports, including plans of care developed by child and family teams. *How care authorization is structured has the effect of assigning critical responsibility and power, will impact the experience of stakeholders in the system, and will affect both cost and quality goals.*

There are many different approaches to structuring care authorization. For example, in some systems of care, particularly those serving very "deep-end" populations of children and families, screening, assessment, evaluation, and care planning are done at the local level, but then the state may have to approve care plans. In some systems of care using managed care technologies, a lead agency at the local level may be assigned care planning responsibility, but a statewide system administrator, such as an administrative services organization (ASO), has to approve the plan. In other arrangements, local systems of care have both care-planning **and** care authorization responsibilities, and it is not surprising in these arrangements to see the state allocation to the localities capped.

Systems of care that rigidly separate care planning and care authorization tend to perpetuate a "we-they" mentality within the system between planners, providers, and consumers of care on the one hand and funders and managers of care on the other. By the same token, systems of care that invest *carte blanche* care authorization responsibility with care planners without incentives to manage utilization and control costs tend to lead to "runaway" systems. In these runaway systems, costs escalate to the point of jeopardizing whatever quality outcomes the system is producing. Box 2.16A lists safeguards to control such runaway systems.

2.16A Safeguards to a Runaway System

- Effective Practice Leadership
- Family and Youth Partnerships/Investment of Families and of Youth
- Integration of Natural Supports in Care Plans
- Strengths-Based Assessment and Care Planning
- Cost/Quality/Outcome Monitoring Linked
- Fiscal Incentives/Disincentives Tied to System of Care Goals
- Care Management

Pires, S. (2009). *Safeguards to a runaway system*. Washington, DC: Human Service Collaborative.

A goal of systems of care is, as much as possible, to align the interests of system funders, managers, providers, and families and youth, which suggests creating structures in which all parties at both state and local levels share responsibility for cost, quality, and youth and family satisfaction outcomes. Those responsible for care planning, for example, need to be as concerned about cost issues as are system funders and managers because, as noted earlier, the reality is that dollars are finite in every system. Similarly, funders and managers need to be as concerned about quality and satisfaction issues as much as other stakeholders because cost control without regard to these issues generates cost pressures in other arenas, such as increases in juvenile detention and hospital recidivism.

Care monitoring and review has to do with who or what structure has responsibility and what the process is for monitoring implementation of care plans at the individual child and family level. However this function is structured, it is critical to preventing the "out of sight, out of mind" phenomenon that often characterizes traditional systems where caseloads are overwhelming. In this phenomenon, once a child and his or her family have a plan of care, the system collectively breathes a sigh of relief, moves on to the next child, and puts the first out of mind, not paying attention again until a crisis occurs, a pre-determined length of stay has elapsed, or funding has run out. This phenomenon historically occurs most often in the case of children, youth, and families who pose the most complex, serious issues and challenges. Ironically, this is precisely the population to which systems of care want to pay the most ongoing attention in order to avert crises, determine what duration of care does make sense, and ensure costs do not go through the roof.

Care monitoring and review may be structured as a shared responsibility among care managers, child and family teams who do care planning, providers, and the families and youth themselves. Care planners, for example, may build "action dates or events" into the plan of care to ensure timely review; care managers and/or providers may be charged with reporting back on some regular basis to care-planning teams, including families and youth, on care progress. Or, it may be the function of one designated person to monitor and report on care progress. Care monitoring and review may be going on at both state and local levels. For example, at the local level, care monitoring and review may be both at the level of the individual child as well as across the population of children served locally. At the state level, care monitoring and review may be conducted only with respect to certain populations of children served, such as those using the most expensive services or those at risk of involvement in the juvenile justice system or of placement in residential care. Again, a major goal is to try to align as much as possible the interests of stakeholders at both state and local levels in this process.

Using Child and Family Teams to "Authorize" Services

Systems of care using child and family teams in a *Wraparound* approach must decide to what extent the plans of care developed by the team will drive "medical necessity," that is,to what extent the child and family (*Wraparound*) teams will determine what services and supports the child needs and will receive without having to obtain prior authorization from another entity. Some systems of care allow the plans of care developed by child and family teams to determine medical necessity without the need for external authorization. In these systems, external entities, such as a statewide Administrative Services Organization, may pay attention only to "outlier" utilization, for example, children who seem to be using too much service or staying in restrictive services for too long compared with typical utilization by children with similar challenges. Other systems of care allow plans of care developed by child and family teams to serve as medical necessity, except for certain high-cost and restrictive services, such as residential treatment, which require prior authorization and which may be authorized for only a certain period of time. In **Arizona**, the child and family team plan of care determines medical necessity, except for residential treatment, which requires prior authorization, and county-based behavioral health managed care organizations monitor utilization. In **Wraparound Milwaukee**, the plans of care developed by the child and family team determine medical necessity, including for Medicaid-covered services as in Arizona, except for residential treatment, inpatient hospitalization, and day treatment, which the county behavioral health agency authorizes in its role as a managed care entity. Box 2.16B describes management of service utilization in a *Wraparound* approach that uses child and family teams.

Care planning, care authorization, and care monitoring and review, while distinct functions, are closely linked. Although they may or may not be the responsibility of a single entity, the more there is an alignment of interests and shared outcomes across these functions, the greater the likelihood of meeting quality, satisfaction, and cost goals.

2.16B Utilization Management in a *Wraparound* Approach Using Child and Family Teams

- Care plans build in action dates or events for review.
- Care plans have scheduled review dates.
- Care plans require regular "report backs" from providers.
- Families and youth provide information and review of services.
- Family and youth voice drives monitoring and reviews.

Culturally Competent UM Structures

UM structures need to respect the circumstances and cultural diversity within families. When service and support plans are not authorized and service barriers and gaps arise as a result, or when children are stuck in inappropriate placements, monitoring and review structures need to ensure appropriate changes in service authorization and service provision procedures. To be culturally competent, UM structures need to pay particular attention to service utilization among diverse children and families to ensure that there is not a perpetuation of either the under-service (i.e., lack of access to supportive services) or over-service in restrictive services (e.g., residential treatment or other out-of-home placements) that has characterized traditional service delivery to diverse populations. Culturally competent UM requires a change in the way service utilization data are collected and analyzed, as well as outreach to diverse populations regarding service utilization issues.

EXAMPLE 2.16

Pennsylvania's managed care system has an "early warning system" that, among other things, flags disparities and disproportionality in use of behavioral health services by racially and ethnically diverse members.

WEB RESOURCES

Applying Utilization Management Principles to a Comprehensive Service System for Children with Emotional and Behavioral Disorders and Their Families: A Feasibility Study at:
www.springerlink.com/index/R432423U468184U4.pdf

Integrating Care for Children with Special Needs in Publicly Financed Managed Care at:
www.hhs.gov/od/documents/SPCSNpaper.doc

Mental Health Services Program for Youth (MHSPY) Replication at:
www.rwjf.org/reports/npreports/mhspye.htm

Key Questions: Utilization Management

- What is our utilization management (UM) structure?
- How does it link cost and quality of care concerns?
- How is UM tied to our quality improvement process?
- How does our UM structure promote alignment of interests across stakeholder groups?
- Who is currently responsible for care authorization? Does it make sense?
- How is care monitoring and review currently structured? Is it effective?
- Do our structures create too much tension between care planners such as child and family teams, care authorizers, and care monitors, or do we have too few checks and balances in our care-planning and delivery systems?

NOTES

2.17 Financing

Overview

Show me the money.

The financing structure concerns itself with what funds will be used to finance the system of care and how the funds will be used and managed. As Illustration 2.17A shows, there are multiple funding streams across multiple systems that are potential sources of financing for systems of care. These funding streams tend to operate categorically and are protected by different interest groups. The traditional rigidity and lack of coordination among these funding streams pose daunting challenges to families, providers, and administrators alike. The more that system builders understand these funding streams—how they might be utilized and their constraints—the more likely they can develop less categorical, more integrated financing approaches. Some of these funding streams are controlled at the state level, some at the local level, and some jointly, and there are unique funding streams controlled by tribal authorities. There are pros and cons to utilizing each type of funding, which can vary based on state, tribal, and local circumstances. Obviously, state, tribal, and local stakeholders need to play a role in determining what types of dollars can be utilized and for what purposes in systems of care.

ILLUSTRATION 2.17A

Examples of Sources of Funding for Children/Youth

Medicaid
- Medicaid Inpatient
- Medicaid Outpatient
- Medicaid Rehabilitation Services Option
- Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Targeted Case Management
- Medicaid Waivers
- TEFRA Option

Substance Abuse
- SA General Revenue
- SA Medicaid Match
- SA Block Grant

Mental Health
- MH General Revenue
- MH Medicaid Match
- MH Block Grant

Child Welfare
- CW General Revenue
- CW Medicaid Match
- IV-E (Foster Care and Adoption Assistance)
- IV-B (Child Welfare Services)
- Family Preservation/Family Support

Juvenile Justice
- JJ General Revenue
- JJ Medicaid Match
- JJ Federal Grants

Education
- ED General Revenue
- ED Medicaid Match
- Student Services

Other
- Temporary Assistance for Needy Families (TANF)
- Children's Medical Services/Title V—Maternal and Child Health
- Mental Retardation/ Developmental Disabilities
- Title XXI—State Children's Health Insurance Program (SCHIP)
- Vocational Rehabilitation
- Supplemental Security Income (SSI)
- Local Funds

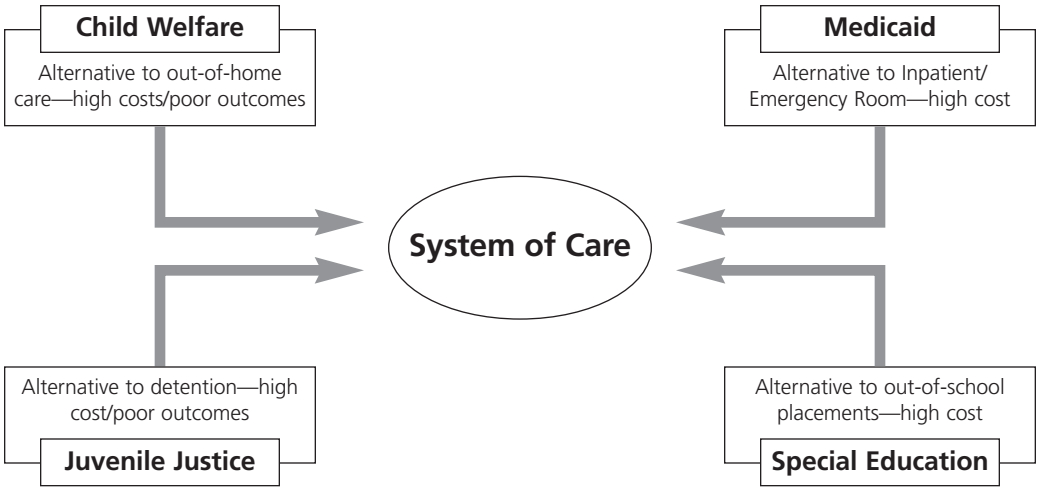
The use of the term "funding streams" is really a misnomer since these funds typically do not flow together into one pool. Indeed, they are fragmented and tend to be rigidly structured and protected. The world of financing for children's services is one of "boxes within boxes," a construct that is challenging to virtually all stakeholders.

Creating "Win-Win" Financing Scenarios

Part of the strategic challenge for system builders is to understand these funding streams, who controls them, what they are buying, and what *other systems'* issues are. Another aspect of the strategic challenge is to understand how to use these various funding streams to support systems of care and then to convince various interest groups that use of these funds within the system of care can be a "win-win" situation (see Illustration 2.17B). For example, *child welfare directors* might be convinced that use of child welfare general revenues to support alternatives to residential treatment through the system of care makes more sense than their continuing to spend large amounts on residential treatment with little evidence of efficacy. *State Medicaid directors* might be convinced that the home and community-based supports available through the system of care—facilitated by implementing an effective Rehabilitation Services Option in Medicaid—will help to reduce expenditures on hospital, psychiatric residential treatment, and emergency room admissions; on lengths of stay or recidivism rates; or on psychotropic medications. Similarly, the system of care may provide a viable alternative to incarceration for juveniles involved in the delinquency system and thus be attractive to *juvenile justice* stakeholders. *School officials* could utilize the home and community-based services and supports as alternatives to removing children from regular classrooms and increasing special education costs. *Early childhood advocates* may see that investment in the system of care will offset future expenditures in special education or

ILLUSTRATION 2.17B

Creating "Win-Win" Scenarios



other specialized services. This strategic analysis will vary from one community to another. The more system builders know about the various funding streams and who controls them, the more comprehensive can their analysis and financing strategies be.

Thinking of Financing Across Systems

One of the factors that makes financing systems of care challenging is that system builders are thinking of benefits *across* child-serving systems, whereas (unless they are part of the system-building effort) other systems are thinking about the benefits to their own system. For example, state Medicaid directors may not be so interested in reducing expenditures on residential placements if Medicaid plays no role in funding residential care. Medicaid directors may become interested, however, if there is a groundswell of support for using Medicaid to pay for psychiatric residential treatment.

While system builders must think strategically about what will appeal to each interest group and agency director that controls a funding stream, they must also think strategically about how to approach legislators and governors' executive staff, who should be more concerned about spending and outcomes across systems than individual agency directors may be.

Financing Strategies and Structures

There are various types of financing strategies and structures used in systems of care, but they all begin with the basic principle that the **system design itself needs to drive the financing strategies and structures, not the other way around**. (This also means that system builders are clear about what the system design is!) For the Annie E. Casey Foundation, Mark Friedman identified a number of key financing strategies critical to systems of care (see Box 2.17A), including:

- **Redeployment of existing dollars:** In most states and communities, there are very few new dollars for services to children and families, which means that to finance new types of services, dollars must be redirected from areas that are producing high costs or poor outcomes, such as out-of-home placements.
- **Refinancing to maximize federal match dollars:** This strategy includes maximizing Medicaid dollars by expanding services or child populations covered under Medicaid, or increasing the enrollment of eligible children, or expanding the Medicaid provider network, or maximizing the capacity to bill for covered services. For example, **Cuyahoga County, Ohio**, cross-walked *Wraparound* skill sets to Medicaid billing categories to enhance providers' capacity to bill *Wraparound* activities to Medicaid for Medicaid-eligible children. Refinancing also involves maximizing Title IV-E by ensuring effective drawdown of federal dollars for all IV-E eligible children and for the various activities that are allowable under IV-E, such as case management and training.
- **Raising new revenue:** This strategy includes various efforts to generate new funds, such as advocacy with state legislatures and taxpayer referenda that create special tax revenue for children's services. An example is Proposition 63 in **California**, which

creates an additional tax on the incomes of those earning more than $1 million a year, with the revenue earmarked for mental health services for adults and children.

- **Creation of new structures,** such as pooled, braided, and blended funding and collapsing out-of-home and community service budget line items so that "savings" in out-of-home spending can be used for home and community services. *Strategically, system builders need to obtain assurances from policy makers that savings generated by reducing out-of-home placements or lengths of stay or out-of-school day placements will revert back to the system of care (and not go to other purposes, such as state deficit reduction or the building of highways).*

2.17A Financing Strategies to Support Improved Outcomes for Children, Youth and Families

FIRST PRINCIPLE: System Design Drives Financing

REDEPLOYMENT:
- Using the money we already have
- The cost of doing nothing
- Shifting funds from treatment to prevention
- Moving across fiscal years

REFINANCING:
- Generating new money by increasing federal claims
- The commitment to reinvest funds for families and children
- Foster Care and Adoption Assistance (Title IV-E)
- Medicaid (Title XIX)

RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN:
- Donations
- Special taxes and taxing districts for children
- Fees and third party collections including child support
- Trust funds

FINANCING STRUCTURES THAT SUPPORT SERVICE GOALS:
- Seamless Services: Financial claiming invisible to families
- Funding Pools: Breaking the lock of agency ownership of funds
- Flexible Dollars: Removing the barriers to meeting the unique needs of families
- Incentives: Rewarding good practice

Friedman, M. (1995). *Financing strategies to support improved outcomes for children.* Washington, DC: Center for the Study of Social Policy.

Some systems of care will pool dollars from multiple systems, which creates a large "match fund" as one strategy for maximizing federal reimbursement. Some systems of care promise savings to traditional systems in return for gaining access to those systems' dollars. In some systems of care, dollars are cut from the budgets of traditional systems and reallocated to the system of care specifically to create new service capacity. Increasingly, systems of care are experimenting with incentive-based financing structures, such as capitation and case rate financing in which the state may capitate the county, or the state and/or county may provide a case rate to a lead care management entity or entities.

There are pros and cons to all of these financing structures. For example, a structure that maximizes federal reimbursement can generate new dollars for the system of care but also has specific administrative and technical challenges associated with it, has implications for the types of services that can be provided, and requires that state and/or

local dollars be available for match. A structure that redirects dollars from "deep-end" services to home and community-based services and supports through reinvestment strategies provides an important means of funding a system of care, but it requires "front door" spending, that is, creation of some home and community-based service capacity, before "back door" ("deep-end") dollars can be redirected. Otherwise, children and families have nowhere to go.

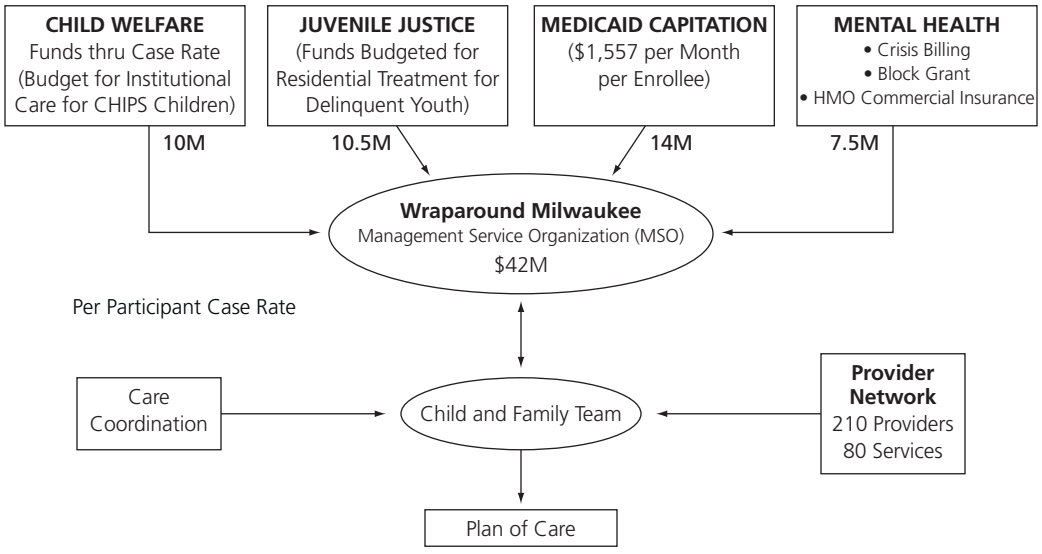
Examples of Financing Strategies

Following are a number of examples illustrating the strategies described by Friedman.

EXAMPLE 2.17A

In **Milwaukee County, Wisconsin**, Wraparound Milwaukee is one example of a system of care using **blended funding** and **redirecting spending** on residential treatment and juvenile detention from child welfare and juvenile justice systems to community services and supports. Milwaukee estimated that, without having redesigned its system and re-directed dollars, child welfare spending on residential treatment would have increased from $18 million in 1996 to $43 million today; instead, Milwaukee is spending less on residential treatment today than in 1996 and is serving more children. To prevent disruptions in placements of children in foster care, **Milwaukee** also used combined funding to finance a Mobile Urgent Treatment Team (MUTT), which can work with children and families in any setting and over a flexible 30-day time period. Both the child welfare system and the schools provided general revenue funds, which Wraparound Milwaukee can **maximize** by billing **Medicaid** for Medicaid-eligible children. For example, child welfare provided $450,000 in funding; Wraparound Milwaukee is able to generate another $200,000 in Federal Medicaid match, creating a $650,000 mobile crisis capacity for children and families in child welfare. Use of MUTT has helped to reduce the placement disruption rate in child welfare from 65% to 38%. (**www.milwaukeecounty.org**)

What Are the Pooled Funds?

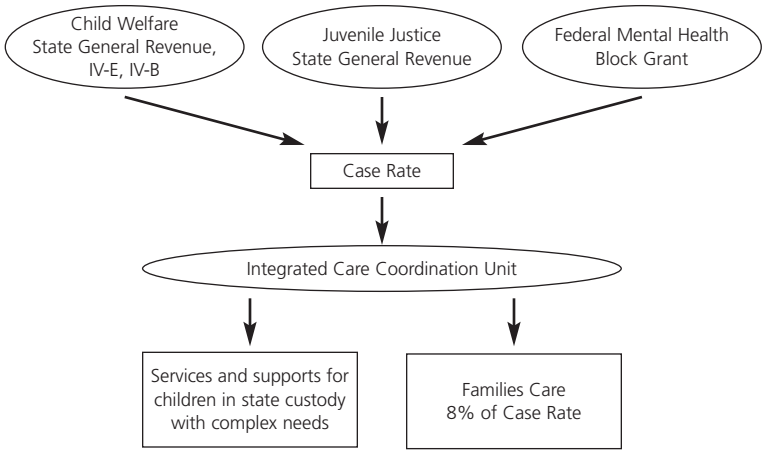


Adapted from Wraparound Milwaukee 2008. Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.

EXAMPLE 2.17B

Central Nebraska Integrated Care Coordination Unit is another example of **pooled funds** to reduce out-of-home placements and redirect spending to home and community-based services and supports for children in state custody with complex needs. This approach has led to a reduction in the percentage of children living in group or residential care (from 35.8% to 5.4%), a 2.3% reduction in children "stuck" in hospital care, and an increase in the percentage of children living in the community (from 41.4% to 87.1%) reunited with family, living with relatives, in family foster care, or in independent living. (**www.regionsix.com/ICCU.aspx**)

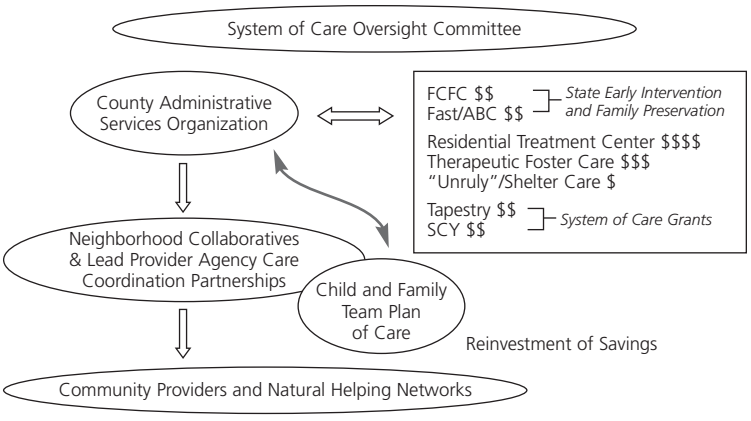
Example: Pooled Funds for Nebraska's Integrated Care Coordination Units



EXAMPLE 2.17C

Cuyahoga County provides an example of a system of care using **braided or "virtual" blended dollars** from mental health, child welfare, and other systems on behalf of several different populations of children, youth, and families involved, or at risk for involvement, in multiple systems, including families coming to the attention of child welfare where the child has not been removed, children in or at risk for residential treatment, youth with multiple status offenses, and a subset of the birth to three population whom the county's early intervention system was having trouble engaging. Plans of care developed by neighborhood-based Care Coordination Partnerships determine the services and supports that a child will receive, with the supporting county agencies agreeing through Memoranda of Agreement to allow certain of their funding streams to be tapped to pay for the services in the plans of care. The funding streams are not literally pooled, remaining in each of the supporting county agencies' budgets, but they are, in effect, virtually pooled through the system of care structure. The system is overseen by an in-house administrative services organization, called the System of Care Office, which reports to the Deputy County Administrator for Human Services. (**www.cuyahogatapestry.org**)

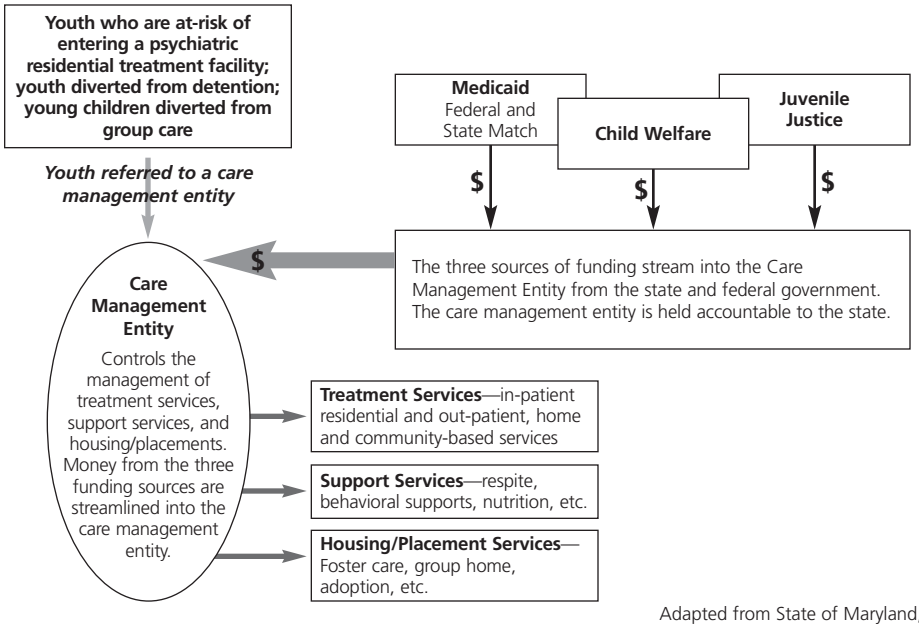
Example of "Virtual" Pooled Funds: Cuyahoga County (Cleveland)



EXAMPLE 2.17D

Maryland is an example of a state initiative to redirect Medicaid dollars from psychiatric residential treatment to regional care management entities. Maryland is planning to redirect Medicaid dollars spent on psychiatric residential treatment to regional care management entities by using a 1915 (b) Medicaid managed care waiver for Medicaid-eligible children and a 1915 (c) Home and Community Based Waiver to cover non-Medicaid-eligible children and families. (The 1915 (c) waiver is through the Center for Medicare and Medicaid Services federal demonstration grant program to allow use of home and community-based waivers for psychiatric residential treatment.) In addition, the state will use the same regional care management entities to redirect dollars from the juvenile justice system for youth who can be diverted from detention and dollars from the child welfare system for young children who can be diverted or removed from group homes. (**www.goc.state.md.us**)

Example of Redirecting Funds: State of Maryland



Adapted from State of Maryland, 2004

A longer range strategy is a taxpayer referendum to earmark tax dollars, through, for example, allocating a percentage of sales, property, or income taxes to children's services.

EXAMPLE 2.17E

The Children's Trust Fund in **Miami, Dade County, Florida**, created through a taxpayer referendum, generates over $30 million a year in funding for early intervention. (**www.thechildrenstrust.org**)

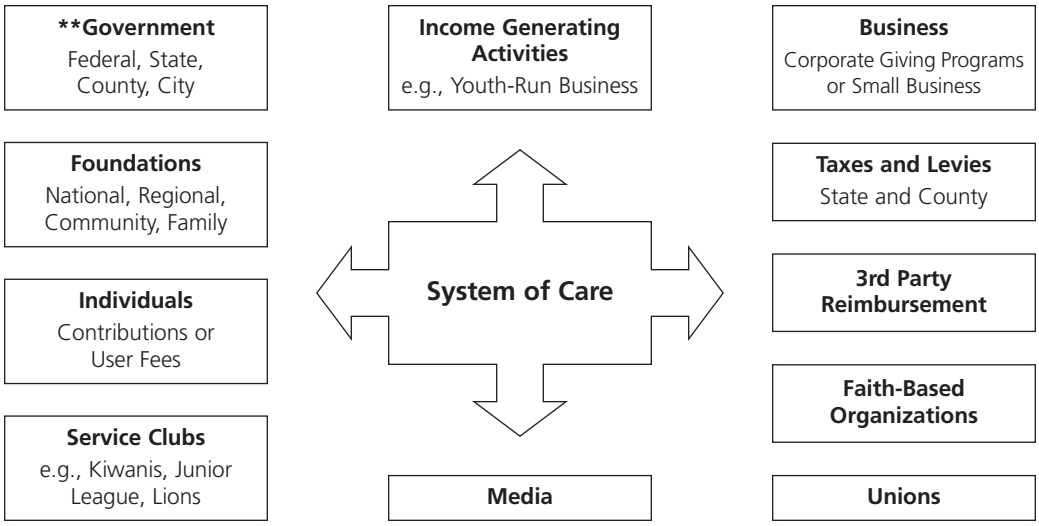
Comprehensive Strategy

Part of a comprehensive financing strategy is to draw on multiple funding sources (see Illustration 2.17C). Although government funding streams are the largest, other sources of funds—that is, foundations, businesses, donations, and so on—are also important. They are often sources of flexible dollars and lead to broader community buy-in for the system-building effort. It should be noted, however, that the size of these non-governmental dollars does not begin to compare with the amount of government funding for children's services. *Realignment of traditional government funding streams is an absolute necessity for systems of care both to ensure sustainable financing and to ensure that government spending on children's services is tied to system of care reform goals.*

Box 2.17B is a graphic depiction from federal system of care sites showing the diversity of funding support being tapped in these sites.

