



Indiana System of Care **Resource Manual**



Section III Essential Functions

Section III.I

System-Level Coordination

Learning Objectives:

1. To learn who should participate in a coordinating body.
2. To understand the roles that coordinating bodies play in the governance and operation of a system of care and examine structures and models used throughout the country and in Indiana.
3. To learn about the roles and responsibilities of a system or wraparound coordinator.

Summary:

This section describes some of the “nuts and bolts” infrastructure elements that are necessary to make a system of care work. A coordinating body with strong local leadership and at least minimal staff support are essential to hold the system together. In some communities a system or wraparound coordinator is the “glue” that helps the collaborative effort stay on track. The coordinating body may be newly formed for the system of care or may be an existing community-wide body that decides to incorporate system of care values and practice into its current coordinating role. Communities throughout the country and in Indiana have adopted a variety of different structures that make sense in the context of their own leadership, existing collaborations and environment.

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System-level Governing Body

The system level governing body needs to be representative of child-serving organizations in the community. The name of the governing body is chosen by its members, however for our purposes we term it a “consortium”, a name adopted by a number of Indiana communities. Pires (has defined governance as “decision making at a policy level that has legitimacy, authority, and accountability”. The “legitimacy, authority, and accountability” come in part from strong family representation as well. In her Primer (2002 p. 26) Pires includes 14 strategies for involving family members in planning and these hold true for participation in governance as well ([see Toolkit #3.1.1](#)). It is imperative that community leaders make a strong commitment, demonstrated by action, to insure family participation in the consortium. Without this representation, the mandates of system of care governance are not met.

At a minimum, representatives from child welfare, juvenile justice, mental health, education, including special education, family members, and family advocacy organizations, such as mental health associations, should be represented. Many communities in Indiana have other prominent organizations that serve children locally, and these should have representation on the consortium as well. Many communities also include representatives from the medical profession, faith groups, and community service organizations. Representatives on the consortium need to have authority to act on behalf of their agencies or organizations and a willingness to meet to engage in the collaborative process on a regular basis.



What are its Characteristics?

Characteristics of governing bodies for systems of care can and do vary widely in different communities, but in general, according to Pires (2002, pp.30-32), they must have authority, clarity of purpose, credibility, capacity, shared responsibility for the target population, and be representative of the community involved.

In Indiana, some consortium members derive their authority from the legal mandates of their agencies and others from memoranda of understanding among them. Service provider representatives or care management organizations may have contractual commitments with government entities. Additionally, community commitment from influential leaders, family members, and family advocacy organizations add legitimacy to the group.

Consortium members must be clear about what they are governing. Early in the process they must work together to define such things as mission, guiding principles and values, target population, and expected outcomes. In other words, what are the expectations of each member and/or their constituency about what the system of care is to accomplish? Common beliefs are the glue that can hold together the alliance during tough times. Without these clear, written statements, policies and procedures, confusion and frustration are likely to ensue.

Early in the process, many community governing bodies (including Federal system of care grant sites) choose to develop theories of change. A theory of change simply articulates a community’s consensus about the needs of children in the community and the strategies that will help them to meet those needs (Hernandez and Hodges (2003). From the development of the change theory, communities can move to create a visual logic model that expresses in words and graphics the population to be served, guiding principles, system of care strategies, and outcomes for all levels (practice, child and family, and system) of the system ([available online here](#)). Engaging in this process helps a diverse group of community stakeholders ensure that their expectations and actions are in line to provide a system they envision will benefit children and families.

It should go without saying that the consortium must be representative of all stakeholders involved with children and youth in the community. Anyone “left out” may doubt

the legitimacy of the system, and cause it to fail. The group's membership may grow or get smaller over time, depending on the needs of the system and the youth and families served.

Members of the consortium must have credibility in the community. They must be willing to communicate the goals of the system and have the ability to speak for their organizations. Those representing families must be willing and able to speak up for their interests. The consortium also must have the capacity to govern. Members must be able to commit time, talent, staff, and data for evaluation and outcome measurement. Most communities in Indiana have hired a coordinator and included in the job description the role of convening the consortium. This role/position should not be minimized, since successful collaborative alliances do not happen without nurturing. Though the coordinator may not necessarily be the leader of the consortium (often that role is rotated among members who are community leaders), responsibility for keeping the consortium together and on task may fall to her/him. Calling meetings for times convenient to members, assuring organized regular (at least monthly) meetings that begin and end on time and have a written agenda, and ensuring regular written and oral communication with members are just some of the responsibilities of the coordinator who has this role (McIntyre, 2002).

