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Leveraging Change in the Region 3 Behavioral Health Services' System of Care

Site Report for Case Studies of System Implementation

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Authors

Sharon Hodges, Ph.D.
Principal Investigator

Kathleen Ferreira, M.S.E.

Nathaniel Israel, Ph.D.

Jessica Mazza, B.A.

The Research and Training Center
for Children's Mental Health

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Case Studies of System Implementation is a five-year research project through the Rehabilitation Research and Training Center in the Department of Child and Families Studies, Louis de La Parte Florida Mental Health Institute, University of South Florida. This study is jointly funded by the National Institute on Disability and Rehabilitation Research, U.S. Department of Education and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

EXECUTIVE SUMMARY

In 2005, Region 3 Behavioral Health Services, Nebraska participated in a national study of system of care implementation conducted through the Research and Training Center for Children's Mental Health at the University of South Florida. This report describes strategic efforts to leverage system change in the Region 3 System of Care and provides insight into how factors affecting system implementation contributed to the development of a system of care for children with serious emotional disturbance and their families. The report presents factors identified by Region 3 stakeholders as critical to their system development and provides insight into particular successes as well as areas for further development.

The investigation used a case study design. A national nomination process was conducted to identify established systems of care. A site selection process involving document review and key stakeholder interviews was used to identify participating sites. Case study data was then collected using semi-structured interviews with administrators, managers, direct service staff and families; direct observation; document review; and a review of aggregate outcome data.

Region 3 Behavioral Health Services was nominated for inclusion in this study due to its accomplishments in serving youth with SED and their families through the establishment and sustainability of a system of care on a regional level. Region 3 is one of six behavioral health regions within the state of Nebraska, and services are provided to a large number of rural and frontier communities. Region 3 is unique in its success in providing services over a broad geographic area, but even more impressive is the involvement of families and family organizations as meaningful decision-making partners within the system.

Key Findings

Region 3's achievements in system of care development include:

- Effective partnering with families and youth
- Collaboration
- A strengths-based approach to serving families
- Expansion of access to services
- Value-based fiscal planning and decision making
- Sophisticated structure and use of evaluation data

A unique feature shared by the communities that have agreed to participate in this study is their constant reflection upon areas for improvement within their system. Within Region 3 Behavioral Health Services, there is an identified willingness to continue to expand access and services to a diverse population of children and families within the state.

System stakeholders discussed actions that advanced their efforts as well as actions that placed great strain on the system and their response to these negative actions. Some areas identified for further development include:

- Strengthening and developing partnerships
- Addressing population diversity
- Developing future leaders
- Adapting evidence-based practices to the system of care
- Expanding key state-level alliances

In summary, the Region 3 Behavioral Health Services Children's System of Care continues to strengthen its partnerships with families and youth, who have been involved in the system from its inception. The multi-tiered evaluation data that is continually collected and utilized to inform services is clear evidence of Region 3's commitment to continually improve services and supports to meet the needs of children and families in the system.

This report provides site-specific findings for the system of care in Region 3 Behavioral Health Services, Nebraska. Cross-site findings for Case Studies of System Implementation will be published independently of this report.

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INTRODUCTION

For more than 20 years, stakeholders across the country have worked to reform children's mental health services by creating community-based systems of care. Systems of care is an organizational philosophy that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based services and supports for children with serious emotional disturbance (SED) and their families (Stroul, 1993; Stroul & Friedman, 1986). Research has demonstrated that systems of care have a positive effect on the structure, organization, and availability of services for children with SED (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Rosenblatt, 1998; Stroul, 1993). However, the field of children's mental health has much to learn about how local systems of care actually develop, the conditions that support or impede their implementation, and what factors interact together to establish well-functioning systems (Hernandez & Hodges, 2003). The purpose of Case Studies of System Implementation is to understand how stakeholders facilitate local system of care development and what factors, conditions, and strategies contribute to the development of systems of care for children with SED. A brief summary of the study is included in Appendix A.

The purpose of this study is to understand how stakeholders facilitate local system of care development

Region 3 Behavioral Health Services, Nebraska was selected to participate in Phase I of this study because it is an established system that has demonstrated its ability to achieve positive outcomes for children with SED and their families.

This study focuses on the system of care within Region 3 Behavioral Health Services as a whole rather than concentrating on the activities of specific agencies or individuals involved in the system. This kind of systems thinking encourages building an understanding of key elements of a system and how they contribute to system development (Checkland, 1993). This holistic study of system implementation is designed to develop knowledge of how local communities employ strategies that allow them to serve children with SED in the least restrictive, most clinically appropriate setting possible.

Site Selection Criteria

- Identified needs for local population of children with serious emotional disturbance
- Goals for identified population that are consistent with system-of-care values and principles
- Actively implementing strategies to achieve expressed goals for identified population
- Outcome information that demonstrates progress toward these goals
- Ability to reflect on key transitions in development of system over time
- Sustainability over time

The Region 3 Behavioral Health Services System of Care is...

an adaptive network of structures, processes, and relationships grounded in system of care values and principles that effectively provides children and youth with serious emotional disturbance and their families with access to and availability of services and supports across administrative and funding boundaries. (See Appendix B for details)

Key points of investigation for this study include:

- Fundamental mechanisms of Region 3's system implementation;
- How factors that contributed to Region 3's system implementation interacted to produce a well-functioning system of care;
- How local context influenced Region 3's system implementation;
- Specific change agents or triggering conditions critical to Region 3's system of care;
- Conditions that support or impede Region 3's system development.

This report will summarize findings from research conducted in the Region 3 Behavioral Health Services System of Care. The report will include a discussion of factors identified by Region 3 stakeholders as critical to their process of system implementation and will illustrate how system planners and implementers leveraged system change.

RESEARCH METHODS

The research team worked with Region 3 Behavioral Health Services for four months prior to on-site data collection. The site visit took place the week of November 28, 2005.

This investigation used case study design. Data collection included extensive document review and key stakeholder interviews in advance of the site visit. In addition, Region 3 System of Care stakeholders identified and defined key system implementation factors prior to the research team's site visit. On-site data collection included semi-structured interviews with a variety of system partners. These interviews were conducted with administrators, managers, direct service staff and families. Direct observation of naturally occurring meetings and events, continued document review, and a review of aggregate outcome data also occurred. A brief description of these methods follows.

Key Methods

- Document Review
- Implementation Factor Brainstorming and Rating
- Interviews
- Direct Observation

Document Review was used to provide organizational-level data related to system implementation as well as system-of-care development in a historical context. Region 3 Behavioral Health Services documents included state and region level materials related to the goals and intent of the system, legislative history, grant information, regulations or guidelines, budget justifications, monitoring reports, annual reports, and extensive evaluation reports of accomplishments and outcomes.

Factor Brainstorming was used to identify critical factors in local system implementation. The research team worked with key system leaders via conference calls, and reviewed documents to identify and define structures, processes, and relationships that were considered critical to system implementation.

A **Factor Rating Exercise** was used to validate the locally identified system implementation factors by a broader group of system stakeholders. Interview participants were asked to complete a mail-in questionnaire in which they confirmed the factors and their definitions and rated the factors in terms of both ease/difficulty and effectiveness of implementation. Twelve ratings exercises were returned.