ILLUSTRATION 2.17C

Where to Look for Money and Other Types of Support



2.17B Sources of Funds (In Addition to Federal Grant Funds) Used Across Sites

SOURCE	SYSTEM	DESCRIPTION
State	Mental Health	General fund, Medicaid (including FFS/managed care/waivers), federal mental health block grant, redirected institutional funds, and funds allocated as a result of court decrees
	Child Welfare	Title IV-B (family preservation), Title IV-B (foster care services), Title IV-E (adoption assistance, training, administration), and technical assistance and in-kind staff resources
	Juvenile Justice	Federal formula grant funds to states for juvenile justice prevention, state juvenile justice appropriations, and juvenile courts.
	Education	Special education, general education, training, technical assistance, and in-kind staff resources
	Governor's Office/Cabinet	Special children's initiatives, often including interagency blended funding
	Social Services	Title XX funds and realigned welfare funds (TANF)
	Bureau of Children with Special Needs	Title V federal funds and state resources
	Health Department	State funds
	Public Universities	In-kind support, partner in activities
	Department of Children	In states where child mental health services are the responsibility of child agency, not mental health, sources of funds similar to above
	Vocational Rehabilitation	Federal- and state-supported employment funds
	Housing	Various sources
Local	County, City, or Local Township	General fund
	Social Services/Child Welfare	Locally controlled funds
	Juvenile Justice	Courts, probation department, and community corrections
	Education	Local schools (including in-kind donations of staff time), school district, and school supervisory unions
	County	May levy tax for specific purposes (mental health)
	Food Programs	In-kind donations of time and food
	Health	Local health authority-controlled resources
	Public Universities and Community Colleges	In-kind support; research and evaluation resources
	Substance Abuse	In-kind support
Private	Third Party Reimbursement	Private insurance and family fees
	Local Businesses	Donations and in-kind support
	Foundations	Robert Wood Johnson, Annie E. Casey, Soros Foundations, and various local foundations
	Charitable	Lutheran Social Services, Catholic Charities, faith organizations, homeless programs, and food programs (in-kind)
	Family Organizations	In-kind Support

Koyanagi, C., & Feres-Merchant, D. (2000). Systems of care: Promising practices in children's mental health. In *For the long haul: Maintaining systems of care beyond the federal investment* (Vol. 3). Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practice.

Discretionary Grant Dollars as Venture Capital

Virtually all systems of care rely on discretionary grant dollars, including federal and foundation grants, demonstration grants, one-time legislative allocations, and the like. These dollars provide critical start-up and leverage funds and are an important source of flexible dollars. However, *systems of care that rely solely on discretionary dollars will not sustain themselves over time* and, arguably, are not truly systems of care in that they are not fundamentally altering traditional delivery systems by changing the ways in which they spend their dollars. Instead, they are creating a delivery system that is an alternative to, but not a reform of, traditional systems. System builders need to think of discretionary grant dollars more as *venture capital* to underwrite development of the system of care, but not as the operating funds that will sustain the system over time.

Who Controls the Dollars?

As part of the financing structure, systems of care must decide who will control and manage dollars. In some systems of care, dollars for the system of care are lodged with a lead government agency, for example, the state or county mental health agency, even though they include dollars from many agencies across traditional systems. In other systems of care, dollars are lodged with a new quasi-governmental agency or contracted out to a commercial managed care organization or to a nonprofit Care Management Entity. In still other systems, dollars are placed with an interagency body at the state and/or local level, and in others, dollars may remain with their home (categorical) agencies, which agree to reimburse the system of care for expenditures affecting their respective populations.

There are obviously pros and cons to these financial management structures, many of which have to do with control, accountability, and flexibility. When dollars remain with home agencies, for example, the system of care has less control and flexibility (and, arguably, also less accountability) than when cross-system dollars are placed with the system of care itself. Structures that accord the system of care greater control, flexibility, and accountability facilitate attainment of system of care goals and help to alleviate some of the frustrations that typically are associated with financing issues. In any of these structures, however, the system of care governance (policy and oversight) body ultimately has control over how resources are allocated.

The financial management structure also must concern itself with who has authority to spend dollars at the frontline practice level. In some systems of care, care managers are allocated a budget that they control, enabling them to purchase services and supports flexibly in a *Wraparound* approach. Similarly, systems of care may allocate budgets to child and family service-planning teams. These approaches help to integrate financial and clinical considerations in service provision, which, as noted earlier, is highly desirable in systems of care, which have both cost and quality of care goals. On the other hand, such a structure requires training of frontline workers, families, and youth and excellent communication between fiscal and service-level staff to ensure efficient use of dollars. Other systems of care may require greater top down approval of decisions

made at the service-planning and care management level in the interests of exercising more control over spending. The risk in this structure is a constant tension between those concerned about cost goals and those concerned about quality of care.

Budget Structures

A key element of the financial management structure is the budget structure. Systems of care sometimes must operate within traditional line item budget structures imposed by the larger governmental system. However, effective system builders recognize the importance of translating line item budgets to *program budgets*, which give a much clearer picture of the costs of all activities that make up systems of care and thus give a clearer picture of what the system of care actually is financing. A good program budget is a strategic tool that reflects mission, values, and priorities. *It is an excellent learning and advocacy tool for system stakeholders*. Illustration 2.17D below shows a program budget for a neighborhood-based system of care.

ILLUSTRATION 2.17D

Example: Program Expenditure Budget for a Neighborhood-Based System of Care

Cost Categories	Proposed Total Costs	Neighborhood Governance	Family Leadership	Family Service/ Support	Removal of Barriers	Community Organizing	School Linkage	Tracking and Evaluation	Volunteers	Partnership Building	Exec. Direction & Support
Salaries	446,000	21,000	29,000	190,000	21,000	26,000	35,000	15,000	30,000	18,000	63,000
Fringe	133,000	6,300	8,700	57,000	6,300	7,800	10,500	3,900	9,000	5,400	18,900
Building Occupancy	93,600	8,700	12,300	36,800	2,400	4,300	4,000	2,500	4,300	2,500	15,800
Professional Services	109,000	17,600	22,100	32,400	3,600	2,700	2,700	18,600	2,700	2,900	3,700
Travel	43,700	12,300	5,300	10,300	9,000	1,200	3,000	500	500	500	1,600
Equipment	6,000	600	600	600	600	600	600	600	600	600	600
Food Services	25,000	0	4,000	1,000	18,000	0	1,000	0	1,000	0	0
Subcontracted	89,000	0	0	89,000	0	0	0	0	0	0	0
Operating Supplies & Expenses	21,500	1,800	700	8,600	200	1,300	2,100	500	1,500	4,100	4,100
Other (stipends, transportation, child care)	84,000	0	40,000	9,000	35,000	0	0	0	0	0	0
Equip. Lease	25,000	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Property	25,000	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Insurance	13,500	2,700	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
GRAND TOTALS	1,115,100	80,000	125,900	459,900	84,300	51,100	64,100	45,800	55,300	36,800	113,900

Because the program budget shows the amount of funds spent by activity, it creates a picture of the system's priorities. For example, over 50 percent of the resources of the system depicted in this program budget are spent on family services and supports and family leadership activities, which accurately reflects the system of care's priorities. A program budget provides a tool for involving stakeholders in program prioritizing.

In addition, as shown in Illustration 2.17E, a program budget identifies revenue sources by program activity, providing a picture of who is paying for what. It shows which activities, for example, may be too heavily dependent on one funding source.

ILLUSTRATION 2.17E

Revenue Totals Across Sources	Proposed Total Costs	Neighborhood Governance	Family Leadership	Family Service/ Support	Removal of Barriers	Community Organizing	School Linkage	Tracking and Evaluation	Volunteers	Partnership Building	Exec. Direction & Support
	REVENUE ALLOCATION BY PROGRAM										
Foundation	217,100	40,000	30,000	25,000	28,300	24,000	0	22,800	12,000	15,000	20,000
ADM–State	258,800	2,500	28,400	157,900	3,000	20,000	0	5,000	12,000	5,000	25,000
County–CFS	124,900	20,000	30,000	30,000	10,000	5,000	0	3,000	12,000	2,000	12,900
Dept. of Ed.	70,100	2,500	1,600	0	0	0	60,000	0	0	0	6,000
Family Preservation Grant	373,400	5,000	20,000	230,000	35,000	0	0	12,000	18,000	14,000	39,400
In-Kind	29,300	0	10,000	10,000	5,000	1,00	0	0	800	0	2,500
Donations	21,300	5,000	900	5,000	1,000	100	2,100	3,000	500	800	5,000
Other Grants	20,200	5,000	900	5,000	1,000	100	2,100	3,000	0	0	3,100
GRAND TOTALS	1,115,100	80,000	125,900	459,900	84,300	51,100	64,100	45,800	55,300	36,800	113,900

In this program budget example, the school linkage activity is vulnerable because it is almost entirely dependent on one funding source—the Department of Education. If that contract ends, so will the school linkages program, unless more diverse funding can be found. The example above also shows that every funding source is contributing to the development of family leadership. This reflects the system of care's goal and system builders' efforts to incorporate funding for family leadership into every grant and contract they pursue or receive. At its heart, a program budget is a strategic tool that can be used to build stakeholder buy-in and consensus.

EXAMPLE 2.17F

In a neighborhood-based system of care in the Southeast, all stakeholder partners—families, staff/providers, and governing body—received training and technical assistance in understanding and developing program budgets and in the use of program budgeting as a strategic device for identifying priorities, airing differences, and building consensus. Workshops were held with families and with staff, and consultation was provided to the board. In addition, facilitation was provided for an all stakeholders meeting to review and reach consensus on a program budget as part of the system's strategic planning process.

The Importance of Medicaid

Medicaid is a critical financing stream for children, youth, and families involved, or at risk for involvement, in multiple systems. Medicaid is what is known as a federal-state match program; its financing comprises state (and sometimes local) monies and federal "match" dollars. The size of the federal match varies by state, depending on poverty and other indicators. It is at least a 50% match, and the match may be close to 80% in states with high poverty levels. Tribal communities that provide services through tribal-run facilities and programs receive 100% federal match through what is called the federal "pass-through" program.

Medicaid provides a number of options that states can use to fund appropriate health and behavioral health services for children and, sometimes, for family members, depending on eligibility and benefit design. Although there are federal basic requirements, states have considerable leeway in how their Medicaid programs are structured, that is, who is covered, what services are covered, what rates are paid, which providers can be included, what outcomes will be tracked, and so on. Because it is such a key financing source, system builders must become very familiar with their State Medicaid Plans, analyzing them to see whether they are consistent with system of care goals and engaging state Medicaid staff as partners in change efforts.

There are pros and cons associated with the various Medicaid options states may choose, which need to be analyzed as part of a strategic financing approach to systems of care. The options discussed here include:

- The **Rehabilitation Services Option (Rehab Option)**, which allows flexibility to cover a broad array of home and community-based services; many states use the Rehab Option, but covered services vary from state to state; system builders need to ensure that the Rehab Option, besides covering an appropriate array of services and supports for children and youth and their families, includes definitions of covered services that are tailored for child and youth populations, and are not just "adult focused"

EXAMPLE 2.17G

Hawaii is an example of a state whose use of the Rehabilitation Services Option enables it to cover a broad range of services under Medicaid, including: mobile crisis; crisis residential; intensive family intervention, including Multisystemic Therapy and other intensive in-home services; therapeutic foster care; partial hospitalization; family and youth peer support; parent training in behavioral management; intensive outpatient treatment for substance abuse; Functional Family Therapy; and community-based clinical detox, as well as more traditional clinic and hospital-based services.

- **1115 Research and Demonstration Projects and 1915(b) Managed Care/Freedom of Choice Waivers**, which also allow flexibility to cover a broad array of services and supports, although the federal 1115 and 1915 (b) waiver process can be challenging, and managed care initiatives need to be implemented carefully, with customized approaches for children with serious challenges and for populations at very high risk, such as children in child welfare, through, for example, risk-adjusted rates and coverage

of appropriate services; in addition, states must ensure "cost neutrality," that is, that they do not spend more under the waiver than they would have without the waiver

EXAMPLE 2.17H

New Mexico and **Arizona** are examples of states using managed care waivers that include evidence-based and effective services for the child welfare population, such as Multisystemic Therapy and family support services. And, **Arizona**, to guard against under-service, also incorporates a risk-adjusted rate (i.e., a higher payment) into its managed care system for children involved in child welfare, recognizing their higher service utilization needs. The Arizona managed care system also has built an urgent response system for children coming into care in child welfare. (**www.azdhs.gov/bhs**)

- **Home and community-based waivers (1915c)**, which allow flexibility to cover populations, as well as types of services, not covered in a state's Medicaid plan, but which can be used only for those who would otherwise be in an institutional (i.e., hospital) level of care, not currently including residential treatment facilities; however, the federal Medicaid agency is funding demonstrations of home and community-based waivers as alternatives to psychiatric residential treatment facilities, which is an opportunity for some states to utilize Medicaid to fund more home and community-based alternatives for children and youth who would otherwise be in psychiatric residential treatment facilities

EXAMPLE 2.17I

A number of states, such as **New Jersey** and **Minnesota**, have Home and Community-Based Service (HCBS) waivers for children with chronic physical or developmental disabilities; a smaller number, such as **Kansas**, **Indiana**, **Michigan**, **New York**, **Vermont**, and **Wyoming** have HCBS waivers for youth with serious emotional disorders; **Wisconsin's** HCBS waiver covers primarily children with autism. Ten states have Centers for Medicare and Medicaid psychiatric residential treatment facility (PRTF) demonstration grants, which are testing home and community-based waivers for PRTF alternatives; these include: **Arkansas**, **Florida**, **Georgia**, **Indiana**, **Kansas**, **Maryland**, **Mississippi**, **Montana**, **South Carolina**, and **Virginia**.

- **Targeted case management**, which can be targeted to high-need populations, such as children with serious emotional disorders, but which is not sufficient without other services being available; in the past, the federal Medicaid agency has scrutinized states' use of targeted case management, for example, for children in child welfare, to ensure that it is not being used in lieu of other systems' case management responsibilities (i.e., as a cost shift to Medicaid); if structured appropriately, targeted case management is an excellent vehicle for helping to finance intensive care management approaches for children with serious and complex issues

EXAMPLE 2.17J

Massachusetts is an example of a state that is utilizing targeted case management to help finance intensive care management through Care Management Entities for children with serious emotional disorders.

- **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** provision, allowing coverage for youth with physical, developmental, and behavioral health disabilities who can meet Supplemental Security Income (SSI) disability criteria and whose families exceed the income levels of Medicaid eligibility, but does not expand the array of services covered in the State Medicaid Plan; cost concerns are an issue, so often TEFRA is limited to a small number of youth, and, in any event, many youth with serious behavioral health disorders have difficulty meeting the SSI disability criteria; however, even with these constraints, TEFRA is an important vehicle for covering children whose families might otherwise have to relinquish custody to child welfare to access health or mental health care

EXAMPLE 2.17K

Minnesota and **Wisconsin** are examples of states that have the TEFRA option.

- **Administrative case management**, which can be used to help families access and coordinate services, but which is not sufficient without other services being available

EXAMPLE 2.17L

New Jersey is an example of a state that is using administrative case management dollars to fund some of the activities of family-run organizations, including educating families about and linking them to Medicaid eligibility.

- **Medicaid as part of a blended or braided funding strategy**, which allows for the most flexible provision of an integrated array of services and supports, but involves significant restructuring of financing and accountability mechanisms (and must still ensure an "auditable" trail for Medicaid purposes)

EXAMPLE 2.17M

In **Milwaukee County, Wisconsin**, Wraparound Milwaukee is an example of a blended funding approach using Medicaid dollars.

The following is not an option states may choose under Medicaid but is a mandated aspect of the program and especially important to children:

- The **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** program, which is the broadest entitlement to services for children and youth, ages 0 to 21, and requires periodic screens and provision of medically necessary (federally allowable) services, even if those services are not included in a state's Medicaid plan; however, in practice, EPSDT is implemented primarily with respect to physical health issues (even though federal law requires inclusion of behavioral health screens and services if needed); also, because of the broad nature of EPSDT, cost concerns are an issue, requiring effective utilization management. EPSDT, however, is a federally mandated vehicle for screening Medicaid-eligible children and linking them to appropriate physical and mental health services, and the courts have recognized this

EXAMPLE 2.17N

Examples of states and localities in which the courts have ruled in favor of plaintiffs bringing EPSDT lawsuits, including for children in child welfare and for children with serious emotional disorders, are **Arizona**, **California**, **Massachusetts**, and **Pennsylvania**.

Box 2.17C provides examples of Medicaid strategies that states use to cover evidence-based and promising community-based services. For each strategy, it includes advantages, issues, and examples of how states use these approaches.

The "bottom line" is that states are cobbling together a variety of options to cover and contain home and community-based services under Medicaid and that an overarching strategic financing plan, which crosses systems serving children and families, often is missing.

2.17C Examples of Medicaid Options States Use to Cover Evidence-Based and Promising Community-Based Services

MEDICAID OPTION	ADVANTAGES	ISSUES	EXAMPLE
Rehabilitation Services Option	• Flexibility to cover a broad array of services and supports provided in different settings (e.g., home, school)	• Service definitions often adult-oriented • Provider-service mismatch	• OH—developing new service definitions and case rates for intensive home-based services and Multisystemic Therapy
Managed Care Demos and Waivers—1115 and 1915 (b)	• Accountability and management of cost through risk structuring/sharing • Flexibility to cover wide range of services and populations	• Managed care not without risks/challenges • Federal waiver process can be challenging • Cost neutrality issues	• NM—covering Multisystemic Therapy • AZ—covering family support and urgent response for child welfare
Home and Community-Based Waivers—1915 (c)	• Flexibility, broader coverage, waiver of income limits and comparability	• Alternative to hospital-level of care but PRTF (i.e., residential tx.) may be issue • Cost and management concerns/limited to small number	• KS, NY, VT, IN, WI, MI—have HCBS Waivers • AK, FL, GA, IN, KN, MD, MS, MT, SC, VA—have community alternatives to psychiatric residential treatment facilities demonstration grant
Early and Periodic Screening, Diagnosis and Treatment—EPSDT	• Broadest entitlement • Supports holistic assessments and services • No waiver or state plan amendment requirements	• Management mechanism critical because of cost concerns • Oriented more to physical health in practice	• RH • PA
Targeted Case Management	• Can be targeted to high need populations, such as child welfare • Supports small case load focus (e.g., 1-10)	• Not sufficient without other services • Federal attention	• VT • NY
Administrative Case Management	• Ability to cover basic case management services to support enrollment access	• Not sufficient without other services	• NJ—covering some activities of family-run organizations
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	• Avenue to eligibility to community-based services for children who meet SSI disability criteria—allows disregard of family income	• SSI criteria not easy to meet for children with SED • Does not expand types of covered services • Cost issues, so generally small program	• MN • WI
Medicaid as Part of a Blended or Braided Funding Approach (without a waiver)	• Holistic, integrated (across systems) financing, supports broad array of services, natural supports and individualized care	• Involves significant restructuring	• Milwaukee Wraparound • DAWN Project • Massachusetts Mental Health Services Program for Youth • New Jersey Partnership

The Importance of Redirecting Funds

As noted earlier, in most states, tribes, and communities, dollars for children's services are finite and not sufficient to the need. Although system builders may be successful in obtaining discretionary grant dollars to underwrite development of the system, they cannot count on new monies to sustain the system of care over time. While Medicaid is a critical financing source, not all children involved in systems of care are eligible for Medicaid and some services and supports cannot be paid for by Medicaid. This situation leaves redirection as a critically important strategy to finance systems of care. Redirection is identifying dollars spent on "poor outcome and/or high-cost" services and reallocating them to effective home and community-based services and supports within a system of care. Part of the strategic analysis that system builders need to undertake is to identify where they are spending dollars on poor outcome and/or high-cost services (see Box 2.17D).

2.17D Redirection Opportunities

Where are you spending resources on high costs and/or poor outcomes?

- Residential Treatment?
- Group Homes?
- Detention?
- Hospital Admissions/Re-admissions?
- Too long stays in therapeutic foster care?
- Inappropriate psychotropic drug use?
- "Cookie-cutter" psychiatric and psychological assessments?

With the growing evidence of the effectiveness of home and community-based services and supports and of system of care technologies such as Care Management Entities, even for youth with the most challenging and complex issues, and of the generally poor outcomes and high costs of out-of-home placements, state, tribal and local agencies that spend dollars on out-of-home placements increasingly are looking to redirect (see Box 2.17E). They include Medicaid, child welfare, juvenile justice, education, and mental health agencies. These systems also are increasingly sensitive to the racial and ethnic disproportionality that characterizes out-of-home placements. Racially and ethnically diverse children are overrepresented in out-of-home placements. Cost, quality, and equity issues all are informing a movement toward redirection.

Illustration 2.17F shows a state in which all the agencies spending dollars on out-of-home placements are considering redirecting these dollars to regionally based Care Management Entities. This redirection would provide a child and family team *Wraparound* approach, access to a broad array of home and community-based services, and intensive care management for children and youth who would otherwise be placed or remain too long in out-of-home placements, such as group homes, detention, and residential treatment.

2.17E Example: The High Cost of Out-of-Home Care

Maryland

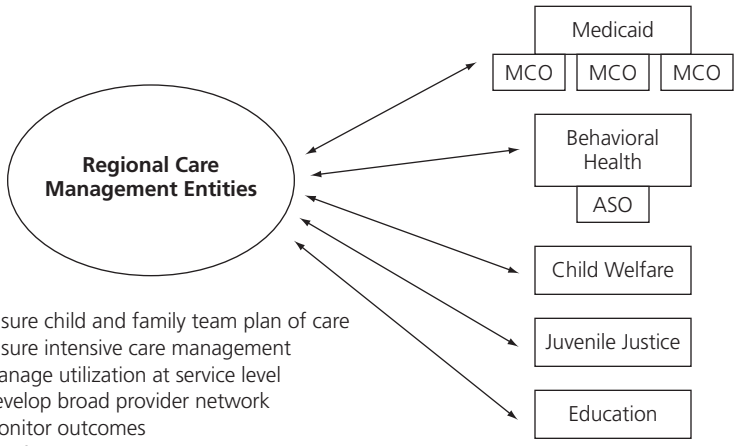
- 700 youth are in psychiatric residential treatment centers (RTCs) at any given time, paid for by Medicaid
- Average length of stay = approx. 1 year
- Residential stay costs an average of $7,000+ per youth, per month
- For 700 youth, spend $59M+ per year on psych residential treatment
- 2/3 of the youth are involved with child welfare and/or juvenile justice; 1/3 of the children are non-system involved

The Cost of Doing Nothing

- If **Milwaukee County** had done nothing: the $18m. spend by child welfare on residential treatment ten years ago would be $48m. today
- **Project Bloom (Colorado)** "Cost of Failure Study"—Early childhood services at an average cost per child of $987/year save $5,693/year in future special education costs

ILLUSTRATION 2.17F

Redirection to Care Management Entities: Locus of Management Accountability for Cross-Agency High Utilizing Children



- Ensure child and family team plan of care
- Ensure intensive care management
- Manage utilization at service level
- Develop broad provider network
- Monitor outcomes
- Link families and youth to peer support

Use same decision support tool—Child and Adolescent Needs and Strengths (CANS) — to determine need for Care Management Entity

Revenue Generation and Reinvestment

Revenue generation and reinvestment as used here have primarily to do with the structure that determines who gets to claim and reinvest federal match dollars under Medicaid and Title IV-E that are generated by the system of care as well as savings created by the system of care through reducing reliance on "deep-end" spending. In addition, it has to do with the structure for collection of revenue through third-party billing and federal financial participation (FFP) claiming.

Some systems of care have fallen victim to losing the dollars they have generated by maximizing Medicaid revenue and/or by creating savings from reducing use of "deep-end" services. Instead of reverting to the system of care, the dollars generated or saved have gone back into state or county coffers for other purposes. *Effective system builders recognize that they need to obtain assurances up front that dollars generated by maximizing federal participation or by creating savings will come back into the system of care for purposes of serving more children or creating new service capacity*. In addition, effective system builders ensure that the system of care has a structure in place to collect revenues not only from these sources but also from other third-party billing sources, such as insurance companies.

System builders also need to consider whether a fee structure is warranted and tease out the pros and cons of charging fees for certain services based on ability to pay. Charging fees that are manageable for families helps to finance the system so that more children can be served; in addition, it also may encourage greater attention on the part of stakeholders (families and providers, for examples) to the issue of value, that is, whether the service or support being considered is worth the price involved. On the other hand, fees may discourage families from seeking or using services. System builders need to consider thoughtfully the advantages and disadvantages of implementing a fee structure and of the particular fee structure that is chosen, if one is.

A Strategic Financing Approach

Development of a strategic financing plan needs to be a key priority of system builders once they have reached consensus on a system design. There are two basic questions that must be answered first in a strategic financing approach—*financing for whom and financing for what?* Answering these questions requires stakeholders to address a number of issues, including the following in Box 2.17F.

2.17F A Strategic Financing Approach

Financing for Whom—What Is Your Population Focus?

- Who are the populations of children and youth for whom you want to change practice/outcomes?
- Adopt a Cross-System Approach: What other systems serve these youth and their families; who controls potential or actual dollars; which systems now spend a lot on high cost/poor outcome services, for example, restrictive levels of care, deficit-based assessments, and polymedications?
- What opportunities are available for redirection?

Financing for What—What Do You Want to Achieve on Behalf of the Population or Populations?

- What are the outcomes you want to achieve with respect to the population or populations of focus?
- Your values govern the outcomes—Is there consensus?

Financing for What—What Are the Required Services/Supports and Practice Model?

- What services and supports (benefit design) will lead to effective outcomes for your identified population or populations?
- What is the "practice model" (e.g., strengths-based, family-driven, youth-guided, culturally and linguistically competent, individualized, effective, home and community-based care) you want to promote?

Financing for What—How Are You Organizing the Delivery System? What Is the System Design?

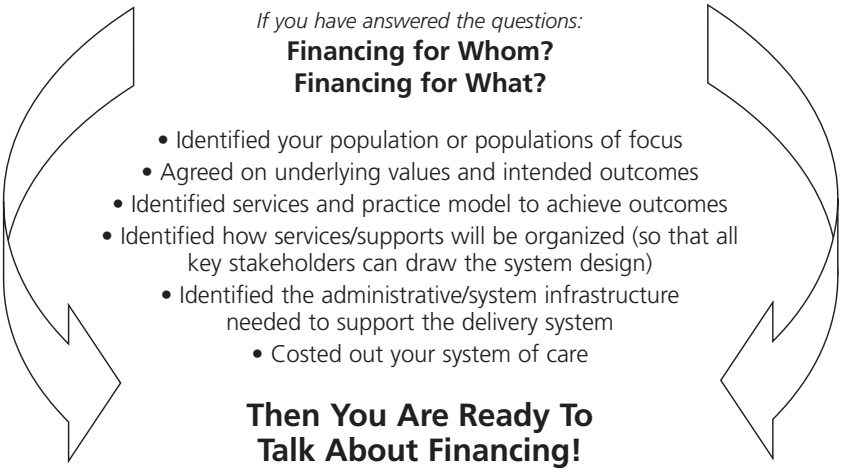
Need to address:
- Identifying early, and providing access for, all populations
- Creating a locus of accountability for the population or populations that have complex needs and multi-system involvement

Financing for What—What Are the System Infrastructure Requirements?

For example:
- Training and capacity development
- Data systems
- Quality improvement
- Financial management
- Purchasing/contracting
- Family/youth partnership capacity

How Much Will It Cost?

Cost out your system of care based on:
- Population numbers
- Expected utilization (given outcomes and system redesign)
- Types of services/supports
- Required administrative/system infrastructure



Once system builders are clear about what they want to finance and on behalf of which population or populations, they can undertake a strategic financing analysis. The steps involved in such an analysis include the following in Box 2.17G:

2.17G Steps in a Strategic Financing Analysis

- Map the state and local agencies that spend dollars on the identified population or populations, how much they are spending and on what.
- Identify resources that are untapped, such as Medicaid dollars (e.g., if the child welfare system is spending 100% general revenue to buy services that could be paid for by Medicaid).
- Identify utilization and expenditure patterns associated with high costs or poor outcomes (e.g., large expenditures on out-of-home placements or on psychiatric and psychological evaluations that do not lead to individualized, strengths-based, solution-focused interventions).
- Identify disparities and disproportionality in access to services and supports (e.g., racially and ethnically diverse children overrepresented in out-of-home placements).
- Identify funding structures that will best support goals (such as blended funding).
- Identify short- and long-term financing strategies, such as redirecting spending from out-of-home placements to community-based care or garnering support for a taxpayer referendum to generate new dollars.