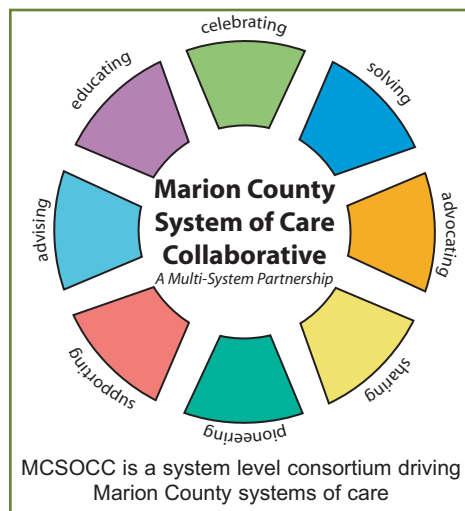
Finally, members must feel a shared responsibility for the population that is served. This extends to legal mandates and financial commitments, which are not altered by their collaboration. However, if those whose agencies share responsibility for serving the targeted group of children and families bring their combined resources to the table, then no one agency or organization feels that the responsibility is theirs alone. This is not an easy task, but is critical to the success of local systems of care.

What Structures are Used?

This question must be answered by the consortium and community in which the system of care is built. Pires (2002, p. 36) offers examples of structures utilized in different systems throughout the country. The consortium may utilize a nonprofit board of directors model, or operate

more like a system management team. It may be a looser confederation whose structure is more like a networking forum. As long as the roles and expectations of members are clear to them and agreed upon by all, the structural model and specific membership criteria are matters of local preference and utility.

The system of care is managed by the consortium by consensus. Such decisions as who will be served, how they will access the system, availability and types of services, adherence to mission and values, and outcomes identification and measurement, all fall under the auspices of the governing body. Often permanent subcommittees, or ad hoc work groups are formed to make policy and solve inevitable conflicts.



Indiana Examples

As an example, the Dawn Project in Marion County has received much attention, both locally, and at the state and national levels. While there is no expectation that what works for Marion, the largest county in Indiana, is wholly appropriate for other counties, not only with smaller populations but much different demographic characteristics, there may be useful elements and lessons to be learned from the Marion County experience. In *The Dawn Project – A New Day...A New*

Beginning: A Brief History and Guide to the Development of a System of Care in Marion County, Indiana (2002), McIntyre outlines the steps taken and lessons learned in the creation of Dawn. Anderson, McIntyre, Rotto and Robertson (2003) discuss the critical components of collaboration in the creation and sustainability of the project. Additionally, Volume 3 of the Health Care Reform Tracking Project's Promising Approaches series (Hepburn and McCarthy 2003) entitled *Making Interagency Initiatives Work* devotes a chapter (pp.38-49) to the Dawn Project and its efforts to maintain a working collaboration with multiple partners and stakeholders in Marion County. More recently a case study entitled *Leveraging Change in the Marion County, Indiana System of Care: The Dawn Project* (Hodges, et al. 2009) was released by researchers at the University of South Florida. The report concluded that the Dawn Project exhibited a strong commitment in working collaboratively through the consortium to make data based decisions that enhance the system of care as well as outcomes for individual children and families.

General Resources

According to Karl Dennis, one of the founders of the wraparound movement (discussed in subsequent sections), “collaboration is an unnatural act performed by non-consenting adults”(see Dennis and Lourie, 2006). While this humorous definition can apply to the creation of systems of care and the necessity for collaborative efforts in order to make them work, there are guidelines available to help in avoiding the pitfalls.

Winder and Ray’s Collaboration Handbook (1997) is an excellent step-by-step guide for creating and maintaining effective collaborations. Likewise the Pires Primer (2002) offers many guidelines and references to help communities develop their systems of care.

System Management in Indiana

System Coordinator Role

As mentioned above, most funded communities in Indiana have elected to hire a coordinator in order to help their system development efforts move forward. The role of this person varies from community to community. However, those who have exhibited early success have allowed the coordinator both time and resources to help build the system infrastructure. He or she must be able to “nudge” the consortium as a group and its individual members along the road to realizing their goal of a coordinated system of care. Fragile collaborations can fall apart easily without careful ongoing cultivation, and the coordinator must have the personality, communications skills, and stature in the community to keep the effort alive and well.

Specific duties of the coordinator vary from community to community. In the beginning, it may be necessary for the coordinator to carry a small caseload. Long-term success for systems of care, however, has been observed in communities that have coordinators committed solely to the role of system coordination. In Indiana, the coordinator is usually employed by a community mental health center with the approval of the consortium. Other consortium member agencies may contribute to the coordinator’s salary or benefits, or provide office space or computer support as in-kind help. The coordinator is responsible for cross-system communication, and

convening the consortium. Other roles may include fund raising for flexible dollars for wraparound and working with the TA Center in planning for cross-system training and technical assistance.

Leadership of Consortium

It is common in some communities for the consortium to have an Executive Committee (or other leadership group) comprised of public payors and at least one family member. This group, because it has access to funds that can be retooled for community based care, may take responsibility for deciding what resources are available to use for services to children and families. They may decide to blend or braid funds using a case rate, or collaboratively pay for services based on individual child and family needs using a fee for service model. They also may take responsibility for soliciting flexible funds from community organizations.

