Pennsylvania Care Partnership and the
Office of Mental Health and Substance Abuse Services

System of Care: A Comprehensive Toolkit for County Implementation

Enhancing Your Strengths to Build a System of Care.

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We hope you find this toolkit valuable. It is intended to help counties across the Commonwealth as they develop and implement a System of Care, and it also serves as a reference guide for existing System of Care sites. The materials are for use by anyone and can be downloaded on the PA Care Partnership website.

Acknowledgments

We want to acknowledge the contributions of many individuals who have helped support, develop, and build the PA Care Partnership over the past several years. Without the vision of our partners, we would not be able to do this work. Pennsylvania is fortunate to have an extensive array of services for children, youth, young adults, and their families. We have strong relationships with our system partners, including Education, Mental Health, Addiction Services, Child Welfare, Juvenile Justice, and, more recently, our youth and family partners. These relationships form the foundation of the PA Care Partnership.

The PA Care Partnership would not exist without funding from Substance Abuse Mental Health Services Administration (SAMHSA), the Office of Mental Health and Substance Abuse Services (OMHSAS) of Pennsylvania, our partner counties, partner grants, providers, youth and family leaders, county implementers, and our system partners across the Commonwealth. We particularly wish to acknowledge that several of the concepts in this guide come from the works of Beth Stroul, M.Ed. and others who are committed to creating a better world for all youth and families.

Welcome to the PA Care Partnership!

Dear Pennsylvania Partners,

We are pleased that you have decided to review our System of Care (SOC) Toolkit for County Implementation, and we are confident that you can build on your many strengths to be a System of Care County.

This concept is not new to Pennsylvania. As you will see, SOC not only builds upon but strengthens our state's strong history with our Child and Adolescent Service System Program (CASSP). Both are comprehensive approaches that support children and adolescents with complex behavioral health challenges and their families. They seek to ensure that services and/or treatment are planned collaboratively with the family and all agencies and/or systems involved in the child's or adolescent's life.

SOC, however, expands the role of youth and families as decision-makers at the individual, county, and state levels to ensure they receive the most beneficial and culturally and linguistically competent services and supports. Systems work more effectively, allowing communities to nimbly respond and adapt to challenges. The result? Better outcomes today for youth and families—and a pathway to sustainability tomorrow.

We believe that this toolkit will provide you with the latest proven approaches to implementing or expanding the System of Care approach in your county. In order to best support you in this work, our staff—both within the PA Care Partnership and the Office of Mental Health and Substance Abuse Services, Bureau of Children's Services—are here to help. We have an array of tools, technical assistance resources, and training that can assist you at any point in your journey. Never hesitate to let us know how we can help.

Thank you—so much—for your consistent dedication to improving the efforts to support our children, youth, young adults with complex mental health needs, and their families.

Sincerely,

Scott Talley
Director, Office of Mental Health and Substance Abuse Services, Bureau of Children's Services

Mark Durgin
Director, PA CARE Partnership

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How to Use this Toolkit for Implementation

This toolkit and resource guide will help you gain a better understanding of the PA Care Partnership's approach to implementing and sustaining a System of Care—its value to communities as well as its flexibility. It begins by exploring what SOC is, as defined by the State Leadership and Management Team[1] (SLMT) and reviews the foundations for success and sustainability that have already worked well in SOC counties across the Commonwealth. You will learn about the support and information that is available to you from the PA Care Partnership staff and website, including valuable resources, best practices, and examples of successful strategies. At the end of this toolkit, you'll find extensive resources and appendices that may be of particular value to your county's unique needs.

[1] The PA Care Partnership's State Leadership and Management Team (SLMT) is an equitable partnership of system, family, and youth leaders who work together to assure that the System of Care values are incorporated into all decision-making, policymaking, and service planning and delivery.

Why This Work Matters

A System of Care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that...

...in order to help families function better at home, in the community, and throughout life.

Why System of Care Will Work for You

The PA Care Partnership believes that an effective System of Care relies on the adoption of a core set of values that are easily adapted to the realities of any community—including the kinds of challenges that come with stretched resources and decreased budgets. In adopting these core values, systems work more efficiently and save community resources by preventing or reducing entry into higher levels of care or out-of-home placement. Moreover, youth and families have an equitable role in making decisions about their own care leading to better outcomes for all.

The Evolution of SOC in Pennsylvania

Since 2009, Pennsylvania has been the recipient of several SAMHSA grants[2] that have allowed us to build an infrastructure to implement a statewide approach to SOC to serve children, youth, young adults, and their families who have, or may be in need of, effective community-based services and supports to assist with mental health challenges. Federal funding, however, is always intended to be "seed money"—an opportunity to identify what works and how to improve it.

In this spirit—and with the understanding that the needs of an urban county are not at all the needs of a rural county—Pennsylvania's own SOC model has evolved into a sound philosophy and flexible approach to promote equity and trust among youth, caregivers, child-serving systems, and provider partners based on the individual community's strengths and culture. The goal of System of Care is to modify the way that youth, families, government, and counties interact with each other so that:

- Youth/young adults and families with lived experience[3] are central to the design, implementation, and operation of services and supports working in equal partnership.
- Youth and family organizations support individual youth/young adults and families and participate fully in policy and funding decisions.
- All child-serving system partners collaborate, share resources, and coordinate with each other and with youth and families.
- Natural supports[4] are equally as valuable as formal supports (i.e., paid services).
- Communities engage and transform to become welcoming and supportive of all youth, young adults, and families.

[2] For more on SAMHSA's System of Care, please see Appendix A.

[3] Lived experience is meant to include youth/young adults who have or have had serious behavioral, emotional, mental health, or co-occurring challenges, as well as the families and caregivers who support them.

[4] Natural supports are those personal and everyday connections established through family, school, a neighborhood, and the wider community.

Our Mission, Vision, and Values

Mission Statement:

To strengthen the collaboration of the Commonwealth and local efforts in weaving behavioral and mental health supports and services into a seamless system of care for children, youth, and their families.

Vision Statement:

Every youth and family in the Commonwealth will be able to access and navigate a unified network of effective services and supports, which are family and youth-driven, community-based, culturally competent, and meets their individual needs.

Core Values:

The following core values are the foundation of the PA System of Care. Originally based on seven (7) original standards, they have evolved over time to integrate and reflect the CASSP principles already established in counties across the Commonwealth.

- Youth-driven
- Family-driven
- Home- and Community-based
- Strength-based & Individualized Practices & Processes
- Trauma-informed
- Culturally and Linguistically Competent
- Connected to Natural Helping Networks
- Data-driven, Quality and Outcomes-Oriented
- County Leadership Team and Governance Boards
- Multi-System Integration
- Youth and Family Services and Supports Planning Process

For a side-by-side comparison of CASSP principles and SOC values, please see “Moving from CASSP Principles to SOC Values” on the next page.

Transitioning from CASSP to a SOC at the County Level

Pennsylvania's rich history with CASSP since 1985[5] means that many counties already have a strong infrastructure in place for a smooth transition to the SOC philosophy and approach. In fact, CASSP counties may recognize great similarities between their work and the table below. A transition to SOC may be particularly straightforward for those counties that already have a comprehensive service array, Medicaid funding, and individualized care and coordination among the child-serving systems. And for those counties that want to improve their outcomes in any of these areas, the SOC approach will help achieve focused results.

Moving from CASSP Principles to SOC Values

The chart below demonstrates the close connection between CASSP principles and SOC values. Counties currently implementing a CASSP approach should be able to see a natural evolution to SOC.

Child & Adolescent Service System Program (CASSP)	**System of Care (SOC)**
Principle	Value
Child-centered	Youth-driven
Child-Centered Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and build on the strengths of the child and family to meet the mental health, social, and physical needs of the child.	Youth are included in all decisions that affect their care and well-being. Youth are encouraged to share their experiences and their opinions. They are also encouraged to be leaders and advocates at the county and state levels.

[5] See Appendix B for a timeline of CASSP and SOC in Pennsylvania.