Box 2.17H presents a list of expenditure and utilization questions that system builders can ask about providing services to the identified population or populations.

2.17H Expenditure and Utilization Questions

1. Which state, tribal, and local agencies spend dollars on services for the children and families that are the focus of the system of care?
2. How much do they spend?
3. What types of dollars are spent (e.g., federal, state, tribal, entitlement dollars, and general revenue)?
4. What services are financed?
5. How many children and youth use services?
6. What are the characteristics of these children and youth (e.g., by age, gender, race/ethnicity, diagnosis, and region)?
7. What services do they use?
8. How much service do they use?
9. What are the disparities in use—regionally? By race/ethnicity?

Box 2.17I presents reasons as to why system builders should undertake this strategic financing analysis.

2.17H Why Undertake This Analysis?

Population crosses multiple systems.
Multiple systems pay for services.

Analysis can help to identify:

- Areas of strength, gaps, duplication, and inefficiency
- Disparities and disproportionality in spending and use

Analysis can help to support:

- More efficient/effective use of dollars through cross-agency strategic financing plan

Financing Family and Youth Voice and Family- and Youth-Run Organizations

Financing mechanisms to ensure strong family and youth voice in systems of care, including funding for family- and youth-run organizations, need to be treated as a "cost of doing business" in systems of care. Such mechanisms are a critical aspect of system infrastructure needed to achieve system of care goals.

At the policy and system management levels, financing is needed to ensure that families and youth are able to participate as partners on governance bodies, on planning committees and advisory boards, and in quality improvement and evaluation activities, as trainers, as peer mentors, and as ombudsmen; to provide advocacy and education to build the family and youth movement; and to organize family and youth groups, councils, and organizations. Typically, contracts with family organizations are the vehicle used by systems of care to ensure family and youth voice at policy and management levels. For example, in **Arizona**, state general revenue, federal discretionary grant dollars, and federal block grant monies are used to support contracts both with the statewide family-run organization, *MiKid*, and with local family organizations, such as *Family Involvement Center* in Maricopa County (Phoenix). Funds can be used to recruit families and youth, pay stipends for participation in policy and management activities, help with transportation to meetings, provide education materials, and so forth. In **Hawaii**, the state's contract with *Hawaii Families as Allies* supported development of a family leadership curriculum and a leadership academy for families to understand the legislative system, the structure of child-serving systems, relationship building with policy makers, how to make family voice heard, and other activities.

At the service delivery level, financing is needed to ensure families and youth can participate as partners in child and family (service-planning) team meetings, provide peer support to other families and youth, and provide direct services and to ensure that families can receive supportive services and that services are not limited to "the identified child." For example, in **New Jersey**, the state funds locally based family-run organizations, using a combination of state general revenue, Medicaid administrative case management dollars, and federal discretionary grants, to provide peer support,

education, and advocacy. In some states, such as **Massachusetts** and **Arizona**, Medicaid will pay for family and youth peer support as a covered service, thereby expanding financing of this important resource in systems of care. In **Arizona**, the *Family Involvement Center* is also a direct service provider, able to bill Medicaid not only for peer support but also for respite, skills training and development, health promotion and behavioral coaching, and case management.

The **Rhode Island** *Parent Support Network (PSN)* serves as one example of a family-run organization that is drawing financing from multiple state agencies serving children and families, diversifying its funding base, and supporting a number of programs that are directed and implemented by families and youth to support systemic change (see Illustration 2.17G). PSN started as a small project out of the Rhode Island Mental Health Association in 1986 and then became an independent 501(c)(3) nonprofit by 1993 with the support of a federal statewide family network grant.

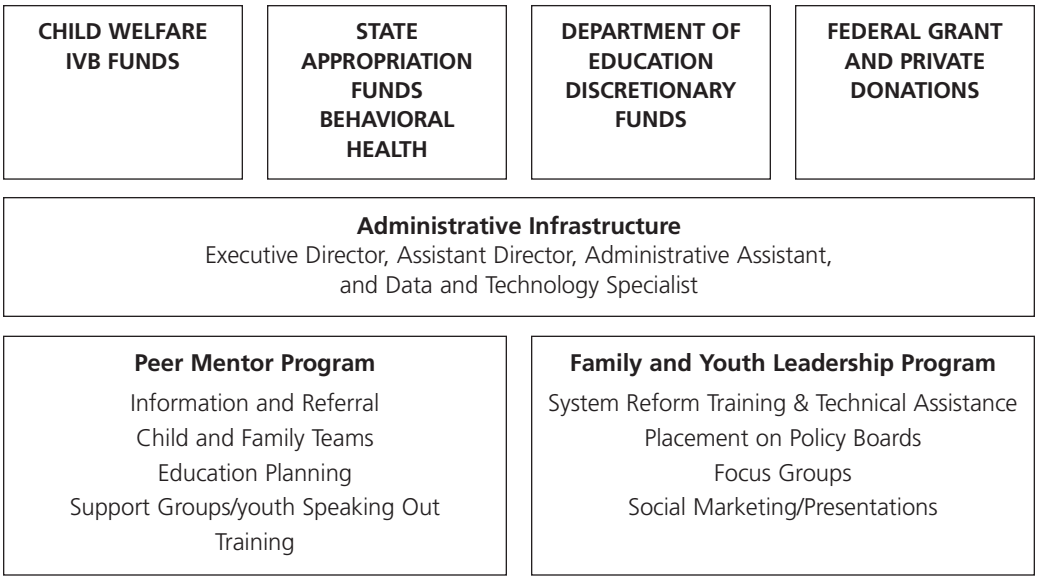
PSN learned early that key to building its funding base was the ability to develop relationships across state systems serving children, youth, and families. PSN worked creatively to utilize funding sources in the state to implement family- and youth-directed programs and activities. For example, a major need identified by families and youth was to have a peer who could provide support at an individualized child, youth, and family level and help youth and families work with education, behavioral health, child welfare, juvenile justice, and other systems to receive necessary services and supports and preserve the family. PSN has been able to utilize child welfare Title IV-B funding, state appropriations allocated to the Department of Children, Youth and Families, Department of Education discretionary funds, and private foundations to support its peer mentor program. The peer mentor program provides ongoing information and referral with a toll-free helpline; support for families involved in public systems; support through the *Wraparound* and education planning processes; ongoing education and individualized advocacy training; and family- and youth-directed support groups.

In addition, PSN has been able to develop new positions, programs, and approaches with federal grant dollars that, for the most part, have been sustained with state appropriation funds based on producing successful outcomes for children, youth, and families. PSN's work has included: development of the "Youth Speaking Out" youth group; a family and youth leadership program; supports for families and youth to participate on policy boards and in trainings; implementation of ongoing focus groups; and, conducting of public awareness activities.

In building a diversified funding base, PSN has learned that it is important to have a sound administrative infrastructure that includes: management leadership, supervision, administrative support, a fiscal and management information system and technology, and staff capacity needed to support the ability to take on new funding opportunities and programs.

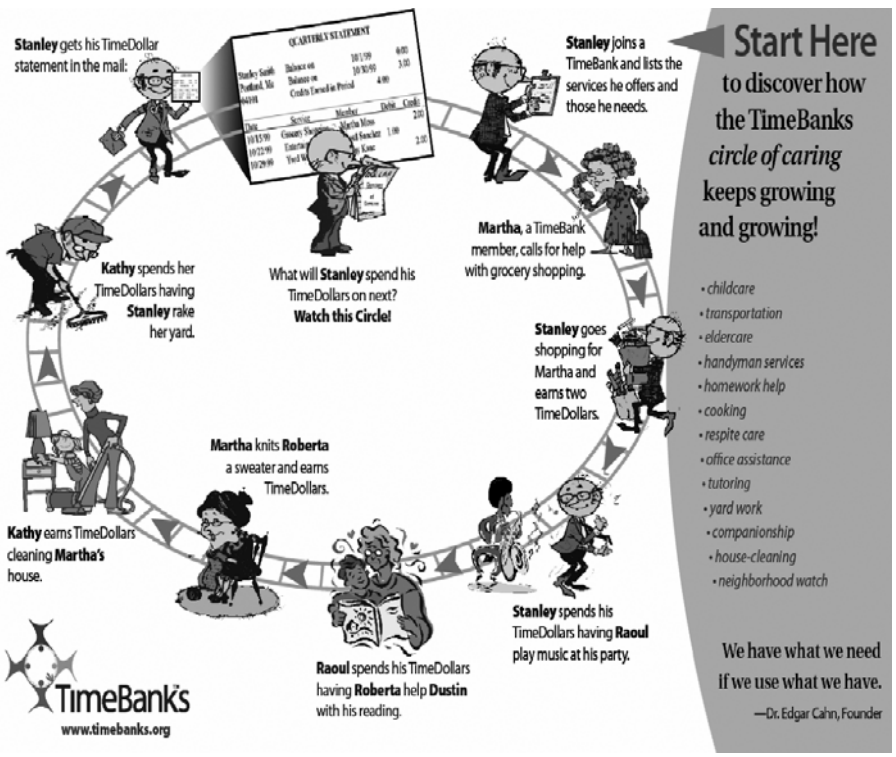
ILLUSTRATION 2.17G

Parent Support Network of Rhode Island
Diversified Funding Sources and Approaches



Families, youth, and culturally diverse constituencies need to be active and informed partners in the development of financing strategies. The more these key stakeholders know about funding streams and the politics around them, the more effective they can be in advocating for needed changes. More important, funding priorities and the strategies to support them should be driven by the strengths and needs of those most affected by them. Financing viewed through a multicultural lens may lead system builders to strategies "outside the box." For example, a strategy being used by PSN in **Rhode Island** is built around the concept of "reciprocity," where there is no monetary fee for services, yet all participants "contract" for services by agreeing to provide volunteer hours through a "Time Bank" to expand the organization's capacity to support families and youth (see Illustration 2.17H). (For more information about Time Banks, see: www.timebanks.org.)

ILLUSTRATION 2.17H



Tribal Financing

Sustainable financing for tribal systems of care can be particularly challenging. Children and families in tribal communities typically are eligible for both tribal authority funding and state and local funds. However, this funding requires partnerships between the tribe and the state and locality. Some tribal systems of care also serve children and families in different states, compounding the challenge of developing strategic partnerships. Holly Echo Hawk and colleagues at the National Indian Child Welfare Association have explored the unique financing challenges that face tribal systems of care as well as strategies developed by tribal communities to sustain and grow system-building efforts. For example, as in **Arizona**, tribes have negotiated with the state in including certain tribal paraprofessionals as behavioral health providers. In **Oklahoma**, the Choctaw Nation, which received a federal Circles of Care planning grant over 10 years ago, has sustained its system using a number of strategies, in particular, growing its own workforce and integrating the system of care values and approach into the overall Choctaw Nation service delivery system.

WEB RESOURCES

Effective Financing Strategies for Systems of Care: Examples from the Field—A Resource Compendium for Developing a Comprehensive Financing Plan at: **http://rtckids.fmhi.usf.edu**

Bazelon Center for Mental Health Law at: **www.bazelon.org**

The Finance Project at: **www.financeproject.org**

National Indian Child Welfare Association at: **www.nicwa.org**

Spending Smarter: A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness at: **http://nccp.org/publications/pub_634.html**

Making Dollars Follow Sense: Financing Early Childhood Mental Health Services to Promote Healthy Social and Emotional Development in Young Children: **http://nccp.org/publications/pub_483.html**

AT-A-GLANCE: Financing Infant & Toddler Child Care (2005): **www.zerotothree.org/site/DocServer/Financing.pdf?docID=523**

Key Questions: Financing

- Are we clear about what we want to finance and for whom?
- Have we undertaken a strategic financing analysis?
- How does our financing structure support our system of care goals, for example, flexible, individualized service provision, coordination of care, and family and youth voice?
- Do we know what our State Medicaid Plan covers? Do we have strategies for strengthening the use of Medicaid?
- Have we examined cross-system financing strategies, such as pooled or braided funding?
- Have we developed a program budget? How do we use it to inform our strategic planning and advocacy efforts?
- How are state and local entities partnering with the tribes to identify sustainable financing strategies?

NOTES

2.18 Human Resource Development

Human resource development (HRD) focuses on a number of elements to ensure adequate numbers of appropriately trained personnel—both in house and within provider and other stakeholder communities—with the skills, knowledge, and attitudes to work effectively in systems of care. Box 2.18A lists HRD functions, which require strategic planning and are tied to quality improvement goals.

2.18A Human Resource Development Functions

- Assessment of workforce requirements (i.e., what skills are needed, what types of staff/providers, and how many staff/providers) in the context of system change
- Recruitment, retention, and staff distribution
- Education and training (pre-service and in-service)
- Standards and licensure

Culturally Competent, Family- and Youth-Driven HRD Strategies

Families, youth, and culturally diverse populations need to be involved in the development of HRD strategies. They are themselves potential resources as staff and as trainers; they need to inform the types of competencies that staff and providers must have; and they are directly affected by HRD decisions. Box 2.18B offers a variety of strategies that systems of care use to involve families and diverse communities in HRD functions. For example, families and youth are involved in developing workforce specifications, job descriptions, and credentialing requirements; they serve on personnel and procurement selection committees; and they serve as trainers.

2.18B Strategies to Involve Families, Youth, and Diverse Communities in HRD Functions

- Being involved in assessing workforce requirements;
- Helping to develop requirements for job announcements and having input on hiring decisions;
- Hiring family members and youth in paid staff roles;
- Engaging leaders from culturally diverse communities to assist with recruitment;
- Partnering with historic Black and Hispanic colleges and other institutions both to recruit and to train existing and prospective staff in cultural competence; and
- Utilizing families and culturally diverse constituencies to develop questions in interview protocols that reflect cultural awareness.

EXAMPLE 2.18A

In a county system of care in the northeast, families help to write job descriptions, participate on interviewing panels, and help to orient new staff.

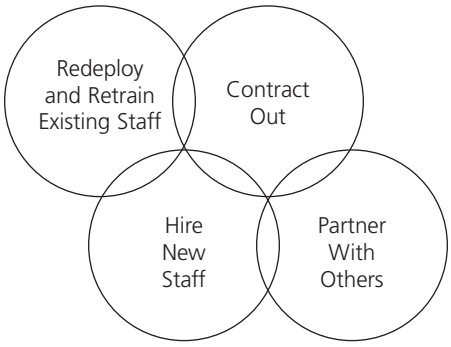
In a medical school in the northeast, families train residents in children's mental health services from a family's perspective.

Staffing Structure

There are many ways to staff systems of care, and Illustration 2.18A shows some of those ways. Some systems of care redeploy—and retrain—existing child-serving system staff. Some hire new staff, including family members and youth. Some contract out certain staff functions; some augment capacity by partnering with other agencies and organizations; and some use a combination of these staffing approaches.

ILLUSTRATION 2.18A

Staffing Systems of Care



There are pros and cons to all of these approaches. For example, hiring all new staff or contracting out most system of care functions may lead to an attitude of disinvestment on the part of traditional agency staff, which will make it impossible to create the changes needed in traditional systems to support systems of care. On the other hand, utilizing only traditional system staff may make it difficult to create a flexible staffing structure that is essential for a flexible delivery system. Augmenting staff capacity by partnering with other agencies and using their resources extends the reach of the system of care but also leaves it vulnerable if the partner agency's priorities change.

Effective system builders also recognize that the staffing structure must incorporate opportunities for advancement and foster leadership at all levels and among all types of staff, both professional and paraprofessional. There are issues of salary equity among professionals and between paraprofessionals and professionals that need consideration. There are issues related to incorporating natural helpers and staff who reflect the racial and cultural identity of the population being served. There are decisions to be made about which types of staff are needed to staff which functions, and there will be advantages and disadvantages to the decisions that are made.

Systems of care typically must develop their staffing structures within existing parameters or mandates, for example, those created by accrediting organizations or funding sources such as Medicaid, or licensing requirements. Also, systems of care have different access to staff. Rural systems, for example, often have difficulty finding requisite professional staff, whereas other systems have a plethora of professionals but have difficulty integrating paraprofessional staff such as natural helpers.

Effective system builders try to achieve balance and a range of expertise, a high degree of appropriateness, flexibility, and cultural competence within their staffing structure. However, there is no one correct staffing structure, and local circumstances and characteristics affect the staffing structure, in any event.

EXAMPLE 2.18B

A rural county in a southern state designed an intensive care management component within its system of care that called for highly credentialed care managers, partly because stakeholders believed that state Medicaid regulations required credentialed staff for Medicaid reimbursement purposes and partly because of the culture within the local mental health agency. However, because of both the very rural nature of the county and low salary scales, the system of care could not recruit nearly a sufficient number of care managers meeting the credentialing requirements. Waiting lists for care management ensued, resulting in frustration and poor outcomes. In this case, the staffing structure, if for no other reason than it was unachievable, hindered goal attainment at many levels of the system. Eventually, system builders redesigned the care management component to utilize parents (some of whom, while highly experienced, lacked the required credentials) and paraprofessionals working under a credentialed supervisor. The supervision structure enabled the system to continue to bill Medicaid for intensive case management services.

Recruitment and retention of staff, typically, is a major issue in child-serving systems. Some systems, such as those in **Arizona**, will pay off college loans as a recruitment tool for behavioral health providers.

Staff Involvement, Support, and Development

Staff involvement, support, and certainly staff development can and need to be structured in their own right. However, the extent to which staff feels supported and develops its capacities also is affected by the ways in which numerous other system of care functions are structured. For example, if the care management function is structured in a way that allows for small enough caseloads that staff actually can get to know youth and families, staff is likely to feel supported and have opportunity to develop. And, if the care management function is structured in a way that gives care managers latitude and flexibility to work with youth and families and that provides supportive, knowledgeable supervision, staff is also likely to feel supported and have opportunity to develop. Similarly, a quality improvement process structured in a way that draws on the knowledge of frontline clinicians and feeds results back to them has the effect of supporting clinicians and providing them opportunity to learn and develop.

Like families and youth, staff at all levels of the system has valuable perspectives and knowledge bases on which the system needs to draw. Involving staff in system design and decision making provides one means to support staff. Staff, like families and youth, also needs tangible supports. For example, staff working in dangerous neighborhoods needs back-up supports. Some systems create buddy systems, pairing workers so that, for example, one family might have two care managers who work in partnership with one another and with the family. Staff needs access to well-trained and supportive supervisors for guidance, brainstorming, coaching, and encouragement. Staff obviously needs adequate compensation, respite, recognition, and time for reflection.

Constraints within systems, for example, budget shortfalls, may hinder provision of adequate staff support, so system builders need to recognize the ways in which staff will experience inadequate support and how lack of support may affect attainment of system goals. System builders also need to look for potential contingency arrangements. For example, one system was unable to give well-deserved salary increases to staff because of budget shortages, so instead, with the involvement of staff, identified several other ways to compensate and support staff, including more flexible hours and opportunities for training and enrichment.

Staff, or human resource, development—ensuring that there are adequate numbers of staff with the skills, knowledge, and attitudes to perform effectively in systems of care—is one of the most critical functions requiring structure. Training obviously is one key aspect of staff development and is discussed more fully below. However, staff development encompasses more than training. The National Institute of Mental Health (NIMH) defines "human resource development" as "the explicit and coordinated efforts of an organization to achieve the right number and right kinds of people in the right places at the right times doing the right things to carry out its mission effectively."* NIMH further defines human resource development as encompassing a broad set of activities, including: planning and evaluation (i.e., assessing workforce issues as they relate to the mission of the organization, particularly in the context of system change); workforce management, including recruitment, retention, distribution, and utilization of staff; education and training, including both pre-service preparation and in-service training; and sanctions and regulations such as standards and licensure.

All personnel involved in systems of care, from frontline practitioners to supervisors to system administrators, are being called upon to develop new skills, learn new things, and adopt new attitudes. *As is true of all major change initiatives, few personnel come to systems of care with all the requisite skills, knowledge, and attitudes*. Effective system builders know this and address the issue by structuring ongoing staff development programs that are both informed by and inform quality improvement processes.

Staff development needs to be a concern of state-, tribal-, and local-level stakeholders. Local-level and tribal-level stakeholders usually can articulate most clearly the strengths and gaps in staff and provider capacity as well as community-wide or tribal

*National Institute of Mental Health. (1992, September). *Human resource development program, national task force strategic plan*. Rockville, MD: Author.

strategies for addressing staff development requirements. State-level stakeholders may have resources to contribute to local or tribal efforts and can utilize local and tribal staffing analyses to inform statewide HRD agendas.

Box 2.18C offers one framework for the types of skills and attitudes that staff hiring and training structures need to encompass.

2.18C Staffing Considerations for Effective Frontline Practice

A. Hiring procedures include methods to assess and screen out workers with characteristics such as:
- A confrontational style
- Hostility in response to family or youth hostility
- Negativism
- Labeling families or youth as resistant
- A controlling personality

B. Screening procedures include methods to assess and select workers with the following characteristics:
- Empathy
- Respectfulness
- Concern
- Warmth
- Genuineness
- Positive life experiences

C. Screening, hiring, and training procedures select and develop workers with general skills such as the following (as well as specific skills demonstrated empirically to be helpful with specific populations they will serve):
- Attending
- Observing
- Listening
- Discriminating and communicating to content and feelings of the clients' experience
- Developing a positive alliance
- Self-disclosure
- Moving from the general to the specific
- Goal setting
- Operationalizing goals
- Breaking youth and family concerns into specific action steps
- Contracting skills

Adapted from Kinney, J., Strand, K., Hagerup, M., & Bruner, C. (1994). *Beyond the buzzwords: Key principles in effective frontline practice*. Des Moines, IA: National Center for Service Integration.

Orientation and Training of Key Stakeholders

Orientation is the function of familiarizing those involved in systems of care at all levels to the basic values, principles, goals, and operations of the system. It is an absolutely critical and sometimes overlooked function that needs to be structured. Orientation can be built into parent support and educational activities, into intake structures, into staffing structures, into interagency meetings, into public awareness campaigns, into provider updates, and the like. It is an ongoing function because neither system of care operations nor stakeholders are static.

EXAMPLE 2.18C

A small southeastern state includes an orientation handbook as part of its intake structure. The handbook explains clearly the values, principles, goals, and operations of the system of care. Intake staff walks through the booklet with youth and families to increase familiarity with the system upon first contact with it.

Training is closely linked to staff development, family involvement, and provider readiness functions. Few system builders or those providing services within systems of care come to the task with all the requisite skills, knowledge, and attitudes. Training structures that are ongoing, tied to system of care principles and goals, and inclusive of key stakeholders are needed. Various types of training need to be structured in systems of care. Some training within systems of care is specialized and targeted to particular stakeholders. for example, training parents and teachers in behavior management skills, training pediatricians to recognize mental health problems, training administrators in program budgeting, and training evaluators in participatory evaluation techniques. Some training needs to occur systemwide, for example, cultural competency training, collaboration skill building, and parent-professional partnering. *Effective system builders develop training structures to ensure that training is provided in an ongoing fashion and covers both systemwide and targeted areas of need.*

Box 2.18D provides one example of core competencies needed by staff in systems of care.

2.18D Trinity College Competencies for Staff Who Work with Children and Adolescents Experiencing A Serious Emotional Disturbance and their Families

I. Demonstrates respect for children and adolescents experiencing a serious emotional disturbance and their families.

A. Uses language and behavior that consistently respects the dignity of children and adolescents experiencing a serious emotional disturbance.
B. Demonstrates holistic understanding of children and adolescents experiencing a serious emotional disturbance and their families.
C. Involves child or adolescent in all aspects of service-planning and support activities.
D. Provides information as needed.
E. Communicates understanding of unique issues facing family members.
F. Solicits family input and collaboration in service-planning and support activities.
G. Demonstrates knowledge of family support resources.
H. Provides formal and informal support as needed.

II. Demonstrates knowledge about serious emotional disturbance.

A. Demonstrates knowledge about the differential characteristics and courses of serious emotional disturbances/disability.
B. Demonstrates knowledge about psychotropic medications.
C. Demonstrates understanding of the effects of stressful life events on children, adolescents, and families.

III. Demonstrates understanding of principles of collaborative community-based care.

A. Understands and demonstrates the principles of unconditional care.
B. Understands the principles of child and family-centered services.
C. Understands the principles of community-based care.

Continued on following page.

2.18D Continued

IV. Demonstrates knowledge of a variety of approaches to intervention and support for children, adolescents, and their families.
- A. Demonstrates respectful communication and/or counseling skills.
- B. Demonstrates ability to teach simple and complex skills including physical, social, intellectual, and emotional skills.
- C. Demonstrates understanding of a variety of program models and philosophies (and acknowledges that these change as knowledge evolves over time).
- D. Demonstrates knowledge of a range of crisis prevention and intervention approaches.

V. Demonstrates ability to design, deliver, and ensure highly individualized services and supports.
- A. Routinely solicits personal goals and preferences.
- B. Designs personal growth/service plans that "fit" the needs and preferences of the child/adolescent and family.
- C. Encourages and facilitates personal growth and development toward maturation and wellness.
- D. Facilitates and supports natural support networks.

VI. Works in a cooperative and collaborative manner as a team member (agency teams, family members, service recipients, foster parents, concerned others).
- A. Coordinates service and support activities with others.
- B. Assists in building positive team relationships.

VII. Demonstrates knowledge of a variety of service systems for children and adolescents experiencing serious emotional disturbance and their families.
- A. Identifies and accesses wide range of community resources.
- B. Develops and maintains good relationships with community representatives.
- C. Demonstrates knowledge of entitlement and benefit programs.
- D. Integrates community resources into service planning.
- E. Participates in public education and overall advocacy.

VIII. Demonstrates knowledge of legal system and individual civil rights.
- A. Demonstrates knowledge of legal system.
- B. Demonstrates knowledge of individual rights.
- C. Connects individuals to legal and advocacy resources as needed and/or requested.

IX. Conducts all activities in a professional manner.
- A. Adheres to recognized ethical standards.
- B. Performs work in a positive manner.

X. Pursues professional growth and development.
- A. Seeks out learning opportunities.
- B. Evaluates work effectiveness.
- C. Integrates new learning into daily work practices.

Meyers, J., Kaufman, M., & Goldman, S. (1999). Training strategies for serving children with serious emotional disturbances and their families in a system of care. In *Promising practices in children's mental health (1998 series)* (Vol. 5). Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practices.

Effective training structures also recognize and utilize the training resources within stakeholder groups. For example, parents and youth can be trainers; providers have training expertise; community resource people and organizations have training expertise; traditional systems have training expertise (and dollars for training.); and universities fundamentally are training resources. Box 2.18E provides the types of training programs, and their characteristics, that are available for workers in systems of care.

2.18E Education and Training Opportunities for Workers in Systems of Care

Types of Training Programs	Characteristics
University-based, Academic Program	Preservice doctoral, master's, or specialty degrees
College-Undergraduate	Four-year degree
Learning Center Model	Courses, undergraduate/graduate workshops, consulting, resources
Certificate Programs	Specialized academic programs
Agency-sponsored Training	Formal programs, possible career ladder credit
Agency-based Training and Supervision	Informal training, orientation, in agency in-service training
Specialized Workshops	Sponsored by independent training centers and consultant companies
State Training and Technical Assistance Institutes and Programs	Sponsored with state funding for training on state and local identified needs
Training Conferences	Sponsored by associations
Learning Resources	Journals, newsletters, videos, etc.
Informal Contacts	Informal discussion of work-related issues among practitioners on and off the job
Technology-based Approaches	University-based distance learning, use of Internet

Meyers, J., Kaufman, M., & Goldman, S. (1999). Training strategies for serving children with serious emotional disturbances and their families in a system of care. In *Promising practices in children's mental health (1998 series)* (Vol. 5). Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practices.

EXAMPLE 2.18D

Hawaii is an example of a state that contracts with universities to support system of care goals with respect to both training and recruitment. Through these contractual agreements, university faculty teaches courses on systems of care and effective practices. The contracts enable students from across disciplines to rotate through the system of care for children with behavioral health challenges to obtain real world experience. The contracts indirectly support recruitment purposes and help to change university curricula to incorporate key system of care concepts. The state has contracts with psychiatry and psychology departments,school of social work, and the Advanced Practice Registered Nurse Program within the state university.

System builders need to be strategic about how to build on and adapt existing training structures, such as those supported by Title IV-E (child welfare) dollars, since dollars for training are often scarce. In traditional systems, each agency tends to develop its own training and staff development agenda, using its own training resources. *Systems of care try to develop strategic training and HRD activities across child-serving systems*. A more traditional approach is when systems, programs, and practice operate in isolation, creating separate training agendas and utilizing an "expert model" only. Systems of care take a more unified approach in which state systems pool training efforts, and families, youth, and the community are integral participants in all aspects of training. Box 2.18F describes the characteristics of traditional, modified, integrated, and unified approaches to training.