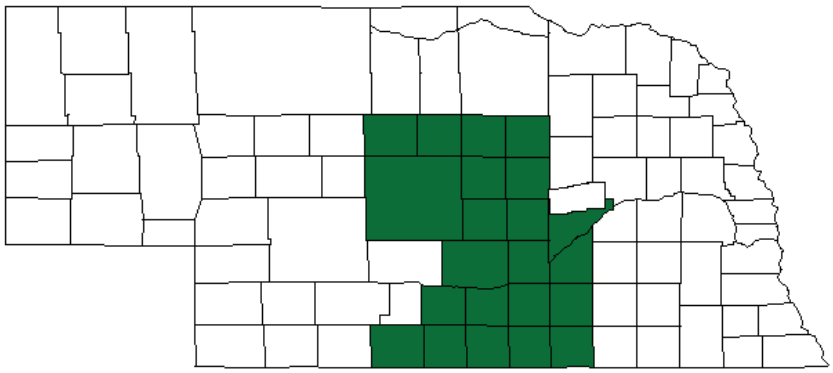
Factor Card Sorts were completed by interview participants for the purpose of understanding how the local system implementation factors related to one another, whether participants believed some factors were more significant or required earlier emphasis in order to accomplish system change, and whether certain factors were used in combination with one another to effect system change. Participants were given a set of 3x5 cards that had a factor printed on each, and they were asked to sort the cards

according to the above criteria. They had the option to remove factors they did not believe were important in Region 3's system of care and to add factors they believed should be included.

Semi-Structured Interviews were conducted with key stakeholders in person and by telephone for the purpose of understanding personal perceptions and beliefs about the process of system-of-care implementation. Individual interviews lasted approximately 1 hour, and the Regional Administrator assisted in identifying key people to be included in the interview process. Group and individual interviews were conducted with a total of 27 individuals of varying roles throughout the system.

Direct Observation of Region 3 System of Care service delivery structures and processes was used for the purpose of examining aspects of system implementation in action. Observation of five formal meetings and activities included regional management team meetings, interagency meetings, leadership meetings, and clinical meetings. In addition, informal observations of system activity were conducted while on site, such as a school wraparound services observation.

Figure 1. Map of Region 3



REGION 3 BEHAVIORAL HEALTH SERVICES SYSTEM CONTEXT

Region 3 Behavioral Health Services, one of six regions in the state of Nebraska, is a 22-county area that covers 15,000 square miles in the south central part of the state. The region has a population of approximately 223,143 people. According to 2000 census data, there has been a 2.1% population decrease from 1990-2000 (U.S. Census Bureau, 2000).

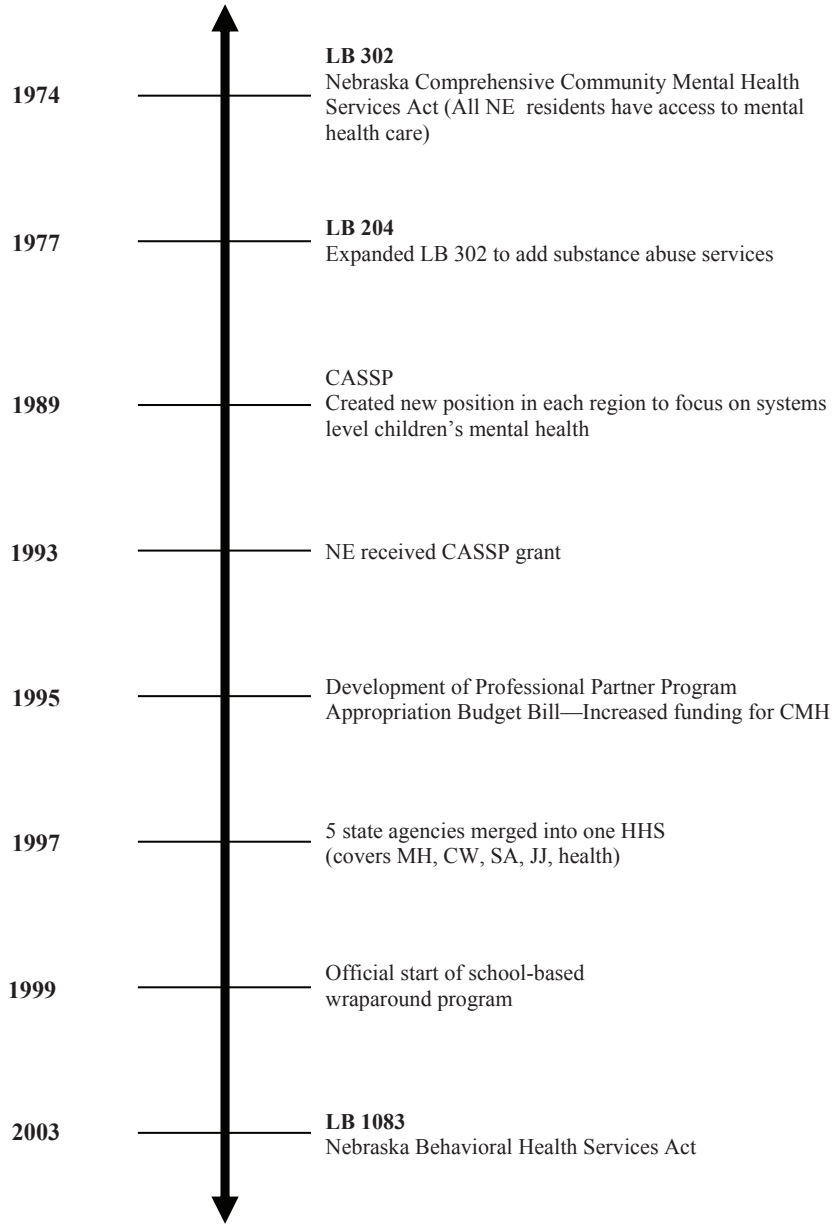
The racial/ethnic composition of Region 3 is 98% white, 2.2% Hispanic/Latino, 0.3% Native American, and 0.2% Black/African-American. U.S. Census data indicate a rising Hispanic/Latino population in the region. The median household income is $31,867; 12% of all families are below the poverty level; and 16% of children under age 18 are below the poverty level (U.S. Census Bureau, 2000).

Region 3 began its system of care efforts in 1989. At that time, the state legislature created a position for an administrator of behavioral health services in each of the six regions, with a focus on children's mental health at a system level. In 1995, the state developed the Professional Partner Program to assist families who have children with serious emotional disturbance. The Professional Partner Program utilizes the wraparound approach through intensive therapeutic case management. In 1997, Region 3 received a federal system of care grant, which allowed for a strengthening of their system of care. This specifically provided the opportunity for an expanded service array, the development of a comprehensive evaluation unit, and effective collaboration with agency partners. This collaborative effort

includes Region 3 and the Department of Child Protection and Safety (a combination of Children Welfare and Juvenile Probation) as well as the Department of Education and the local family organization, Families CARE, which has had an active role in the system since its inception.

Region 3 is currently serving as a statewide system of care model, and is providing technical assistance to other regions in their development of the Integrated Care Coordination Unit (ICCU) programs.

Figure 2. Timeline: Region 3 System of Care Development



REGION 3 ACHIEVEMENTS IN SYSTEM OF CARE DEVELOPMENT

The Region 3 Behavioral Health Services System of Care has numerous achievements that have made it an exemplary service system for children with or at risk of Serious Emotional Disturbance and their families. These accomplishments flow from a shared purpose in which stakeholders within the system have adopted system of care values to such a great extent that they are not viewed simply as system of care values but have internalized the values as their own. A few of these accomplishments include:

1. **Effective partnering with families and youth.**

   Families and youth not only have a voice within the system but are active participants and drivers of the system. Family involvement includes a family organization (Families CARE) that has been an equal partner in the system since its inception. Family organizations are viewed as critical to system functioning. The Region has developed concrete strategies regarding how to help Families CARE remain a strong and viable partner within the system by contracting with the family organization to conduct evaluations and disseminate evaluation data, specifically related to the wraparound process. Youth have a functional role within the system, leading an empowerment and advocacy organization, Youth Encouraging Support (YES). Families and youth are also active members in the State Infrastructure Grant.