<table>
<tr><th>Family-focused</th><th>Family-driven</th></tr>
<tr><td>The family is the primary support system for the child, and it is important to help empower the family to advocate for themselves. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring, and evaluation. A family may include biological, adoptive, and foster parents, siblings, grandparents, other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.</td><td>Families have a primary decision-making role in the care of their children, and opportunities are provided for positions of leadership at the county and state level.</td></tr>
<tr><th>Community-Based</th><th>Home and Community-Based</th></tr>
<tr><td rowspan="4">Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies but also social, religious, cultural organizations, and other natural community support networks.</td><td>System of Care builds on the strengths of the community where the family lives to provide high-quality services that are most easily accessed by families. (See also “Connected to Natural Helping Networks” in this column below.)</td></tr>
<tr><th>Strength-Based and Individualized Practices and Processes</th></tr>
<tr><td>Strength-based and individualized practices and processes identify and build on the strengths of the family and child. Families are included and drive the creation of individual plans to provide needed services. Formal and informal supports are used to create services and supports for each child and family. Plans are individualized based on the needs of the youth, young adult, and family. The plan changes frequently based on ongoing individualized assessments of strengths and needs.</td></tr>
<tr><th>Trauma-Informed</th></tr>
<tr><td>Every person working with an organization or program should understand the effects of trauma on the individuals they serve and promote cultural and organizational change in responding to those they serve.</td></tr>
</table>

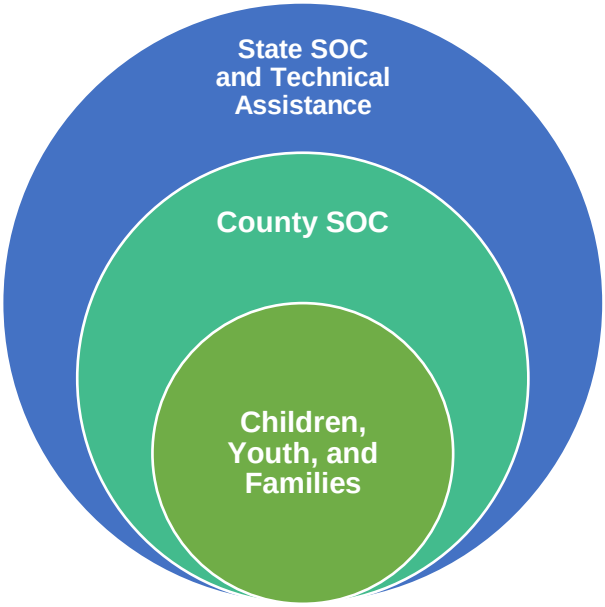
Multi-System Services	Multi-System Integration
Multi-System Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.	Services and supports are integrated at the system level, linking child and transition-aged serving agencies and programs across administrative and funding boundaries and mechanisms.
	County Leadership and Governance
	County Leadership Teams and Governance Boards are comprised of representatives from child-serving and transitional age systems, family partners, and youth partners.
Culturally Competent	Cultural and Linguistic Competence
Culture determines our worldview and provides a general design for living and patterns for interpreting reality that is reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of a particular group of people.	Cultural and Linguistic Competence (CLC) supports authentic collaborations between people and systems to ensure that youth and families receive culturally responsive care. Culture represents a set of attitudes, values, beliefs, symbols, and behaviors shared by a group of people, but different for each, and usually communicated from one generation to the next. Linguistic competence reflects the capacity of all service providers to convey information in a manner that is easily understood by the youth and families they serve.
Least Restrictive/Least Intrusive	Connected to Natural Helping Networks
Least Restrictive/Least Intrusive Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.	Natural helping networks are personal associations and relationships, independent from formal services that are developed in the community and enhance the quality and security of a family or person’s life.

	Data-driven, Quality and Outcomes-Oriented
	Decisions are made using concrete information about what is actually happening, rather than relying on personal stories or gut feelings to identify high-risk children and youth.
	Youth and Family Services and Supports Planning Process
	The planning process facilitates integrated services and supports planning among youth, families and key child-serving systems.

Infrastructure of Pennsylvania's System of Care

The Pennsylvania System of Care consists of three major components:

1. Children, Youth, and Families
2. County System of Care
3. State System of Care and Technical Assistance

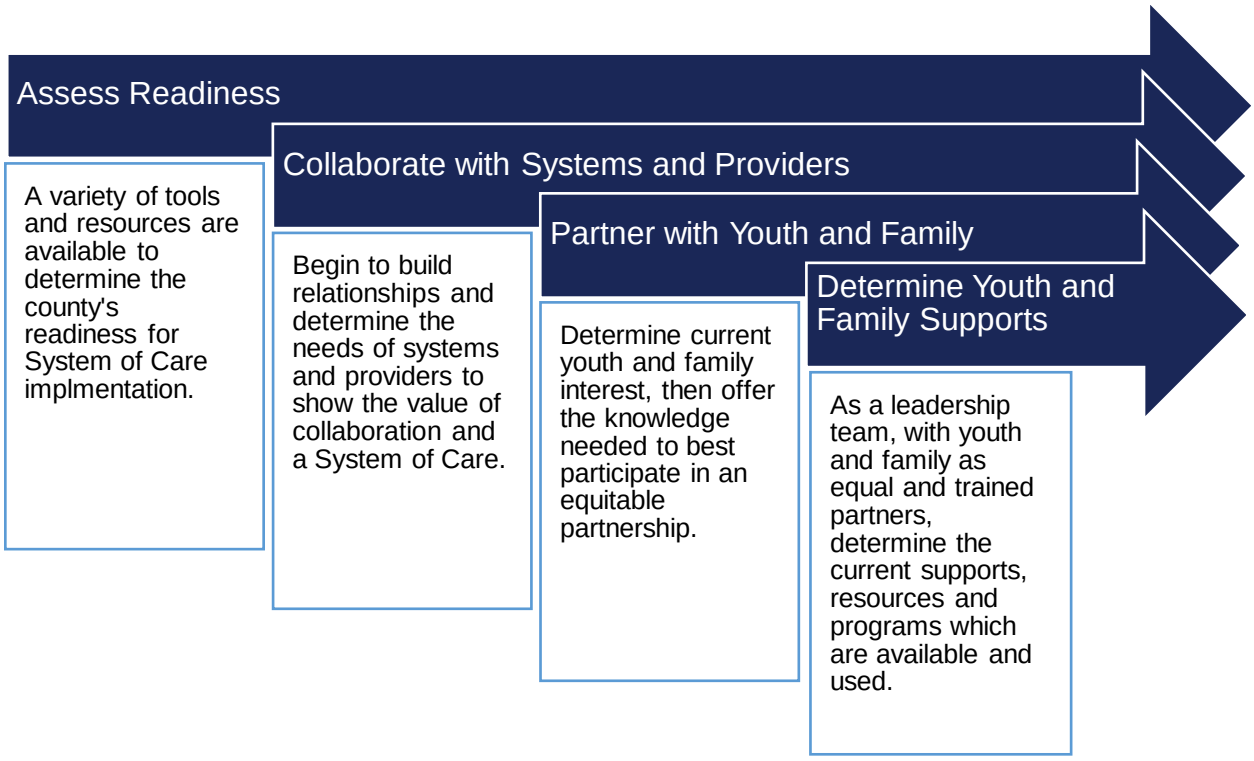


The PA Care Partnership is a partner of the Office of Mental Health and Substance Abuse Services (OMHSAS) and Bureau of Children's Services (Children's Bureau) within the Pennsylvania Department of Human Services (DHS). Under the guidance of OMHSAS, the PA Care Partnership contracts with individuals and organizations for essential consulting and technical assistance services (e.g., Trauma, First Episode Psychosis, Youth Organization, Family Organization).

Pennsylvania's SOC is supported at all levels by the resources and guidance offered by SAMHSA. More information on the national model can be found in Appendix A of this toolkit. Links to external resources can also be found in this toolkit's Resources section.

Implementing a System of Care in Your County

The Commonwealth's counties are demographically and culturally diverse, as are local infrastructures and methods for implementing programs and services. System of Care counties, however, recognize that this highly adaptable philosophy embraces diversity. The common denominator is a shared approach, illustrated here:



Understanding Your Current Framework

To begin this process, we ask that you utilize the System of Care assessment tool to develop a baseline understanding of how your county is currently functioning. As you build your baseline, we will be able to provide tools and support to you and your leadership team for expansion. These tools are customizable to best meet your individual needs. There is no right or wrong way to begin, and we want you to know that you may stop a process and begin something new along the way. We are flexible and want you to have the best experience possible. In fact, SOC is always evolving to reflect what we learn from our current counties, our state partners, and our national partners.