2.18F A Developmental Training Continuum

	Traditional	Modified	Integrated	Unified
System	State systems develop training along specialty guidelines—Promotion of stronger specialty focus.	State systems independently adopt similar philosophy, promoting collaboration.	State systems begin sharing training calendars. Promotion of cross-training; joint funding.	State systems pool training staff, merge training events.
Program	Community agencies and universities operate in isolation. Disciplines train in isolation from one another. Instruction is often didactic, "expert." No support for cross-training.	Community agencies and universities begin joint research and evaluation. Pre-service training remains separate from the field.	Community agencies and universities begin to integrate field staff/families into pre-service training. Student field placements cross agency boundaries. Cross-agency training gains support.	Community agencies and universities collaborate with larger community, e.g., families as co-instructors; curricula reflect practice goals. Training geared to system goals.
Practice	Participation in professional conferences on individual basis within agency boundaries. Services are provided within agency boundaries.	Staff receive training which promotes collaboration, but receive it within agency boundaries. Specialty focus predominant. Services remain within agency boundaries.	Service teaming is promoted through cross-agency training.	Service teams with full family inclusion are the norm. Redefined specialty practice roles develop to support professional identity while promoting collaboration.

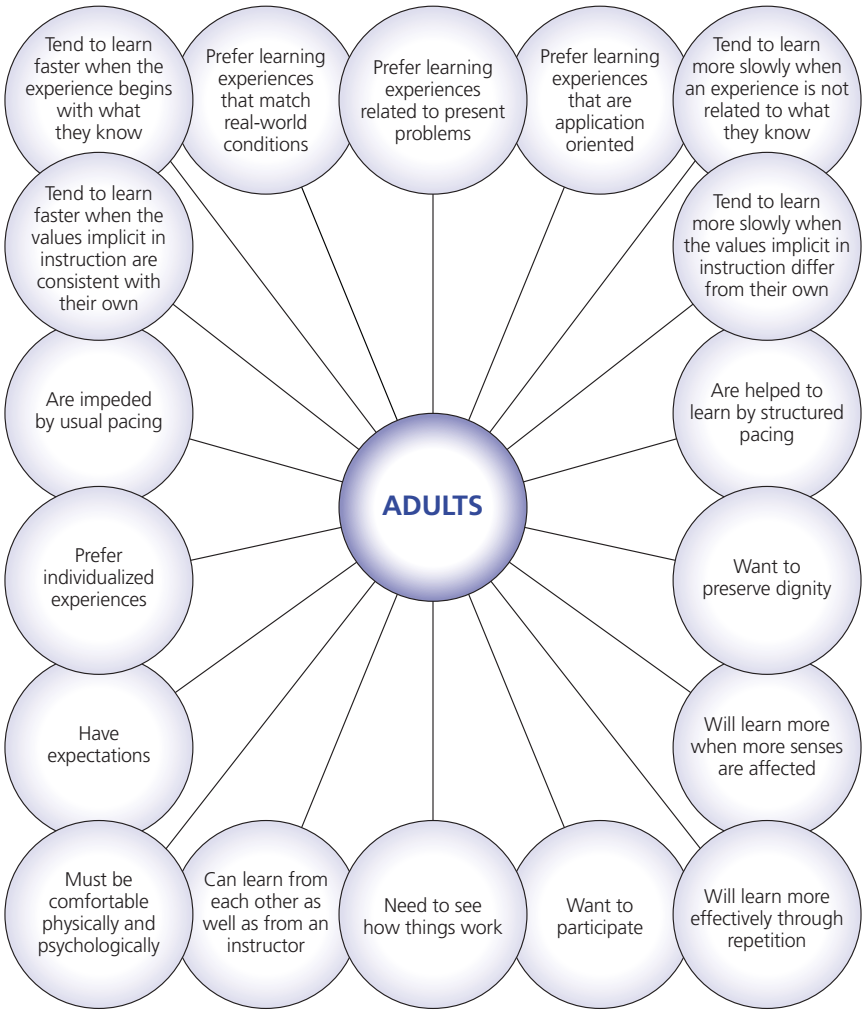
Meyers, J., Kaufman, M., & Goldman, S. (1999). Training strategies for serving children with serious emotional disturbances and their families in a system of care. In *Promising practices in children's mental health (1998 series)* (Vol. 5). Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practices.

EXAMPLE 2.18E

North Carolina provides an example of a state that is developing a more integrated training approach through its formation of a System of Care Child and Family Team Curriculum and Training Workgroup, composed of a cross-section of state and local agencies, several university partners, and family partners. The goal of a cross-agency and stakeholder training agenda is to develop a consistent practice model (e.g., family-centered practice) in implementing a system of care approach. The North Carolina State Collaborative (made up of representatives from all the major systems serving children, youth, and families, community-based organizations, nonprofits, university partners, and family members) worked together to obtain additional grant funding from the North Carolina Crime Commission (to augment a federal system of care grant from the Children's Bureau) to conduct trainings on system of care principles and the child and family team approach. A parent, youth, and family team conducted the trainings. They also have pooled resources to develop a cross-agency child and family team curriculum, funding family members to participate on the curriculum development team. In addition, they are pooling funds to train child and family team facilitators. (**www.dhhs.state.nc.us/dss/systemofcare/soc.htm**)

In restructuring old and building new training components, effective system builders also take into account how adults learn best—typically by doing, by being able to apply new skills readily, and by being respected as having much to contribute as well as to learn (see Illustration 2.18B).

ILLUSTRATION 2.18B



Rothwell, W. J., & Sredl, H. J. (1992). *The ASTD reference guide to professional human resource development roles and competencies*. (2nd ed., Vol. 2). Amherst, MA: HRD Press.

Both orientation and training are critical to changing attitudes, increasing knowledge, and building skills. Because there is turnover among key stakeholders, because constant repetition of critical information is essential in major change initiatives, and because the larger field is continually generating new data about effective treatments, practices, and technologies in systems of care, orientation and training need to be structured as ongoing functions. However, in many organizations, training is not ongoing and often fails because of some of the factors described in Box 2.18G.

2.18G Why Training Fails

1. **Training Viewed as Education**
   In many organizations, training is viewed as a form of education and as a result loses its unique contribution to the organization. Training should be aimed at short-term skill development with immediate contributions to improved performance on the job. Its effectiveness should be continually evaluated as part of a larger, long-term, educational goal for the entire organization.
2. **Training Viewed as a Fringe Benefit**
   Many organizations view training as a right and privilege for all employees and lose sight of its ultimate performance improvement purpose. Unless performance improvement is the goal of training, it cannot be held responsible for results.
3. **Classroom Mentality**
   For most organizations, training occurs in an isolated, protected environment that is far different from that of the performance environment. It is still dominated by the lecture format and conforms to the general framework of classroom instruction. This prevailing belief that training should occur in a classroom and away from the job is one of the reasons why transfer of training from the classroom onto the job is so difficult to effect.
4. **Lack of Management Commitment**
   Managers rarely give more than lip service commitment to training programs. Supervisors and other managers must be willing to actively support the performance improvement efforts through participation and resource sharing.
5. **Dumping**
   Employees are often not expected to integrate the training that they received with their jobs. As a result, training is viewed as an end in itself, which leads to this "dumping" phenomena. ***Dumping*** means transferring employees from their jobs into training courses, and then transferring them back to their jobs without any expectations concerning their responsibilities or accountabilities. Clear goals and objectives must be established to make the training job-relevant.
6. **Too Much Emphasis on Development and Delivery**
   If trainers spend too much time on developing and delivering training courses and too little time interacting with the client unit, the results can be disappointing. Appropriate emphasis should be placed on needs analysis, consulting assistance, and follow-up after training to maximize performance improvement on the job.
7. **Lack of Performance-Based Evaluation**
   When training evaluation techniques focus on satisfaction indices only and not on other factors such as performance and impact of the training on organizational results, training will remain little more than entertainment. New accountability mechanisms need to be established that measure the trainees' transfer of training capabilities.
8. **Too Much Content is Covered**
   Current training techniques tend to cover too much information in any given curriculum. There is always a tendency to add "just one more topic." In order for training to be effective in improving performance, it should be trimmed down to a manageable size to allow the trainee to process the content in a meaningful manner rather than simply retaining the information in its concrete form.
9. **Focusing Exclusively on Knowledge Objectives**
   Too much training is primarily information-centered and not skill-centered. In an applied performance environment, training professionals must guide subject matter experts to unravel the relationships between knowledge and skill because increased knowledge without skills will rarely contribute to improved performance and organizational results.
10. **Inappropriate Trainees**
    Inappropriate selection of trainees can be a waste of time for the trainees, the trainers, and the organization. Often the wrong population of trainees is selected for a particular training program. They don't want the training, don't need the training, do not possess the necessary prerequisites, or will not have the opportunity to use the new skills on the job.
11. **Lack of Follow-up after Training**
    For the most part, trainers see their responsibilities ending when the training is over. This lack of follow-up by the trainers leaves a big question mark as to how the training is being implemented on the job and whether the skills have been appropriately transferred. It is critical to performance improvement that trainers begin to see their role as a continuing one.
12. **Constraints in the Performance Environment**
    Performance environments can create obstacles and barriers that may be insurmountable without the support and commitment of management and training personnel. Negative effects due to disincentives, unclear expectations, lack of interpersonal support, and poor supervision can greatly diminish the effects of training programs.

Meyers, J., Kaufman, M., & Goldman, S. (1999). Training strategies for serving children with serious emotional disturbances and their families in a system of care. In *Promising practices in children's mental health (1998 series)* (Vol. 5). Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practices.

State Structures to Support Capacity Building

As noted earlier, a number of states have created statewide entities to support training and capacity building in effective practices and larger system of care reform principles. **Maryland's** Innovations Institute is one example. The Institute was created by the Governor's Children's Cabinet and is housed at the state University of Maryland. It provides training and capacity building related to system reform goals; evidence-based and effective practices; and fundamental reform practices. such as partnering with families and with youth, cultural and linguistic competence, and operating in a cross-system fashion, including through child and family teams in a *Wraparound* approach. **New Jersey** provides another example through its Behavioral Research and Training Institute at the state University of Medicine and Dentistry of New Jersey. As part of its training structure, New Jersey also created a Web-based training and certification system for use of the Child and Adolescent Needs and Strengths (CANS) screening and assessment tools that are used systemwide.

WEB RESOURCE

Annapolis Coalition on the Behavioral Health Workforce at: **www.annapoliscoalition.org**

Key Questions: Human Resource Development

- Have we undertaken a Human Resource Development (HRD) assessment and developed strategies to ensure that we have an adequate number of personnel (in house and contracted) with the right skills, knowledge, and attitudes to function effectively in a system of care?
- How do we involve families and youth in our HRD strategies?
- How are our HRD strategies culturally and linguistically competent?
- How do we orient key stakeholders to our system of care? Is orientation a one-time activity or an ongoing function?
- How have we created training structures (pre-service and in-service) to support system of care goals?
- Have we explored multiple avenues for accessing training, for example, existing system training programs and dollars?
- Do we have partnerships with universities to incorporate system of care principles into university curricula across disciplines?

NOTES

2.19 External and Internal Communication and Social Marketing

Overview

External communication is a large umbrella that covers efforts to inform those outside the system of care—for example, the public at large, the press, and legislators—about system of care goals and operations, achievements, and challenges. External communication needs to be structured for various purposes, among them: to inform the public about system of care availability, to raise public awareness, and to generate support for the system of care. Effective external communication structures are critical to sustain and grow systems of care—baldly put, if no one knows what you are doing, no one will care if you go out of business. Having said that, however, aggressive external communication may also result in a greater demand for services than the system can support. Part of an effective campaign is making the public and policy makers aware of the system's capacity, particularly in light of perceived or actual demand. *Effective systems of care launch public awareness campaigns, use data from the system to inform legislators and other key policy makers, and ensure that information is available to families and youth who may need, or know of others who may need, system services and supports*.

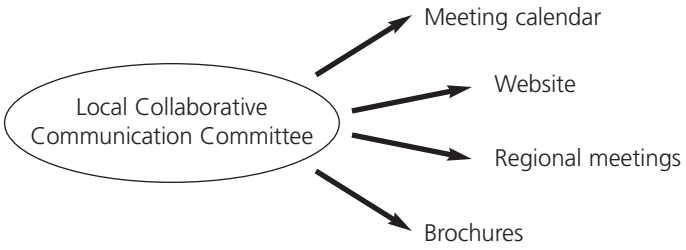
Effective system builders cultivate relationships with the media and with legislators; place editorials in newspapers; help reporters develop feature stories; help reporters make the connection between the local system of care and related national stories, such as the *President's New Freedom Commission Report on Mental Health*; and create billboard campaigns and events that generate good publicity. They also engage in specific marketing approaches to create awareness and buy-in. **Social marketing** is discussed below.

Internal communication is equally as important as external communication, that is, putting structures in place to ensure that there is an ongoing exchange of information across key stakeholders within the system of care. *System goal attainment can be too easily frustrated by a failure to communicate and/or miscommunication among system builders because misinformation, rumors, and gossip can sabotage a developing system*.

EXAMPLE 2.19A

North Carolina is an example of a state that partnered with the local system of care to deliberately structure internal communication mechanisms to support the system-building effort. It created a Local Collaborative Communication Committee, representing the cross-agency and family stakeholders involved in the system, to plan a variety of ways to ensure communication, such as a Website, regional meetings, brochures, and a meeting calendar. The State Collaborative pooled resources to finance development of the Website, and one of the nonprofit agencies participating on the Collaborative serves as fiscal agent for the Website.

Communication Mechanisms in the North Carolina System of Care



Social Marketing

Social marketing has to do with using commercial marketing practices and techniques to promote social change (rather than for profit making). Typically, social marketing is used when the goal is to change behavior of a large number of people usually over a long period of time. Effective communication obviously is one aspect of social marketing, but the term entails more. Social marketing requires system builders to be strategic about identifying and framing what it is they are trying to "market," to whom (various audiences), and how (because some approaches are more effective than others with different audiences). For example, system builders trying to market the system of care to budget staff in the governor's office may find that presentation of cost-benefit data, in a readily accessible format, may be the most compelling approach. In contrast, system builders trying to reach diverse families who have felt disenfranchised from traditional systems may find that the best way to market the system of care is through the stories of other diverse families who have experienced the system of care as helpful.

QUESTION
'Who is a social marketer?'

ANSWER
'Everyone!'

The world of commercial marketing provides a framework that can be adapted to social marketing for systems of care. It encompasses what are often referred to as "the four Ps":

- **Product**—that is, what the system of care offers to various stakeholders; what the benefit of the system of care "product" is to various audiences (e.g., the system of care approach may offer better value to state agency purchasers than traditional ways of delivering services because it produces better outcomes at comparable or lower cost)

- **Price**—that is what is the "cost" to various audiences of buying into the system of care (e.g., the cost to frontline staff in having to make the practice changes to operate in a system of care is anxiety at having to change, concern about whether the change will be effective, and the time and energy required to make a change)
- **Place**—that is, where (and with whom) will the system of care get the most mileage in placing its marketing messages (e.g., families, legislatures)
- **Promotion**—that is, what communication strategies and vehicles will be most effective with various audiences, for example, media outreach, community events, personal contacts, and others

In applying social marketing to systems of care, some also would add a fifth "P"—for *policy*, because social marketing efforts ultimately must lead to policy changes that support the system of care.

In the world of social marketing, it is a mantra that "everyone needs to be a social marketer." Also, system builders need to structure social marketing as an ongoing function, recognizing another mantra in the field that people need to hear new information an average of 11 times before it starts to sink in. If that is indeed true, then social marketing certainly needs to be an ongoing function in systems of care that are trying to convey new information to many different audiences (e.g., families, staff, providers, various state and local agencies, legislators, families, youth, and the general public).

EXAMPLE 2.19B

On the West Coast, a county system of care launched a specific marketing campaign geared to other agencies to create awareness of and buy-in for the system of care, using data strategically to appeal to the interests of each particular agency. For example, with the school system, system builders used data showing improvements in academic performance with involvement in the system of care; with the juvenile justice system, they used data regarding referrals to law enforcement agencies.

EXAMPLE 2.19C

In a southwestern city, system builders created a recognizable logo and slogan for the system of care, which appear on posters, on the backs of buses, on buttons, bumper stickers, coffee mugs, and notepads. System builders in this community make sure that the natural gathering places for youth and families—that is, pediatricians' offices, schools, public libraries, fast food restaurants, supermarkets, and faith organizations—have supplies of these items in sight, along with informational materials and brochures.

The federal Center for Mental Health Services has supported a national social marketing campaign and technical assistance to state, tribal, and local systems of care for several years. The goals of the federal contract are the following:

- Promote social inclusion of children and youth with mental health challenges and promote mental health;
- Use social marketing strategies to help increase the likelihood that children and youth with serious emotional challenges and their families are appropriately served and treated;
- Increase awareness of mental health needs and services for children and youth among mental health providers, system of care communities, intermediary groups/organizations, and the public;
- Demonstrate to communities that the mental health needs of children and youth with serious emotional challenges and their families are best met through utilization of systems of care;
- Use social marketing strategies to help build capacity within system of care communities to sustain services and supports for children and youth with serious emotional challenges and their families; and
- Assist the federal Substance Abuse and Mental Health Services Administration in implementing the National Children's Mental Health Awareness Day Initiative.

(See www.vancomm.com and www.systemsofcare.samhsa.gov.)

WEB RESOURCES

Vanguard Communications at: **www.vancomm.com**

Social Marketing Institute at: **www.social-marketing.org**

Social Marketing Resource Guide at:
www.turningpointprogram.org/toolkit/content/smresourceguide.htm

Turning Point Social Marketing National Excellence Collaborative (a project of the Robert Wood Johnson Foundation) at: **www.socialmarketingcollaborative.org/smc**

Key Questions: External and Internal Communication and Social Marketing

- What are our internal structures for communicating across levels and partners?
- How have we structured social marketing as a core function of system building?
- What structures have we put in place for external communication?
- How do our social marketing activities systematically partner with families and with youth? How are they culturally and linguistically competent?

NOTES

2.20 Quality Management, Continuous Quality Improvement (CQI), and Evaluation

Quality management has to do with putting structures in place that are capable of telling system builders and other key stakeholders whether what is being done is making any difference for the better in the lives of the children and families being served, for the taxpayers who support the system, and for the community in which the system operates. This question needs to be asked and responded to continually; it is not a one-time query and response. To ask and answer this question—and the many subsets of questions attached to it—system builders need to develop structures that measure quality, that provide feedback loops, and that have response (i.e., quality improvement) capabilities.

I wouldn't mind paying that tax if I knew it was helping.

It is especially critical to partner with families and culturally diverse constituencies in the design and implementation of Continuous Quality Improvement (CQI) structures because definitions and perceptions about "quality" vary. It is also especially critical to partner with these stakeholders because the system's expectations about quality service provision directly impact them. In addition, it is important to understand families' experiences, not only as ultimate outcome issues, but as quality of life issues; family and youth voice is critical to this understanding and, therefore, to any CQI activity. Effective system builders structure the CQI process to reflect the system's values and goals, and key stakeholders, including families and youth, are involved in the design and implementation of CQI—through committee structures, participation in focus groups, involvement in targeted assessments, and the like.

CQI structures and methods in systems of care include both quantitative and qualitative data collection and entail a participatory evaluation framework. System builders need to be clear about what they are measuring for quality. There are many different aspects of systems of care that can be measured for quality. *The most fundamental, however, is the quality of the interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided.* The quality of these interactions can be measured by looking at treatment efficacy and service outcomes such as clinical and functional outcomes, by measuring the satisfaction of those involved in the interactions—families, youth, and clinicians—and by considering issues of value, that is, analyzing cost as compared with effectiveness and satisfaction.

But is our life any better?

Box 2.20A describes steps in the quality process.

2.20A Steps in the Quality Process

- Discussions about values
- Evolution of principles for action
- Development of guidelines for interventions
- System guidelines
- Clinical guidelines
- Ethical guidelines
- Measuring performance
- Outcomes
- Report cards
- Processing feedback

Manderscheid, R. (1998, May). From many into one: Addressing the crisis of quality in managed behavioral health care at the millennium [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of Behavioral Health Services and Research, 25*(2).

2.20B A Framework for Addressing Family Needs Comprehensively

Level of Family Need	Targeting of Service	Form and Cost of Service	Outcome for Family	Impact on Community
Support and Prevention	• Sexually active teenagers • Families in low-income neighborhoods	• Sex education, contraceptive programs, clinics • Family resource center	• Teens do not become pregnant • Parenting skills improve	• Reduced incidence of social problems associated with teen pregnancy • Stronger neighborhoods
Early Intervention	• Pregnant teens and teen parents • Parents of infants and toddlers with special needs • Recently unemployed	• Early identification of need • Prenatal and perinatal services • Linkages to service to meet special needs of the parents and children	• Improved birth outcomes • Economic stability and physical security in spite of risks • Reestablish stable family circumstances without public assistance • Children enter school ready to learn	• Reduced incidence and prevalence of environmental induced developmental disabilities such as fetal alcohol syndrome • Reduced truancy Reduction in violent activity and other risky behavior by youth
Focused Intervention	• Families with substantiated reports of child abuse or neglect • Families without homes • Families with children at risk or involvement with juvenile justice system	• Income, food, and housing assistance to establish a basic level of economic security and physical safety, job training and assistance in locating employment • Parenting education • More intensive service to meet special needs of parents and children • Less-intensive, home based family preservation services • Family reunification services	• Establish stable family situation with public assistance • Parents learn how to provide a safe and nurturing environment for their children • Facilitate return of children to biological parents or to another permanent living arrangement	• Fewer families experience crises that threaten their viability • Lower probability of long-term dependency on public assistance
Crisis Intervention	• Families at imminent risk of having a child removed from the home (child welfare, juvenile justice, mental health, developmental disability, etc.)	• Child and family team • Kinship care • Family foster care • Therapeutic foster care • Residential facility	• Help parents resolve crisis that undermines their ability to provide a safe and nurturing home for their children	• Reduced isolation of children from their families and communities

Usher, C. (1998, May). Managing care across systems to improve outcomes for families and communities [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of Behavioral Health Services and Research, 25*(2).

Box 2.20B gives an example of a framework for considering outcomes at several levels—that of the child and family being served, the larger community, and cost issues.

System builders also need to be clear about *how* they are measuring quality, because there are many different ways to measure it—some yet to be discovered in what is a relatively new area of endeavor for systems of care. Some systems of care measure clinical and functional outcomes as one means to assess quality. Some measure system outcomes, for example, the number of children in out-of-home care. Some measure parent and youth satisfaction. Some measure cost, access, and service utilization patterns. Some measure public opinion. *Effective system builders structure CQI processes that incorporate multiple measures and that rely on multiple sources—youth and families, providers, staff, community stakeholders, and agency administrators—to determine what is important to measure and to provide information to gauge quality.*

Systems of care are data driven.

Box 2.20C provides one example of outcome measures in a system of care using multiple measures from multiple sources and intended for multiple audiences.

2.20C Full Ongoing Outcome Data Set for California System of Care Model Counties

WHAT	SOURCE	WHEN	PRIMARY AUDIENCE
System level measures and outcomes			State and local policy makers, interagency partners, program managers
Placements			
State hospital: number, length of stay, cost	State data systems	Collected monthly	
Group Home: number, cost			
Acute psychiatric hospital: bed days, cost			
Restrictiveness of living environment (Restrictiveness of Living Environment Scale—ROLES)	County data Clinician/case manager	Collected monthly Entry, exit, annual	
Educational performance (for youth in selected special education/mental health programs)		Ongoing annually	Program managers, interagency partners, local policy makers
School attendance	School records		
School performance	Achievement tests		
Juvenile justice (for youth in selected mental health/juvenile justice programs)	Court records	Ongoing, one-year pre- and post-program	
Recidivism: arrests and citations by type of offense			
Consumer level measures and outcomes			Clinicians and consumers, program managers, local policy makers
Functioning, competence, and impairment from caregiver, consumer, and clinician perspectives		Entry, six months, annually, and discharge	
Child Behavior Checklist	Caregiver		
Youth Self-Report	Child		
Child and Adolescent Functional Assessment	Clinician		
Scale	Caregiver, child		
Satisfaction (Client Satisfaction Questionnaire 8)	Caregiver	Sampled periodically	
Family Empowerment Scale			Consumers, program managers

Rosenblatt, A., Wyman, N., Kingdon, D., & Ichinose, C. (1998, May). Managing what you measure: Creating outcome-driven systems of care for youth with serious emotional disturbances [Special Issue on System Accountability in Children's Mental Health]. M. Hernandez (Ed.), *Journal of Behavioral Health Services and Research, 25*(2).

Box 2.20D provides examples of various instruments used to measure outcomes related to children's mental health.

2.20D Examples of Child/Adolescent Mental Health Instruments

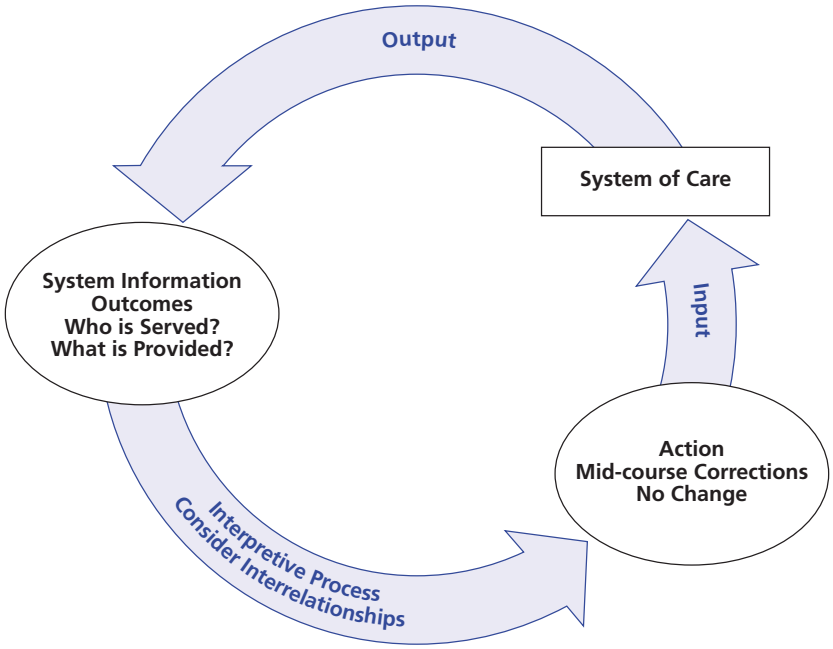
INSTRUMENT	DOMAIN	DATA SOURCE	METHOD
Child Behavior Checklist (CBCL)	Symptomatology	Parent/caregiver	Self-report
Child and Adolescent Functional Assessment Scale (CAFAS)	Level of functioning	Case manager/clinician	Completed after interview with child or family member
Family Assessment Device (FAD)	Family functioning	Parent/caregiver	Self-report questionnaire
Consumer Satisfaction Questionnaire (CSQ-8)	Consumer satisfaction	Parent/caregiver	Self-report questionnaire
Family Satisfaction Questionnaire (FSQ)	Consumer satisfaction	Parent/caregiver	Self-report questionnaire

Koch, J. R., Lewis, A., & McCall, D. (1998, May). A multistakeholder-driven model for developing an outcome management system [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of Behavioral Health Services and Research, 25*(2).

Effective system builders also recognize how critical it is to structure CQI processes that not only ask about quality but also respond to issues that surface through the asking. *Structures that amass data about quality but fail to do anything with the data create frustration among many groups of stakeholders—for example, staff, providers, families, and legislators—and raise credibility issues that can affect attainment of system of care goals and system sustainability*. Effective CQI structures incorporate mechanisms that provide regular feedback about quality issues—good and bad—to system stakeholders at all levels and initiate in a timely way improvement steps in response to quality concerns (see Illustration 2.20A).

ILLUSTRATION 2.20A

Ecology of Outcomes: Using the Results



Hernandez, M., Hodges, S., & Cascardi, M. (1998, May). The ecology of outcomes: System accountability in children's mental health [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of Behavioral Health Services and Research, 25*(2).

Example of Use of Data for Continuous Quality Improvement

EXAMPLE 2.20A

Michigan requires its local community mental health authorities to use the Child and Adolescent Functional Assessment Scale (CAFAS), and then the state uses data from the CAFAS to inform quality improvement and use of evidence-based and effective practices (e.g., Cognitive Behavior Therapy for depression).

Example: Statewide Quality Improvement Initiative

Michigan: Use data on child/family outcomes (CAFAS) to:

- Focus on quality statewide and by site
- Identify effective local programs and practices
- Identify types of youth served and practices associated with good outcomes (and practices associated with bad outcomes)
- Inform use of evidence based practices (e.g., Cognitive Behavior (CBT) for depression)
- Support providers with training informed by data
- Inform performance-based contracting

QI Initiative designed and implemented as a partnership among State, University and Family Organization

Hodges, K., & Wotring, J. 2005. State of Michigan.

Family and Youth Involvement in CQI Structures

Effective systems of care involve families and youth as partners in the development of the CQI structure, in the quality review process as reviewers and interpreters of findings, in the dissemination of CQI results, and in the development and implementation of adaptations required by CQI findings. In **Arizona**, for example, families work in partnership with staff on quality review teams for the behavioral health managed care system.