2. **Collaboration.**

   Stakeholders within Region 3 Behavioral Health Services share a commitment to genuine collaboration and what it means. Collaboration within Region 3 sometimes requires going beyond one's "comfort zone" to ensure that children and families are receiving the best possible services. This includes an established level of trust which allows for the development of networks across all service sectors, engagement in collective problem solving, and the sharing of resources across system partners. All partners within Region 3 take equal responsibility for the children and families they serve and feel personally accountable for outcomes. The Region created structural changes that have strengthened collaboration, such as co-location of staff from various agency partners who have been positioned in a number of office locations throughout the Region.

3. **Strengths-based approach to serving families.**

   Stakeholders within the system of care are cognizant of the necessity of meeting families "where they are" and providing services and supports for their current level of need while helping families gain autonomy and problem solving skills. Case planning begins by identifying the strengths of the family and is conducted with active participation of the family.

Additionally, families are served as a unit instead of as individual clients and are viewed as critical partners in the treatment process.

4. **Expansion of access to services.**

   Services for children and families within Region 3 have been expanded dramatically over the course of the system's development. Region 3 has broadened admission criteria for many services, including the Integrated Care Coordination Unit (ICCU) and the development of the Early Intensive Care Coordination (EICC) program. Services and supports have been added for new post-adoption families and have been expanded to include substance abuse treatment and the development of family drug courts. These types of strategies have resulted in services that are accessed more easily and have less duplication. Finally, outreach at the individual community level has allowed Region 3 to meet the needs of rural and frontier families, responding to the Region's geographic size as well as the varying customs and beliefs of families.

5. **Value-based fiscal planning and decision making.**

   Strategic fiscal decisions have allowed Region 3 to sustain system partnerships across funding transitions. These strategies include restructuring services as well as sharing resources across agency partners, even while working within traditional financial structures. Stakeholders are able to illustrate cost savings to gain support of state legislative and funding authorities and to reinvest cost savings to expand services. In addition, Region 3 has worked with community-based partners in the writing of grants and strategizing to sustain funding levels across funding cycles and sources.

6. **Sophisticated structure and use of evaluation data.**

   Evaluation within Region 3 is an extremely high priority. There is a dual focus on clinical and administrative use of data. Region 3 is unique in its ability to create reports that describe functioning at the system, program, and individual client levels. This capacity encourages people at all levels (including frontline staff and families) to ask relevant questions, and evaluation staff are positioned to respond to these data-based requests. In addition, evaluation staff educate all stakeholders about the data to allow them to make short- and long-term data driven decisions.

The above accomplishments of the Region 3 Behavioral Health Services System of Care illustrate the exemplary work conducted within the Region to ensure the best possible services for children with or at risk of SED and their families. Above all, the system has maintained a focus on the role of families and youth in the functioning of the system, the strengths of families served, and the diversity of families within this rural and frontier geographic area.

REGION 3 BEHAVIORAL HEALTH SERVICES SYSTEM IMPLEMENTATION FACTORS

System implementation factors are structures, processes, and relationships that are used strategically by local system developers to build their system of care. Key stakeholders identified and defined implementation factors specific to the Region 3 Behavioral Health Services' System of Care. Eight factors were considered critical to the system's implementation. These factors should not be considered static. The importance and relative emphasis of each factor and its component parts changed over time as the system developed. Findings related to these factors are presented in the sections that follow. Themes related to individual factors, factor comparisons, and the relationships among factors will be discussed.

System Implementation Factor Themes

The discussion below highlights emergent themes for individual system implementation factors. Data collected through interviews and observations were highly consistent with data collected through the Factor Ratings Exercise. The findings presented below integrate data from these multiple sources. Factors are presented in alphabetical order.

Collaboration

Stakeholders within Region 3 Behavioral Health Services stressed the uniqueness of the rural/frontier landscape as an important aspect of collaboration, stating that there is a frontier attitude in which providers must work together and support each other in order to be successful. The geographical landscape was also identified as a challenge to collaboration. One service provider stated, "Geography makes it difficult, the Region serves a broad and diverse population." However, one evaluator noted that "Most partners understand the importance of collaboration in a rural environment with few resources both financial and in services." Consequently, although the rural landscape is a perceived barrier, it also serves as an impetus for system partners to sustain collaboration in Region 3.

It was apparent through observation and interview that system partners view collaboration as key to their strength as a system. The sharing of resources (money, staff, time, and training opportunities) and inclusion of all partners in

Table 1. Region 3 System Implementation Factors

Region 3 System Implementation Factors
1. Collaboration
2. Evaluation
3. Family and Youth Participation
4. Leadership
5. Resource Commitment
6. Responsiveness to Change
7. Shared Vision
8. State-Level Support
Identified Fall 2005

Collaboration is...

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

the planning and implementation of system activities appear critical to Region 3's collaborative efforts.

Collaboration, according to one stakeholder, "is a mind set of participants and facilitators." A common theme that emerged from the data is that respondents found leadership to be essential to successful collaboration. One administrator stated that collaboration is made easy by "leadership that values [it]." According to another, "it has at times been a struggle, but a struggle they have been able to overcome. Strong leadership in a variety of settings has helped this cause." The key to collaboration within Region 3 has been "constant communication," "continued meetings and updates," and "people willing to work together."

Evaluation

Most stakeholders found evaluation an easy factor to carry out in the Region 3. Although there is "a lot of work for the evaluation staff," they are viewed as very effective. Stakeholders stated that evaluation has been made easy because of "an ongoing commitment to evaluation processes," and that the system is assisted by a "good evaluation staff with vision for how [evaluation] fits into the system of care." A theme emerging from data is that evaluation is seemingly inherent to the system, that it is a "part of training and process," and that there is a "strong philosophy that evaluation is a vital and important part [of the system]."

A few respondents perceived evaluation to be difficult for the system. One evaluator stated that it is sometimes difficult for workers to understand how data can sustain or create new services and acknowledges that it is time consuming. In addition, managers do not always utilize or value the data.

Almost all respondents found the system to be effective at evaluation. An emergent theme was that the commitment of system leaders allowed for the effectiveness of system evaluation, and that "Leaders in Region 3 understand the power and impact of data so they have promoted and helped to sustain the evaluation process by…allowing evaluation to be a part of all other services provided by Region 3, and making sure that the Evaluation Department has the financial and technical resources to do their work." Some felt that evaluation allowed the system to continue to improve and allows Region 3 to be responsive to changing needs. One respondent warned against the temptation to utilize evaluation data in a punitive

Evaluation is...

described as a process through which local data are gathered on child and family progress toward goals, service quality, cost effectiveness, program capacity, and system effectiveness. Evaluation processes allow system planners and implementers to track and report data on outcomes for the purpose of decision making and quality improvement and to share with families, providers, and people outside of the system of care. The process of evaluation has been based on the development of a local capacity to conduct evaluation activities and the daily use of evaluation data. Using data on a daily basis improves the ability of the system to produce better outcomes within programs and across the system.

manner and stressed the importance of using it as a "positive avenue to improvement."

Family and Youth Participation

Within Region 3 Behavioral Health Services, it was noted through observations and interviews that family and youth are strong partners within the system. Family driven and youth guided care are exemplified by the inclusion and active participation of family members on boards at all levels throughout the system, a well-established and highly valued family organization, and a successful youth-run organization within Region 3.