So, let's start: The Rating Tool for Implementation of the System of Care Approach© (System of Care Rating Tool) is designed to assess progress in developing a System of

Care for children, youth, and young adults with behavioral health conditions and their families. It assesses System of Care implementation in a defined geographic area, typically a community or region. As a web-based instrument, it is easy to administer with minimal burden. The Rating Tool may be used by an individual community or region, or by a state, tribe, or territory to assess multiple communities or regions within their jurisdictions. In addition to assessing the level of implementation of the System of Care approach, the information gathered can inform the allocation of resources and technical assistance aimed at improving service delivery and outcomes.

For more information, or to complete the Rating Tool online, contact the PA Care Partnership. We will provide all the required information and detail what is needed from each county. Once completed, the results will be sent back to the county's identified recipient. If you'd like to view the tool in advance, please see Appendix G.

Framework for Change or Improvement

What does your county define as the framework for change? And when you discuss change, how does it make you and others feel?

Oftentimes change can be scary, unwanted, and unknown. As we explore the SOC philosophy, we hope you see that this change is fairly subtle, and the tools we provide you can help replace anxiety with excitement at the opportunity to make small shifts that can have a large impact. Here are some things to consider:

a. What is your current array of services and supports?
b. What philosophy currently guides your systems work, and does that philosophy include Youth and Family voice?
c. Do you have a supportive infrastructure?

Let's break it down:

a. **Your Current Array of Services:** Pennsylvania offers one of the most comprehensive children's mental health service arrays across the nation, and with our Behavioral HealthChoices Program, we have continued to expand that service array to include programming and best practices to meet the ever-changing needs of our children and youth. However, these service providers are most likely trained in delivering care based on CASSP and not on the expanded SOC values.

Ask: As part of a system of care, what services or supports could be enhanced, changed, or added to increase family and youth voice and choice, natural and community supports, and/or improve both home- and community-based outcomes?

b. **Your Current System Philosophy:** While it may or may not be formalized or documented, your county already has an approach to building, interacting, and providing services and supports to youth and their families across systems. It's time to take a look at why and how your county does this work in order to make the most strategic adjustments.

Ask: Is your county's current approach cohesive? Siloed? Fragmented? Does your county currently involve youth and family in decision making? What areas do you feel can be adjusted to better align with SOC values? What training and support would be helpful to your team?

c. **Your Infrastructure Support:** Infrastructure, in this case, includes county governance structures, financing, partnerships (child-serving systems, families, youth, providers, evaluation and quality assurance), and their adoption and application of SOC values.

Ask: Do you already have an integrated approach within your existing infrastructure, or will you need to develop strategies to get everyone on board for this work? What other grants have your county received for related work? What is the spirit of collaboration between county system partners?

Understanding these three elements of the framework, you'll be better poised to determine your county's Core Strategy areas—the foundation for your SOC. The Core Strategy areas that should be reviewed and planned for are:

- **Policy and Administration:** How will you look at county-based policy, administrative, and regulatory changes to reflect SOC values?

- **Services and Supports:** How will you expand or enhance the current array of services, supports, and resources based on the SOC approach?

- **Financing:** How can you create or improve your financing strategies, e.g.:

    - Behavioral HealthChoices
    - Data (Child Welfare, Juvenile Justice, Needs-based, PA Youth Survey, Consumer and Family Satisfaction Team Surveys)
    - Partner with Behavioral Health Managed Care Organization (BH-MCO)

- **Training and Technical Assistance:** What will you need from the PA Care Partnership, and what plans for sustainability do you have (or can create) to assure this work continues?

- **Infrastructure:** How do you generate support from your infrastructure to move towards SOC values?

- **Sustainability:** In what ways can each Core Strategy Area be developed from the start to ensure that SOC is sustained and expanded? Who else will need to be at the table? How will you make the case for sustainability with data?

The PA Care Partnership and the Office of Mental Health and Substance Abuse Services (OMHSAS) can help you customize Core Strategy areas based on your county's reality.

We also invite you to explore the extensive resources in Appendix E.

The Leadership Teams: State and County Level

Leadership and Management Teams may look and operate differently across Pennsylvania, but ultimately, a Leadership and Management Team at either the state or county levels is comprised of an equitable partnership of system, family and youth leaders who work together to assure that the System of Care values are incorporated into all decision-making, policy-making, and service planning and delivery.

If your county already adheres to CASSP principles and has a leadership team in place, then there is no need to reinvent the wheel. Build on this foundation to ensure that youth and family have an equal voice.

State and County Leadership and Management Teams (SLMT and CLMT) are not legal entities of incorporated 501(c) (3) organizations. They are decision-making boards and are grounded in the National System of Care philosophy to promote equality and trust among youth, caregivers, children, young adult serving systems, and provider partners based on the individual community's strengths and culture. They enhance and strengthen the way that youth, families, government, and communities interact with each other so that:

- Youth, young adults, and families are central to the design, implementation, and operation of services and support at the state and local level.
- Youth, young adults, and family supports and/or organizations support individual youth and families and participate fully in policy and funding decisions.
- All child and young adult serving system partners collaborate, share resources, and coordinate with one another and with youth and families.

Teams are comprised of: youth/young adults with behavioral health issues that are or have been involved with child welfare, juvenile justice, drug/alcohol, delinquent and dependent courts, and/or education systems; family partners who are now, or have raised, a child or children with behavioral health issues that have also been involved with child welfare, juvenile justice and /or education system; and, system leaders from behavioral health, child welfare, juvenile justice, drug and alcohol, education, juvenile courts, county administration, and early childhood.

At the state level, a representative from each segment leads SLMT meetings in a Tri-Chair model. Additionally, given the range and depth of System of Care programs across the Commonwealth, the SLMT has subcommittees that conduct a deeper dive into select areas (e.g.: cultural and linguistic competency, evaluation, communications).

Let's look closely at how to build a strong County Leadership and Management Team.

The County Leadership and Management Team

Again, there is great flexibility in how county-level teams are structured and operate, as long as the SOC philosophy and values remain at the core of the work. That said, and as a guide, the following table represents typical roles and key functions:

Position	Key Functions
County SOC Coordinator/Local Director	Oversees the development of the strategic plan and day-to-day implementation of local programs. Understands local needs, barriers for youth and families at the county level. Assembles advisory board and key staff. Builds strong relationships between youth- and family-serving partners/systems. Ensures culturally and linguistically appropriate training and technical assistance are provided. Seeks ongoing funding from the county, state, or private sources and/or aligns existing resources to support SOC functions.
Family Support Specialist	Represents the family voice with lived experience in CLMT decision-making. Works closely with families served by the CLMT to build resiliency and ensure needs are identified and met. Helps coordinate the work of family-serving organizations and ensures the cultural and linguistic backgrounds of youth and family are honored.
Youth Support Specialist	Represents the youth voice with lived experience in CLMT decision-making. Helps to identify and work with other youth to identify and implement opportunities to build resiliency and leadership skills (e.g.: through youth groups or youth-driven events).
Resource Coordinator(s)	Depending on county needs and available resources, a resource coordinator might be tasked with identifying and coordinating available supports for youth, families, cultural and linguistic competency, etc. ***This work may also be accomplished on an as-needed basis through CLMT subcommittees.***
County Advisory Board	Convenes regularly and is comprised of members from youth and family-serving agencies and system partners (e.g.: mental health providers, social service agencies, juvenile justice). Provides input into CLMT strategic planning and implementation promotes System of Care values, collectively identifies community needs, and shares resources.

We encourage System of Care counties to structure their CLMT in a way that's right for them. For some counties, this may mean that leadership resides with a mental health provider that has historically committed to including youth and family voice in decision-making. For others, it may mean that leadership comes from a youth- and family-serving county agency. Either way, these tips may help you build a CLMT that works best for your county.[6]

Getting Your Team Off the Ground

Search Your County's Landscape

Beyond the leadership team that you may already have in place through CASSP, your county may already have existing coalitions and organizations dedicated to youth and family services. It may be worth exploring how you can coordinate your work effectively—especially if their goals generally align with yours. The key to successful collaboration, however, will be based on a willingness to adopt System of Care values for work going forward.

Brainstorm a List of Potential Participants

Host a brainstorming session to identify individuals and organizations dedicated to youth behavioral health. Look at community leaders and stakeholders. Identify possible champions for your work (e.g., a juvenile court judge). Consider your county's cultural diversity to ensure that your list is genuinely representative. Look outside typical partners to any sector that might have a stake in the well-being of youth and family (e.g., business community or faith community).

Most importantly—and from the start—you will want to identify family and youth members/leaders with lived experience to lend their critical voice to all decision-making as equal partners. This essential step is central to the core SOC values and demonstrates your commitment to improving the way services are offered in your county.