Cultural Competence in CQI Structures

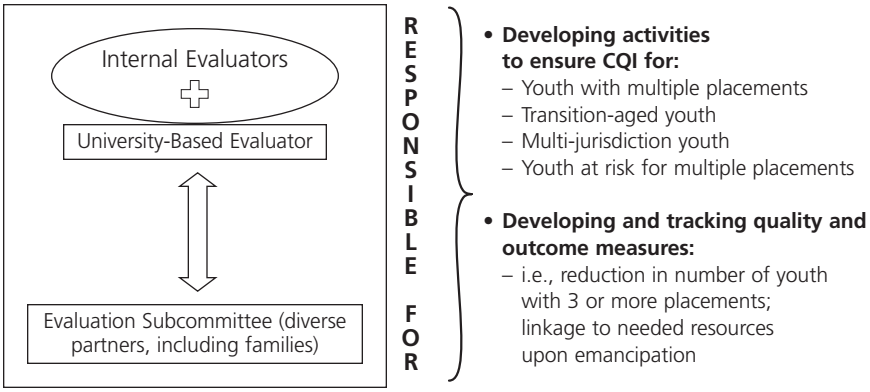
Effective system builders strive to incorporate cultural competence into their CQI structures. Historically, there have been disparities in data collection, analysis, and reporting with respect to diverse populations. Working with stakeholders from diverse communities, system builders can build data specificity for diverse populations into the system and can ensure that interpretation of data reflects the experience of diverse families. Box 2.20E describes factors that, historically, have contributed to data disparities with respect to racially, ethnically, and linguistically diverse communities.

Quality management structures in systems of care utilize a variety of data, such as utilization management data, formal evaluations, contract and performance monitoring data, management reports, grievance and appeals process data, and the like.

EXAMPLE 2.20B

Contra Costa County, California, a child welfare system of care grantee, is an example of a jurisdiction that has developed structures for utilizing data to drive quality. It formed an in-house team of "internal evaluators"; contracted with an external, university-based evaluator; and created an evaluation subcommittee representing diverse stakeholder partners, including families and youth. These entities are responsible for developing activities to ensure CQI with respect to their identified target populations, which include youth with multiple placements, transition-aged youth, multi-jurisdictional youth, and youth at risk for multiple placements. The CQI partnership has developed and is tracking quality and outcome measures specific to these populations, such as reduction in the number of youth with three or more placements and linkage of youth to needed resources upon emancipation.

Example: Utilizing Data to Drive Quality: Contra Costa County's CQI Structure



2.20E Factors Contributing to Data Disparities in Diverse Communities

FACTOR	ISSUE
Barriers for Diverse Community Participation (Individual and System Specific)	• Level of trust with the formal system of care and the perception of the process as intrusive or meaningful • Level of individual's fluency and familiarity with the English language • Level of sophistication of the system's Limited English Proficiency standards and guidelines to provide meaningful linguistic supports and compliance with Title VI of the Civil Rights Act • Availability and extent of the training provided to data collectors representatives of the predominant culture • Availability, participation, and training of bilingual and/or bicultural data collectors representatives of the communities served • Lack of formal partnerships with community-based organizations (and ISOC) that can function as "bridges" for the data collection protocol • Lack of access to services • Lack of awareness and understanding of the importance of data collection and analysis on behalf of diverse recipients of services
Framework for Understanding Community Context and Needs	• Overall relevance and applicability of the questions and tools for ethnically and racially diverse communities • Degree to which the specific questions and tools are relevant for specific communities • Level of relevance of the answers to the questions based on the context of the community and culture • Lack of understanding of diverse community characteristics and needs which may remain excluded from the data collection process and analysis
Racial and Ethnic Categories	• Adherence to the minimally defined federal ethnic and racial categories may contribute to the exclusion of specific populations from participation (or data analysis) due to their absence in the classification standards • Ethnic and racial self-reporting may influence erroneous race/ethnicity selections due to lack of comprehensive categories representative of the individual's "identity" or simply lack of knowledge on behalf of the individual
Data Collection, Analysis, and Presentation	• Aggregate data profiles exclude diverse communities from specific data analysis • Disaggregate data profiles run the risk of excluding specific populations due to small data samples or cells within the context of specific statistical analysis
Applicability of the Data	• Lack of data specificity does not allow for applicability of the results to all populations or communities • The presentation of the data may target the predominant culture ("one size fits all" approach) and is not applied to inform communities of the status of their particular cultural group • The format in which the data is presented is beneficial or detrimental to a particular subset of the population by inclusion or elimination, or by limiting the analysis of the data to specific variables that may not be as relevant within the context of disparities
Availability of Instruments and Tools	• Availability of standardized instruments with specific populations and different socio-economic levels • Availability of the instruments in different languages

Aristy, J. (2002). *Factors contributing to data disparities in diverse communities*. Washington, DC: Georgetown Child Development Center.

Evaluation

Effective systems of care use evaluation data for many reasons, including: accountability; supporting a continuous quality improvement (CQI) structure; planning and decision support; changing practice; cost monitoring; social marketing, such as getting information to the media and marketing results to legislators, the community, and others; and informing policy. Evaluation is viewed here as a larger umbrella than CQI. CQI is fundamentally a *management* mechanism to track progress, measure quality, and make adjustments as needed. Evaluation data support a CQI process but are also used for other purposes. Evaluation is especially important as a *policy* tool; that is, evaluation gauges the value or significance of the system of care as a means to guide policy at the governance level.

Box 2.20F describes examples of evaluation information reported to key stakeholders in a statewide system of care.

2.20F Evaluation Information Reported on the Contract Outcome Report

- Percentage of parents satisfied with services
- Percentage of children satisfied with services
- Percentage of collateral providers satisfied with services
- Percentage of children with improved school behavior
- Percentage of children with a history of arrest who avoided re-arrest during services
- Average change of score (difference) between CBCL scores at beginning and end of services
- Percentage of required data forms actually submitted for analysis

Rouse, L., Toprac, M., & MacCabe, N. (1998, May). The development of a statewide continuous evaluation system for the Texas children's mental health plan: A total quality management approach [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of Behavioral Health Services and Research, 25*(2).

The Importance of Participatory, Culturally Competent Evaluation

Increasingly, effective system builders are recognizing the importance of developing *participatory* evaluations in which stakeholders help to shape the focus and process of evaluation and are included in the interpretation and dissemination of results and findings. Evaluations that are structured in a way that leave key groups of stakeholders, such as families, youth, staff, providers, or diverse communities, questioning methods or results will create credibility issues for evaluators. On the other hand, evaluators in a participatory structure must be careful not to compromise objectivity.

EXAMPLE 2.20C

In a rural area in west central Florida, a group of community residents is engaged in a participatory evaluation of the development of their neighborhood system of care. Self-selected neighborhood evaluation team members participated in joint training with university researchers.

A bottom line is that evaluation needs to be viewed by stakeholders as an essential element in and connected to system building and not as some phenomenon that occurs "out there," which may or may not be useful. A criticism of the research community is that it conducts evaluations that are not useful to policy makers and practitioners; on the other hand, policy makers often do not take the time to understand the uses of evaluation as a tool to guide policy making. Effective system builders structure evaluations that make the link, pre- and post-evaluation, between the research and policy-making parameters.

Qualitative and Quantitative Data

To eliminate disparities and disproportionalities, improve access and quality of care, and achieve outcomes, system builders need to build evaluation structures that identify, collect, analyze, interpret, and disseminate both quantitative and qualitative information that is meaningful to stakeholders. Box 2.20G provides examples of how to collect data.

2.20G Examples of How to Collect Data

- Questionnaires
- Surveys
- Interviews
- Focus groups
- Clinical outcome data
- Service utilization data
- Claims data
- Network analyses
- Financial analyses (e.g., expenditure data)

The *System of Care Practice Review* is an example of a qualitative research tool to measure adherence to system of care principles at the practice level. It uses a case study methodology that relies on multiple data sources, including families and youth receiving services, to measure the fidelity of service provision to system of care principles such as being individualized and strengths based, culturally competent, family driven, and youth guided. It has been used in the national evaluation of federal system of care grantees. (See http://logicmodel.fmhi.usf.edu/SOCPR.html.)

Examples of Outcomes Measured by Systems of Care

EXAMPLE 2.20D

In **Milwaukee County, Wisconsin**, Wraparound Milwaukee reports and collects quantitative and qualitative outcome data. They then use these results to track progress, inform CQI internally, and inform legislators and others.

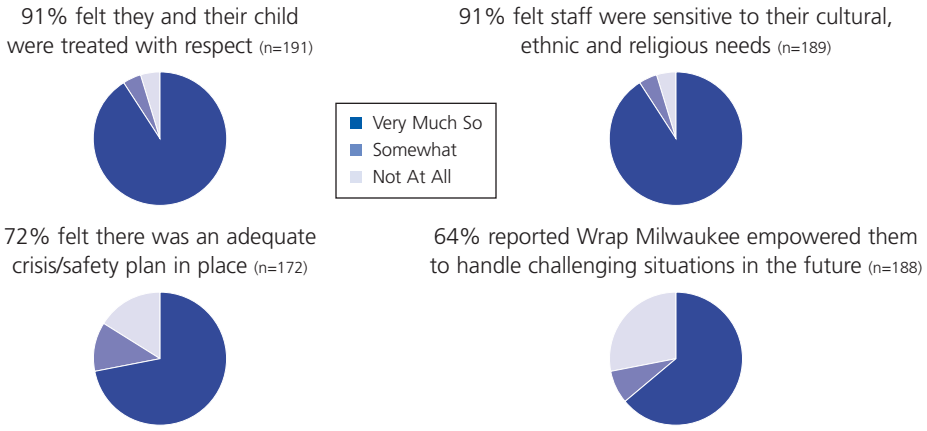
Example: Outcomes for Milwaukee Wraparound

- Reduction in placement disruption rate from 65% to 30%
- School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Decrease in average daily RTC population from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days to less than 200 days per year
- Average monthly cost of $4,200 (compared to $7,200 for RTC, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization)

Milwaukee Wraparound. 2004. Milwaukee, WI.

Example: Family/Caregiver Experience Wraparound Milwaukee

*Nearly half had previous CPS referral



EXAMPLE 2.20E

The DAWN Project in ***Indianapolis, Indiana***, also reports and collects quantitative and qualitative outcome data and similarly uses these results to track progress, inform CQI internally, and inform legislators and others.

Outcomes: Marion County, IN (DAWN Project)

- Reduced recidivism (youth are 78% less likely to return to a child-serving agency)
- Improved scores on CAFAS, CBCL, BERS
- Improved school attendance and academic performance
- 86% of families reported that services were helpful
- 82% of youth reported that services were helpful
- 86% of families reported that services reflected their family's strengths and culture

WEB RESOURCES

National Evaluation of Systems of Care at:
www.systemsofcare.samhsa.gov/programs/evalprogram.aspx and at:
www.tapartnership.org/SOC/SOCevaluatingNational.php

System of Care Practice Review at: **http://cfs.fmhi.usf.edu/tread/Misc/SOCPR.cfm**

National Technical Assistance and Evaluation Center for Child Welfare Systems of Care Grantees at:
www.acf.hhs.gov/programs/cb/tta/ntaeccwscg.htm

Key Questions: Quality Management, Continuous Quality Improvement, and Evaluation

- What are the outcomes we want to achieve? Are they clear to all key stakeholder groups?
- Do we have data systems to collect information to measure outcomes?
- What approaches have we identified to collect both qualitative and quantitative data?
- What is our structure to ensure Continuous Quality Improvement (CQI)?
- How does our CQI structure create buy-in and participation of key stakeholders, including families, youth, staff, providers, and racially, ethnically, and linguistically diverse communities?
- How does our CQI structure reflect system of care values? How is it linked to system improvement?
- How will our evaluation data be useful to system builders and funders?
- How are our evaluation data credible and meaningful?

NOTES

2.21 Information and Communications Technology

Overview

A key aspect of the strategic analysis that system builders need to address is determining how information and communications technology can be used to support the goals of the system of care. Increasingly, in health care in general as well as in systems of care, technology is being used to improve access, quality, accountability, and coordination of care. Box 2.21A provides definitions of both information and communications technology.

Information and communications technology increasingly is being used in systems of care to support system goals at service delivery, management, and policy levels.

2.21A Technology Definitions

Information technology (IT) is defined by the Information Technology Association of America as "the study, design, development, implementation, support or management of computer-based information systems, particularly software applications and computer hardware. IT deals with the use of electronic computers and computer software to convert, store, protect, process, transmit, and securely retrieve information."

Communications technology is defined by BNET as "electronic systems used for communication between individuals or groups. Communication technology facilitates communication between individuals or groups who are not physically present at the same location. Systems such as telephones, telex, fax, radio, television, and video are included, as well as more recent computer-based technologies, including electronic data interchange and e-mail."

Information Technology Systems

Effective system builders try to develop information technology (IT) systems that provide "real-time" information to support decision making and accountability. Data are needed to guide child and family service-planning teams, care managers, clinicians, and other direct service staff, to track service utilization, to measure and assess the quality and cost of care, to track outcomes, and to communicate information to key audiences, such as legislators.

How information systems are structured can make people's jobs more difficult or easier and can frustrate or support goal attainment. Staff members, for example, will buy into and use only IT systems that make sense to them. Everyone has heard stories of staff members who keep a "shadow" paper file because the IT system does not make sense to them, or they view it as unreliable, or they do not know how to use it, or it is too cumbersome to use. Families will buy into systems of care only if the information provided to them makes sense to them, which is why effective system builders enlist staff and families, providers, and agency partners in designing IT systems.

Most systems of care have to navigate existing IT systems, for example, those in child welfare, Medicaid, mental health, and often systems at both state and local levels. A goal of systems of care is to create integrated or at least compatible IT systems across child-serving agencies. That is often an enormous and time-consuming undertaking for systems of care, particularly for those that are not focusing on a total eligible population of children but on a subpopulation, such as those in or at risk for out-of-home placement, which is a much smaller number of children. In this case, the large existing IT systems may have little incentive to make substantial changes. On the other hand, systems of care that are focusing on a smaller number of children often are able to structure their own IT capability, drawing on data from the larger system. Strategic decisions have to be made about how much energy to devote to changing larger IT systems or to developing customized ones, and there are pros and cons to these decisions. Increasingly, child-serving agencies are providing care managers and other frontline staff with hand-held electronic devices to facilitate recording of interactions with families and with youth in real time to ensure more accurate service records and to reduce administrative demands on direct service staff.

EXAMPLE 2.21A

System builders in **Wraparound Milwaukee** partnered with IT specialists to design an Internet-based clinical and financial software package, called *Synthesis*, that integrates child and family team plans of care with service use data, allows providers to bill online (reducing reimbursement time from five weeks to five days), and maintains provider contract data. The IT system supports integration of cost and quality outcomes and facilitates the flexible, responsive service delivery approach that is the guiding principle of the system of care. Some 300 people—care managers, administrators, families, evaluators, and providers—use the system, which is reducing paperwork-processing time enormously. Access safeguards are built into the system. System builders use a "train the trainers" approach to build the capacity within the system of care to expand knowledge about how to use the system. **Cuyahoga County, Ohio**, is leasing *Synthesis* and receiving technical support from Wraparound Milwaukee. *Synthesis* is capable of interfacing with the child welfare system's IT system and can extract data needed for Medicaid reporting and auditing purposes.

Electronic Health Records

Increasingly in children's services, information technology is being used to support the development of electronic health/behavioral health records (EHRs) that provide the ability to send a readable medical or behavioral health record from place to place, for example, from a community mental health center to a family or from one provider to another, or from a provider to a care manager. A number of states are working on the development of EHRs that have various interoperability characteristics. Minnesota's e-Health Initiative defines interoperability of EHR as "the ability of two or more EHR systems or components of EHR systems to exchange information electronically, securely, accurately and verifiably, when and where needed."

Minnesota delineates the following types of interoperability:

- **Technical interoperability**, which means the transmitting of data accurately and securely from one point to another. It involves the infrastructure (hardware, software, and data transmission).
- **Semantic interoperability**, which speaks to the communication of the data in a way that both the sender and the receiver understand what the data mean (for example, communication in the EHR of the side effects of a particular medication)
- **Process interoperability**, which means creating the best practices between the sender and the receiver.

(See http://health.state.mn.us/e-health/index.html.)

EXAMPLE 2.21B

In **Allegheny County, Pennsylvania**, Medicaid managed care organizations providing physical and behavioral health care to Medicaid-eligible children have partnered with the child welfare system to develop an EHR that will capture information about where children are in placement and relevant contact information for caregivers and information about medical and behavioral health screens, well-child visits, and use of behavioral health services. The EHR will help the county meet the requirements of the Fostering Connections to Success and Increasing Adoptions Act of 2008, which requires child welfare systems and Medicaid to partner in developing more coordinated health access and health records for children in foster care. The EHR will make it easier for child welfare workers, managed care organization care coordinators, and families (birth, foster, adoptive, kinship, and guardian) to know what services have been provided and what services are needed and will help to prevent inappropriate utilization (e.g., use of inappropriate psychotropic medications when multiple providers are prescribing meds without communicating with one another). (**www.chcs.org**)

Increasing Use of Communications Technology

Communications technology also is an important tool to support system of care goals at the service delivery, management, and policy levels. For example, at the *policy level*, some systems of care have created Websites that capture and allow ongoing communication of policy-relevant outcomes, such as reductions in out-of-home placements, to broad audiences. At the *management level*, Web-based systems are used to communicate information about system-building activities, such as planning meetings, for training, for sharing information about system of care resources, and the like. **New Jersey**, for example, has a Web-based certification system for training stakeholders in the system of care in use of the Child and Adolescent Needs and Strengths (CANS) screening and assessment tools. Increasingly, systems of care utilize teleconferencing and videoconferencing to address management issues, such as orientation to new procedures, or, at a policy level, to share lessons learned and outcomes that have a bearing on policy change. More recent Internet communications tools, such as Facebook, Skype, and Twitter, are becoming especially useful communications technology tools for linking youth who are building youth movements in systems of care.

Growth in Telehealth

Particularly in the past decade, there has been a rapid growth in use of communications technology to support *service delivery*. The *Journal of Medical Internet Research* defines telehealth as "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, education and information across distance." Under the umbrella of telehealth could come a variety of activities at the service delivery level that are supported by technology, ranging from the simple for example, telephones, to the more complex, for example, videoconferencing or Web-based networking. Activities supported by communications technology might include, for example: hotlines; access to psychiatric or other types of behavioral health consultation, screening, assessment, and evaluation; crisis stabilization; therapy; medication prescribing and management; treatment monitoring; behavioral health promotion and education; care management; peer support; and self-help. Telecommunications, in effect, is substituting for face-to-face contacts between service providers and families and youth. With the right kinds of privacy protections, technology capability, orientation, and training of providers and families and youth alike, communications technology is becoming an increasingly effective way to increase access to services and improve efficiency. Telehealth can be used to reach populations that are isolated by distance, such as families living in rural and frontier communities, families who are isolated by language barriers, and families isolated by stigma, lack of transportation, and other barriers, for example, families in inner cities. By increasing access to care managers, crisis supports, peer supports, specialized consultations, medication management, and the like, especially for populations of children who need more frequent contact, telehealth also can help to reduce use of hospital emergency rooms and psychiatric beds and of residential treatment centers.

EXAMPLE 2.21C

Kansas is an example of a state that has utilized both telepsychiatry and telepsychology for some time through the Center for Telemedicine and Telehealth at the University of Kansas Medical Center. The Center began providing access to child psychiatric consultation for community mental health centers in remote areas of the state; expanded to include telepsychology (i.e., individual and group therapy); and expanded further to provide mental health consultation to schools, group homes, and inner-city communities in Kansas City, including urban child care programs. (**www2.kumc.edu/telemedicine**)

While Medicaid policies vary across the states, about two-thirds of the states cover some aspects of telehealth through Medicaid; however, coverage of telehealth for behavioral health services has lagged behind coverage for primary care. Box 2.21B gives an example of **Minnesota's** coverage policy for telemedicine delivery of mental health services.

Part of the strategic analysis that system builders need to conduct is to examine their particular state Medicaid telehealth coverage policies to ensure they are applicable to and being utilized for identified child, youth, and family populations. Sometimes, a state Medicaid plan may cover telehealth for behavioral health services, but low reimbursement levels frustrate providers' ability to offer these services. In addition,

provision of telehealth requires certain capital investments, such as broadband lines and videoconferencing capability, which individual providers may be unable to afford. Some states have created reciprocal agreements to allow telehealth providers from another state to operate in their states, whereas other state policies require that providers have to be licensed in the particular state. There are pros and cons to these approaches. For example, allowing telehealth providers from another state to operate within one's own state might help to improve access to these services and create economies of scale in capital start-up costs. However, providers licensed in another state may have less stringent licensing requirements, which could affect quality of care.

2.21B Telemedicine Delivery of Mental Health Services

Effective October 1, 2006, the Minnesota Health Care Plan (MHCP) covers delivery of mental health services through telemedicine.

Telemedicine delivers mental health services using two-way interactive video that can:
- Extend limited resources
- Expand the geographical area over which a mental health provider can offer direct service
- Save time and energy without compromising quality
- Allow providers and the recipient greater flexibility and increased access when delivering and receiving services
- Allow recipients to receive needed services without having to travel long distances

Eligible Recipients
Recipients are eligible to receive their mental health services via telemedicine under these circumstances:
- Telemedicine is determined medically appropriate
- Before receiving services via telemedicine, a recipient must provide his or her consent
- Recipients must be present to receive service through the telemedicine method

Eligible Providers
Providers currently authorized to provide mental health services may conduct the same services via telemedicine, **except for the following services**:
- Day treatment
- Partial hospitalization programs
- Residential treatment services
- Case management, face-to-face contact

Providers must:
- Conduct a risk analysis
- Develop a risk management plan
- Employ strategies to minimize vulnerabilities in technological equipment and systems
- Create safe and private accommodations for recipients receiving services by telemedicine
- Ensure procedures are in place to prevent system failures that could lead to a breach in privacy or cause exposure of recipient mental health records to unauthorized persons
- Use high-quality interactive video and audio communications systems and equipment
- Be prepared administratively, operationally, and technologically
- Interactive telemedicine systems must be compliant with privacy and security requirements and regulations of the Health Insurance Portability and Accountability Act (HIPAA)

Billing
- Services provided via telemedicine have the same service thresholds and authorization requirements as services delivered face-to-face.
- Bill for mental health services delivered via telemedicine with modifier GT.
- MHCP does not reimburse for connection charges or origination, set-up, or site fees.

(www.dhs.state.mn.us/dhs16_136606)

In addition to Medicaid reimbursement and licensing requirements, telehealth also has to be accepted as a viable service option by both providers and families and youth, and training and orientation for all is needed. Interestingly, growing research on telehealth, including telepsychiatry and other behavioral health services, suggests that it is comparable in outcomes to face-to-face encounters and that families find it convenient and cost effective. The major point here is that system builders need to engage in an analysis and discussion of telehealth needs and capacity in their particular states and communities to determine how best to take advantage of this growing opportunity for systems of care.

WEB RESOURCES

American Academy of Pediatrics IMPACT Children's Mental Health E-News at:
www.aap.org/mentalhealth/mh5n.html

American Telemedicine Association Telemental Health Special Interest Group at:
http://media.americantelemed.org/ICOT/sigtelemental.htm

School-based Telemental Health Services: Reaching Underserved Populations at:
www.rtc.pdx.edu/PDF/fpS0708.pdf

Telemental health in Schools at:
http://csmh.umaryland.edu/resources/CSMH/briefs/TelepsychIssueBrief.pdf

Telemental Health Guide at: **www.tmhguide.org**

Key Questions: Information and Communications Technology

- What is achievable with respect to the information technology (IT) system? Should we develop our own? Try to change existing ones? Both?
- Do we have IT systems in place to track, measure, assess, and communicate our activities?
- Do our IT systems provide us with real-time data to support more informed decision making at the service delivery, management, and policy levels?
- How are we using communications technology to support policy makers, managers, providers, families, and youth in our system of care?
- How are we using telehealth as a means to improve access to services and supports?
- How do our state Medicaid policies support telehealth delivery for behavioral health services?

NOTES

2.22 Protecting Privacy

Protecting privacy, that is, the issue of maintaining confidentiality, is sometimes raised in system building as an obstacle to a number of system goals, such as implementing interagency collaboration and cross-agency service planning, utilizing parents in staff or peer support roles, or implementing participatory evaluations. The concern expressed is that such objectives might compromise the privacy of children and families in care, and those expressing such concern often cite federal statutes such as the Health Insurance Portability and Accountability Act (HIPAA).

The issue of confidentiality is certainly an essential one; however, the types of concerns expressed above have largely proven to be red herrings. Many systems of care have found ways to maintain (indeed, some would argue, improve) confidentiality while pursuing system of care objectives like those described above. Some also have made the point that HIPAA actually provides tools that communities can use to structure information-sharing agreements. (See, for example, a monograph developed by John Petrila for the federal Center for Mental Health Services, *Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems*, at: www.gainscenter.samhsa.gov/pdfs/integrating/Dispelling_Myths.pdf.)

Effective system builders treat the issue of confidentiality as critical but not as an obstacle. They engage families, staff, and providers to develop structures to protect privacy *and* allow information to be shared across agencies, providers, and family members, who are trying to reduce fragmentation and duplication. In Boxes 2.22A and 2.22B, the Youth Law Center explores issues of confidentiality, making points that are still relevant after over a decade.

The issue of ensuring privacy is a concern for state, tribal, and local stakeholders. Local stakeholders need to be aware of state and tribal statutes governing confidentiality, and community norms and attitudes toward privacy have a bearing on structures to ensure privacy.

2.22A Confidentiality Need Not Hamper Service Coordination

1. **What information is confidential, and what is not?**
   Generally, only identifiable client information is confidential. Thus, information that does not identify particular individuals such as aggregate statistical information is typically not considered confidential. Even identifiable information, however, may be disclosed under specific circumstances. For example, federal education laws designate certain identifiable information "directory information," which may be disclosed with appropriate notice to parents.
2. **What exceptions exist to the confidentiality requirement?**
   Some statutes permit agencies to share confidential information for broadly stated purposes such as administration of the program, audits, determination of eligibility for services, and medical emergencies. Others permit disclosure of specific uses of information such as child abuse reports, health records, juvenile court records, and criminal histories. Still others specifically authorize interagency information sharing for the purpose of developing treatment programs or providing more comprehensive services.
3. **What information can be released with consent, and what are the requirements for such a release of information?**
   Virtually all statutes authorize disclosure of confidential information with the consent of the client. Such disclosure generally requires a written release signed by the legally responsible person or entity. For information pertaining to minors, it is important to know whose consent is required. Parental consent is generally both required and sufficient, unless statutes give minors capacity to consent to their own care and release of their own records. The requirements for a valid written release are often set out in statutes and may include the name of the person who is the subject of the information, the name of the person or agency who is disclosing the information, the recipient of the information, the reasons for sharing the information, the nature of the information that will be disclosed, the signature of the person giving consent, and the date the consent is signed, as well as other items. To be valid, consent to release confidential information must be "informed." The person consenting must understand what information will be disclosed and to whom and the purpose and benefits of the disclosure.
4. **What other mechanisms are available for sharing confidential information?**
   In addition to release of authorized information by written consent, many statutes authorize disclosure of information through other mechanisms such as interagency agreements, memoranda of understanding, and court orders. Again, one must be familiar with the specific requirements of these mechanisms to use them properly. A thorough understanding of confidentiality requirements is only the beginning. Individual providers must implement confidentiality rules in a manner that fosters respect for clients and their privacy.

Wilber, S. (1995). *Glass walls*. San Francisco: Youth Law Center.

2.22B Confidentiality Need Not Hamper Service Coordination

A. The Principle of Limited Information: In all agency functions, the information collected and recorded should be limited to data genuinely needed to fulfill the agency's goals. This principle is especially important for agencies with computerized data systems. Seemingly limitless computer memory capacities may encourage staff to collect and record all interesting information whether or not it relates to program goals. In some situations detailed information should not be kept in client files even though it may be relevant to the agency's work. For example, it may be sufficient to note in a client's record the fact that the client received medical care instead of recording the details of the client's medical condition. If another agency has a valid need for more information about the client's medical history, that agency can obtain a specific release for the medical information from the client.

B. Agency Gatekeeper: Many agencies designate one individual to act as the "gatekeeper" of confidential information concerning agency clients, fielding requests for confidential information. He or she might be the agency's attorney or an experienced staff member with special training. The gatekeeper's duties may include:
- Maintaining a library of confidentiality materials;
- Providing training or agency employees;
- Responding to requests for information and maintaining records of requests and responses;
- Developing forms for information requests; and
- Suggesting changes in information-management practices when appropriate.

C. Confidentiality Oaths: Several statutes require confidentiality oaths, particularly for researchers, and some agencies use these staff pledges of confidentiality. The oaths are usually written and signed. They constitute promises to use information only for designated purposes and not to disclose the information to any other person or agency unless specifically authorized.

