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 local 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 two broad headings: The Importance of Leadership and Constituency Building and The Importance of Being Strategic. These groupings obviously are related, as effective leaders are strategic, and strategizing effectively requires leadership on many different fronts at both state and local levels.

The Importance of Leadership and Constituency Building

• A Core Leadership Group
• Evolving Leadership
• Effective Collaboration
• Partnership with Families and Youth
• Cultural Competence
• Connection to Neighborhood Resources and Natural Helpers

• Bottom Up and Top Down Approach
• Effective Communication
• 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, day care providers, Head Start)
• Understanding of Major Financing Streams
• Connection to Related Reform Initiatives
• Clear Goals, Objectives, and Benchmarks
• Trigger Mechanisms—Being Opportunistic
• Opportunity for Reflection
• Opportunity for Reflection
• Adequate Time

*I am 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.
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 resource materials.
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 four Cs”—constituency representativeness, credibility within the community, capacity to engage other stakeholders, and commitment to the difficult work of system building—the more effective it will be. Also, effective core group leadership needs to exist at both state and local levels.

2.1 The 4Cs of Core Leadership

<table>
<thead>
<tr>
<th>Constituency (representativeness)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
</tr>
<tr>
<td>Capacity</td>
</tr>
<tr>
<td>Commitment</td>
</tr>
</tbody>
</table>

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.

Magrab (1999) points 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 points out that leadership for systems of care requires a shift in the leadership paradigm from independence to interdependence and from competition to collaboration.

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, local leaders, judicial leaders, provider leaders, community leaders, leaders among natural helpers—all are important to the growth of systems of care.

RESOURCES


II. The System-Building Process

**KEY QUESTIONS**

- Is our leadership representative, credible, committed?
- How have we ensured that our leaders have the capacity (e.g., skills, technologies, resources, 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 who have emotional disorders and their 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 the systems and services 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. The following chart offers guidance for collaboration.

### 2.2 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.

Box 2.3 describes challenges to collaboration and offers strategies to meet these challenges.

### 2.3 Challenges to Collaboration/”Barrier Busters”

<table>
<thead>
<tr>
<th>CHALLENGE</th>
<th>BARRIER BUSTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language differences: Mental health jargon vs.</td>
<td>• Cross training</td>
</tr>
<tr>
<td>court jargon</td>
<td>• Share each other’s turf</td>
</tr>
<tr>
<td></td>
<td>• Share literature</td>
</tr>
<tr>
<td>Role definition: “Who’s in charge?”</td>
<td>• Family driven/accountability</td>
</tr>
<tr>
<td></td>
<td>• Team development training</td>
</tr>
<tr>
<td></td>
<td>• Job shadowing</td>
</tr>
<tr>
<td></td>
<td>• Communication channels</td>
</tr>
<tr>
<td></td>
<td>• Share myths and realities</td>
</tr>
<tr>
<td>Information sharing among systems</td>
<td>• Set up a common data base</td>
</tr>
<tr>
<td></td>
<td>• Share organizational charts/phone lists</td>
</tr>
<tr>
<td></td>
<td>• Share paperwork</td>
</tr>
<tr>
<td></td>
<td>• Promote flexibility in schedules to support attendance in meetings</td>
</tr>
<tr>
<td>Addressing issues of community safety</td>
<td>• Document safety plans</td>
</tr>
<tr>
<td></td>
<td>• Develop protocol for high-risk kids</td>
</tr>
<tr>
<td></td>
<td>• Demonstrate adherence to court orders</td>
</tr>
<tr>
<td></td>
<td>• Maintain communication with District Attorneys</td>
</tr>
<tr>
<td></td>
<td>• Myths of “bricks and mortar”</td>
</tr>
<tr>
<td>Maintaining investment from stakeholders</td>
<td>• Invest in relationships with partners in collaboration</td>
</tr>
<tr>
<td></td>
<td>• Share literature and workshops</td>
</tr>
<tr>
<td></td>
<td>• Track and provide meaningful outcomes</td>
</tr>
<tr>
<td>Sharing value base</td>
<td>• Infuse values into all meetings, training, and workshops</td>
</tr>
<tr>
<td></td>
<td>• Share documentation and include parents in as many meetings as possible</td>
</tr>
<tr>
<td></td>
<td>• Strength-based cross training</td>
</tr>
<tr>
<td></td>
<td>• Develop QA measures based on values</td>
</tr>
</tbody>
</table>

RESOURCES


KEY QUESTIONS

■ What can we do to improve collaboration?
■ Does our collaboration have a concrete purpose tied to goals?