If you are unsure how to begin recruiting youth and family partners, seek out recommendations from:

- Current leadership team members
- Youth- and family-serving organizations or training programs in your county or region
- Your county's human services and juvenile justice agencies
- Area schools and your region's educational Intermediate Unit

[6] Several of these tips have been adapted from *Oklahoma Systems of Care Toolkit*, Oklahoma Department of Mental health and Substance Abuse Services, 2009.

- Support groups
- Cultural and faith-based organizations.

Invite People to Join

Plan an initial organizational meeting and invite your list of potential participants—either through a call, a letter, or an email. Because calendars are full (and few people are anxious for "another meeting"), your invitation needs to do more than explain what you hope to accomplish. It needs to clarify why this meeting—and CLMT membership—will be valuable *to them.*

For system partners, membership may:

- Promote diversity
- Foster engagement of those participating in services and programs
- Improve policy relevance and effectiveness
- Enhance service delivery to create more predictable outcomes
- Increase systems' responsiveness to youth and families.

For youth and family members, benefits of CLMT membership might include:

- Opportunities to receive mentorship
- Opportunities to offer peer support to those who are entering systems.
- Participation in trainings and workshops
- Leadership opportunities
- New skills in advocacy and public speaking
- Career advancement and networking opportunities
- Improved confidence
- Strengthened personal recovery that validates their worth in the system.

For more guidance, please refer to the sections below on Engaging System Partners, Engaging Youth, and Engaging Families.

Clarify Expectations

Your first organizational meeting should introduce a commitment to the System of Care values and an overarching philosophy that lets attendees know you hope to change the

way youth and families are served. Be prepared to share how that might look at the county-level—including a set of initial expectations for all CLMT members (staff and Advisory Board). Guiding questions for this discussion might include:

- When, where, and how often will you meet?
- What will members be expected to contribute?
- How will you make decisions?
- What kinds of decisions will you make (e.g.: review policies, provide recommendations, identify new issues brought forth by community members)?
- How will you agree to maintain confidentiality?
- How will system partners gain support from their own organizations' staff?
- Would you benefit from conducting an environmental or needs assessment?
- How might team members take the values of SOC back into their own work?
- How and when will system partners communicate with their providers?
- How will family and youth partners convey information to other family and youth—and how will they bring new challenges and barriers back to the CLMT?

These ground rules and early expectations will set important guidelines for how the team will function and collaborate. You'll be creating a safe environment in which everyone is better poised to work together, adopt a positive/strength-based approach, and ensure that all voices are heard and respected.

Your First Six Months

Run a Great Meeting

Everyone on your CLMT has their own responsibilities outside of this work. They need to see consistent value in your meetings, and that's more easily accomplished when meetings are run smoothly and efficiently.

Regularly ask your CLMT for input on meeting agendas, then create an agenda for each meeting that identifies what needs to be accomplished (e.g.: problem-solving, decision-making, reporting information, sharing resources), as well as intended outcomes. Provide this agenda (along with any pertinent materials) several days in advance. Be

sure you've confirmed the date, time, and location for your meeting (along with any A/V needs) and include this information on your agenda. If there's a call-in number for those who can't attend in person, include this as well.

Your first few meetings are likely to include many people who have never met. Consider beginning with an ice breaker that will help members get to know each other as people. A multitude of resources are available online to kickstart your thinking. Once your group is warmed up, review your agenda and timeframe for each item to be discussed. Ask if there are any new issues that need to be addressed and ask for consensus on how to discuss them. Encourage everyone to participate in discussion, reminding members that their voices are of equal value.

In these initial meetings, it may be important to frame each session with a reminder of the potential impact your CLMT meetings can have in your county. It will also be meaningful to allow time for introductions, and team members should be able to share how their own work and experience aligns with the work of your CLMT.

At the end of each meeting, revisit your agenda once again to summarize what was discussed and what action items now need to be addressed. Capture these in meeting notes and be sure to share these with CLMT members after the meeting.

Finally, ask participants to provide input on whether the meeting met their needs and expectations. This can be accomplished through discussion or a quick online survey that is sent with meeting minutes. The feedback you receive will help guide future agendas and meeting outcomes.

It's helpful to remember that, in between your meetings, circumstances can change, and decisions can be made that will have relevance in your work. Consider touching base with members via email before forthcoming agendas are finalized to see if there are any new or unforeseen issues that need to be addressed. Communication is key.

Start with a Mission, a Vision, and a Plan

As soon as you're ready, your CLMT will benefit from developing a shared mission, vision, and strategic plan. These activities can have a way of building enthusiasm for this shared work.

There are many methods for developing a mission and vision statement, but to clarify the distinction between the two:

- **A mission statement describes *what* you do.** The PA Care Partnership's statewide mission statement is: *"To strengthen the collaboration of the Commonwealth and local efforts in weaving behavioral and mental health supports and services into a seamless system of care of children, youth, and their families."*

- **A vision statement describes *why* you do it.** The PA Care Partnership's vision statement is: *"Every youth and family in the Commonwealth will be able to*

access and navigate a unified network of effective services and supports which are family and youth-driven, community-based, culturally-competent, and meets their individual needs."

- **A strategic plan explains *how* you will do it.** It is your roadmap for the future and identifies your priorities (goals) and how you will get there (objectives). This early—and essential—step is covered in-depth later in this toolkit.

While you can't expect these three important steps to come together overnight, see if your CLMT can agree on a timeframe for completing them. The sooner you are all on the same page, the sooner you'll be able to improve lives in your county.

Essential Team Norms to Improve Collaboration

Predictably, and because there are diverse personalities, experiences, and cultures together in one space, teams can have trouble with particular components of interpersonal communication and interaction. Following some essential team norms[7] can help alleviate many of the problems that may arise:

- **Team members as coworkers:** All team members are equal and have an understanding of each other's' functions; every team member's opinion will be thoughtfully considered; each team member will keep all commitments by the agreed upon due date; each team member agrees to constantly assess whether team members are honoring their commitments to the team norms.

- **Team member communication:** Team members will speak respectfully to each other, will not talk down to each other, and will recognize and thank each other for their contributions.

- **Team member interaction in meetings:** Team members will listen without interrupting; hold no side or competing conversations; follow the rules for effective meetings; attend meetings on time; end meetings on time; work from an agenda; use minutes recorded at each meeting as reference points.

- **Team organization and function:** Leadership will rotate monthly, and the team management sponsor will attend at least one meeting a month.

- **Team communication with other employees, including managers:** Team members will make certain they have an agreement on what and when to communicate, and complaints about team members will be addressed first among team members.

[7] Adapted from *Group Norms or Relationship Guidelines Help You Create a Cohesive Team*, Susan M. Heathfield, Updated February 24, 2019.

- **Team problem solving, conflict resolution, and decision making:** Team members will make decisions by consensus, but the majority will rule if a timely consensus is not reached, and conflicts will be resolved directly among the people in conflict.

Team norms can be expanded for your specific needs and can encompass as many topics as your team deems necessary for successful functioning. It's best to start with a few team norms and add more as needed.

The PA Care Partnership has provided extensive coaching training[8] to improve interpersonal communication. Key takeaways from this work include:

- **Withhold our assumptions of others' motives or positions.** Typically, people take a position and defend it, yet these positions are often based on assumptions that may or may not be accurate. When we can put these assumptions to the side, we are able to hear clearly and respond compassionately.
- **Leave our positions at the door.** None of us are more than, or less than, anyone else. Through dialogue, we are equals who each possess relevant knowledge.
- **Foster the spirit of inquiry**. Encourage opportunities for members to explore their own assumptions and the evidence that leads them to take a particular viewpoint. This is often accomplished through questions that invite reflection (as opposed to defensiveness).

Whether working with team norms or coaching your team, make sure that your agreements are written and posted where team members are reminded of their commitment.

Who Else Needs to Be at the Table?

At this stage—or as you complete your strategic plan—you may realize that CLMT membership is incomplete. Are there gaps in representation? Do you need to do more to recruit family and youth voice? Is there diversity in membership that reflects your community? Do you need to reach out to representatives from other stakeholder groups to better inform the CLMT's work? How is the provider voice represented? These questions are worth asking periodically, and you implement—and sustain—your programs and services.