D. Staff Training: To follow legal mandates and respect individuals' privacy rights, it is essential for agencies to establish thorough and ongoing programs of staff instruction. Staff training on confidentiality should include:
- The reasons for ensuring confidentiality of information about children and families;
- The specific client information the agency needs to collect and maintain;
- The reasons why the agency needs the information;
- The types of information the agency will share with other agencies;
- The purpose of information sharing among agencies;
- The legal provisions, particularly federal and state statutes and regulations, applicable to the agency's work;
- The importance of clearly explaining to clients why consent is essential;
- The need for sensitivity to language and cultural issues;
- The requirements of informed consent, and the necessary elements for written releases;
- Special issues that arise from the use of automated management information systems.

Wilber, S. (1995). *Glass walls*. San Francisco: Youth Law Center.

EXAMPLE 2.22

The **Montgomery County, Maryland**, Department of Health and Human Services is engaged in an effort to build an integrated service delivery model based on system of care values across the lifespan, that is, across its major divisions of aging and disability services; behavioral health; children, youth, and families; public health; and special needs housing. It has synthesized confidentiality requirements of federal and state laws into readily accessible, standardized, and short guidance sheets for its staff and providers. Guidance covers such federal laws as HIPAA, the Family Education Rights and Privacy Act (FERPA) that pertain to children in special education and Part C (early intervention) programs, and Federal Confidentiality of Alcohol and Drug Abuse Patient Records, as well as a host of Maryland state laws in such areas as child welfare and domestic violence. The Department also has developed a readily accessible guidance sheet for consumers for use department-wide explaining privacy rights, how information can and cannot be disclosed and to whom, consumers' health information rights, and information about how to file a complaint or report a problem. The Department also has developed a standard information release form and is developing computer-based training on confidentiality and consumer rights, which will have capacity to track who has been trained and who still needs training. (**www.montgomerycountymd.gov/hhs**)

WEB RESOURCES

Ethics and Confidentiality at: **www.childwelfare.gov/systemwide/ethical/confidentiality.cfm**

Critical Issue: Addressing Confidentiality Concerns in School-Linked Integrated Services Efforts at: **www.ncrel.org/sdrs/areas/issues/envrnmnt/css/cs300.htm**

Vermont's Partnership Between Domestic Violence Programs and Child Protective Services Confidentiality Series at: **http://new.vawnet.org/Assoc_Files_VAWnet/VTNetworkDV-CPSPub5.pdf**

Information Sharing and Confidentiality at: **www.hogg.utexas.edu/programs_InfoShare.html**

Key Questions: Protecting Privacy

- How do the structures we have in place protect privacy at the same time they allow for needed communication across partners?
- How do the structures we have in place respect community norms and attitudes toward confidentiality and abide by federal, state, and tribal statutes?

NOTES

2.23 Ensuring Rights

System builders need to develop structures that ensure that the rights of children and their families are protected and that stakeholders agree on what those rights are. For example, there are rights with respect to fair treatment, absence of harm, access to care that meets quality standards, treatment with respect and dignity, non-discrimination, self-determination, and the right to grievance and appeal processes without fear of recrimination. Structures to ensure the rights of children and families need to be built at both state and local levels.

Historically, neither traditional systems nor managed care systems have had stellar records when it comes to grievance and appeals processes. Criticisms of these systems are that either they are unfathomable—it is difficult to figure out how they work—or they take so long that they discourage people from using them, or they create a perception (and perhaps reality) that there will be recriminations if families use them. Obviously, grievance and appeals processes structured in such a way will create tensions among stakeholders and diminish system of care credibility. *System builders affirm that children and families have rights by being very clear about what those rights are and by structuring grievance and appeals processes that are understandable, efficient, fair, and tied to quality improvement processes*. Another strategy that systems of care use is to connect families and youth to peer mentors who can help them navigate grievance and appeals processes and resolve issues.

With rights also come responsibilities, and effective systems of care articulate the responsibilities of youth and families, for example, the responsibility to treat others with respect, to observe program guidelines, and the like. Providers and staff also have rights and responsibilities. Again, effective system builders articulate these and create structures to allow for grievances to be aired and appeals to be heard.

Box 2.23 provides an example of language that describes member (i.e., consumer) rights and responsibilities in a managed care system.

2.23 Member Rights and Responsibilities

The contractor must provide and organize services so that the member's rights are protected and respected. The contractor must inform each member, its personnel, and subcontractor and/or provider staffs of these rights. **The member has the right to:**

1. Be free from mental, emotional, social, and physical abuse, neglect, and exploitation.
2. Have medical and other records kept confidential and released only with the member's or the member's legal guardian's permission or in accordance with applicable law.
3. Understand the plan of care and services to be provided, including the names of subcontractors and/or providers.
4. Participate in the development, implementation, and review of the plan of care.
5. Know the name and professional background of anyone who is providing a service.
6. Receive benefits or services regardless of race, color, sex, national origin, handicap, or disability.
7. Require all subcontractors and/or providers to present positive identification before allowing them in the member's home or residence.
8. Have privacy protected.
9. Refuse to receive or participate in any service or activity once the potential consequences of such refusal have been explained.
10. File a complaint or grievance without fear of reprisal.
11. Be in control of time, space, and lifestyle to the extent that the member's health, safety, and well-being are not jeopardized.
12. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality.
13. Make and act upon decisions (except those decisions delegated to a legal guardian) as long as the health, safety, and well-being of the member are not endangered.
14. Designate or accept a representative to act on the member's behalf.
15. Not be required to purchase additional services that are not covered by the project.
16. Not be charged for additional services unless prior written notice is given to the member.
17. Make an advance directive including the right to appoint an agent to make medical treatment decisions on his or her behalf if the member becomes incapacitated.
18. Have access to medical and other records with 72-hour notice.

The member has the following responsibilities:

1. To consult the case manager on changes in residence, caregiver, legal guardian, or other situations that directly affect the member's independence or quality of life.
2. To maintain project eligibility and to notify the project of any changes that may affect such eligibility.
3. To respect subcontractor and provider property that is placed in the member's residence for use by the member or caregiver.
4. To tell the case manager if the member does not understand the plan of care or services included in the plan of care.
5. To keep the project informed of all insurance coverage.
6. To cooperate with subcontractors and/or providers nor in any way interfere with the subcontractor and/or provider performing assigned duties and responsibilities.
7. To not abuse any subcontractor and/or provider performing assigned duties and responsibilities.

Van Dyk, D., & Halverson, C. (2000). *Piloting the health and home program for frail, elderly, long-term Medicaid patients*. Princeton, NJ: Center for Health Care Strategies.

WEB RESOURCES

North Carolina Infant-Toddler Program Notice of Child and Family Rights at:
www.ncei.org/ei/pdf/NoticeofRightsCondensed.pdf

Protecting Consumer Rights in Public Systems at:
www.eric.ed.gov/ERICWebPortal/recordDetail?accno

Key Questions: Ensuring Rights

- How have we clearly articulated the rights and responsibilities of families and youth as well as of providers and staff?
- Have we structured a grievance and appeals process that is understood, efficient, and fair? How do we know?
- How does our grievance and appeals process relate to our quality improvement structure?

NOTES

2.24 Transportation

Effective system builders recognize that both staff and families and youth in systems of care have transportation needs. For example, how will care managers transport themselves and families? Will they use their own cars and be reimbursed for mileage? Will they use agency vehicles, public transportation, or taxis? How will transportation be provided to families and youth who need transportation help? Will they be given vouchers? Will there be a system of care van? How will transportation be handled for sending families, youth or staff out of town for training or conferences and the like?

Transportation is an issue particularly, though not solely, for inner city families and for staff and families and youth in rural communities. Systems of care that fail to deliberately organize, that is, structure, a response to transportation needs frustrate the ability of staff to do their jobs well and the ability of families and youth to use services and involve themselves in system activities. *There is no one right way to organize transportation in systems of care, but it is incumbent upon system builders to identify transportation issues and structure a systemic response to them.*

Transportation resources may be available through Medicaid, TANF (Temporary Assistance to Needy Families), protection and advocacy programs, schools, family resource centers, health agencies, and community, civic, and faith-based organizations, among others. These resources may not be sufficient to the need, but they are worth exploring. In some communities, systems of care pay family organizations to provide transportation for families and youth. Some systems of care also have obtained transportation resources through civic associations, businesses, and local foundations.

WEB RESOURCE

Operating a Program that Provides Transportation to Low-income Families at:
www.nationalserviceresources.org/node/17241

Key Questions: Transportation

- What are our policies and procedures with respect to transportation? For staff? For youth and families?
- Have we identified community resources and other agencies to augment transportation capacity?

NOTES

2.25 System Exit

System exit has to do with the structures that are put in place for follow-up and aftercare.

These may include linkage to parent and youth support networks, connection to natural supports in the community, periodic respite services, periodic "base touching" by care management staff, youth group activities, and the like. Follow-up also may entail involving families and youth who have experienced the system as resources for the system, for example, as peer mentors, on policy bodies, as members of quality improvement committees, and the like. Follow-up services and supports, as well as ongoing involvement in the system of care as resources, can help families and youth to feel less isolated, can help to prevent deterioration in child and family well-being, and can ease the transition out of the system of care. Linkage to follow-up services and supports also can help to reduce long-term dependency on the system of care. Effective system builders structure follow-up and aftercare approaches that are supportive but non-intrusive and cost effective.

WEB RESOURCE

Families, Juvenile Justice and Children's Mental Health "'Intensive Aftercare' in Juvenile Corrections: The Colorado Experience" at: **www.rtc.pdx.edu/pgFPS97TOC.php**

Key Questions: System Exit

- How have we structured follow-up and aftercare supports for families and youth?
- How have we created opportunities for families and youth to remain involved in the system of care as resources to other families and youth?

NOTES

2.26 Technical Assistance and Consultation

Effective system builders utilize consultants and technical assistance (T.A.) *strategically and for a variety of different purposes*. The following provides a loose taxonomy for the various purposes of T.A. and consultation:

- **Technical Assistance:** provision of specialized, practical knowledge on a particular aspect of system building, for example, on maximizing federal revenue or on partnering with parents or youth.
- **Consultation:** providing advice and opinions.
- **Coaching or Mentoring:** acting as "trusted guide," providing direction, prompting, and instruction.
- **Facilitation:** providing support to system-building processes such as a stakeholder planning process.
- **Persuasion:** acting as "provocateur" or "national expert" when systems are stuck or when local system builders cannot carry the message themselves, sometimes simply because it is difficult to be a "prophet in one's own land."
- **Training:** teaching and skill building to prepare or qualify trainees to perform as required.

There is a certain blurring of boundaries across these areas, but at the least it may help system builders think about the kinds of support needed, for whom, and at what stages of development.

Effective system builders try to avoid lurching from one T.A. demand or encounter to another, but instead create a structure for identifying and responding to requirements for outside support. The structure needs to be flexible, take into account strengths and needs across system features and stakeholders, and make connections among all of these. For example, the parent coordinator may identify a need for T.A. related to engaging parents in system building at all levels. At the same time, system builders have identified a need for training of clinicians on conducting strengths-based assessments and on partnering with families in developing individualized service and support plans of care. On the one hand, T.A. is needed; on the other, training—but they are related to each other. The training related to clinicians' skills, attitudes, and knowledge can have an impact on the engagement of parents systemwide. The T.A. provided to the parent coordinator on engaging parents systemically can have a bearing on the readiness and capacity of families to partner in the service-planning process. There needs to be a coordinated T.A. approach, not one in which various consultants and trainers are operating independently without understanding the broader strategy.

Effective system builders also think strategically about the **uses of national, local, and peer** T.A. resources. There are pros and cons to all. National consultants bring knowledge and experience from having worked in multiple states and local communities and can bring a needed "national perspective." However, they may be less intimately knowledgeable about the local system, and it may not be possible, for reasons of time, money, and travel, for the national consultant to be involved closely over a sustained period of time. Local consultants may have the advantage of being more available and perhaps more knowledgeable about local dynamics. Also, it is a worthwhile goal to build local T.A. capacity. However sometimes, precisely because they are more intimately involved, local consultants may carry "baggage" that makes it difficult for system builders to use them or throws into question their objectivity. Peer T.A. providers, that is, colleagues working in other systems of care, often bring very practical knowledge and the perspective of those who have "walked in the same shoes." However, peer consultants also may be limited by their knowledge of only their own system, be unable to "translate" from their own system to another and, because they are working in other full-time roles, may be available for only brief or periodic consultation.

She was a local child welfare director; how can she possibly be objective?

We need a national perspective to shake things up.

We need local T.A. capacity.

Following is Illustration 2.26, which shows peer T.A. activities.

Effective system builders at both state and local levels tend to use all types of T.A. and consultation, drawing on national, local, and peer resources. Some system-building efforts, such as the Casey Foundation's Urban Mental Health Initiative, have used a team approach to T.A., combining the skills and knowledge of both national and local T.A. providers and promoting greater coordination and synergy across T.A. efforts. Other systems of care, such as the federal Center for Mental Health Services grantee sites, have developed T.A. plans as part of their overall strategic planning effort. The important point is that T.A. and consultation, like other system of care functions, needs to be structured.

ILLUSTRATION 2.26

JURISDICTION	SUBJECT	IMPACT
1. Community and neighborhood-based service delivery to achieve outcomes for children and families.		
Jefferson County, Kentucky, consulting with Stark County, Ohio	Developing a neighborhood-based strategy for providing supports and services to children and families.	Helped Stark County redesign their school-based services initiative using Kentucky's Neighborhood Place and Family Resource Center model.
Santa Barbara and San Diego Counties, California (teams from each consisting of county staff, schools, and parents)	Involving parents in planning for system reform. Creating cross-system professional development program.	San Diego immediately involved parents in its cross-system professional development program as participants and planners. Santa Barbara developed a cross-agency training program.
2. Innovative financing strategies		
New Jersey, New York, Vermont, and Missouri Depts. of Mental Health and Child Welfare Services	Integrating behavioral health and child welfare services in a managed care environment.	Developed a working paper on *Meeting the Mental Health Needs of Children: Integrating an Approach to Managed Care*. Monthly telephone calls among the four states continue as they work on issues collectively.
Cross-systems teams of state and local staff from Michigan, Missouri, and Vermont	Determine what the key opportunities and challenges are to creating public sector managed care plans that complement and work with local governance boards.	A paper was developed which clarifies the challenges and opportunities, and suggests ways that local governance boards can become involved in managed care planning and implementation.
3. Strategies to link schools with other human services and community supports in order to improve students' school success		
Grady Health System of Atlanta, Georgia, and Mt. Sinai Medical Center of New York City	Learning how a large institutional medical system can work better for adolescents. How can teenage pregnancy be prevented through the use of an abstinence-based program?	Grady Health System has built a new Adolescent Reproductive Health Center, using many of the principles learned from Mt. Sinai.
The School District of Philadelphia and the San Diego Unified School District	How to meet students' and families health and social services needs within a school environment.	Both Districts have developed more responsibility to schools and school clusters to use their resources to support student health and social services. Philadelphia increased its use of "blended funding" for student support services.
4. Developing comprehensive community care to meet the mental health needs of children and their families		
Vermont Department of Mental Health with Kansas Keys Consulting (a parent advocacy group)	Developing and sustaining local family advocacy networks on behalf of children with emotional problems.	Family advocates will be added to Vermont's community mental health centers.
Stark County, Ohio, consulting with Jefferson County, Kentucky	Successful models of governing and financing an integrated, family-centered approach to mental health service delivery.	Developed specific recommendations for Jefferson County to link finance and program staff and to build sustainable funding for mental health services. Tools developed include a financing matrix, IV-E fiscal plan, and Family Treatment Plans to track pooled funds.

Center for the Study of Social Policy. (1998, December). *Learning from colleagues: The experience of the peer teaching assistance network*. Washington, DC.: Author.

WEB RESOURCES

Welfare Peer Technical Assistance Network at: **www.peerta.acf.hhs.gov**

Peer Technical Assistance in Children's Services at:
www.cssp.org/major_initiatives/peer_tech_asst.html

Peer Technical Assistance Casey Family Programs at:
www.casey.org/Resources/Initiatives/PeerTA

Early Childhood Peer Technical Assistance Network at:
http://ncadi.samhsa.gov/promos/sess/technical.html

Key Questions: Technical Assistance

- How are we building technical assistance (T.A.) and consultation into our system?
- How are we being strategic about our use of national, local, and peer resources?
- How is T.A. across our system of care coordinated for maximum effect?
- Is our structure for T.A. flexible but comprehensive?
- What are the qualities of the T.A. or consultation that have made it effective?

NOTES

III The System-Building Process

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III. The System Building Process

Core Elements of an Effective System-Building Process

This section of the *Primer* focuses on the *process* of system building. Process has to do with *how*, that is, the manner in which, system builders proceed—whom they involve, the relationships they establish, how they conduct themselves, and so forth. From analyzing systems of care around the country, a number of observers have identified certain core elements that are essential to an effective system-building *process*.* These elements include at least those listed below, though, undoubtedly, there are others, some yet to be identified. For purposes of discussion, the *Primer* groups these elements under three broad headings: *The Importance of Leadership and Constituency Building; The Importance of Being Strategic*; and *The Importance of an Orientation to Sustainability*. These groupings obviously are related because effective leaders are strategic, strategizing effectively requires leadership on many different fronts at state, tribal, and local levels, and strategic leaders pay attention to sustainability (and growth) of the system of care from the start.

The Importance of Leadership and Constituency Building

- A Core Leadership Group
- Evolving Leadership
- Leadership Across Stakeholder Groups
- Effective Collaboration
- Meaningful Partnership With Families and With Youth
- Cultural and Linguistic Competence
- Connection to Neighborhood Resources and Natural Helpers
- Bottom Up and Top Down Approach
- Effective Communication Vehicles
- Conflict Resolution, Mediation, and Team-Building Mechanisms
- A Positive Attitude

The Importance of Being Strategic

- A Strategic Mindset
- A Shared Vision Based on Common Values and Principles
- A Clear Population Focus
- Shared Outcomes
- Community Mapping—Understanding Strengths and Needs
- Understanding and Changing Traditional Systems
- Understanding of the Importance of "De Facto" Mental Health Providers (e.g., Schools, Primary Care Providers, Child Care Providers, and Head Start)
- Understanding of Major Financing Streams
- Connection to Related Reform Initiatives
- Clear Goals, Objectives, and Benchmarks
- Catalyst Mechanisms—Being Opportunistic
- Opportunity for Reflection
- Adequate Time

*I remain indebted to Ira S. Lourie, M.D., for his contributions to this section. Much of his thinking about core process elements in system building is reflected in his book, *Principles of Local System Development*. There are many other valuable resources concerning process, a number of which are referenced throughout this section. (See: Lourie, I. (1994). *Principles of local system development*. Chicago: Kaleidoscope.)

The Importance of an Orientation to Sustainability**

- Infusing System of Care Into Traditional System Policies, Operations, and Practices
- Cultivating Leaders and Champions
- Partnership Between States and Localities and States and Tribes
- Training, Coaching, and Capacity Building
- Attention to Financing Strategies for the Long Haul
- Outcome Data
- Generating Broad Support and an Advocacy Base
- Adaptability

As noted earlier, a great deal has been written already about these elements of an effective system-building process. In deference to the body of work that does exist, this section of the *Primer* provides brief explanations about each of these elements along with suggested resources.

**The work of Beth A. Stroul and her study with Brigitte Manteuffel on the sustainability of federally funded system of care grant communities has reinforced and expanded upon many of the principles described in the original *Primer*. This section incorporates findings from that study. See: Stroul, B. A., & Manteuffel, B. (2008). Sustaining systems of care. In B. A. Stroul & G. M. Blau (Eds.), *The system of care handbook*. Baltimore, MD: Paul H. Brookes Publishing.

The Importance of Leadership and Constituency Building

A Core Leadership Group

Someone has to start and keep the ball rolling in system building. Core group leadership members come from the constituencies that are affected by, and have a vested interest in, system of care building such as family members and youth, neighborhood and community representatives, state and local officials and agency heads and staff, providers, advocates, funders, professional organizations, university researchers, union representatives, and legislative body representatives. The core leadership group may start out small and grow over time, or vice versa. The more a core group has "the five Cs"—*constituency* representativeness, *credibility* within the community, *capacity* to engage other stakeholders, *commitment* to the difficult work of system building, and *consistency* in vision and message—the more effective it will be (see Box 3.1). Also, effective core group leadership needs to exist at all levels—state, tribal, and local. A core leadership group does not mean that the same people necessarily make up the same core group over time, but that there is a core leadership group over time conveying the same system of care vision.

3.1 The 5Cs of Core Leadership

Constituency (representativeness)

Credibility

Capacity

Commitment

Consistency

Pires, S. (2009). *The 5Cs of core leadership*. Washington, DC: Human Service Collaborative.

Evolving Leadership

Successful system-building processes tend to draw on different leadership styles at different developmental periods. Initially or during periods when system building becomes stalled, the charismatic, visionary leadership style often dominates. In a developing system, the facilitative leadership approach of "giving away power," of empowering others to share leadership responsibilities, may prevail. In a maturing system, the leader with strong management skills may hold sway. There are no right or wrong leadership styles among these in and of themselves—only timing and task make them so—and *all* are needed in system building. Successful system builders pay attention to the types of leadership styles that are needed at different developmental stages throughout the process and draw on leaders from across their stakeholder groups to provide the types of leadership needed.

Nearly a decade ago, Phyllis Magrab, one of the first to address the issue of leadership in systems of care, pointed out that the type of "connective leadership" needed in system building recognizes that leadership "embraces all varieties of behavior" and "combines many strategies to achieve goals." She notes that "critical to the model is the issue of timing, choosing the appropriate behavior for the specific moment." Connective leaders, she notes, "use themselves as versatile leadership instruments." Magrab also pointed out that leadership for systems of care requires a shift in the leadership paradigm from independence to interdependence and from competition to collaboration. (Magrab, P. (1999). The meaning of community. In R. Roberts & P. Magrab (Eds.), *Where children live: Solutions for serving young children and their families*. Stamford, CT: Ablex Publishing Corporation.)

Leadership Across Stakeholder Groups

Successful systems of care strive to develop leadership and share leadership across stakeholder groups. Parent and youth leaders, state leaders in both executive and legislative branches, tribal leaders, local leaders, judicial leaders, provider leaders, community leaders, and leaders among natural helpers—all are important to the growth of systems of care.

WEB RESOURCE

Georgetown University Center for Child and Human Development Leadership Academy at:
http://gucchdtacenter.georgetown.edu/Activities/Leadership_Academies.html

KEY QUESTIONS

- Is our leadership representative, credible, and committed?
- How have we ensured that our leaders have the capacity (e.g., skills, technologies, resources, and knowledge) to lead effectively?
- Are we paying attention to the types of leadership we need at various stages of development?
- How are we developing leadership across stakeholder groups?

NOTES

Effective Collaboration

Collaboration is at the heart of system building. Children, youth, and families depend on multiple agencies, providers, community supports, and funders, as well as their own internal resources. When one hand does not know what the other is doing, inefficiencies, frustration, and ultimately poor outcomes result at both system and service levels. Building systems of care requires resources from across agencies and among partners. Without collaboration, effective system building cannot occur. As discussed in the *Introduction* to the *Primer*, the non-categorical approach that is an essential characteristic of systems of care requires effective collaboration. *Collaboration for the sake of collaboration, however, can be just as destructive to system building as no collaboration. Effective collaboration has a purpose and concrete objectives, which change over time.*

Effective collaboration does not just occur because stakeholders are well meaning. It takes time, energy, and attention to relationship building, trust building, capacity building, team building, conflict resolution, mediation, development of a "common language," and communication. Box 3.2 offers guidance for collaboration.

3.2 Principles to Guide Collaboration

- Build and maintain trust so collaborative partners are able to share information, perceptions, and feedback and work as a cohesive team
- Agree on core values that each partner can honor in spirit and practice
- Focus on common goals that all partners will strive to achieve
- Develop a common language so all partners can have a common understanding of terms such as "family involvement" and "culturally competent services"
- Respect the knowledge and experience each person brings
- Assume best intentions of all partners
- Recognize strengths, limitations, and needs; and identify ways to maximize participation of each partner
- Honor all voices by respectfully listening to each partner and attending to the issues they raise
- Share decision making, risk taking, and accountability so that risks are taken as a team and the entire team is accountable for achieving the goals

Stark, D. (1999). *Collaboration basics: Strategies from six communities engaged in collaborative efforts among families, child welfare, and children's mental health*. Washington, DC: Georgetown Child Development Center, National Technical Assistance Center for Children's Mental Health.

Box 3.3 describes challenges to collaboration identified by **Wraparound Milwaukee** and offers their strategies to meet these challenges.

3.3 Challenges to Collaboration/"Barrier Busters"

CHALLENGE	BARRIER BUSTERS
Language differences: Mental health jargon vs. court jargon	• Cross training • Share each other's turf • Share literature
Role definition: "Who's in charge?"	• Family driven/accountability • Team development training • Job shadowing • Communication channels • Share myths and realities
Information sharing among systems	• Set up a common data base • Share organizational charts/phone lists • Share paperwork • Promote flexibility in schedules to support attendance in meetings
Addressing issues of community safety	• Document safety plans • Develop protocol for high-risk kids • Demonstrate adherence to court orders • Maintain communication with District Attorneys • Myths of "bricks and mortar"
Maintaining investment from stakeholders	• Invest in relationships with partners in collaboration • Share literature and workshops • Track and provide meaningful outcomes
Sharing value base	• Infuse values into all meetings, training, and workshops • Share documentation and include parents in as many meetings as possible • Strength-based cross training • Develop QA measures based on values

Wraparound Milwaukee. (1998). *Challenges to collaboration/"barrier busters."* Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.

RESOURCES FROM THE ORIGINAL PRIMER

Hodges, S., Nesman, T., & Hernandez, M. (1999). Promising practices: Building collaboration in systems of care. In *Systems of care: Promising practices in children's mental health* (1998 series) (Vol. 6). Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practice.

Mattesich, P., & Monsey, B. (1992). *Collaboration: What makes it work. A review of research literature on factors influencing successful collaboration*. St. Paul, MN: Wilder Foundation.

Melaville, A., & Blank, M. (1993). *Together we can: A guide for crafting a profamily system of education and human services*. Washington, DC: Government Printing Office.

Stark, D. (1999). *Collaboration basics: Strategies from six communities engaged in collaborative efforts among families, child welfare, and children's mental health*. Washington, DC: Georgetown Child Development Center, National Technical Assistance Center for Children's Mental Health.

Winer, M., & Ray, K. (1994). *Collaboration handbook: Creating, sustaining and enjoying the journey*. St. Paul, MN: Wilder Foundation.

WEB RESOURCES

Child Welfare Information Gateway Guiding Principles for Systems of Care: Interagency Collaboration at: **www.childwelfare.gov/systemwide/reform/soc/history/interagency.cfm**

National Indian Child Welfare Association Child Behavioral Health Collaboration Initiatives at: **www.nicwa.org/projects_initiatives**

KEY QUESTIONS

- What can we do to improve collaboration?
- Does our collaboration have a concrete purpose tied to goals?

NOTES

Meaningful Partnership With Families and With Youth in System Building Processes

The family movement in the children's mental health arena early on adopted the maxim: *"Nothing about us without us."* Recognition of the importance of youth voice has grown sufficiently that youth, too, rightfully echo the same sentiment. The system-building process that fails to develop a meaningful partnership with the constituencies that will depend upon the system is inherently suspect and limited in its capacity to build an effective system. *Meaningful partnerships with families and with youth require concerted attention, dedicated resources, and capacity building across all parties*. Box 3.4 summarizes some of the critical elements involved in developing effective processes to build and grow partnerships with families and with youth.

3.4 Partnership Involves

- Team Building
- Communication
- Negotiations
- Conflict Resolution
- Leadership Development
- Mutual Respect
- Skill Building
- Information Sharing

WEB RESOURCES

Family Involvement at: **www.tapartnership.org/content/familyInvolvement/default.php**

Family Involvement in Public Child Welfare Driven Systems of Care: A Closer Look at:
www.childwelfare.gov/pubs/acloserlook/familyinvolvement

Family Involvement in Managed Care Systems at:
http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/issues/issue_06/6_I_familyInvolvement.pdf

Family Engagement: A Web-Based Practice Toolkit at:
www.hunter.cuny.edu/socwork/nrcfcpp/fewpt/introduction.htm

Youth Involvement in Systems of Care at:
http://systemsofcare.samhsa.gov/headermenus/docsHM/youthguidedlink.pdf

Youth Involvement Resources at:
www.tapartnership.org/content/youthInvolvement/resources.php

KEY QUESTIONS

- How strong are our partnerships with families within our system-building process? With youth?
- Have we explored multiple avenues for strengthening our partnership-building processes?
- Do we have resources dedicated to partnership strengthening?

NOTES

Cultural and Linguistic Competence in System Building Processes

Effective system of care processes respect, and make every effort to understand and be responsive to, cultural and linguistic differences. Typically, systems of care are serving children and families from diverse racial, ethnic, and socioeconomic backgrounds. The recognition of this undergirds the principle and practice of individualizing services and supports. In addition, every family has its own culture, and youth culture is distinctive in its own right.