NOTES
The family movement in the children’s mental health arena has adopted the maxim: “Nothing about us without us.” The system-building process that fails to develop a meaningful partnership with the constituency that will depend upon the system is inherently suspect and limited in its capacity to build an effective system. Meaningful partnerships with families and youth require concerted attention, dedicated resources, and capacity building across all parties. Box 2.4 summarizes some of the critical elements involved in developing effective partnerships with families and youth.

<table>
<thead>
<tr>
<th>2.4</th>
<th>Partnership Involves</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Team Building</td>
<td></td>
</tr>
<tr>
<td>• Communication</td>
<td></td>
</tr>
<tr>
<td>• Negotiations</td>
<td></td>
</tr>
<tr>
<td>• Conflict Resolution</td>
<td></td>
</tr>
<tr>
<td>• Leadership Development</td>
<td></td>
</tr>
<tr>
<td>• Mutual Respect</td>
<td></td>
</tr>
<tr>
<td>• Skill Building</td>
<td></td>
</tr>
<tr>
<td>• Information Sharing</td>
<td></td>
</tr>
</tbody>
</table>


Box 2.5 suggests ways to facilitate youth involvement.

<table>
<thead>
<tr>
<th>2.5</th>
<th>Implications for Agencies and Clinicians of Youth Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Establish guiding principles that include using a strengths-based, youth- and family-centered approach; promoting independence and interdependence; valuing youth/adult partnerships.</td>
<td></td>
</tr>
<tr>
<td>• Employ youth as staff members.</td>
<td></td>
</tr>
<tr>
<td>• Create the organizational and program environments (such as norms, program guidelines, evaluation) jointly with youth participants.</td>
<td></td>
</tr>
<tr>
<td>• Support staff training in effective youth/adult partnerships.</td>
<td></td>
</tr>
</tbody>
</table>

Illustration 2.1 depicts service arrangements characterized by different levels of family partnership.

<table>
<thead>
<tr>
<th>Professional Centered</th>
<th>Family Focused</th>
<th>Family Allied</th>
<th>Family Centered</th>
<th>Team Centered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adversarial professional-parental relationship</td>
<td>Families are helpers and allies</td>
<td>Families are one down</td>
<td>Professionals are one down to families</td>
<td>Wraparound model</td>
</tr>
<tr>
<td>Professional is the expert</td>
<td>Caregiver is an equal</td>
<td>Professional is the expert</td>
<td>Parents know best</td>
<td>Team makes decisions</td>
</tr>
<tr>
<td>Parent is the problem</td>
<td>Professional and professional work collaboratively to address mutually agreed upon goals</td>
<td></td>
<td>Professional's role is to support families to help their child</td>
<td>Team includes family, provider, child, and others</td>
</tr>
</tbody>
</table>


The following are two examples out of many of partnerships with families and youth in systems of care.

**EXAMPLE 2.1**

A frontier community in a western state partners with families in all aspects of the planning and delivery of services. At the service level, families develop and approve their own family team. The model improves access through designating family contacts to reach families who otherwise might be reluctant to seek help.

An East Coast state has built partnerships with families and youth into its system-building effort at both state and local levels. It funds family organizations; requires use of paid family support coordinators to assist families in the services planning process; ensures families are represented on state- and local-level policy and management teams; utilizes families as trainers and ensures families receive training; involves families in the Quality Improvement process, in the development of Requests for Proposals and policies and procedures; and has developed a Youth Council to create more effective partnerships with youth.
RESOURCES


KEY QUESTIONS

- How strong are our partnerships with families? With youth?
- Have we explored multiple avenues for strengthening our partnerships?
- Do we have resources dedicated to partnership strengthening?

NOTES
Cultural Competence

Effective systems of care respect and make every effort to understand and be responsive to cultural 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 to recognizing that all children 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 over-represented in the most restrictive, “deep-end” services and under-represented in quality community-based services. This tends to be the case even in states and communities with relatively few racial and ethnic minority families.

To be effective, system-building processes must pay attention to the impact of culture, ethnicity, race, gender, sexual orientation, and class within the process itself, as well as on how systems operate and the ability of families to access and use services. In addition, successful systems leaders draw on a variety of approaches and strategies employed on an ongoing basis to build cultural proficiency into the system of care.

Box 2.6 articulates elements of cultural competence in systems of care.