In fact, recruiting members for your CLMT can be an open and ongoing process. Continue to use your existing networks and contacts to recruit new members. Build on the natural abilities of youth and families to recruit their peers. Let your CLMT guide

[8] Adapted from "Coaching Philosophy to Enhance Discussion" from *The Fifth Dimension of Leadership* by Peter Senge.

your process for onboarding new members—from application to orientation and mentoring.

Celebrate Your Victories

Creating a better world is hard work—and the work doesn't end. It's why celebrating every victory—from small successes to major milestones—is essential. It re-energizes and refocuses members on the important work they're doing. We strongly recommend that every meeting include time for participants to share and celebrate these moments.

Leadership and Management Team Best Practices:

1. The team's configuration should include:

    a. System leaders who represent the policies and services that are delivered to support birth-to-21 (e.g.: mental health, drug and alcohol, child welfare, juvenile justice, education, intellectual disabilities, physical health, transition-age youth/young adults, and the courts).
    b. Family leaders/members with the lived experience of raising one or more children who have been involved in one or more child-serving system(s).
    c. Youth and young adult leaders/members with lived experience who have been involved in one or more child-serving system(s).

2. To ensure a genuinely shared decision-making process, the input of youth/young adult and family members should be weighted equally with that of system partners in all decision-making, regardless of the actual number of members on the leadership team/governance board. As a best practice, youth, young adult, and family members should comprise 50% of management teams, with the remaining 50% comprised of system partners.

3. Family and youth/young adult leaders/members are equal partners who receive training opportunities, information, and education about systems, services, funding, data, etc. They are encouraged to share their own and others' experiences and thoughts on the services and supports endorsed by the larger team.

4. Regularly scheduled meetings are held at times and locations that are convenient for youth and family members.

5. All information distributed and discussed is free of jargon and can be easily understood by every member to support fair and equal decision-making.

6. Policies and procedures assure both the implementation and sustainability of an effective system of care.

For a comprehensive collection of additional resources that can help you develop a SOC CLMT, as well as more information on the SLMT's structure, members, roles, and responsibilities, visit Appendix D and Appendix E.

Qualities of an Effective System of Care Leader

Whether your county is shifting from a CASSP model, enhancing your System of Care, or essentially starting from scratch, this work requires a leader who is responsible for day-to-day SOC activities. For the purposes of this toolkit, we are using the term "Project Director." Still, it may also be known as a System of Care Coordinator, Project Manager, or System of Care Coordinator. Regardless of the title, successful SOC leaders understand that implementing and sustaining a System of Care is a journey. It takes time to change the way "business is done."

Leading a county-level SOC requires effective management and administration, but this only scratches the surface. At times, you'll need to step back to see that 40,000-foot bird's eye view of your county's work; other times, you may need to dive into the tall grass to understand what's happening on the ground.

Here are a few common denominators shared by strong System of Care Project Directors/Coordinators:

- **Act as a convener to bring the right people and systems to the table.** This means you'll need to understand the youth- and family-serving systems in your county. See this toolkit's next sections on Engaging Youth, Engaging Families, and Engaging System Partners for more.

- **Lead—then share leadership.** It will be important to set expectations for your County Leadership and Management Team from the get-go. As the team evolves, work towards a goal of sharing leadership with youth, family, and system partners to ensure that all voices are fully represented and reflected. One foundational activity that can help cement your team's collective work is the development of a mission and vision statement based on PA Care Partnership values. Your team may also decide to establish sub-committees to focus on core areas of interest (e.g., Cultural and Linguistic Competence or Communications), and these are opportunities for sharing leadership as well.

As a SOC Project Director, you may need to step back and see the 40,000-foot bird's eye view of your county's work. Other times, you may need to dive into the tall grass to understand what's happening on the ground.

- **Assess your county's needs.** The process for this assessment can take many forms, but this early step allows you to build a set of programs and services that are truly needed, not duplicative, and improve outcomes for youth and families.

- **Develop a strategic plan.** In concert with your County Leadership and Management Team, craft your roadmap—including S.M.A.R.T. goals and concrete measures for evaluating success. See this toolkit's section on Strategic Planning for more.

- **Build cultural and linguistic competency into all you do.** As a core System of Care value, this ensures that all people are treated with the respect they deserve. See this toolkit's section on Building Cultural and Linguistic Competence for more.

- **Provide training and resources.** If, for instance, one of your goals is to build capacity in a trauma-informed approach, your trainings can be delivered to system providers, school district personnel, mental health providers, youth, family, and the wider community.

- **Communicate, communicate, communicate.** You'll need to stay in close touch with County Leadership and Management team members—it's central to healthy internal communications. But county stakeholders, youth, and families also need to know about your work—and this requires communicating to external audiences. For instance, communications can help ensure that you attract the end-users of your programs and services. As you seek to sustain and expand your work, communicating with county decisionmakers or funders is central to making the case that your work deserves support. See this toolkit's section on Communication and Social Marketing for more.

- **Know county and Commonwealth policies.** The Commonwealth of Pennsylvania's counties operate independently. System structures, administration, policies, and regulations often look very different from one county to the next. Be certain you're familiar with your county's specific requirements.

- **Identify and pursue funding opportunities.** SOC counties can uncover additional and braided funding opportunities to support costs that cannot be billed to Medicaid. See the Funding section for approaches you can take.

- **Seek help as needed.** The PA Care Partnership can help you identify the right training, technical assistance, and resources for your county. See Training and Technical Assistance as well as Appendix J for more.

- **Finally, celebrate successes large and small.** We urge you to reflect regularly on the accomplishments and successes you and your team achieve. Change is slow, and much work may still need to be done, but this practice can be an important reminder that your county is moving in the right direction, and youth and families see happier and healthier outcomes.

Engaging Systems Partners

System partners help families to function better at home, in school, in the community, and throughout life. Systems vary throughout the Commonwealth and may include a combination of public agencies, private organizations, and the faith-based community. Your county may have more or fewer systems, but typical system partners might include:

- Mental Health Services
- Social Services
- Educational Services
- Health Services
- Substance Abuse Services
- Vocational Services
- Recreational Services
- Juvenile Justice Services
- Early Childhood Services
- Domestic Violence
- Autism and Intellectual Disabilities

As you identify the system partners you'd like on your team, remember that your invitation needs to answer a critical question for those whose calendars are already full: "What's in it for my organization/agency?"

Note that system partners may already be working together in some capacity. For instance, here in Pennsylvania, you'll find Child Welfare, Mental Health, and Drug and Alcohol all operating under the umbrella of Human Services. The challenge—and opportunity—comes in de-siloing systems that don't typically work together, such as Mental Health and Juvenile Justice (court system).

As you identify the system partners and personnel who belong on your team, remember that your invitation to join in this work needs to answer a critical question for those whose calendars are already full: "What's in it for my organization/agency?" You'll need to make the case that adopting the SOC philosophy and approach will improve *their* outcomes (as well those for the youth and family they serve). Be as specific as possible, and whenever possible, use data and/or build upon existing work that they may already be doing with CASSP.

Effective Integration of Systems in SOC

When youth and family-serving systems are integrated effectively, mechanisms are established to manage and coordinate care in a person-centered approach that meets the needs of youth and family's social, emotional, and physical health. This integration taps into the natural and community supports that are available to youth and family.

Here are a few examples of how that might look at the county level:

- The county leadership team/governance board (with equal weight given to youth, family, and system partners), provides guidance and support on the use of grant funds.

- Systems work together to address the complex needs of children and families in a spirit of community partnership. Interagency collaboration is reflected at both the governance and direct practice levels.

- Applying a strengths-based approach to deepen relationships, enhance partnerships, and build capacity, trainings are regularly offered to system personnel, youth, and families. For instance, the Coach Approach to Adaptive Leadership and Adaptive Leadership for System Change trainings allow participants to explore interpersonal interactions build a stronger supportive environment. Other examples of valuable trainings include trauma-informed care, Family Road Map, and Young Adult Road Map.

- Relationships—between system members, youth, and family—are genuine and central to everyone's success. New and emerging networks streamline workloads, improve efficiency, and ultimately enhance youth and family satisfaction.

Best Practices for Effective Multi-System Integration:

- Leadership Teams ensure that the mission, vision, and desired outcomes of each child-serving system are clearly incorporated into SOC planning.

- Cross-system trainings are developed and facilitated in partnership with providers, community partners, youth, and families.

- Each system agrees to facilitate access to local services and supports for all youth and families, regardless of their initial point of contact with child-serving system partners.

- Youth and family data are frequently shared and accessible to all system partners involved in child-serving systems in the county.