In addition to recognizing that all children, youth, and families bring a unique cultural background with them, effective systems of care also acknowledge and address proactively the disparities in access and treatment that historically have been the experience of diverse families in traditional systems. One would be hard pressed to find a state or locality in the country in which ethnically, racially, and linguistically diverse children and families are not overrepresented in the most restrictive, "deep-end" services and underrepresented in quality community-based services. This disparity tends to be the case even in states and communities with relatively few racial and ethnic minority families.

For effective system-building processes, system leaders must pay attention to the impact of culture, ethnicity, race, gender, sexual orientation, and class within the process itself, as well as to how systems operate and the ability of families and youth to access and use services. In addition, successful system leaders draw on a variety of approaches and strategies employed on an ongoing basis to build cultural and linguistic proficiency into the system of care.

Box 3.5 articulates elements of cultural competence in systems of care.

3.5 Core Elements of a Culturally Competent System of Care

- Commitment from top leadership
- Willingness to conduct an organizational self-assessment
- Needs assessment and data collection
- Identification and involvement of key diverse persons in a sustained, influential, and critical advisory capacity
- Development of mission statements, definitions, policies, and procedures reflecting the values and principles
- Development of a strategic plan
- Commitment to recruitment and retention of diverse staff
- Commitment to training and skill development
- Development of certification, licensure, and contract standards
- Targeted service delivery strategies
- Development of an internal capacity to oversee and monitor the implementation process
- Evaluation and research activities that provide ongoing feedback about progress, needs, modifications, and next steps
- Commitment of agency resources (human and financial)

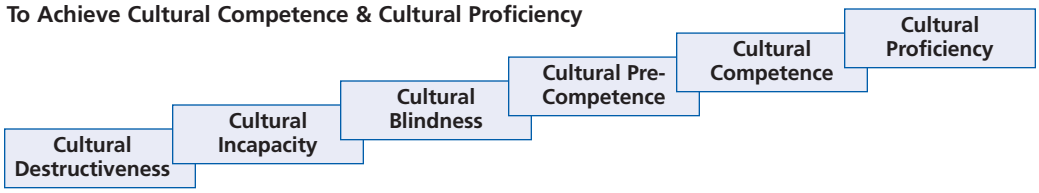
Isaacs, M., Benjamin, M., et al. (1989-1998). *Towards a culturally competent system of care* (Vols 1-3). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Achieving cultural competence in systems of care is developmental; that is, it does not simply happen overnight. It requires concerted attention over time and clear designation by system leaders that it is a priority. Box 3.6 illustrates the cultural competence developmental continuum as applied to health care organizations striving to achieve cultural proficiency.

3.6 Cultural Competence Continuum

Cultural competence at the organizational and individual levels is an ongoing developmental process. The following chart is designed to highlight selected characteristics that organizations may demonstrate along two stages of the cultural competence continuum. These characteristics have been adapted and expanded from original work of Cross et al.

Selected Characteristics of Health Care Organizations Striving To Achieve Cultural Competence & Cultural Proficiency



Cultural Competence

- Create a mission statement that articulates principles, rationale, and values for culturally competent service delivery.
- Implement policies and procedures that support practice models that incorporate culture in the delivery of services.
- Develop structures that allow consumers and other community members to plan, deliver, and evaluate services.
- Implement policies and procedures to recruit, hire, and maintain a diverse and culturally competent workforce.
- Provide fiscal support and incentives for improving cultural competence at the board, program, and staff levels.
- Dedicate resources to conduct organizational self-assessment.

Cultural Proficiency

- Continue to add to the knowledge base of culturally and linguistically competent practice by conducting research and developing new treatments, interventions, and approaches for health education.
- Employ staff and consultants with expertise in culturally and linguistically competent health care practice, health education, and research.
- Publish and disseminate promising and proven health care practices and interventions and health education materials.
- Pursue actively resource development to continue to enhance and expand the organization's current capacities.
- Advocate with and on behalf of individuals, children, and families from traditionally underserved populations.
- Establish and maintain partnerships with diverse constituency groups, which span the boundaries of the health care arena.

Cohen, E., & Goode, T. (1999, Winter). *Rationale for cultural competence in primary health care* (Policy Brief No. 1). Washington, DC: Georgetown University Child Development Center, National Center for Cultural Competence.

Valuing diversity is a key principle of systems of care. In addition, it should be noted that federal law, Title VI of the Civil Rights Act of 1964, prohibits discrimination on the basis of national origin and also applies in cases where individuals with limited English proficiency (LEP) have trouble accessing services because of language barriers. The federal government has issued policy guidelines to federally funded health and social services providers on how to comply with Title VI, including the issue of linguistic access to services (Executive Order 13166 of The President of the United States. [Improving Access to Services for Persons with Limited English Proficiency] 65 C.F.R. 50, 121 (Aug. 16, 2000); U.S. Department of Health and Human Services, Office for Civil Rights. [Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency] 65 C.F.R. 52, 762 (Aug. 30, 2000); U.S. Department of Justice, Civil Rights Division. [Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons With Limited English Proficiency; Policy Guidance] 65 C.F.R. 50, 123 (Aug. 16, 2000)).

RESOURCES FROM THE ORIGINAL PRIMER

Isaacs, M., Benjamin, M., et al. (1989-1998). *Towards a culturally competent system of care* (Vols. 1-3). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

U.S. Department of Health and Human Services. (2000). *Mental health: Culture, race, and ethnicity*. [A Supplement to Mental Health: A Report of the Surgeon General]. Washington, DC: Author.

WEB RESOURCES

Cultural and Linguistic Competence at: **http://gucchd.georgetown.edu/64269.html**

Planning for Cultural Competence in Systems of Care at:
www.dhhs.state.nc.us/MHDDSAS/childandfamily/soctoolbox/toolbox-iv/iv-planning-cultural_lingusticcompetence.pdf

Guiding Principles for Systems of Care: Cultural Competence at:
www.childwelfare.gov/systemwide/reform/soc/history/principles.cfm

KEY QUESTION

- How does our system-building process respect and address issues of ethnicity, race, class, gender, and sexual orientation to ensure a culturally and linguistically competent and ultimately proficient system of care?

NOTES

Connection to Neighborhood Resources and Natural Helpers

Successful systems of care blend formal services and natural supports, helping youth and families to access and make use of both. Natural supports are those found within the neighborhoods in which youth and families live and within the affinity groups with which they associate (or would associate if they existed). Natural supports include people such as natural helpers, organizations such as faith-based organizations and parent associations, programs such as mentoring, and activities such as parent support and educational activities.

Families and youth are the best definers of natural supports that make or could make a difference in their lives. They are a critical voice in defining the supports that need to be available systemically and those that need to be integrated within their own individualized plans of care. Use of natural supports is essential to achieve quality, efficacy, and cost outcomes, particularly for families who have children with serious disorders and for poor, inner-city, and rural families who often feel isolated and for whom clinical services are especially in short supply. A connection to neighborhood resources and natural helpers also is critical to incorporate cultural competence into system building processes. Successful system builders ensure that natural helpers and providers of neighborhood resources and supports are engaged in the system-building process. This endeavor requires leadership across stakeholder groups at neighborhood, local (e.g., city and county), tribal, and state levels.

Box 3.7 describes the types of support that natural helpers can provide in a system of care.

3.7 What Natural Helpers Can Provide

Natural helpers can provide many types of help. Arbitrarily, we have categorized this help into five areas: skill building, emotional support, community leadership and network, resource acquisition, and concrete help.

Some natural helpers (and some professionals) have assets in all five areas, but people who are strong in only one or two areas still can make important contributions. These examples are presented to help people think outside the box of traditional service delivery and to recognize the wealth of resources that can be drawn upon to help families help themselves.

Examples of Skills Building

- Helping others recognize their strengths, see a future, and set and reach measurable goals
- Helping others keep family members safe
- Helping others strengthen relationships
- Helping others learn to get and keep goods and services: transportation, housing, legal assistance, child care/baby-sitting, employment, food and clothing, financial aid, furniture and household goods, medical and dental services, toys, recreational equipment, and recreational opportunities
- Serving as a role model
- Helping others exercise their rights and responsibilities
- Teaching professionals how better to help

Examples of Providing Emotional Support

- Listening, being available, spending time
- Providing positive regard, without judgment
- Avoiding gossip and manipulation
- Addressing issues of isolation by being bridges and confidants

Resource Acquisition

- Providing information about where to find transportation and housing
- Providing help in dealing with landlords, installment sellers, and loan sharks
- Providing help in getting good deals on items: trading with junk dealers, hock shops, informal food and clothing banks, etc.

Concrete Help

- Babysitting
- Fixing things
- Cleaning up junk
- Gardening

Bruner, C., et al. (1999). *Wise counsel: Redefining the role of consumers, professionals and community workers in the helping process.* Des Moines, IA: Child and Family Policy Center.

EXAMPLE 3.1

In Latino and African American communities in the Southeast, neighborhood residents partner with formal providers in a service delivery model that integrates natural helpers. Both providers and residents participate in training to learn how to partner and to establish the roles and responsibilities of each. Natural helpers provide outreach, emotional and basic support, information, and linkage to formal helping systems in the model.

RESOURCES FROM THE ORIGINAL PRIMER

Bruner, C., et al. (1999). *Wise counsel: Redefining the role of consumers, professionals, and community workers in the helping process*. Des Moines, IA: Child and Family Policy Center.

Lazear, K., Pires, S., Pizarro, M., Orrego, M., Lara, S., & Lavernia, A. (2001). *Natural helper and professional partnership in children's mental health: Lessons learned from the Equipo del Barrio at Abriendo Puertas, Inc*. Tampa: University of South Florida, Louis De La Parte Florida Mental Health Institute.

WEB RESOURCE

Walking Our Talk in the Neighborhoods at:
www.eric.ed.gov/ERICWebPortal/contentdelivery/servlet/ERICServlet?accno=ED440184

KEY QUESTION

- How is our system of care process connected to natural helpers and informal supports in the community?

NOTES

Bottom Up and Top Down Approach

Neither a bottom up (i.e., local) nor a top down (i.e., state) approach on its own can lead to sustainable systems of care. Engagement and buy-in from stakeholders at both local (i.e., neighborhood, community, city, and county) and state levels are needed, as well as engagement and buy-in from tribal communities. Working simultaneously at all levels requires leadership and strategic partnerships and alliances.

Obviously, the more compatible are stakeholder objectives across state, tribal, local, and community levels, the greater the likelihood of success, if for no other reason than that system building requires resources from all levels. Compatibility may not be entirely achievable, but it is necessary to recognize its importance and make the effort to create it as opportunities continually present themselves. *In general, the greater degree of alignment of interests across stakeholder groups at all levels, the more effective and sustainable is the system-building effort.*

WEB RESOURCE

Coordinating Top Down and Bottom Up Strategies for Education Reform at:
www2.ed.gov/pubs/EdReformStudies/SysReforms/fullan1.html

KEY QUESTIONS

- How does our process address the issue of buy-in at all levels, state, tribal, and local?
- What is our plan for strengthening engagement and buy-in at all levels?
- Have we explored how compatible our system-building effort is with related activities and objectives at state, tribal, local, and community levels?
- What are our strategies to advance compatible agendas?

NOTES

Effective Communication Vehicles

System building is a complex task involving multiple players at different levels. Effective communication, both internal and external, is critical for many reasons. Communication conveys information, and information is power. Lack of communication is guaranteed to leave certain groups of stakeholders—whether it is parents, youth, providers, county officials, state officials, judges, and others—feeling powerless and disenfranchised (not to mention angry and hostile to the system-building effort). Effective communication helps to prevent the misinterpretation of system design and implementation intentions that so often characterizes complex reform efforts. Communication also is critical to quality improvement and to "learning as you are going." Communication can help to build credibility, which in turn helps systems of care to grow. Communication also is essential to increase awareness of challenges facing youth and families, for example, behavioral health issues, and to reduce stigma.

Boxes 3.8 and 3.9 describe a variety of goals for communication, as well as essential communication tools.

3.8 Overall Communication Goals

- Developing and implementing communication plans for enhanced visibility and crisis management
- Generating positive media coverage by cultivating relationships with reporters
- Increasing the awareness and involvement of specific, targeted groups of individuals
- Changing attitudes or teaching new skills to clients and staff
- Generating support from the public, policy makers, and clients for community reforms across your state
- Encouraging financial contributions

Bonk, K., Griggs, H., & Tynes, E. (1999). Designing a communications plan. In *The Jossey-Bass guide to strategic communications for non-profits* (Chapter 4). San Francisco: Jossey-Bass. [Cited in *The Evaluation Exchange, 7*(1). Cambridge, MA: Harvard Graduate School of Education, Harvard Family Research Project.]

3.9 Communication Tools

Public relations materials are important tools for reaching reporters, donors, policy makers, and others in the target audience. These should include:

- A consistent and easy-to-recognize logo and stationery design
- An easy-to-understand, one-page fact sheet about the organization
- At least one press kit on the issues and activities to be highlighted in the media
- Hard copy brochures and consistent Website content
- Video, slides, overheads, and computer presentations
- Reports and studies for public release as news items
- One-paragraph and one-page biographies on spokespeople and agency heads
- Copies of the current newsletter, if there is one
- Copies of newspaper articles about the group

Bonk, K., Griggs, H., & Tynes, E. (1999). Designing a communications plan. In *The Jossey-Bass guide to strategic communications for non-profits* (Chapter 4). San Francisco: Jossey-Bass. [Cited in *The Evaluation Exchange, 7*(1). Cambridge, MA: Harvard Graduate School of Education, Harvard Family Research Project.]

WEB RESOURCE

Social Marketing for Systems of Care at:
http://systemsofcare.samhsa.gov/TechnicalAssistance/smc.aspx

KEY QUESTION

- How have we incorporated effective communication vehicles into our system-building process to reach both internal and external audiences?

NOTES

Conflict Resolution, Mediation, and Team-Building Mechanisms

In our world of complex systems, ever-expanding knowledge bases, and intricate webs of human relationships, it is a challenge for diverse groups of people to come together to make decisions effectively and solve problems. Even when stakeholders share a common vision, cohesion and consensus among disparate stakeholder groups do not simply materialize and remain constant. To address the interests of all those at the table and to reach decisions that will lead to mutually acceptable actions, the system-building process must ensure that the capabilities and strengths of all members of the group are brought to bear on the solutions and actions that emerge. Where there is clear purpose, open communication, active participation, respectful disagreement, and consensus decision making, there is greater likelihood of sustainable decisions and long-term effectiveness. Successful system builders integrate conflict resolution, mediation, and team-building mechanisms into the process, recognizing that these are approaches and skills essential to develop and sustain systems of care.

RESOURCES FROM THE ORIGINAL PRIMER

Parker, G. M. (1996). *Team players and teamwork*. San Francisco: Jossey-Bass Pfeiffer.

Saint, S., & Lawson, J. R. (1994). *Rules for reaching consensus: A modern approach to decision making*. San Francisco: Jossey-Bass Pfeiffer.

Schwarz, R. M. (1994). *The skilled facilitator: Practical wisdom for developing effective groups*. Chapel Hill: The University of North Carolina, Institute of Government.

Schwarz, R. M. (1995). *Ground rules for effective groups* (Rev. ed.). Chapel Hill: The University of North Carolina, Institute of Government.

WEB RESOURCES

Association for Conflict Resolution at: **www.acrnet.org**

Maternal and Child Health Leadership Competencies: Interdisciplinary Team-Building at: **leadership.mchtraining.net/index.php?module...id**

KEY QUESTIONS

- How does our system-building process incorporate mechanisms for conflict resolution, mediation, and team building?
- Do we take the time to build a sense of team and to resolve conflicts?
- How does our process build skills in conflict resolution, mediation, and teaming?

NOTES

A Positive Attitude

There is an abundance of research in the health field to suggest that a *positive outlook* is associated with emotional and physical well-being and longevity. This finding would seem to be the case in the system-building arena as well. System of care observers have noted that successful systems seem to be blessed with leaders who think positively, even in the face of pretty daunting challenges and setbacks. It is easy to find the negatives and "celebrate the problems" in system building. It also is singularly unhelpful. This is not to suggest that effective system leaders are or need to be unrealistic or naïve. Indeed, successful leaders typically have considerable experience across diverse arenas and constituencies. And, it is precisely because they are realistic that they recognize the importance of finding and stressing the positive. They know that a system of care can be derailed too easily by naysayers both within its own ranks and from outside its ranks, and that typically there is much that can be attacked as the system challenges existing ways of doing business and suffers its own growing pains. On an ongoing basis, successful leaders identify and help others to see what is positive and worth continuing efforts to achieve.

KEY QUESTION

- Is our process getting bogged down in negativity? What can we do as systems leaders to identify and help others to see the positive on an ongoing basis?

NOTES

The Importance of Being Strategic

A Strategic Mindset

Effective system builders plan and implement strategically, that is, they are continually scanning the environment looking for opportunities—to generate interest, build constituencies, create buy-in, re-engineer financing streams, utilize existing structures, and the like. Being strategic is both a science and an art. It is knowing how to use data, for example, and having good political instincts. It is knowing the timing and nature of key legislative and budget decisions and capitalizing on relationships with policy makers. It is understanding how traditional systems could change and figuring out how to convince traditional agency directors to join system change efforts. It is understanding the implications for systems of care of related reform efforts, such as Medicaid managed care and child welfare privatization, and figuring out ways to connect those reform efforts to system of care building.

The list of potential strategic alliances and opportunities is, quite literally, endless in system building. It is constrained only by limited vision and a failure to comprehend the connections that are possible. At its heart, system building has to do with strategically managing complex change. This template shows elements that are needed for change to occur and factors that impede change (see Illustration 3.1). For example, if system partners seem confused, perhaps the vision is not clear. If staff or providers are anxious, perhaps they have not been provided the training that would give them the skills to do what is being asked.

ILLUSTRATION 3.1

Building Local Systems of Care
Strategically Managing Complex Change

Vision	+	Skills	+	Incentives	+	Resources	+	Action Plan	=	**CHANGE**
	+	Skills	+	Incentives	+	Resources	+	Action Plan	=	**CONFUSION**
Vision	+		+	Incentives	+	Resources	+	Action Plan	=	**ANXIETY**
Vision	+	Skills	+		+	Resources	+	Action Plan	=	**RESISTANCE**
Vision	+	Skills	+	Incentives	+		+	Action Plan	=	**FRUSTRATION**
Vision	+	Skills	+	Incentives	+	Resources	+		=	**TREADMILL**

Adapted from T. Knosler (1991), TASH Presentations. Washington: DC.

RESOURCES FROM THE ORIGINAL PRIMER

Pires, S. (1991). *State child mental health planning*. Rockville, MD: National Institute of Mental Health.

WEB RESOURCE

Strategic Planning (in nonprofit or for-profit organizations) at:
http://managementhelp.org/plan_dec/str_plan/str_plan.htm

KEY QUESTIONS

- How does our process operate with a strategic mindset?
- Are we exploring every legitimate means available to support our system-building effort?
- Have we become adept at scanning the environment to identify opportunities to advance our system-building efforts?

NOTES

A Shared Vision Based on Common Values and Principles

A first step in being strategic is to engage in a process to understand one another's values, lay a common foundation of principles, and develop a shared vision for the system of care. Without a unifying vision based on agreed-upon values and principles, it is difficult to move to articulating goals, objectives, and desired outcomes, and it is impossible to analyze whether the structures that are created are anchored by a shared perspective on the future.

Boxes 3.10 through 3.13 provide examples of values and principles relevant to systems of care.

3.10 Original System of Care Values and Principles

Core Values

1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.
3. The system of care should be culturally and linguistically competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

1. Children with emotional disturbances should have access to comprehensive array of services that address their physical, emotional, social, and educational needs.
1. Children with emotional disturbances should have access to comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult services system as they reach maturity.
9. The right of children with emotional disturbances should be protected, and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics; and services should be sensitive and responsive to cultural differences and special needs.

Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev. ed.). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. (Reprinted by permission.)

3.11 Major Cultural Competence Principles

A core set of principles underlies the concept of cultural competence and acts as guidelines for developing culturally competent delivery systems:

- The family as defined by each culture is the primary system of support and preferred intervention
- The system must recognize that minority populations must be at least bi-cultural and that this status creates a unique set of psychological/emotional issues to which the system must be equipped to respond.
- Individuals and families make different choices based on culture-blind or culture-free interventions.
- Inherent in cross-cultural interactions are dynamics that must be acknowledged, adjusted to, and accepted.
- The service system must sanction, and in some cases mandate, the incorporation of cultural knowledge into practice and policy-making activities.
- Cultural competence involves determining a client's cultural location in order to apply the helping principle of "starting where the client is" and includes understanding the client's level of acculturation and assimilation.
- Cultural competence involves working in conjunction with natural, informal support and helping networks within the minority community (e.g., neighborhood organizations, churches, spiritual leaders, healers, community leaders).
- Cultural competence embraces and extends the concept of "self-determination" to services offered in communities of color.
- Culturally competent services seek to match the needs and help-seeking behavior of the client population.
- Beyond services, culturally competent agencies recognize that they also have a role of advocacy and empowerment in relationship to their clients and the minority community in which they attempt to deliver highly responsive services.

Isaacs, M., Benjamin, M., et al. (1989(1998). *Towards a culturally competent system of care* (Vols. 1(3). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

3.12 Principles for an Early Childhood Mental Health Service System

A family-centered early childhood mental health service system including mental health and related services should be/requires:

1. Designed to support parents of young children to nurture and build caring relationships with them.
2. Designed to support caregivers of young children to nurture and build caring relationships with them.
3. Delivered to the greatest possible extent in natural settings including homes, child care, health care, and family support settings.
4. Designed to respect developmental processes as well as be flexible and individualized to meet the needs of children, parents, and other caregivers. It is important to underscore the two themes embedded in this principle (i.e., respect for developmental processes and flexible/individualized approach to services).
5. Sensitive to cultural, community and ethnic values of the families.
6. Caregivers, home visitors, family workers, and administrators working with infants, toddlers, and pre-schoolers should have access to clinical program and case consultation to strengthen their competencies in promoting emotional development in all young children, in young children who are at high risk of developing diagnosable problems, and in young children with already diagnosable problems.
7. Family service workers, home visitors, and others working with families of toddlers and pre-schoolers and their families (including kinship and other foster parents, grandparent, and non-custodial fathers), should have access to mental health program consultation, case consultation, and back up supports for families requiring more intensive interventions, particularly if there are issues of substance abuse, domestic violence, child maltreatment, depression, and other mental illness.
8. Caregivers, home visitors, family workers, and administrators working with families of infants, toddlers, and pre-schoolers should have access to clinical support in dealing with staff issues such as burnout, cultural, and workplace conflicts.
9. Young children, families, and programs experiencing crises related to violence, community disasters, or family-specific crisis should have immediate and as necessary access to crisis intervention and supports.
10. Developing a family and caregiver-centered early childhood mental health service system requires building partnerships among both primary and secondary support services at the community and state level.

Knitzer, J. (1998). Early childhood mental health services: A policy and systems development perspective. In S. J. Meisels & J. P. Shonkoff (Eds.), *Handbook of early childhood interventions* (2nd ed.). New York: Cambridge University Press.

3.13 Principles of Family Support Practice

1. Staff and families work together in relationships based on equality and respect.
2. Staff enhance families' capacity to support the growth and development of all family members—adults, youth, and children.
3. Families are resources to their own members, to other families, to programs, and to communities.
4. Programs affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multi-cultural society.
5. Programs are embedded in their communities and contribute to the community building.
6. Programs advocate with families for services and systems that are fair, responsive, and accountable to the families served.
7. Practitioners work with families to mobilize formal and informal resources to support family development.
8. Programs are flexible and continually responsive to emerging family and community issues.
9. Principles of family support are modeled in all program activities, including planning, governance, and administration.

Family Support America. (2001). *Principles of Family Support Practice*. Chicago: Author.

KEY QUESTIONS

- What is our shared vision?
- Is it based on common values and principles?
- Does it reflect consensus among all key stakeholder groups?

NOTES

A Clear Population Focus

Developing a population focus, that is, being clear about who the children, youth, and families are for whom the system is being built, is an essential feature of effective system-building processes. Strategically, clarity about the population becomes a unifying frame of reference for system builders who are coming from different categorical programs; state, tribal, and local perspectives; and stakeholder group interests. It is essential as well to inform the community-mapping process and to clarify issues of governance, system design, and financing.

Developing a clear population focus does not mean that one must adopt either a narrow or a broad "population focus." Either is possible, or something in between. What it does mean is that system builders need to agree upon and articulate who the children and families are for whom the system is being built—from among or including all of the total population of children and families who depend on public systems for services and supports.

Box 3.14 describes the populations of children and families who rely on public systems for services and supports.

3.14 The Total Population of Children and Families Who Depend on Public Systems

- Children and families eligible for Medicaid
- Children and families eligible for the State Children's Health Insurance Program (SCHIP)
- Poor and uninsured children and families who do not qualify for Medicaid or SCHIP
- Families who are not poor or uninsured but who exhaust their private insurance, often because they have a child with a serious disorder
- Families who are not poor or uninsured and who may not yet have exhausted their private insurance but who need a particular type of service not available through their private insurer and only available from the public sector
- Children and families who qualify for tribal authority funding

Pires, S. (1997). *The total population of children and families who depend on public systems*. Washington, DC: Human Service Collaborative.

Within this total population of families that depends on public systems for services are numerous **subpopulations** of children and families who have particular service needs over and above those of the total population. For example:

- Children and families who also are involved in child welfare, juvenile justice, special education, substance abuse, mental health, mental retardation, and developmental disability systems, and systems serving children with special physical health care needs.
- Children and families who need only brief, short-term services; those who need intermediate term care; and those who require services over an extended period of time.
- Children who are in or at risk for out-of-home placement.

- Children who do not have serious disorders but who need a basic service or support, children who do have serious disorders, and those who are at risk for serious disorders. (Risk factors can be described in many ways—e.g., having a parent who has a serious mental illness, having been exposed to abuse or neglect, being poor, or being a member of a minority group—all are risk factors, and there are, of course, others. System builders need to create some clarity about what they mean when they use the term, "at risk.")
- Children who have co-occurring disorders—an emotional disorder and substance abuse, an emotional disorder and developmental disability, an emotional disorder and a chronic physical illness, and the like.
- Children and youth who cover a broad age range, from infants and toddlers, to pre-schoolers, to latency-age children, to adolescents, to young adults.
- Children and families who come from diverse racial and ethnic groups.
- Children and families who live in cities, suburbs, in rural and frontier areas, and in tribal communities.

The various subpopulations described above are not homogeneous. Every decision that system builders make about who is included carries implications for the types of strategies that need to be developed. For example, inclusion of infants and toddlers requires specialized infant and early childhood mental health services; partnerships with Head Start, child care, pre-kindergarten, and similar early childhood programs; and linkages with Child Find and Part C (Early Intervention Program of the Individuals with Disabilities Education Act). Inclusion of rural families carries implications for outreach and access, service capacity, attention to issues of isolation, and the like. Inclusion of children involved in the child welfare system ensures an overrepresentation of children who may have serious attachment and post-traumatic stress disorders and who require such specialized services as sexual abuse treatment services. Inclusion of children and youth involved in child welfare and juvenile justice systems raises unique child and community safety issues, and linkages with court systems are critical.

This is not an argument for systems of care to be all things to all people, which is a specious argument in any event. *Rather, it is an argument for system builders to develop a clear population focus and to be thoughtful about the characteristics, strengths, and needs of subpopulations within the identified population or populations so that relevant strategies will be pursued and responsive structures built.*

Box 3.15 describes major risk factors for families as well as strengths and protective mechanisms. It provides one type of framework for considering populations at risk for needing services and mediating variables for risk that might inform development of certain strategies over others.

3.15 Major Factors that Place Children and Youth At Risk and Strengths/Protective Mechanisms

Residential Factors
- Homelessness
- Living in homeless shelter or other temporary housing
- Crowded living space
- Substandard housing
- Housing with high levels of lead
- Housing in high-density communities
- Geographic isolation (urban or rural)

Family Factors
- Teenage parents
- Single-parent household
- Family instability
- Parental substance abuse
- Death of parent or major caregiver
- Domestic violence, including child abuse and neglect
- Parental imprisonment
- Marital conflict, separation, or divorce
- Generational conflict
- Poor parenting skills

Legal Factors
- Violation of civil rights and liberties
- Incarceration or detention
- Dealings with juvenile justice system
- Exposure to police harassment or brutality

Safety Factors
- Living in neighborhood/community with high levels of violence
- Attending schools with high levels of violent incidents
- Participating in gang activities and/or drug-related activities
- Inability of family to protect from violent situations

Income/Economic Factors
- Poverty
- Low-paying jobs
- Dependence on welfare (AFDC)
- Fixed income (SSI, pensions)
- Lack of steady employment
- Migrant work or seasonal employment

Spiritual Factors
- Lack of spiritual values
- Lack of involvement in church or other worship rituals
- Over-reliance on spiritual life (living in "other" world)

Social Factors
- Immigration/migration to a new geographic area or country
- Language/communication barriers
- Lack of friends
- Dependence on gangs
- Lack of community support
- Lack of meaningful leisure-time activities
- Overexposure to racism, discrimination, oppression, homophobia
- Isolation/lack of knowledge of cultural/social activities
- Lack of services

Educational/Vocational Factors
- Behind peers in school grade level
- Poor academic achievement
- High school dropout
- Illiteracy (unable to read)
- Learning disability
- Inability to obtain employment
- Lack of access to jobs
- Lack of training and skills for job market

Medical Factors
- Lack of access to medical care
- Lack of health care insurance
- Lack of preventive treatment, such as immunizations
- Chronic diseases (such as AIDS, diabetes, etc.)
- Sexually transmitted diseases
- Teenage pregnancy

Psychological/Emotional Factors
- Undiagnosed or unrecognized depression
- Witness or exposure to chronic violence
- Inability to effectively handle stress
- Hospitalization for psychiatric reasons
- Suicide attempts or completion
- Blocking or ignoring emotional needs
- Childhood traumas
- Behavioral management problems
- Low self-esteem based on gender, etc.