### 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)


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
II. The System-Building Process

designation by systems leaders that it is a priority. Box 2.7 illustrates the cultural
competence developmental continuum as applied to health care organizations striving to
achieve cultural proficiency.

<table>
<thead>
<tr>
<th>2.7 Cultural Competence Continuum</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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.


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 (see Resources below).
RESOURCES


KEY QUESTIONS

■ How does our system-building process respect and address issues of ethnicity, race, class, gender, and sexual orientation to ensure a culturally competent and ultimately proficient system of care?

NOTES
Successful systems of care blend clinical services and natural supports, helping families to access and make use of both. 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 supports include people such as natural helpers, organizations such as churches and parent associations, programs such as mentoring, and activities such as parent support and education 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 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. They also ensure that natural helpers and providers of neighborhood resources and supports are engaged in the system-building process. This requires leadership across stakeholder groups at neighborhood, local (e.g., city, county), and state levels.

Box 2.8 describes the types of support that natural helpers can provide in a system of care.
2.8 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


EXAMPLE 2.2

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.
II. The System-Building Process

RESOURCES


KEY QUESTIONS

■ 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. Working simultaneously at both levels requires leadership and strategic partnerships and alliances.

Obviously, the more compatible are stakeholder objectives across state, 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.

**RESOURCES**


**KEY QUESTIONS**

- How does our process address the issue of buy-in at all levels, state 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, 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, providers, county officials, state officials, judges, whomever—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 mental health issues and reduce stigma.

Boxes 2.9 and 2.10 describe a variety of goals for communication, as well as essential communication tools.

### 2.9 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


### 2.10 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 stationary 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

RESOURCES


Heartland Center for Leadership Development. (1993). *How to get your story in the news: 10 tips for working with local media*. Lincoln, NE.

Vanguard Communications. (2002). *Caring for every child’s mental health campaign*. Washington, DC.

KEY QUESTIONS

■ 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 does 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 developing and sustaining systems of care.

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 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 systems leaders are or need to be unrealistic or naive. 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 nay-sayers 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.
RESOURCES


KEY QUESTIONS

- Do we take the time to build a sense of team and resolve conflicts?
- How does our process build skills in conflict resolution, mediation, and teaming?
- 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.

**ILLUSTRATION 2.2**

Building Local Systems of Care
Strategically Managing Complex Change

| Vision + Skills + Incentives + Resources + Action Plan = CHANGE |
| Vision + Skills + Incentives + Resources + Action Plan = CONFUSION |
| Vision + Incentives + Resources + Action Plan = ANXIETY |
| Vision + Skills + Resources + Action Plan = RESISTANCE |
| Vision + Skills + Incentives + Resources + Action Plan = FRUSTRATION |
| Vision + Skills + Incentives + Resources + Action Plan = TREADMILL |

RESOURCES

KEY QUESTIONS
■ How does our process operate with a strategic mindset?
■ Are we exploring every legitimate means available to support our system building effort?

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.

The following four boxes provide examples of values and principles relevant to systems of care.

### 2.11 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 of 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 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 mechanism 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.

### 2.12 Major Cultural Competence Principles

A core set of principles underlie the concept of cultural competence and act 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.


### 2.13 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.

## 2.14 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

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.


### RESOURCES

**KEY QUESTIONS**

- What is our shared vision? Is it based on common values? 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 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 “target population definition.” 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 mental health services.

Box 2.15 describes the populations of children and families who rely on public systems for mental health services and supports.

<table>
<thead>
<tr>
<th>2.15 The Total Population of Children and Families Who Depend on Public Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children and families eligible for Medicaid</td>
</tr>
<tr>
<td>• Children and families eligible for the State Children’s Health Insurance Program (SCHIP)</td>
</tr>
<tr>
<td>• Poor and uninsured children and families who do not qualify for Medicaid or SCHIP</td>
</tr>
<tr>
<td>• Families who are not poor or uninsured but who exhaust their private insurance, often because they have a child with a serious disorder</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
</tbody>
</table>


Within this total population of families that depends on public systems for mental health 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 retardation and developmental disabilities 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 some type of mental health service, children who do have serious disorders, and those who are at risk for serious disorders. (Risk factors can be described in many ways—for example, 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, etc.

• Children and adolescents 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, and in rural and frontier areas.

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 over-representation of children who have serious attachment and post traumatic stress disorders and who require specialized services such 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 spurious 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 target population so that relevant strategies will be pursued and responsive structures built.