Some stakeholders noted that "implementation of services depends on the family" and that "commitment to voice and choice for family is critical to system success." These quotes reflect the active participation of family and youth in the system of care and hints at their importance in system implementation and sustainability. As one respondent stated, "Nothing happens without the family."

Family and youth participation was viewed by many respondents to be easy or very easy to sustain in Region 3. According to one administrator, it is easy because "families and youth have a desire to make a difference." Other reasons cited for the success of this participation were "strong family members, leadership that values family participation, [an] excellent youth coordinator," along with "ongoing education for staff and other potential professional partners."

This factor was also seen as being effectively implemented in the system of care. One administrator stated that "continued support and continued equal partner attitude has made it very effective." However, one evaluator warned that "workers forget that families are experts and have a lot to offer." Succinctly stated by one respondent, "The child and family want a voice. They want to be heard. All we have to do is listen and work together."

Leadership

There is a general consensus within the system that having strong leaders with a system of care vision is critical to success, and that there are strong leaders across all system partners within Region 3. System leaders were described as consistent, passionate, strong, and possessing a shared vision. As one evaluator stated, the "Region 3 administration understands the importance of leadership in a SOC." It was also noted that the system uses leadership to "foster the sustainability of the

Family and Youth Participation is...

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

Leadership is...

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

system," and "its only failure was not being able to keep some system partners active after the grant (money) left." This was a common theme in responses, as some stakeholders believed that the completion of the Comprehensive Community Mental Health Services for Children and Their Families Program (CMHS) grant brought significant challenges to system leadership.

Despite obstacles, one respondent stated that "leadership has been strong across system partners. We have experienced leadership changes that have created challenges; however, we have been able to work through the challenges."

Resource Commitment is...

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

Resource Commitment

Overall, there is a consensus within the system that Region 3 can be relied upon to allocate needed resources to ensure that children and families are served. In addition, there is a feeling that the fiscal director and his team are effective at prioritizing needs and utilizing limited resources.

Stakeholders have mixed opinions about the difficulty of implementing resource commitment within the system. One administrator found that the system was "Successful at convincing [the] state to shift existing resources to [the] system of care," but that the system was less successful at obtaining new resources. Reasons that were identified as making this commitment difficult were "Territorialism. Everyone vying for the same dollars," and the concern that there are limited dollars to share with the community and a need for more flexible funds. One evaluator stated, "It is very hard to know how to allocate resources effectively. It has been a struggle to the limited resources and to sustain the SOC."

Responsiveness to Change is...

described as the willingness to adjust planning and implementation based on the system's experiences. This flexibility is created by the availability of constant feedback and the willingness to take action on feedback given. Processes that support constant feedback include meetings at all levels and across all parts of the system and 360º feedback loops. This responsiveness includes being open to changes that provide funding opportunities.

Despite the difficulties faced, most respondents found the system to be effective in its resource commitment. As one administrator stated, "Locally there is an ongoing commitment of necessary resources. At the state level the commitment has remained steady." One reason offered for effectiveness included a skillful "blend of seeing the detail and the big picture."

Responsiveness to Change

There is a general feeling within Region 3 Behavioral Health Services that change is an ongoing process, and they are never finished with building the system.

One stakeholder commented, "This is our culture, we are not satisfied unless we are asking 'What if?' and then willing

to change based on results and data." In general, most respondents found it easy to respond to change, but this was not without its challenges. As one administrator stated, "Some people find change more difficult than others. It is how you deal with those individuals that makes the difference. It goes back to positive relationships." Another respondent stated that there are individuals in leadership positions that encourage this change. According to one respondent, "Leadership continues to be open to change and willing to improve processes and practices. This willingness is modeled to stakeholders who then are willing to try new ways of doing business."

Most respondents found that the system was effective in responding to change. One administrator noted, "The fact that [the system is] sustaining post-grant is a testament to their effectiveness in responding to change." Again, leadership was cited as important to this effectiveness. "Region 3 leadership understands that if it does not change and adapt to the ever changing environment both political and professional, services provided to consumers will be lost." "This ability to see what is happening within the environment and then being willing to change is one of the reasons the SOC still exists."

Shared Vision

Most stakeholders found it easy for the system to maintain a shared vision. It should be noted however, that maintaining a shared vision can be challenging. "This is never easy," stated one respondent, "but we have persistence within the system." Further, another respondent acknowledged that "There have been challenges along the way. Over time it has become easier. The shared vision is commonly understood by various levels of staff and stakeholders within the SOC." It was noted that having a shared vision between parents and care coordinators is sometimes challenging.

The system is effective in implementing a shared vision. Leaders were identified as the "main champion to bring others to the shared vision," and play an invaluable role by "helping all stakeholders understand the shared vision." Clearly evident across the system was the "commitment to the vision by all stakeholders, especially 'front line' staff supervisors, organizations, leadership, providers, and families." Regarding a shared vision, one stakeholder noted, "We live it and we love it."

Shared Vision is...

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

State-Level Support

Stakeholders within Region 3 Behavioral Health Services appeared to have mixed feelings regarding the difficulty and effectiveness of sustaining state-level support in Nebraska. Although the majority of respondents stated that Region 3 is effective at sustaining this support, very few respondents felt that this was an easy task. In fact, comments such as, "The Region is as effective as they can be given the weakness in [the] state-level support mechanism" reinforce the challenges faced by Region 3.

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

Respondents stated that working with the state is a struggle, but Region 3 puts forth a great deal of effort to foster this relationship. In particular, respondents identified the Region's efforts to provide data and ongoing education to the state as examples of their efforts. This ongoing education is viewed as particularly critical with constant changes in leadership at the state level. Finally, in discussing funding difficulties in working with the state, one respondent offered, "It often times becomes a money issue rather than philosophy."

System Implementation Factor Comparisons

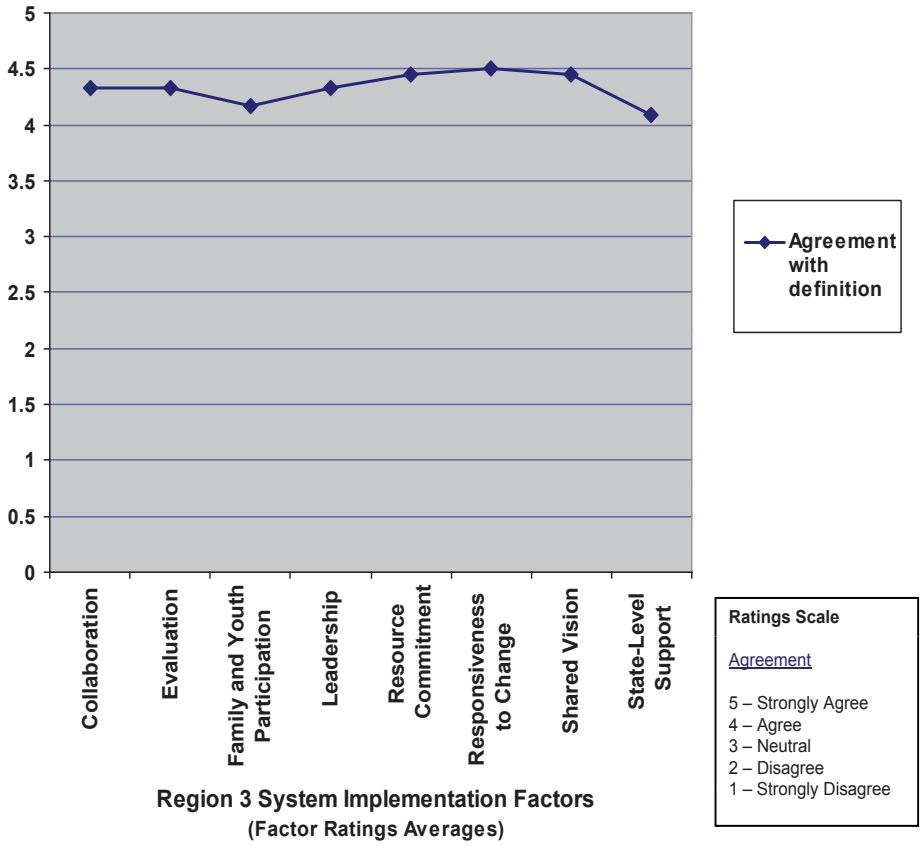
The line graphs below illustrate aggregate data from respondents of the Factor Ratings Exercise for the Region 3 Behavioral Health Services System of Care (SOC). The ratings exercise asked questions related to: 1) agreement/disagreement with the definition for each locally identified factor, 2) its importance for establishment and/or sustainability of the system, 3) its ease/difficulty of implementation, and 4) the site's level of effectiveness in implementing the factor.