- An ongoing, systematic process identifies and addresses any barriers that impact the full implementation of integrated cross-system plans.

Engaging Youth

Youth involvement is necessary to truly meet the needs of youth and families in a system of care. As consumers of services, youth are central to their own recovery and well-being. Involving youth enhances their development and assists in their successful transition to adulthood. Additionally, youth engagement improves the effectiveness of programs and services. As young people feel greater control over their lives, they are less likely to engage in risky behaviors and more likely to positively engage in positive relationships—at home, at school, and in their communities.

This work requires a commitment at every level to the values around youth involvement to engage and empower youth with lived experience, but everyone—including families, adults, system partners, and the wider community—benefits.

Engaging youth and family members for your CLMT is a little like building a great baseball team with a "deep bench." Every team member is highly trained and able to step on to the field to provide relief for each other as needed.

- Families will see their child or sibling become resilient and strengths-based as s/he evolves into a leader and advocate.
- Adults who witness the competence and confidence of young people will come to view youth as legitimate and essential contributors to decision-making. Adults will also become more confident in their own ability to work with youth.
- Partner systems and organizations will discover a renewed clarity and commitment to their own work.
- Policymakers will develop a stronger understanding of the challenges faced by youth in multi-systems and how they might be better served.
- The wider community will benefit from an improved understanding of youth and their challenges, reducing the stigma often associated with young people in systems.

Making room for youth at your table means more than inviting them to a meeting. It means engaging in a genuine dialogue in which system partners listen—fully—to their perspective and respond in meaningful ways. This work is not necessarily easy or intuitive, especially within systems whose function is to respond reactively—not proactively—to the challenges facing youth.

There is often a gap in understanding between youth and adults, but everyone—regardless of age or culture—have valuable wisdom. This diversity, when respected, will

strengthen your work, and a critical first step may need to include a shift in the way youth are perceived, illustrated in this table:

View of Youth Involvement	Outcome	Steps on the Ladder
Youth as Objects Adults know what is best for young people.	Involves youth in adult-controlled situations as the discretion of adults. Young people's contributions are insignificant and underutilized. Young people maintain a powerless position.	1. Manipulation 2. Decoration 3. Tokenism
Youth as Recipients Adults view youth participation as an experience that will be good for them.	Creates an opportunity for young people to learn from the adult experts, which will help them when they become adult contributors.	4. Assigned and informed 5. Consulted and informed 6. Adult initiated, shared decisions with youth
Youth as Partners Adults view youth as important contributors.	Encourages youth to become involved in all aspects of the organization, group, or project. Youth and adults share power and are equal partners in decision-making. Both bring strengths, abilities, and expertise to the table. The system of care is youth-guided.	7. Youth and adult initiated and directed 8. Youth initiated, shared decisions with adults 9. Youth initiated and directed

Source: "Youth Involvement in Systems of Care: A Guide to Empowerment" published by American Institutes of Research, 2005.

Tips for recruiting youth:

- If possible, engage a Youth Coordinator with lived experience for your county's work. The role of a Youth Coordinator is to offer support, encouragement, and guidance to the youth you recruit. This role can build a bridge between youth and adults and serve as an advocate for authentic youth involvement. While s/he supports all efforts to help youth take the lead in system of care activities, the coordinator will be key to assisting with youth-related activities and events (e.g.: legislative advocacy days, local youth conferences).

- While it can be a challenge to find and retain interested youth, you may find willing young people through partner organizations, schools, providers, or recommendations.

- Youth—like anyone—are more likely to commit their time and energy to this work if they are able to see it as meaningful. You can help by framing their participation as an empowering opportunity to improve the systems with which they're familiar. Here are other ways you can also make youth feel welcome:

    - Do as much as possible to hold meetings at times that youth will be available without having to miss school or work.
    - Be sure that any information you share is easily understood and free of the professional jargon often associated with this work.
    - Ask for input on policy recommendations and priorities.
    - Offer training and resources that build the skills that will make youth effective leaders and advocates.
    - Promote collaboration between youth- and family-serving organizations.
    - Ensure that youth cultures are embraced and respected by everyone around your table.
    - Invite youth to take a leadership role in activities that they believe will be of value to other youth in your county (e.g.: teen summit to reduce mental health stigma, Mental Health Awareness Day events, advocacy training)
    - Invite youth to develop and guide communication activities to reach other area youth.

Adults—even parents and professionals in the field—are not always certain how to engage youth in a genuine way. The American Academy of Child & Adolescent Psychiatry's Youth Voice Tip Sheet (linked in the Resources section of this toolkit), offers concrete steps to move you in the right direction. Here are just a few of the adapted guidelines that can ensure youth are sincerely heard and respected:

1. **Learn how to talk to youth—and get to know them as people**. Learn their names and their stories. Ask questions and listen for the answers.

2. **Learn about youth culture.** This includes religion, ethnicity, race, and gender, but it also includes preferences for communication (e.g., social media).

3. **Listen to youth because they do not typically feel heard.** Youth may not always say what we want to hear, and adults would do well to listen without judgment. Trust takes time and patience to grow.

4. **Provide the right information.** Information is power, but that information must be jargon-free and easily understood so that youth are empowered to participate in the decisions that impact their treatment and lives.

5. **Accept that youth may be afraid, frustrated, and angry.** No one wants to live with mental health challenges. No one wants to feel different. No one wants to fear rejection.

6. **Treat youth the way you would want your own child treated.** Youth are more than their diagnosis. Help them learn the skills to thrive.

Engaging youth is critical to creating a true system of care, but there are often barriers. This table illustrates common barriers and possible solutions to youth engagement:

Barriers to Youth Involvement	Solutions to Youth Involvement
Youth have ideas but don't know how to implement them.	Provide training for adults who will partner with young people.
Adults refuse to share power with young people.	Educate adults about the power and benefits of involving youth.
Adults plan projects without involving youth.	Provide training for adults who will partner with young people.
Adults view young people as problems rather than resources.	Create opportunities for youth to train adults and providers.
Youth don't view themselves as change agents.	Listen to and value the suggestions of young people, so they become more comfortable and confident when making suggestions.
Youth are unwilling to get involved (because they have never been invited to the table before).	Use youth leaders to connect with other youth in the community.
Lack of support for young people when they come to the table.	Identify an adult mentor for youth to help in understanding meeting processes and protocols.
Distrust between youth and adults.	Facilitate ice breakers, discussions, or other activities where youth and adults can learn about each other.
Lack of transportation to meetings.	Help youth decide how they will get to the meeting (e.g. provide bus tokens if youth use public transportation or schedule a carpool).
Scheduling of meetings.	Schedule meetings after school and provide food if the meeting is during a meal.

Barriers to Youth Involvement	Solutions to Youth Involvement
Financial constraints.	Provide compensation for youth involvement (cash, vouchers, credits, community service hours).
Cultural differences.	Provide cultural competency training that includes youth. As youth to educate others about their own culture.

You'll know you've truly succeeded in authentically engaging youth when:

- System partners value and seek the input of youth voice.
- Youth are decision-makers, advocates, and educators.
- Youth are able to participate fully in meetings.

For assistance in engaging youth in your county System of Care, contact the PA Care Partnership for technical assistance and support. Please see the Additional Resources and Appendix H in this toolkit for links to more comprehensive resources that can help.

Engaging Families

Central to every SOC is the belief that families are best served when they have a primary decision-making role in the care of their children. In leadership positions, family members with lived experience become equal partners in the policies, procedures, and funding decisions that govern the care of all children in their community.

These family leaders—the ones you will want to engage in your SOC—have the unique knowledge of what it's like to navigate complex systems on behalf of their child. With first-hand knowledge of what does—and doesn't—work, they are essential voices that will not only speak on behalf of other families but help your system partners recognize opportunities for improving and integrating services.

That said, you and your system partners may first need to step back and check your assumptions about what constitutes "family." It will also be helpful to review the different levels of engagement. This will not only help you identify excellent family representatives to serve on your CLMT; it will help every partner better serve and support families in the work you do together.

For our purposes, family can be defined as "**a group of connected people bound by ties of affection and or obligation, most often biological or legal kin, but often including other significant people as determined by the individual, and those people may change over time**." Families are fluid. Family responsibilities (such as employment, caretaking, or systems involvement) mean that they may not have the time, resources, or energy to always be fully engaged. Additionally, family members are under significant stress. Self-worth can be diminished as family members become unsure of their value, and this may also impact engagement.