Box 2.16 describes major risk factors for families as well as strengths/protective mechanisms. It provides one type of framework for considering populations at risk for mental health services and mediating variables for risk that might inform development of certain strategies over others.
## Major Factors that Place Families 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

### Educational/Vocational Factors
- Isolation/lack of knowledge of cultural/social activities
- Lack of services

### Medical Factors
- Lack of access to medical care
- Lack of health care insurance
- Lack of preventive treatment, such as immunizations
- Terminal diseases (such as AIDS, cancer, 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 or color
- 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

---

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 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, 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. 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. These projections are informed by prevalence and utilization data, system capacity, and political realities.

**RESOURCES**


II. The System-Building Process

**KEY QUESTIONS**

- Have we clearly defined whom we are serving?
- Have we examined prevalence and utilization data, capacity, and political realities to determine how many children will be served?
- Have we carefully analyzed the characteristics, strengths, needs, number, past and expected service utilization patterns of the target population?

**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 target population).

The outcomes desired by one constituency may be threatening to another. For example, a systems level outcome of reducing use of residential treatment may be desirable to state and local officials but threatening to providers. 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 target population.

Box 2.17 provides some examples of outcomes in systems of care.

### 2.17 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

II. The System-Building Process

RESOURCES


KEY QUESTIONS

■ 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

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.

II. The System-Building Process

**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 as to 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, 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 is essential for two major reasons: one, because it is the traditional systems that 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, 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.

RESOURCES


II. The System-Building Process

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

Effective system builders recognize that in most communities, schools, day care centers, pediatric practices, 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; this requires linkages not only with primary care providers but also with day care and Head Start programs and the like. 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.

RESOURCES


Practices and Resources Clearinghouse. Safe schools/healthy students action center. Alexandria, VA (www.sshsac.org)
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, it is critical that system builders understand all of the major financing streams that support service delivery for children with emotional disorders and their families. As Box 2.18 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 emotional disorder usually find themselves in the precarious position of having a foot in several boxes at once. 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, who controls which dollars at which levels, and gauge which dollars are feasible for re-direction 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.

### 2.18 Examples of Sources of Behavioral Health Funding for Children and Families in the Public Sector

<table>
<thead>
<tr>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicaid In-Patient</td>
</tr>
<tr>
<td>• Medicaid Outpatient</td>
</tr>
<tr>
<td>• Medicaid Rehabilitation Services</td>
</tr>
<tr>
<td>• Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• MH General Revenue</td>
</tr>
<tr>
<td>• MH Medicaid Match</td>
</tr>
<tr>
<td>• MH Block Grant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ED General Revenue</td>
</tr>
<tr>
<td>• ED Medicaid Match</td>
</tr>
<tr>
<td>• Student Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• SA General Revenue</td>
</tr>
<tr>
<td>• SA Medicaid Match</td>
</tr>
<tr>
<td>• SA Block Grant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CW General Revenue</td>
</tr>
<tr>
<td>• CW Medicaid Match</td>
</tr>
<tr>
<td>• IV-E (Foster Care and Adoption Assistance)</td>
</tr>
<tr>
<td>• IV-B (Child Welfare Services)</td>
</tr>
<tr>
<td>• Family Preservation/Family Support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• WAGES</td>
</tr>
<tr>
<td>• Children’s Medical Services/Title V—Maternal and Child Health</td>
</tr>
<tr>
<td>• Mental Retardation/Developmental Disabilities</td>
</tr>
<tr>
<td>• Title XXI—State Children’s Health Insurance Program (SCHIP)</td>
</tr>
<tr>
<td>• Vocational Rehabilitation</td>
</tr>
<tr>
<td>• Local Funds</td>
</tr>
</tbody>
</table>

II. The System-Building Process

RESOURCES


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 the like. 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.

The following box 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.