Cultural/Ethnic Identity Factors
- Low self-esteem based on race, color or sexual identity
- Dislike of people of same race or culture
- Identity confusion
- Belief in mass media images and stereotypes

Strengths/Protective Mechanisms for At-Risk Families and Children
- Positive peer group
- Academic success or meaningful employment (sense of competency)
- Consistent, caring relationship with an adult
- Ability to express affective emotions (love, anger) in a non-destructive (to self and others) manner
- Participation in sports or non-sport group activities
- Positive self-concept and cultural identity
- Appreciation of one's racial/cultural group
- Strong spiritual orientation and/or participation in religious activities
- Supportive family network (functioning extended family or kinship network)
- Strong internal coping mechanisms

Isaacs, M., & Pires, S. (1994). *Service delivery and systems reform*. [Training Module for Casey Urban Mental Health Initiative]. Washington, DC: Human Service Collaborative.

In addition to defining *who* will be served by the system of care, system builders also must establish *how many* children and families will be served over what time period. To determine how many, system builders must examine both the need for services (i.e., prevalence) and the demand for services (utilization). National prevalence data need to be adapted to local realities; for example, a high incidence of risk factors in a locality may indicate a higher need for services. Analysis of state, tribal, and local utilization data must be approached with the understanding that data often are of poor quality and that demand for services is affected by such variables as accessibility, quality, affordability, stigma, appropriateness, and administrative barriers. As noted earlier, there typically is pent-up or unmet demand in every locality that is not reflected in utilization data.

Determining "how many" also is a capacity issue—how many children and families can the system of care reasonably be expected to serve over what time period, given its capacity? And, it is a political question—what is the extent of pressure and interest from advocates, legislators, tribal leaders, and the like? Strategically, effective system builders articulate global expressions of need because this is important to create a larger picture for the community and its representatives in state and local legislatures and tribal councils. However, effective system builders also move beyond global expressions of need, which seldom get translated to operational realities, and project realistic numbers of children to be served over a given time period. Prevalence and utilization data, system capacity, and political realities inform these projections.

RESOURCES FROM THE ORIGINAL PRIMER

Friedman, R., Kutash, K., & Duchnowski, A. (1996). The population of concern: Defining the issues. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society*. Baltimore: Paul H. Brookes Publishing.

Pires, S. (1990). *Sizing components of care: An approach to determining the size and cost of service components in a system of care for children with serious emotional disturbance*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Pires, S. (1991). *State child mental health planning*. Rockville, MD: National Institute of Mental Health.

KEY QUESTIONS

- Have we clearly defined whom we are serving?
- Have we examined prevalence and utilization data, system capacity, and political realities to determine how many children will be served?
- Have we carefully analyzed the characteristics, strengths, needs, number, and past and expected service utilization patterns of the identified population or populations?

NOTES

Shared Outcomes

The process of identifying shared outcomes provides another route to exploring the values, needs, and interests of various stakeholder groups. Clarity about the outcomes that are expected is essential to inform the types of system structures to be built. For example, if improvement in the clinical and functional status of children is an agreed-upon outcome, then structures need to be in place to ensure that appropriate services are available, children and families can access them, clinicians and natural helpers are trained, and there are ways to measure clinical and functional status over time. Strategically, the process of identifying shared outcomes helps to build consensus among stakeholders regarding what the system is expected to accomplish on behalf of the children and families to be served (i.e., the populations of focus).

The outcomes desired by one constituency may be threatening to another. For example, a system-level outcome of reducing use of residential treatment may be desirable to state and local officials but threatening to providers and a source of worry to families if strong community-based alternatives are not in place. *The process of establishing shared outcomes is one of finding common ground and purpose across diverse stakeholder groups. It is a process guided by values and vision and an understanding of the needs and strengths of the identified population.*

Box 3.16 provides some examples of outcomes in systems of care.

3.16 Examples of Outcomes

- Reduction of out-of-home placements
- Reduction in inpatient and residential treatment utilization and length of stay
- Decrease in recidivism (in juvenile detention; inpatient hospitalization)
- Reduction in abuse/neglect
- Improvement in child functioning
- Improvement in school involvement (i.e., attendance, in-school behavior)
- Improved youth/family satisfaction

Pires, S. (1995). *Examples of outcomes.* Washington, DC: Human Service Collaborative.

RESOURCES FROM THE ORIGINAL PRIMER

Hernandez, M. (Ed.). (1998, May). System accountability in children's mental health [Special Issue]. *The Journal of Behavioral Health Services and Research, 25*(2).

Hogan, C. (1999). *Vermont communities count: Using results to strengthen services for children and families*. Vermont Agency of Human Services. (Available from Annie E. Casey Foundation, Baltimore).

Schorr, L., Farrow, F., Hornbeck, D., & Watson, S. (1995). *The case for shifting to results-based accountability: With a start-up list of outcome measures*. Washington, DC: Center for the Study of Social Policy.

Stroul, B., McCormack, M., & Zaro, S. (1996). *Measuring outcomes in systems of care. In B. Stroul (Ed.), Children's mental health: Creating systems of care in a changing society*. Baltimore: Paul H. Brookes Publishing.

WEB RESOURCES

A Start-Up List of Outcome Measures at:
www.eric.ed.gov/ERICWebPortal/contentdelivery/servlet/ERICServlet?accno=ED461056

KEY QUESTION

- What are the outcomes we have agreed upon across stakeholder groups and agencies that reflect our shared values?

NOTES

Community Mapping—Understanding Strengths and Needs

It is difficult to agree on what to build without a common understanding of what exists and what is needed. Community mapping is a process in which stakeholders together explore the needs, challenges, strengths, and resources within the population to be served, the community, the existing service systems, and provider agencies—keeping the population's strengths and needs foremost in the process.

Community mapping is itself a strategic process. Different stakeholder groups have differing perspectives on what are strengths, problems, and useful resources. A mental health agency director, for example, might consider the mental health clinic a resource, while families view it as inconsequential because it fails to provide culturally relevant, family-focused care. Youth might view the recreation center as a resource, while others might overlook it. Families might consider natural helpers in their neighborhoods as critical resources, while others are unaware of the role they play. *Through community mapping, system builders can develop a fuller, shared appreciation of what needs to be built upon or built anew (or not built at all).*

RESOURCES FROM THE ORIGINAL PRIMER

Kretzman, J., & McKnight, J. (1993). *Building communities from the inside out: A path toward finding and mobilizing a community's assets*. Evanston, IL: Northwestern University, Center for Urban Affairs and Policy Research.

McKnight, J. (1994). *Mapping community capacity*. Evanston, IL: Northwestern University, Center for Urban Affairs and Policy Research.

WEB RESOURCES

Center for Community Mapping at: **www.centerforcommunitymapping.org**

Community Youth Mapping at: **http://cyd.aed.org/cym/cym.html**

KEY QUESTIONS

- How have we mapped the resources, strengths, and needs in our community that are relevant to the families and youth in our system of care?
- How has our community-mapping process taken into account the views of different stakeholder groups on what constitute strengths, resources, and needs?
- How has the process of community mapping helped to build consensus and a stronger coalition among stakeholders?

NOTES

Understanding and Changing Traditional Systems

Successful system builders become very sophisticated in their understanding of how the traditional government systems at federal, state, tribal, and local levels operate; the dollars they control; and the potential of each to change. For systems of care to sustain themselves and grow, system builders must be successful in altering the ways in which the traditional systems utilize their dollars, staff, authority, and other resources. This approach is essential for two major reasons: one, because the traditional systems control the lion's share of the resources that are critical to supporting systems of care and, two, because traditional ways of operating too often contradict the values and goals of systems of care and thus can sabotage system building if left unaddressed.

Without achieving some fundamental changes in the traditional child-serving systems, system builders are unlikely to create local systems of care that can sustain themselves over time. In addition, they run the risk of creating yet another parallel delivery system. *If system builders rely only on grant monies or discretionary state and local allocations without figuring out how to tap into the major system financing streams, such as Medicaid and child welfare dollars, if they hire only new staff without encompassing and retraining existing system staff, and if they create new care management processes that parallel the case management being done in the traditional systems, they are not really creating systems of care but rather demonstration programs or special projects that may never change "business as usual," except for the small number of families fortunate enough to have landed in the demonstration project.*

System builders first need to educate themselves about how and why traditional systems operate as they do. The more knowledgeable they are about these systems, the more strategic they can be in advancing a change agenda.

WEB RESOURCE

Compilation of Selected Federal Programs for Children and Families at:
www.jhsph.edu/WCHPC/Resources/federal_MCH.html

KEY QUESTIONS

- Do we have a sophisticated understanding of how traditional systems operate?
- Have we thought strategically about how to tap into the resources of and change traditional system operations?

NOTES

Understanding of the Importance of "De Facto" Mental Health Providers

(e.g., Schools, Primary Care Providers, Child Care Providers, and Head Start)

Effective system builders recognize that in most communities, schools, child care centers, pediatricians, Head Start programs, and the like are either playing a major role in the provision of mental health services, perhaps with appropriate training but perhaps not, or could be playing a major role in the early identification and referral for treatment of mental health problems. These are natural settings in which children with and at risk for emotional disorders are intimately involved, and thus are natural partners in early intervention, screening, and linkage to appropriate services.

(Early intervention is used here, not just in the context of infants and young children, but as it pertains to *all* children and adolescents—identifying and addressing problems early, before they reach crisis or intractability stages.)

Particularly in an era of managed care in which primary care providers are playing increasingly important roles in identifying and treating emotional disorders, system builders need to reach out to pediatricians, family practitioners, and the like to build effective partnerships for training, assessment, referral, and service provision. Increasingly, there is recognition of the efficacy of intervening with very young children to try to prevent later, more serious problems; such intervention requires linkages not only with primary care providers but also with child care, Head Start, and similar programs. Schools obviously play a singularly important role in the lives of children and already are providing mental health services and supports; they are critical partners in system-building processes.

Linkages with de facto providers require targeted strategies and persistence. Sometimes what happens is that system builders are successful in conveying to these providers how the system of care can be useful to them and then are inundated with referrals. It is critical that system builders approach these providers in a way that engages them as *partners* in the system of care, creating an understanding that the capacity of the system is a collective one.

WEB RESOURCES

National Assembly on School-Based Health Care at: **www.nasbhc.org**

Center for Mental Health in Schools at: **www.smhp.psych.ucla.edu**

Center for School Mental Health at: **http://csmh.umaryland.edu/**

The Center for School-Based Mental Health Programs at:
www.units.muohio.edu/csbmhp/aboutus/index.html

Integration of Primary Care and Behavioral Health: Report on a Roundtable Discussion of Strategies for Private Health Insurance at: **www.bazelon.org/issues/general/publications/RoundtableReport.pdf**

The Child Health and Development Institute of Connecticut at: **www.chdi.org**

Resource Center for Primary Care and Behavioral Health Collaboration at:
www.thenationalcouncil.org/resourcecenter

KEY QUESTIONS

- Have we explored the roles and possibilities of partnerships with de facto mental health providers?
- What are our strategies for linking with de facto providers?

NOTES

Understanding of Major Financing Streams

Strategically, as a key part of the system-building process, it is critical that system builders understand *all* of the major financing streams that support service delivery for children and their families. As Box 3.17 illustrates, these funding streams currently are found in multiple systems and at all levels of government. Boxes are drawn around each of the funding sources to illustrate how independently each typically functions, each supporting its own service delivery system and each contracting with providers (though often with the same providers) in its own particular way.

The world of child mental health financing is one of boxes within boxes. Families who have a child with a serious disorder usually find themselves in the precarious position of having a foot in several boxes at the same time. One of the challenges facing system builders is how to create, if not one big box, at least fewer boxes or more navigable pathways among the boxes.

To do that, system builders need to figure out who is paying for what and who controls which dollars at which levels, and they need to gauge which dollars are feasible for redirection and use in systems of care. *Even when dollars are left outside of systems of care, it is still vital that system builders determine the interface among financing streams to minimize cost shifting and confusion for families who rely on services supported by multiple funding streams.*

3.17 Examples of Sources of Funding for Children/Youth

Medicaid
- Medicaid In-Patient
- Medicaid Outpatient
- Medicaid Rehabilitation Services Option
- Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- Targeted Case Management
- Medicaid Waivers
- TEFRA Option

Substance Abuse
- SA General Revenue
- SA Medicaid Match
- SA Block Grant

Mental Health
- MH General Revenue
- MH Medicaid Match
- MH Block Grant

Child Welfare
- CW General Revenue
- CW Medicaid Match
- IV-E (Foster Care and Adoption Assistance)
- IV-B (Child Welfare Services)
- Family Preservation/Family Support

Juvenile Justice
- JJ General Revenue
- JJ Medicaid Match
- JJ Federal Grants

Education
- ED General Revenue
- ED Medicaid Match
- Student Services

Other
- TANF
- Children's Medical Services/Title V—Maternal and Child Health
- Mental Retardation/Developmental Disabilities
- Title XXI—State Children's Health Insurance Program (SCHIP)
- Vocational Rehabilitation
- Supplemental Security Income (SSI)
- Local Funds

WEB RESOURCES

Effective Financing Strategies for Systems of Care: Examples from the Field—A Resource Compendium for Developing a Comprehensive Financing Plan at: **http://rtckids.fmhi.usf.edu**

Bazelon Center for Mental Health Law at: **www.bazelon.org**

The Finance Project at: **www.financeproject.org**

KEY QUESTIONS

- Have we "mapped out" all of the funding streams that are relevant to our system of care?
- Which of these funding streams can we utilize in our system of care?
- With what funding streams do we need to interface, and what are our strategies for doing so?

NOTES

Connection to Related Reform Initiatives

In virtually every state and community, there are reform initiatives underway that have or should have a major bearing on system building, for example, Medicaid managed care reforms, child welfare privatization, juvenile justice deinstitutionalization, full-service school reforms, special education inclusion efforts, and so on. Effective system builders recognize the strategic importance of connecting to related reform initiatives—to minimize duplication of efforts, maximize resources, and reduce service fragmentation for families.

Box 3.18 summarizes some of the essential characteristics of system reform efforts in the child and family arena, whether they are emanating from mental health, child welfare, juvenile justice, health, or education. It offers a framework for considering the connections among reform initiatives that are possible for system builders.

3.18 Characteristics of Systems Reform Initiatives

CHANGING FROM →	CHANGING TO
Institution based	Community based
Exclusion	Inclusion
Provider focused	Family and youth focused
Clinical approach	Social support approach
Placements (slots)	Tailor-made supports (wraps)
Categorical programs	Shared service arrangements
Bureaucratic	Self-managing teams, networks, webs
Tight central control	Increased local discretion, lateral control
Direct divisions, unit staff	Learning organizations
Units of professional services	Flexible funds, informal organizations
Quality = process + rules compliance	Quality = outcomes for people
Paperwork intensive processes	Electronic information intensive processes
Control by professionals	Partnerships with families and with youth
Only professional services	Partnership between natural and professional supports and services
Multiple case managers	Single point of service coordinator within a team
Multiple service plans for child	Single plan for child and family
Family blaming	Family partnerships
Deficits	Strengths
Fragmented service delivery	Coordinated service delivery
Categorical programs/funding	Multidisciplinary teams and blended resources
Limited services availability	Comprehensive service array
Reactive, crisis-oriented approach	Focus on prevention/early intervention
Focus on "deep-end," restrictive settings	Least restrictive settings
Classroom-based schools	Full-service schools
Centralized authority	Community-based ownership
Creation of "dependency"	Creation of "self-help" and active participation
Needs/deficit assessments	Strength-based assessments
Families/youth as "problems"	Families/youth as "partners" and therapeutic allies
Cultural blindness	Cultural competence
Highly professionalized	Coordination with informal and natural supports

continued

3.18 Continued

CHANGING FROM	CHANGING TO
Child and family must "fit" services	Individualized/Wraparound approach
Input-focused accountability	Outcomes/results-oriented accountability
Funding tied to programs	Funding tied to populations
Categorical programs	Multidisciplinary teams, blended resources, cost sharing
Office based	Home and neighborhood based
Children out-of-home	Children within families
Child only, focused on dysfunction	Family system interventions, family development
Crisis intervention as the entry to services	Early intervention teams and expanded natural support systems
Categorical funding by separate agencies	Pooled/braided funding and neighborhood-based multi-intervention contracts

Pires, S. (1996). *Characteristics of systems reform initiatives*. Washington, DC: Human Service Collaborative.

KEY QUESTIONS

- Have we analyzed how our system building relates to other state, tribal, or local reform initiatives?
- What are our strategies to link related reform efforts?

NOTES

Clear Goals, Objectives, and Benchmarks

Two points are important here. First, as a key element of the system-building process, successful system builders become concrete; that is, they iterate (and reiterate over time) clear objectives tied to goals, with recognizable benchmarks of progress along the way. Objectives clearly state what is to be done, by whom, and by when. *Second, successful builders know that the more that objectives address systemic or structural change, the greater the likelihood of system of care sustainability.*

A structural change objective is one that seeks to change existing structures, for example, the structure of the Medicaid system, or the structure of how providers are paid, or how the delivery system is organized, or how families and youth are involved (see Box 3.19). Other objectives may be worthwhile but are unlikely to create fundamental change. For example, an objective to create a newsletter for parents (a non-structural objective) is worthwhile but does not fundamentally change a system, as would an objective to require involvement of and support for parents in service-planning, monitoring, and discharge and governance processes. Similarly, an objective to change the state Medicaid plan from the clinic to the rehabilitation services option addresses structural change that has a more institutionalized impact on system building than would an objective to create a one-time allocation of funding to create community-based services—though both are worthwhile objectives.

3.19 Structural Change Concerns

Structural change objectives concern themselves with those aspects of current operating procedures (usually the most entrenched) that seem most irrational in light of the values, vision, and goals of the plan. In the world of public child mental health service delivery, the irrational may be that:

- The child mental health, child welfare, juvenile justice, education, health, and substance abuse systems do not collaborate, though they share caseloads.
- Most of the state's population of children in out-of-state residential care have serious emotional disturbance, but the mental health system plays no role in the placement of these children (or prevention of placement), monitoring of their care, or development of after-care plans.
- There is no requirement or mechanism to collect child-specific utilization data or to develop child-specific standards either within the mental health system or across child-serving agencies.
- Clinicians in the system view parents as part of the problem.
- Administrators with operational and budgetary control over child mental health services at state and local levels are predominately adult-focused.

Pires, S. (1991). *State child mental health planning*. Rockville, MD: National Institute of Mental Health.

WEB RESOURCES

Planning for the Child Care and Development Fund:
http://nitcci.nccic.acf.hhs.gov/resources/ccdf_targeted%20_funds_planning_guide.pdf

Strategic Planning at: **www.smartstart-nc.org/ntac_resources/.../Chap5Attachment6.doc**

KEY QUESTION

- Are we developing clear goals and concrete objectives that will create systemic change and that can be measured over time?

NOTES

Catalyst Mechanisms—Being Opportunistic

Often, system-building leaders use catalysts to start or jump-start a system-building process, either one that needs to be launched or an existing one that has stalled. A system-building catalyst might be the opportunity to apply for a major system change grant, such as one of those provided by the Child, Adolescent, and Family Branch at the federal Center for Mental Health Services. It might be a critical legislative report or a lawsuit brought by families and advocates. It might be a change in administration. *System-building efforts are launched and sustained by taking advantage of opportunities; thus, it is critical for system builders to be constantly scanning the environment to identify what those opportunities are (a key element of being strategic)*.

Box 3.20 provides examples of catalyst mechanisms that can be used to launch a new system-building process, energize a stalled one, or intensify and expand one that is thriving.

3.20 Catalyst Mechanisms

- Legislative Mandates (new or existing)
- Study Findings (needs assessments, research, or evaluation)
- Judicial Decisions—Class Action Lawsuits
- Charismatic/Powerful Leader
- Outside Funding Sources (federal, foundations)
- Funding Changes
- Local "Scandals" and Other Tragedies
- Coverage of Successes

Pires, S. (1996). *Catalyst mechanisms*. Washington, DC: Human Service Collaborative.

Opportunity for Reflection

The process of system building is both linear, moving toward goals and clearly stated objectives, and circular, constantly revisiting assumptions, progress, and opportunities. As a matter of strategy, successful system builders take time for reflection. They ask the following and similar questions periodically over time: Is what we are doing working? Are there opportunities we are missing? Are we leaving someone out? What is the impact of what we are doing? Although there are benchmarks reached, objectives achieved, and outcomes realized, system building is not a finite activity. What is built today will be changed tomorrow. The important point is whether change is planned and purposeful or haphazard. That will depend on whether system leaders value the need for reflection and whether evaluation, monitoring, and feedback loops—the structures that support reflection—are in place.

Adequate Time

System building does not happen overnight. Because it takes time, it is strategically important for system builders to experience and celebrate achievements along the way and to recognize the developmental nature of the process. Successful system builders recognize and can tolerate the tension inherent between the desire for immediate results and the recognition that meaningful change often takes time.

KEY QUESTIONS

- As an integral part of our process, how do we continually look for opportunities that can help advance our system-building efforts?
- Are we sufficiently opportunistic?
- How does our process provide opportunity for reflection?
- How does our process strike a balance between "agitating" for change and recognizing that change often takes time?

NOTES

The Importance of an Orientation to Sustainability**

Effective system builders pay attention to the sustainability and growth of the system of care from the outset. For example, if they are launching a system-building effort with the help of a federal system of care grant, they view the grant as "venture capital" to seed development of key system features and capacities, and they understand that "operating capital" has to be identified to sustain these. For example, many new system of care grantee communities use grant dollars to launch or expand a family organization and a youth movement. These are critical components of an emerging system of care that can be financed initially by venture capital (i.e., the grant), but if they are to remain and grow over time, ongoing sources of support must be identified. And, sustainability is not only about money.

Infusing System of Care Into Traditional System Policies, Operations, and Practices

As pointed out earlier in the *Primer*, enduring systems of care transform traditional child-serving systems so that they are operating in a system of care framework. This system transformation means that the policies, operations, and practices of traditional systems such as child welfare, juvenile justice, mental health, and education embrace system of care values and principles, implement system of care technologies such as braided funding, and train/retrain staff and providers in system of care practice approaches. For example, **New Jersey** used a federal system of care grant in one locality to pilot many of the concepts that then became standard features and informed the structural changes in the state's delivery system for children with behavioral health challenges and their families. These structural changes included family-run organizations throughout the state; a single point of access to the system; Care Management Entities for children with complex, multisystem involvement; standardized screening and assessment tools; training of staff and providers in system of care concepts; redirection of child welfare dollars; and changes in Medicaid and other financing streams to support home and community-based services and supports. Successful systems of care institutionalize system of care principles through legislation, regulation, contractual requirements, and other policy instruments.

**The work of Beth A. Stroul and her study with Brigitte Manteuffel on the sustainability of federally funded system of care grant communities has reinforced and expanded upon many of the principles described in the original *Primer*. This section incorporates findings from that study. (See: Stroul, B. A., & Manteuffel, B. (2008). Sustaining systems of care. In B. A. Stroul & G. M. Blau (Eds.), *The system of care handbook*. Baltimore: Paul H. Brookes Publishing.)

Cultivating Leaders and Champions

As noted earlier in the *Primer*, successful systems of care need strong, accountable, and consistent leadership over time and "champions" among broad cross-sections of stakeholder groups. Some examples include legislators and judges who champion the system of care, individuals who are in key supervisory roles, family and youth leaders, key providers, and agency directors. Leadership capacity that is especially important is a focal point for system of care management and oversight and a vibrant family-run organization and a youth movement. In **Arizona**, for example, although regional behavioral health authorities play a key role in day-to-day operations of the system of care for children with behavioral health challenges and their families, the state children's behavioral health division has accountability for overall system management and oversight. The state has supported the sustainability and growth of family voice by implementing policies and contractual requirements for regional behavioral health authorities related to ensuring family involvement, expanding the provider network and developing credentialing processes to support family organizations as providers, and identifying financing at a state level to support the development and growth of family organizations.

Partnership Between States and Localities and States and Tribes

As has been discussed repeatedly throughout the *Primer*, it is very difficult to sustain systems of care at a local level without the state's commitment to partner, or to succeed in a statewide effort to build local systems of care without local or tribal buy-in. In **New Jersey**, for example, the state's roll-out of local systems of care was implemented through a partnership between state and local implementation teams working in concert on shared system implementation objectives.

Training, Coaching, and Capacity Building

Effective systems of care incorporate ongoing mechanisms to train and coach the workforce (i.e., staff, providers, families, and youth) in system of care concepts and technologies, recognizing that system transformation requires the workforce to operate differently, adopt a new practice approach, and become accustomed to new structures, policies, and procedures—and that these changes require concerted focus over time. **Maryland**, for example, created the Innovations Institute at the University of Maryland to support system-building efforts over time. The California Institute for Mental Health has played a similar role in **California**. **New Jersey** also partnered with a state university to support system of care capacity development and training, and **Massachusetts** is developing a similar capacity.

Attention to Financing Strategies for the Long Haul

The *Primer* devotes considerable attention to the importance of developing financing strategies that will support system development, sustainability, and growth over time. Multiple financing approaches are needed, and a strong partnership with the state Medicaid agency is critical. In many states, Medicaid is the largest source of financing for systems of care, and Medicaid policies, the Medicaid State Plan, financing approaches, and the like can be adapted to better support systems of care. In **New Jersey**, for example, the state Medicaid agency partnered closely with the other child-serving systems to design the system of care, broadening covered services and the provider network and establishing the Medicaid agency as the "single payor" mechanism for both Medicaid and non-Medicaid-eligible children involved in the system of care. As committed partners, Medicaid staff was able to identify strategies within Medicaid about which other children's systems were not necessarily knowledgeable, for example, using Medicaid administrative case management dollars to help finance family-run organizations. Sustainable systems implement financing strategies that support essential components of the system of care approach; for example, to sustain a *Wraparound*, child and family team (i.e., individualized) approach to service planning and implementation, financing has to be identified to support providers and clinicians to participate in the team process and financing is needed to support care managers or wrap facilitators. **Hawaii**, for example, identified a billing code under Medicaid to enable providers and clinicians to bill for their time on child and family teams. A number of states use Medicaid Administrative or Targeted Case Management and blended or braided funds to support care managers.

Outcome Data

As noted in the *Primer*, effective systems of care are data driven and utilize data, not only to improve the system as it develops over time but to promote sustainability and growth. They utilize data from evaluations, quality improvement processes, and other sources to identify areas for improvement, document effectiveness, and market results to key audiences, such as legislators. In **Milwaukee County, Wisconsin**, Wraparound Milwaukee, for example, collects outcome data, such as school attendance rates and recidivism rates in juvenile justice, of particular relevance to its key funders. Sustainable systems also use data from the personal stories of families and youth who have been helped by the system of care because those often are powerful messages for key audiences, such as legislators.

Generating Broad Support and an Advocacy Base

Sustainable systems of care use social marketing tools and strategies to build strong support for the system of care, and they create a strong advocacy base by developing the capacity of families and youth to advocate and by reaching out to key constituencies, such as judges and providers. The one "constant" in systems of care is that things change—governors and legislators come and go, administrators change, and new contracts are awarded bringing in new managed care companies and different providers. Without a strong advocacy base, systems of care stop and start over time as opposed to maintaining a growth trajectory. In **New Jersey**, for example, the development of many local family-run organizations and of a youth movement and the cultivation of key judges have been critical to the sustainability and growth of the system of care through multiple governors and changes in administration.

Adaptability

A core feature of being strategic is being adaptable. Adaptability is needed in systems of care not only because the environment is constantly changing but also because new strategies are being tested. Given that strategies may fail, system builders need to adapt; that is, they need to have the capacity to bounce back, be creative and persistent, and try again. Effective system builders also tend to reframe the constantly changing environment in which they operate. Rather than seeing it only as a constantly threatening environment, they recognize that, within this environment, new opportunities arise fairly regularly. Sustainable systems of care capitalize on change as opportunities to grow.

Final Note

Like effective systems of care, the *Primer* is intended to be modified and enriched over time, as knowledge grows and as new players join the system-building effort. With this in mind, the author welcomes suggestions for enhancing the *Primer*, for example:

- New areas that should be added
- Suggested changes to existing areas
- Additional Web resources that should be cited
- Examples for illustrative purposes

Suggestions for the *Primer* can be made by contacting the author as follows:

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