Twelve people responded to the ratings exercise, with a response rate of 55%. Respondents represented all groups within the Region 3 System of Care except for families and youth. It is important to note, however, that the ratings data are consistent with overall interview and observation data collected during the site visit.

Agreement with Definition

The line graph in Figure 3 shows stakeholder responses on the Factor Ratings Exercise regarding agreement or disagreement with the definitions created for each factor. Questions offered the following response anchors: Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree, or Don't Know. These anchors were coded from 1 (Strongly Disagree) to 5 (Strongly Agree). Don't Know responses were excluded in the calculation of mean scores but were used in overall analysis of the data. Participant responses were used to validate data provided by a smaller group of stakeholders, in which critical implementation factors were defined. Respondents had little variability in

Figure 3. Agreement with Definition

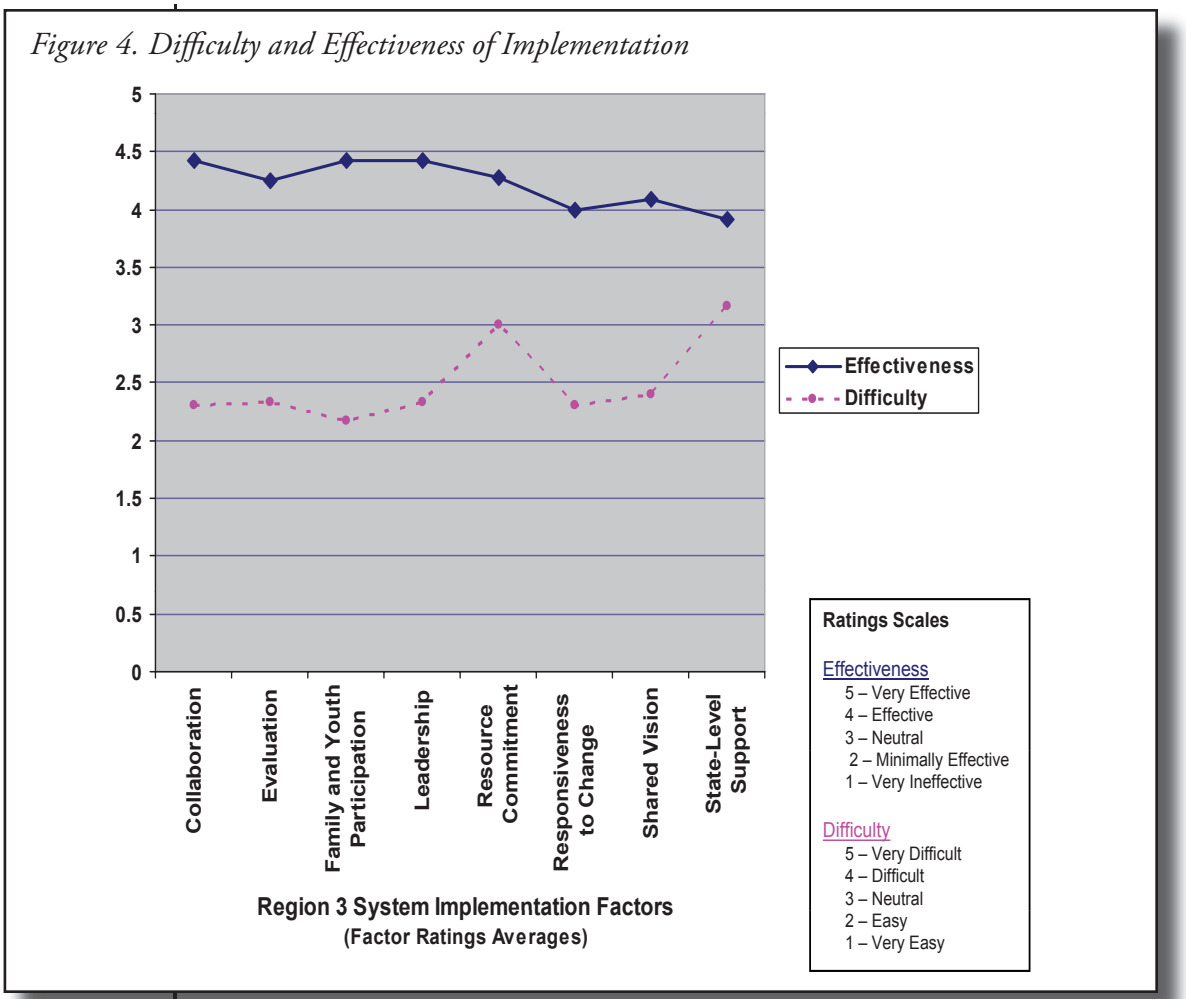


their rating of each factors, with a large majority of respondents stating that they agree or strongly agree that the definitions developed by the smaller group accurately reflect the meaning of these factors in their experience within the system of care. The average for **State-Level Support** was slightly lower than the averages of the other factors, and **Responsiveness to Change** was shown as having the highest level of agreement. Complete definitions for each factor are provided in the section titled System Implementation Factor Themes.

Effectiveness and Difficulty

The research team also analyzed data on the effectiveness and difficulty of implementing the factors within Region 3's System of Care. The line graphs in Figure 4 illustrate stakeholder perceptions of both effectiveness and difficulty of the implementation of each factor within their system. The anchors for the question on Effectiveness consisted of Very Ineffective (1), Minimally Effective (2), Neutral (3), Effective (4), Very Effective (5), or Don't Know (not coded). The questions reflecting the difficulty of implementing each factor offered the following response anchors: Very Difficult (5), Difficult (4), Neutral (3), Easy (2), Very Easy (1), or Don't Know (not coded).

Figure 4. Difficulty and Effectiveness of Implementation



Overall, respondents felt that stakeholders within Region 3's System of Care were effective or very effective at implementing the factors. **Collaboration**, **Family and Youth Participation**, and **Leadership** demonstrated particularly high mean scores. **State-Level Support**, with the lowest mean score, included several "Neutral" responses with all other responses noted as effective or very effective. Mean scores related to the question of ease or difficulty of carrying out each task showed more variability across factors than the issue of effectiveness. **Family and Youth Participation**, **Collaboration** and **Responsiveness to Change** were viewed as the easiest factors to carry out, with **Leadership** and **Evaluation** close behind. The reader will note that 3 of these 5 were also identified as being effectively carried out. Two factors that appear more difficult to carry out, **Resource Commitment** and **State-Level Support** (also identified as being less effectively implemented), included several "difficult" responses as well as several "neutral" and a few "don't know' responses. Further details related to these differentials are reflected in the System Implementation Factor Themes section of this report.