### 2.19 Characteristics of Systems Reform Initiatives

<table>
<thead>
<tr>
<th>CHANGING FROM</th>
<th>CHANGING TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution based</td>
<td>Community based</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Inclusion</td>
</tr>
<tr>
<td>Provider focused</td>
<td>Family focused</td>
</tr>
<tr>
<td>Clinical approach</td>
<td>Social support approach</td>
</tr>
<tr>
<td>Placements (slots)</td>
<td>Tailor-made supports (wraps)</td>
</tr>
<tr>
<td>Categorical programs</td>
<td>Shared service arrangements</td>
</tr>
<tr>
<td>Bureaucratic</td>
<td>Self-managing teams, networks, webs</td>
</tr>
<tr>
<td>Tight central control</td>
<td>Increased local discretion, lateral control</td>
</tr>
<tr>
<td>Direct divisions, unit staff</td>
<td>Learning organizations</td>
</tr>
<tr>
<td>Units of professional services</td>
<td>Flexible funds, informal organizations</td>
</tr>
<tr>
<td>Quality = process + rules compliance</td>
<td>Quality = outcomes for people</td>
</tr>
<tr>
<td>Paperwork intensive processes</td>
<td>Electronic information intensive processes</td>
</tr>
<tr>
<td>Control by professionals</td>
<td>Partnerships with families</td>
</tr>
<tr>
<td>Only professional services</td>
<td>Partnership between natural and professional supports and services</td>
</tr>
<tr>
<td>Multiple case managers</td>
<td>Single point of service coordinator within a team</td>
</tr>
<tr>
<td>Multiple service plans for child</td>
<td>Single plan for child and family</td>
</tr>
<tr>
<td>Family blaming</td>
<td>Family partnerships</td>
</tr>
<tr>
<td>Family as focus</td>
<td>Family as focus</td>
</tr>
<tr>
<td>Needs/deficit assessments</td>
<td>Strength-based assessments</td>
</tr>
<tr>
<td>Families/youth as “problems”</td>
<td>Families/youth as “partners” and therapeutic allies</td>
</tr>
<tr>
<td>Centralized authority</td>
<td>Community-based ownership</td>
</tr>
<tr>
<td>Creation of “dependency”</td>
<td>Creation of “self-help” and active participation</td>
</tr>
<tr>
<td>Child-only focus</td>
<td>Family as focus</td>
</tr>
<tr>
<td>Needs/deficit assessments</td>
<td>Strength-based assessments</td>
</tr>
<tr>
<td>Highly professionalized</td>
<td>Coordination with informal and natural supports</td>
</tr>
<tr>
<td>Child and family must “fit” services</td>
<td>Individualized/wrap-around approach</td>
</tr>
</tbody>
</table>
II. The System-Building Process

CHANGING FROM CHANGING TO
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
Classroom based Full-service schools
Children out-of-home Children within families
Child only, focused on dysfunction Family system interventions, family development
Parents as the problem Parents as service and therapeutic partners
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


RESOURCES


KEY QUESTIONS
• Have we analyzed how our system building relates to other state or local reform initiatives?
• What are our strategies to link related reform efforts?

NOTES
Clear Goals, Objectives, and Benchmarks

Two points are important here. One, 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. Two, 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 clinicians are trained or how families are involved. 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 on service planning, monitoring, and discharge and governance processes. Similarly, an objective to change the state’s 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.

ILLUSTRATION 2.3

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.
- The state mental health agency has a policy of reducing inpatient beds, but the state’s Certificate of Need process, managed by another department, keeps approving applications for new beds.
- 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.
- Three-quarters of state child mental health dollars are spent on inpatient care.
- 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.

RESOURCES

KEY QUESTIONS
- Are we developing clear goals and concrete objectives that will create systemic change and that can be measured over time?

NOTES
Trigger Mechanisms—Being Opportunistic

Something has to start and keep the ball rolling in system building. A system-building trigger mechanism might be the opportunity to apply for a major systems change grant such as 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).

The following box provides examples of trigger or “catalyst” mechanisms that can be used to jump-start a new system-building process, energize a stalled one, or intensify and expand one that is thriving.

### 2.20 Catalyst/Trigger Mechanisms

- Legislative Mandates (new or existing)
- Study Findings (needs assessments, research, or evaluation)
- Judicial Decisions—Class Actions Suits
- Charismatic/Powerful Leader
- Outside Funding Sources (federal, foundations)
- Funding Changes
- Local “Scandals” and Other Tragedies
- Coverage of Successes


Opportunity for Reflection

The process of system building is both linear, moving toward goals and clearly stated objectives, and circular, constantly re-visiting assumptions, progress, and opportunities. As a matter of strategy, successful system builders take time for reflection. They ask 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, and similar questions. 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 systems 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.

RESOURCES


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
Like effective systems of care, this 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 to either the *Structuring Systems of Care* or *The System-Building Process* sections
- Suggested changes to existing areas
- Additional resource materials that should be cited
- Examples for illustrative purposes

**Suggestions for the Primer can be made by contacting the author as follows:**

Sheila A. Pires  
1728 Wisconsin Avenue, NW, Suite 224  
Washington, DC 20007

Telephone: (202) 333-1892  
Fax: (202) 333-8217

E-mail: sapires@aol.com