Different levels of family involvement, inclusion, and engagement each require trust. Consider the distinctions between these levels to better understand how families and systems might interact:

> **Family Involvement:** Here, family voice and choice are not an integral part of this process. Family participation in systems, services, and community activities is either by request or is required by an agency or provider. Agency or provider staff is primarily responsible for the scheduling of appointments or events. There may be a small number of selected family members invited to participate in leadership opportunities. For instance, with family involvement, it is the systems, agencies, or providers that decide:
>
> - The number of parents/family "invited" to meetings.
> - What and how many resource materials to offer parent/family.
> - How families will contribute to goals and what families are responsible for.

Family Inclusion: This is the active and meaningful integration of family members and support persons into the lives of their loved one's resilience and recovery process. It is a family-centered, culturally responsive, and strengths-based approach to improve the quality of life for the loved one and their family. When" included," families will understand:

- The complexities and benefits of being included in the care and treatment plans.
- The role of direct care workers, administrators, and policy makers.
- How their own family relationships impact their ability to engage with the systems and providers who work with their children/youth.
- How regulations and policies governing mental health care include the right of families to be involved. Inclusion encourages families to participate in the care and treatment of the individual.
- Inclusion in setting goals and developing case plans. Decisions are made jointly to ensure their children's safety, permanency, and well-being.

Family Engagement: Engagement is an equitable partnership between families and staff. The shared responsibility is strengths-based, culturally responsive, and embedded in all work. Family and staff work mutually together to accomplish change that is in the best interest of the child, youth, individual, and family. Family engagement is characterized by the following:

- Families are what they think, dream, or have concerns about, and goals are created with or by families.
- Families and staff reflect the diversity of the community (race, ethnicity, language, education level, and geography).
- Partnerships exist between family-led and community-based organizations.
- Families are provided access to relevant knowledge.
- Transparency and partnership exist in all parts of the process.
- Organizational/systems change can be identified because families with lived experience were involved.
- Engagement becomes a core value.
- Engagement exists at all levels, from the individual family level to families in leadership roles.
- The goal of family engagement is not to serve clients. It is to gain partners.

These distinctions can help system partners recognize powerful opportunities for change—opportunities that increase when families are genuinely engaged. And, by witnessing the competence and confidence of family members, system partners will increasingly recognize them as critical contributors in all decision-making. We urge you to make a commitment to engaging families fully—a decision that will also help you attract strong representation to your CLMT.

Once you've identified potential family leaders, use your knowledge around family involvement, inclusion, and engagement to welcome this equal and valued voice to your table. Make participation easier and let them know you will provide whatever support and training they need to develop their voice and leadership skills to serve effectively. Commit to ensuring that meetings are at a time and place that make participation easy.

Effective Partnership with Family Leaders in SOC

Here are some ways that SOC counties can both support and tap into the wisdom of their family leaders:

- Provide meaningful training and technical assistance to family members, counties, and providers, such as:
    - Training in family involvement, roles and responsibilities, communication skills, and meeting facilitation.
    - Certification as a Family Peer Support Service Specialist. These are caregivers with lived experience supporting a family member with behavioral, emotional, mental health, or co-occurring challenges. They provide peer support, information, and guidance in navigating related systems, and these specialists can be called upon to help with crisis response, inpatient treatment, PRTF, support groups, and in a home setting.
    - Training in the Family Road Map (from The Road Map© Series) to build confident, effective managers of today's big crisis and tomorrow's long haul through complicated life situations.
- Encourage family leaders to develop family networks.
- Through your system partners, provide financial and/or emotional support to family members of your CLMT as a way of honoring and valuing their contribution.
- Provide opportunities for family leaders to present information and trainings, serve as committee chairs, assist in interviewing new hires for related agencies, and help plan events and trainings.

Best Practices for a Family-driven SOC:

- Leadership Teams ensure that family members are prepared, trained, supported, and valued.
- Mechanisms are in place to assist family participation in events such as consultation compensation (stipends), transportation, travel reimbursement, and childcare.
- Families have multiple opportunities to provide leadership, advocacy, and support on behalf of other youth and families across the county.
- Families and systems have shared responsibility to ensure informed decision making.
- Families have a primary decision-making role in the county regarding their youth's and family's care and overall wellbeing.
- Families are encouraged and supported to find and/or develop family organizations at the local or state level to support family involvement at the system and service-delivery levels.

Additional resources to support family leaders and families in your county can be found in Appendix H.

Strategic Planning

While building a system of care at the community level requires an ongoing commitment to flexibility, it also requires a commitment to strategic planning. Pulling these realities together means that your plan will always need room to grow and change as circumstances evolve. Starting the strategic planning process can feel overwhelming. You know you need it, but how to begin?

Planning to Plan

One way to start is by planning to plan. A few questions to help guide your thinking include:

- Who will take the lead in planning? Will you use a dedicated workgroup or subcommittee? Will you engage an outside facilitator to assist in this process?
- How will you ensure that the voices of youth, family, and system partners are embedded in your plan?
- How will you ensure that the plan is culturally and linguistically competent and reflects your community's diversity?
- How will the full CLMT be engaged in this work along the way?
- What about hearing from stakeholders outside of the CLMT?
- How will you commit to integrating SOC values and philosophy in your planning process and the final plan?
- How long will the planning process realistically take?
- How we celebrate progress along the way?

The answers to these questions—and therefore, the planning process—will look different from county to county, but ongoing communication is central to the development of every successful plan. Establish a feedback loop to gather input from many voices and integrate new thinking into the strategy. At the minimum, all CLMT members should be assured that their insights are sincerely valued, and they will have the opportunity to offer comments before any plan is finalized.

Start Here: Where Are You Now?

Think of a strategic plan as a road map that will help you get from where you are to where you want to go. Before you can create that map, it's essential to have a crystal-clear understanding of your starting point. But for many, it's easy to see the destination and surprisingly hard to see the world around us as it is right now. The youth, family, and system partners on your CLMT may have different assumptions and beliefs about how well things currently function in your county, and you will need to see that "bigger picture" before you can plan for the future. Some of the questions that your planning team should be able to answer include:

- Have you engaged in community mapping (or conducted a needs assessment)?
- Who are the children, youth, young adults, and families that you want to serve through your SOC?
- How are they currently served by systems in your county?
- How are services currently funded?
- At what level are your county's youth and family members currently engaged in the planning and delivery of services?
- What is currently working well in your county (e.g., relationships with a managed care organization, service delivery by a particular system partner, connections with child- and youth-serving organizations)?
- What frustrations exist in the current way "business is done" in your county (e.g., irregular data collection, siloed systems)?
- Who is already "at the table"—and who else needs to be there?
- Do you have the data you need to drive the decisions you'll want to make? Can you get it?
- What additional resources can you identify to help your SOC succeed (e.g., untapped funding streams, local leaders who will champion your work)?

Mapping Your Community

If you are having any difficulty answering these questions, or if you are just making a best guess without all the information you need, then the community mapping process and/or a needs assessment would be an important step. Either can help you identify available resources and needs, but they take a different approach. Essentially, community mapping shines a light on existing strengths and assets, while, historically, a needs assessment is more focused on "what's missing."

Community mapping invites stakeholders to share their perspectives on what's working, what needs improvement, and what resources might be available. For a SOC, these stakeholders would naturally include system partners as well as the diverse youth and families engaged in these systems. Again, each will have a unique point of view on the same subject, but when viewed as a whole, a richer understanding of your community will emerge—as well as a fuller picture of how your SOC can build upon what currently exists.

Your Population(s) of Focus

The clearer you can be in articulating whom it is you wish to serve, the clearer your strategy will be. Identify your population (and subpopulations) of focus—including their challenges, strengths, and characteristics. Your county may focus on, for instance, children and families eligible for Medicaid, or those who are uninsured. Within those groups, however, there may be subpopulations that you wish to support more specifically. Some examples of these subpopulations might include[9]:

Children and youth who:

- Are at higher risk for serious mental health disorders (e.g., poverty, abuse, neglect)
- Are involved in substance abuse or who have been diagnosed with co-occurring disorders
- Fall within a particular age range (e.g., elementary-aged children or teens)
- Come from specific racial and ethnic groups
- Are already involved in specific systems (e.g., child welfare, juvenile justice, special education, substance abuse)
- Need specific services (short, intermediate, or long-term).