The graphs above reflect that in general, the factors that are easier to implement are more effectively implemented within the Region 3 Behavioral Health Services System of Care. This pattern is reflected with several factors illustrated in Figure 4.

Relationships Among Factors

Taken individually, the factors discussed above represent critical strategies used in Region 3 system of care implementation. The concept of a system, however, suggests that a set of elements can come together to form a whole that has different properties than those of the individual component parts (Checkland, 1993, 1999; Gharajedaghi, 1999). System thinking uses the concept of wholeness as a way to capture the complexity inherent in systems that have multiple component parts, each with its own role and function. To better understand how the Region 3 implementation factors have been used to leverage system development, it is useful to consider them in terms of their roles in system change and their relationships to one another.

Using the factor definitions, the research team first grouped the Region 3 implementation factors into categories according to their primary role in leveraging system change. The factors can be clustered into four categories as shown in Table 2. The relationships among implementation factors are discussed below.

In Region 3 Behavioral Health Services, local leaders have nourished a system of care that is grounded in Child and Adolescent Service System

Table 2. Region 3 System Implementation Factors According to Primary Role

Factors	Factor Roles
Responsiveness to Change Leadership Shared Vision Family and Youth Participation Collaboration	**Facilitating System Values and Beliefs**
Resource Commitment State-Level Support	**Facilitating System Goals**
Evaluation	**Facilitating System Information**
	Facilitating System Structure

Program (CASSP) principles and built on family- and youth-directed efforts. These leaders are present in every stakeholder group and have worked hard to establish and continually renew consensus on a set of shared values that determine the actions and goals of all system participants. These values have been translated into the specific goals of the system, and evaluation is centered on understanding how well these goals are being met. As more stakeholders (including both new service populations and service providers) are integrated into the culture of the system of care, the system is exposed to new ideas about service delivery and service philosophy within the broad framework of the CASSP principles. The system's use of shared leadership and continuous evaluation means that these new ideas are often translated into new actions that are responsive to the needs and strengths of the service population. The links between each of these sets of processes are explored below, beginning with the links between leadership, shared vision, and collaboration.

System Values and Beliefs: Leadership leads to Shared Vision and Collaboration

Implementation factors related to System Values and Beliefs use the intrinsic philosophy of systems of care to create system change. Data confirm that in Region 3, Values and Beliefs factors were critical contributors to system change through shifts created in the fundamental belief structure of system stakeholders. It is notable that five of Region 3's eight implementation factors are clustered in the category of Values and Beliefs. These factors represent the mindset of the system or the shared understanding from which the system is developed.

Stakeholders in Region 3 explicitly linked values and beliefs factors such as *leadership*, *collaboration* and *family participation* with each other. For example, stakeholders indicated that leaders helped establish the system and create a collaborative process that defined the values of the system. As one stakeholder stated, "I think that a strong leader with the vision of a SOC helped to establish and sustain it. Someone like a champion to promote it." Because one of the values that both drove and resulted from this effort was a strong commitment to collaboration, leadership was increasingly identified as a shared property across stakeholder groups. One participant defined it as, "Strong leaders at [the] regional level who believe in collaboration," while another individual stated that Region 3 has, "…strong family members, leadership that values family participation, [and an] excellent youth coordinator."

This view of leadership indicates that both service providers and families have generated and contributed to leadership that sustains the *shared vision* of the system. These system values extend beyond the idea of collaboration; these values are expected to be translated into commonly sought goals. These goals are largely synonymous with the original federal CASSP principles and have been strengthened over time to include an explicit emphasis on family

and youth directedness and competence in serving diverse populations. This *responsiveness to change* is grounded in the values and beliefs of the system and is reflective of the communities' needs. Implementation factors related to values and beliefs have great power to affect change because they shape actions taken within the system. Data suggest that stakeholder ability to respond to change is grounded in a belief that change is possible and that they had the ability to transcend the initial conditions of the system.

System Goals: Shared Vision Leads to Evaluation and State Level Support

The factors related to System Goals facilitate implementation by making system values and beliefs concrete and orienting system activity toward action. Region 3's stakeholders identified two factors related to System Goals and linked these factors to 'shared vision.' Data confirm that the expectations and intended outcomes of the system were used to anchor system development by making the goals of system development clear. Rigorous, regular evaluation and monitoring of progress towards meeting system goals has allowed the Region 3 system of care to garner *state-level support* and additional *resource commitment*.

This process requires constant effort and attention and is seen as important to sustaining and continuously improving the system. This effort is required, in part, because the values and philosophies of state-level administrative and legislative bodies are not always initially consistent with those of the system of care. As one stakeholder explained, this requires "ongoing education to get ongoing buy-in." Another stakeholder remarked, "It is a constant education process for state-level administration. With changes in state-level leadership there is a need to work diligently to help leaders understand and commit to system of care principles." However, this effort to create and disseminate meaningful information about system performance not only allows system leaders to gain state support, it also allows them to be responsive to changing local needs.

System Information: Value-Based Evaluation leads to Responsiveness to Change

Factors related to System Information include the structure and flow of system feedback and incorporate both formal and informal information mechanisms to accomplish system change. Local participants identified one factor related to System Information: *Evaluation*. Evaluation is a critical component of the Region 3 system of care. It generates the information that allows persons at every level of the system to know whether their actions are effective in meeting the needs of their local children and families in a way that is in keeping with their core values.

In Region 3, evaluation data is communicated across all levels of the system and is used to improve the performance of all stakeholders in meeting value-based goals. This information is also used to educate county- and state-level stakeholders on the importance and success of the collaborative system, and to generate additional resources to sustain and improve the

system. One respondent stated that they have "good evaluation staff with [a] vision for how it fits into the system of care," and another stated that this led to "…sharing data with system partners." These data, ultimately, allow them to be "responsive to changing needs, which is a result of continual evaluation."

As stakeholder responses make clear, the use of data is driven by the shared values of system partners and the goals they have generated. Relevant information about system performance is then fed back to stakeholders. One participant remarked, "This is our culture, we are not satisfied unless we are asking, 'What if?' and then willing to change based on results and data." Because a culture has been established that continually looks to respond to data and improve outcomes for families and youth, these data lead to specific policy and practice changes. Because information is rapidly and widely shared in a manner that leads to change at all levels of the system, this system can be viewed as adaptive and responsive to changing community needs.

System Structure

Factors related to System Structure facilitate system change by creating changes in specified roles, responsibilities, and authorities of system participants. Region 3 stakeholders did not explicitly identify specific structures as factors critical to system implementation. However, service systems require structures that routinize training, service delivery, evaluation, and communication. Data indicate that such structures do exist in Region 3, and these structures are an important aspect of day-to-day operations. Two examples of structural change related to system implementation in Region 3 include the ICCU and the co-location of cross-agency staff. It appears that these structural adaptations have been in place for enough time in Region 3 that their existence is accepted as part of routine system operations. The service structure in Region 3 has developed organically, with input from local stakeholders from diverse groups and is guided by many leaders present at all levels of the system. This decentralized decision-making model likely de-emphasizes formal structures, instead focusing stakeholder attention on addressing the tasks at hand without explicit reference to whether or not the needed actions fit within a specific bureaucratic structure.

Implemented strategically and in combination with one another, the 8 factors identified by Region 3 stakeholders were used to leverage system change. Region 3's system development process is ongoing. A foundational characteristic of the system is that stakeholders agree on the outcomes they need to achieve, consistent with a few core values, and then work together to meet those goals.