It is important that the lines of communication between this subcommittee and the larger consortium are kept open at all times. The committee should report all decisions, including policy and funding changes to the larger group as soon as they occur. In some communities an existing collaborative group that addresses issues around children and families may take leadership of the consortium, after adopting the values, principles and service provision philosophy of systems of care. Individual leadership of the meetings may be shared or delegated to a single member or agency on a rotating basis for a set amount of time.

Resources

One of the best resources for building systems of care in local communities is the leadership from other communities who are just a step or two ahead. Avoiding pitfalls and accessing lessons learned can be just two of the benefits of this approach. The TA Center is able to connect you with other communities to learn first hand how they have developed and overcome barriers along the way. There are several communities that have taken strong leadership roles in creating and developing collaborative systems of care. Ask your site coach for help in learning from other communities through individual contacts or peer to peer training and support groups.

Additionally, for those who are interested in written resources, we can recommend the entire series: Systems of Care: Promising Practices in Children’s Mental Health. In particular, Volume VI of the 1998 Series, entitled

“Building Collaboration in Systems of Care” not only tells what research has to say about collaboration, but also outlines foundations, strategies for implementation, results and implications, as well as examples of collaborative sites from around the country. There are a number of on-line resources available as well (a few are listed below).

Finally, to explore the evidence base for structured systems of care (and other important empirically tested concepts) see Burns and Hoagwood’s Community Treatment for Youth, Evidence-Based Interventions for Severe Emotional and Behavioral Disorders (2002). There are several sections in this helpful book that address system characteristics, development, and training. *Additionally, see Effective Models of Care, Section 6 of the Resource Manual, for additional information on this topic.*

Selected Internet Resources

Selected Internet Resources

Search on these helpful national sites for “system of care governance” and other related topics:

- *University of South Florida - Department of Child and Family Studies*
- *Georgetown University Center for Child and Human Development*
- *Research and Training Center at Portland State University*
- *Technical Assistance Partnership for Child and Family Mental Health*

References

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- Dennis, K. and Lourie, I. (2006). *Everything is Normal Until Proven Otherwise: A Book about Wraparound Services*. Washington, DC: CWLA Press.
- Hepburn, K. & McCarthy, J. (2003). Health care reform tracking project: Promising approaches for behavioral health services to children and adolescents and their families in managed care systems. *Making Interagency Initiatives Work for Children and Families in the Child Welfare System, Volume 3*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
- Hernandez, M. & Hodges, S., (2003). *Crafting logic models for systems of care: Ideas into action*. [Making children's mental health services successful series, volume 1]. Tampa, FL; University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies.
- Hodges, S., Nesman, T., & Hernandez, M. (1999). Promising practices: Building collaboration in systems of care. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume VI*. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.
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- Pires, S. (2002). *Building Systems of Care: A Primer*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
- Stark, D.R. (1999) *Collaboration Basics: A Companion Guide – A Partnership for Action*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
- Winer, W. & Ray, K. (1997). *Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey*. St Paul, MN: Amherst H. Wilder Foundation.

Toolkit 3.1.1

Strategies for Involving Family Members in Planning*

- Providing special orientation and training as well as ongoing assistance to parents who need a better understanding of administrative, budgetary, and other issues that play a role in planning. This might also include consulting with parents prior to a meeting to highlight what they might expect to be covered.
- Having more than token representation of parents at meetings.
- Contracting with community-based organizations or parent advocacy groups to develop and direct a process that ensures sustained and thoughtful parental participation in planning,
- Working through Head Start parent advisory groups, Parents Anonymous, and other parent organizations (such as the Federation of Families for Children's Mental Health and the National Alliance for the Mentally Ill Child and Adolescent Network).
- Asking agencies that work with parents (such as schools and child care centers) to recommend parents to participate in planning.
- Paying a stipend to parents who participate in planning sessions, and providing or paying for transportation and babysitting.
- Holding planning meetings in the evenings or on weekends, in communities across the state, and in locations such as schools, community centers, and other settings that may be more familiar and comfortable to parents than state or local office buildings.
- Conducting surveys to elicit the views of a wide range of parents.
- Using parents or others who work regularly with parents to conduct focus groups that probe the views of selected groups of parents such as teenage parents, single parents, grandparents raising children, foster parents, and adoptive parents.
- Working with family support programs to tap into informal networks such as parent support groups or parents who routinely visit a neighborhood drop-in center.
- Working with home-visiting programs and health clinics to involve parents who may be otherwise hard to reach.
- Working with family preservation and family reunification programs to identify and involve families who have benefited from these services.
- Conducting sessions for planning group members, administrators, and staff led by an experienced facilitator to explore attitudes and stereotypes about different ethnic, racial, and religious groups, and about parents.
- Publicly acknowledging the contributions of parents and other family members.