Progress requires constant monitoring and adjustment to meet the needs of the communities in the Region. System sustainability requires the buy-in of a large and diverse group of stakeholders; many of these stakeholders are or will become leaders in the system. These stakeholders also include state legislative, regulatory, and funding bodies. The Region is continuously working to educate these stakeholders about the logistic, fiscal, and philosophical advantages of the collaborative system they have created. This network of relationships among persons, actions, and information changes over time but has proven remarkably resilient and adaptive in meeting the needs of the Region's families, children and youth.

KEY POINTS FOR SYSTEM SUSTAINABILITY

Region 3 Behavioral Health Services has modeled system development and has sustained its system over time. This stability has put the Region in a position to expand efforts throughout the state by working with other Regions to strengthen and improve their services. Stakeholders within the Region constantly evaluate, strategically plan, and implement changes/improvements to the system. However, there have been few times in which stakeholders have made significant mid-course corrections during the system's development. The following key points for system sustainability were identified by the research team as areas in which the Region stakeholders may choose to focus efforts as they continue to develop their system.

1. **Strengthening and developing partnerships.**
   Data indicate that not all partnerships developed during the federal grant were sustained after the federal grant ended. In particular, this impacted school-based wraparound programs, which started in four schools but were cut back due to funding challenges.

   Within the Region, families should continue to be encouraged to create their own "family teams," and this often includes extended family members, religious leaders, teachers, and counselors, as the family's social network can vary greatly and is strongly dependent upon informal supports in their local community. In remote areas of the Region, it is important that stakeholders emphasize the expansion of formal and informal supports. Development of trust among partners and within local communities is critical. When trust within communities is developed, outreach and supports among local providers/helpers will likely be more successful than if offered by formal providers from other areas of the Region.

2. **Addressing population diversity.**
   A discussion of population diversity within the Region addresses two issues—diversity based on varying races/ethnicities as well as the values, customs, and beliefs of rural and frontier communities. Data suggest an increase in minority populations within Region 3. Stakeholders within the Region are mindful of this diversity and are working to improve and expand services to diverse populations. Initial efforts to build community leadership in local community-driven programs should continue. Data indicate that particularly in frontier communities, there is often a refusal of services that are offered from persons outside the immediate community. Local community programs benefit families in two ways: They offer services in the family's immediate area, and they link families to providers and supports familiar to and often trusted by the family.

Local community programs will assist in expanding services to rural and frontier areas.

3. **Developing future leaders.**
   Region 3 should begin to prepare for leadership changes that will naturally occur within their system. A key component to this effort is building leadership that is grounded in the vision and mission of the system. Developing leaders from within the system assists in this effort, as these are persons who have genuinely internalized the values and beliefs of the system. Extensive mentoring and training, including cross-system training, can assist in this endeavor. It is critical for sustainability that new leaders be truly committed to the system of care philosophy. Youth and family organizations also provide leadership in the system. The development of future leaders within these organizations is also critical, and the Region must be attentive to this need.

4. **Adapting evidence-based practices to the system of care.**
   Stakeholders must be cognizant of community context as new programs and services are implemented and must expect initial reluctance to adopt some of these practices. Within the Region 3 database system, numerous programs have demonstrated positive outcomes for children and families. In this context, new practices may be viewed as competing with existing practices. Existing practices have been grounded in the firmly held values, beliefs and customs of individual communities. As such, new practices may require substantial adaptation before they are viewed in the same regard by stakeholders within the community. Region 3 must address context, expect competition among practices, and anticipate conflict among staff as new practices are implemented. Conflicts may require open communication, training surrounding new practices, modeling, and coaching. Utilizing shared outcome data will also help support these new practices and will increase buy-in from all staff.

5. **Expanding key state-level alliances.**
   State-level support in Nebraska fluctuates and has become an area of concern for stakeholders in Region 3. Region 3 is clearly a model of a successful and sustainable system of care, and the state can take advantage of what the Region has done by allowing expansion of their work into other regions across the state. Region 3 is being asked to engage in some of this work (for example, assisting in the development of a state-wide Integrated Care Coordination Unit manual to assist other regions in improving services). Working as a coalition and building partnerships across the state would be a benefit to each region and the

state as a whole. Development of a state-level infrastructure would strengthen these efforts.

In conclusion, the Region 3 Behavioral Health Services' system of care is grounded in a philosophy that families and youth must be active, equal partners in the development of a successful system. In addition, stakeholders in the system acknowledge the various aspects of diversity within their Region and strive to meet the needs of all children and families throughout this large geographic area.

Stakeholders in Region 3, cognizant that children function within a larger familial context, have expanded their population base and services to address the needs of families as one unit, developing programs such as family drug courts, utilizing flex funds for treatment of parents, and providing post-adoption support for families. These day-to-day activities exemplify a genuine respect for children and families that permeates throughout the system.

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APPENDIX A:
STUDY 2 SUMMARY

Study 2: Case Studies of System Implementation

Core Research Team

Sharon Hodges, Ph.D.
Principal Investigator
813-974-4651 (phone)
813-974-7563 (fax)
hodges@fmhi.usf.edu

Kathleen Ferreira, MSE
kferreira@fmhi.usf.edu

Nathaniel Israel, Ph.D.
nisrael@fmhi.usf.edu

Jessica Mazza, BA
jmazza@fmhi.usf.edu

Division of Training, Research, Evaluation, and Demonstration (TREaD)

Division Director: Mario Hernandez
Email: hernande@fmhi.usf.edu

Louis de la Parte
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807
Voice: 813/974-4651
Fax: 813/974-7563
http://cfs.fmhi.usf.edu/tread.cfm

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Study 2: Case Studies of System Implementation

Holistic Approaches to Studying Community-Based Systems of Care

A Five Year Study Investigating Structures and Processes of System-of-Care Implementation

Purpose and Goals:

To identify strategies that local communities undertake in implementing community-based systems of care and provide greater understanding of how factors affecting system implementation contribute to the development of local systems of care for children with serious emotional disturbance and their families.

This study will investigate:

- Fundamental mechanisms of system implementation
- How factors contributing to system implementation interact to produce well-functioning systems serving children with serious emotional disturbance and their families
- How system implementation factors are used in specific or unique combinations to develop local systems of care
- How local context influences system-of-care development
- What structures and processes contribute to the implementation of systems of care
- If system of care implementation is marked by identifiable change agents or triggering conditions
- What conditions support or impede the development of systems of care

Methods:

The investigation will use a multiple-case embedded case study design to investigate how communities operationalize and implement strategies that contribute to the development of community-based systems of care for children with SED and their families. A national nomination process will be conducted to identify established systems of care. A site selection process involving document review and key stakeholder interviews will be used to identify participating sites. Case study data will then be collected using semi-structured interviews with administrators, managers, direct service staff and families; direct observation; document review; and a review of aggregate outcome data. A brief description of these methods follows.

Document review will be used to provide organizational-level data related to system implementation as well as system-of-care development in a historical context. Documents should include any materials related to goals and intent of the system, legislative history, regulations or guidelines, budget justifications, monitoring reports, annual reports, and reports of accomplishments. Documents should be mailed to Sharon Hodges or Kathleen Ferreira one month prior to the site visit.

System implementation factor brainstorming and rating will be conducted in order to identify local factors believed to be critical to system-of-care implementation. This process will consist of identifying system implementation factors, then rating the identified factors on a five-point scale with regard to both their importance and effectiveness in local efforts to develop systems of care. The brainstorming and rating will be completed as an online survey.

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Key stakeholder interviews will be conducted in person and by telephone for the purpose of understanding personal perceptions and beliefs about the process of system-of-care implementation and the role of the identified implementation factors in local system development and their relationship with one another. Interviews lasting approximately 1 hour will be held at a time and place that is convenient for the interviewees, and sites will assist in identifying the key people to be included in the interview process. Initial interviews should be scheduled at least two weeks in advance of the site visit.

Direct observation of service delivery structures and processes will be conducted for the purpose of observing aspects of system implementation in action. Direct observations will be coordinated with naturally occurring agency and community meetings.

Aggregate outcome data will be reviewed for the purpose of establishing progress toward system goals and better understanding linkages between specific strategies and outcomes.

Timeline for Case Studies of System Implementation

The investigation will be conducted in three phases:

- Years 1-2— Two cases will be selected from among established systems that have sustained their effort over time. Preliminary findings for Cases 1 and 2 regarding system implementation factors in local system-of-care development will be reported and used in the selection of cases for years 2-3.
- Years 2-3— Four sites will be sampled and findings reported. Sampling strategies for Cases 3-6 will be developed on the basis of what is learned from the initial cases.
- Years 3-4— Four additional sites will be sampled and findings reported. Sampling strategies for Cases 7-10 will be developed in response to the earlier findings of the study.
- Year 5 – Cross-site analysis and summary and dissemination of findings.

Participation:

A total of 10 communities will be selected for this study. Stakeholders in each community will participate in site visits, in-person and phone interviews, and document review. A site selection process involving document review and key informant interviews will be used to identify established system-of-care sites. Participation of organizations, as well as individuals, will be entirely voluntary.

Results:

It is expected that the results of this study will help both established and potential systems of care to identify strategies for successful system implementation within their local contexts. Findings of each phase will be shared with professional and family audiences through workshops, presentations, issue briefs, newsletter articles and published papers. This effort will be extended to cross-site findings as results become available.

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Research and Training Center
for Children's Mental Health
Department of Child & Family Studies
Louis de la Parte
Florida Mental Health Institute
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807
813-974-4661
http://rtckids.fmhi.usf.edu
rtckids@fmhi.usf.edu

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

APPENDIX B:
SYSTEM OF CARE DEFINITION

Study 2: Case Studies of System Implementation

Core Research Team

Sharon Hodges, Ph.D.
Principal Investigator
813-974-4651 (phone)
813-974-7563 (fax)
hodges@fmhi.usf.edu

Kathleen Ferreira, MSE
KFerreira@fmhi.usf.edu

Nathaniel Israel, Ph.D.
nisrael@fmhi.usf.edu

Jessica Mazza, BA
jmazza@fmhi.usf.edu

Division of Training, Research, Evaluation, and Demonstration (TREaD)

Division Director: Mario Hernandez
Email: hernande@fmhi.usf.edu

Louis de la Parte
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807
Voice: 813/974-4651
Fax: 813/974-7563
http://cfs.fmhi.usf.edu/tread.cfm

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System of Care Definition

A system of care[1] (SOC) is an adaptive network of structures, processes, and relationships grounded in system of care values and principles that effectively provides children and youth with serious emotional disturbance and their families with access to and availability of services and supports across administrative and funding boundaries.

Elements of the SOC Definition	Shared Understanding of Concepts
An adaptive	Incorporating action, reaction, and learning over time (Holland, 1995)
network	A set of linkages across people, organizations or communities (Capra, 2002; Schensul, LeCompte, Trotter, Cromley, & Singer, 1999)
of structures,	Specified roles, responsibilities, and authorities that define organizational boundaries and enable an organization to perform its functions (Bolman & Deal, 1997; Plsek, 2003; Theirry, Koopman, & de Gilder, 1998)
processes ,	Methods of carrying out organizational activities often involving sequences or a set of interrelated activities that enable an organization to perform its functions (Bolman & Deal, 1997; Plsek, 2003; Theirry, Koopman, & de Gilder, 1998)
and relationships	Trust-based links creating connectedness across people and organizations (Folke, Hahn, Olsson, & Norberg, 2005)
grounded in SOC values and principles	As defined by Stroul and Friedman (1994) and Hernandez, Worthington, & Davis (2005)
that effectively provides	Data that demonstrate progress toward goals or desired effect (Hernandez & Hodges, 2001; Hodges, Woodbridge, & Huang, 2001)
children and youth with serious emotional disturbance and their families with	An identified local population of children and youth and their families (CMHS, 2002; Hernandez & Hodges, 2003b)
access to and	Ability to enter, navigate, and exit appropriate services and supports as needed (CMHS, 2003, 2004; Farmer et al., 2003)
availability of	Services and supports in sufficient range and capacity (Stroul, Lourie, Goldman, & Katz-Leavy, 1992; U.S. DHHS, 2003)
services and supports	Formal and informal, traditional and non-traditional assistance (Burchard, Bruns, & Burchard, 2002; Hernandez, Worthington & Davis, 2005)
across administrative & funding boundaries	Unrestricted by categorical administrative and funding boundaries (Pires, 2002; President's New Freedom Commission on Mental Health, 2003; Stroul and Friedman, 1994)

[1] Original System of Care Definition: "A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families." (Stroul & Friedman, 1986).

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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Research and Training Center
for Children's Mental Health
Department of Child & Family Studies
Louis de la Parte
Florida Mental Health Institute
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807
813-974-4661
http://rtckids.fmhi.usf.edu
rtckids@fmhi.usf.edu

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APPENDIX C:
SEMI-STRUCTURED SYSTEM IMPLEMENTATION INTERVIEW GUIDE FOR RTC STUDY 2: CASE STUDIES OF SYSTEM OF CARE IMPLEMENTATION

Historical Development of System of Care

1) Please tell me a little bit about the history of your system of care and your role in the process of developing or implementing it.
   - Initial context
   - Triggering conditions
   - Identifiable change agents
   - Foundational strategies
   - Mid-course changes or realignments

2) How would you describe the population of children and youth with serious emotional disturbance and their families in your community?
   - Clear identification of who the system is intended to serve
   - Issues of context or need specific to this community
   - Change over time

3) What goals does your system have for this population?
   - System of care values and principles
   - Change over time

Identification of Factors Affecting System of Care Implementation

4) What strategies have been used to develop a system of care that can serve the needs and achieve its goals for children and youth with serious emotional disturbance and their families?
   - Fundamental mechanisms of system implementation
   - Structures/processes related to networking, access, availability, administrative/funding boundaries
   - Center's identified factors
   - Participant's role or contribution

5) What strategies do you think have most affected the implementation of your system of care?
   - Clear definition of the named factor from perspective of participant
   - Center's conceptualization of factors
   - Articulation of why this factor has had such an effect
   - Participant's role or contribution

Relationship among System Implementation Factors

6) How have staff and stakeholders been involved in implementation of your system of care? Are there certain groups of staff and stakeholders that have been key to the process?
   - Collaboration across agencies
   - Leadership
   - Governance
   - Direct service
   - Family involvement
   - Evaluators

7) Do you think any of the strategies you identified were more important or fundamental than others?
   - Remind participant of factors he/she has identified

8) Do you think the strategies you identified worked best because they happened in a certain order?

9) Are there strategies that worked best in combination with other strategies?

10) How has the process of system implementation been communicated to staff, stakeholders, and the community?

11) What would you change about the process of implementing your system if you could do it again?

12) What strengths and successes do you associate with implementing your system of care?

13) What challenges do you associate with implementing your system of care?
   - Conditions that impede system development
   - Strategies designed to meet the challenges

14) What kinds of information do you get about how the system of care is performing and how do you use it?
   - Achievement of system goals and outcomes

15) Describe any mechanisms that have been developed to sustain your system of care.

16) Is there someone else who would be important for us to talk to, to help us understand the implementation of your system of care?

17) Is there anything you would like to add to this interview?

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