Knowing "who" you wish to serve tells you "why this work matters," and your answers will drive "what" you do and "how" you do it. All of this will drive your strategy.

[9] "Building a System of Care: A Primer," second edition, published by the National Technical Assistance Center for Children's Mental health at Georgetown University Center for Child and Human Development.

Identifying Strategic Goals and Objectives

The outcomes you hope to accomplish for your population(s) of focus will make a strong foundation for your goals. For a SOC, that might mean:

- Fewer out-of-home placements
- Reductions in inpatient/residential treatments
- Less abuse and neglect
- Increased school attendance with fewer disciplinary referrals
- Greater satisfaction for youth and families.

By setting meaningful and realistic benchmarks for your goals, you and your CLMT will know whether desired progress has been made and/or whether mid-course corrections are indicated.

And, if your goals are in service to the population(s) you wish to serve, then your objectives—how you will achieve your goals—are fundamentally rooted in the changing systems and structures that serve these populations. To put it another way, "Successful builders know that the more that objectives address systemic or structural change, the greater the likelihood of system of care sustainability."[10]

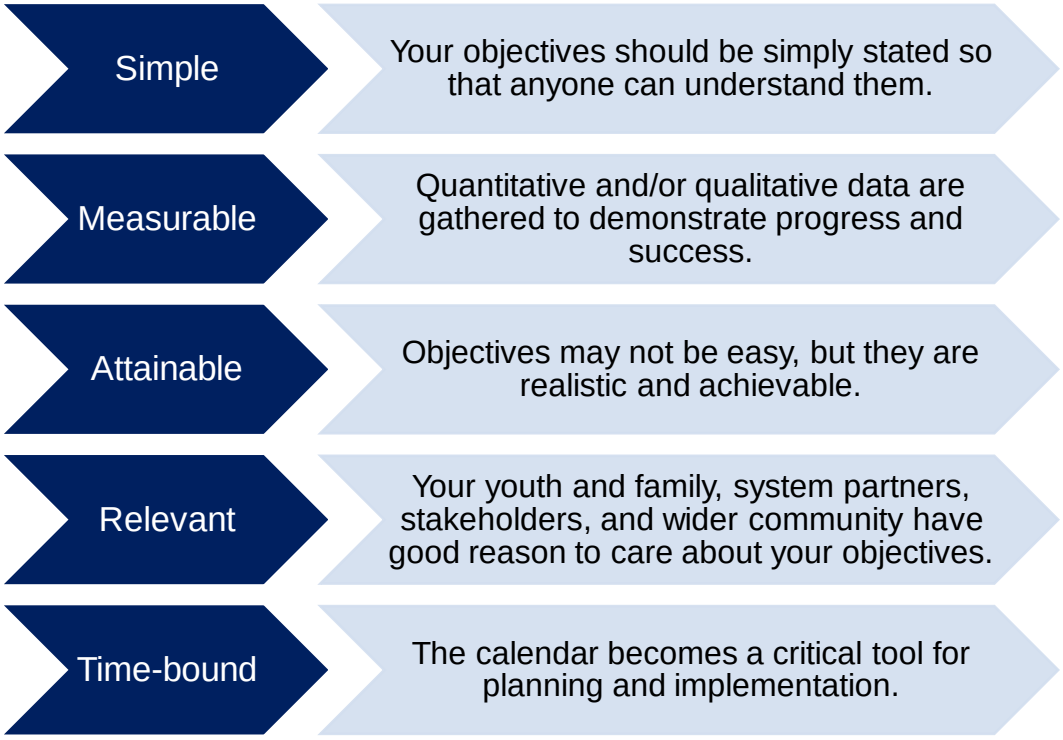
The change you wish to create will likely be advanced in any number of ways—through program implementation, service delivery, data collection, partnerships, strategic alignments, training, funding, etc. But it's not enough to simply state your intention to implement a particular program, generate supplemental funding, or seek new partnerships. It's important to ensure that you can operationalize this work in concert with SOC values. If, for instance, your goal is to reduce out-of-home placements, then:

- How will you ensure that your work is youth- and family-driven?
- How will you demonstrate a commitment to cultural and linguistic competence?

Your work must also be grounded in reality (i.e., what is legitimately achievable), and your objectives must be measured and evaluated over time. By setting meaningful and realistic benchmarks, you and your CLMT will know whether desired progress has been made and/or whether mid-course corrections are indicated.

For this reason, it is helpful to craft S.M.A.R.T. goals and objectives for your strategic plan. If you are unfamiliar with this acronym, or if it's time for a refresher, the following graphic will help you identify the characteristics of a S.M.A.R.T. goal or objective.

[10] Ibid., p. 284.



Developing S.M.A.R.T. goals and objectives allows you to move from the general to the specific. For instance:

This…	Becomes S.M.A.R.T.
• Encourage system partners to become more culturally and linguistically competent.	• Provide [X number of] CLC trainings to [specific system partners] by [date]. • Identify a CLC liaison within each system partner by [date]. • By [date], establish a monthly check-in process with each liaison to identify new challenges and solutions (such as additional training).

While your greatest impact will come from changing systems, there are other meaningful goals and objectives that you may need to incorporate into your plan. You may, for instance, find great value in communicating your work to area families as a way of becoming a trusted resource. Or, you may decide that sustainability requires building relationships with decision-makers and legislative staff. Again, these are worthwhile goals that may deserve a place in your strategic plan, even if they can't directly be tied to systems change.

From Planning to Action

As strong as your strategic plan might be, it is only a piece of paper until it is put into action. That's why it helps to create a concrete action plan that breaks down your objectives into unambiguous, manageable steps. Questions to consider might include:

- Who will be responsible for each activity?
- What is the timeline for each step of your plan?
- How will you keep your desired outcomes in mind?
- How will you recognize successes?
- How will you identify and address barriers and roadblocks?

As you assign responsibilities in your action plan, try to match each task with the staff and partners that possess either a) the needed competencies, or b) the desire the learn or be of help.

It can be particularly helpful for counties to map their action steps against SOC Core Values. In this way, you can be assured that your work is in service to the larger purpose at hand: to ensure that youth and families in your county can access and successfully navigate a unified network of culturally competent services and supports that are based on strengths and meet individual needs.

You can find a County Action Plan Template in Appendix I. For more, visit the Resources section of this toolkit.

Building Cultural and Linguistic Competence

Culture is much more than race or ethnicity. It represents the closely held values, beliefs, attitudes, symbols, and behaviors unique to a group of people that tend to be passed from generation to generation. It accounts for historical events and trauma, as well as any current social, economic, or political context that might impact members—especially those with mental health needs.

The vital work of Cultural and Linguistic Competence deserves an ongoing commitment on the part of individuals and systems. Advance planning assures that you will be responsive in the moment.

Likewise, linguistic competence involves much more than translating brochures into another language. As one definition puts it, linguistic competence represents the capacity to "convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities" (Goode & Jones, 2006).

Through a commitment to cultural and linguistic competence (CLC), we learn to acknowledge, honor, and respect the perspective of everyone. This work is vital to ensuring equity and authentic collaborations across systems, people, and natural supports so that youth and families can receive culturally responsive and respectful care.

Embracing Cultural and Linguistic Competence

This work requires an ongoing commitment on the part of individuals and systems. It asks us to engage in self-reflection to understand our assumptions, and it requires that we keep learning how to respect the beliefs, values, and practices of others.

Here are examples of how your county SOC can build CLC into your work:

- Explore the PA Care Partnership's collection of CLC materials for reference, adaptation, and use in your county. Visit the Resources section of this toolkit as well as the PA Care Partnership's website.

- Conduct a CLC assessment to better understand your community. Make—and implement—a CLC plan that addresses the unique needs you've identified. Share your process and outcomes—both locally and with other SOC counties across Pennsylvania—to hear more voices and engage more deeply in this work.

- Ask for training and technical assistance in this complex and often sensitive topic. Contact the PA Care Partnership at info@pacarepartnership.org or explore Appendix J for training and technical assistance resources.

- Adapt or develop a county-specific dictionary for mental and behavioral health in partnership with local youth, family, and system partners to ensure they meet local health literacy and accessibility concerns.

Best Practices for Cultural and Linguistical Competence:

- Leadership Teams understand the demographics and diversity of their county.

- Leadership Teams promote participation in culturally relevant and culturally specific training for youth, family, system partners, and community partners.

- Leadership Teams ensure the availability of translation and interpretation services for those with limited English proficiency.

- Culturally and linguistically diverse families, representative of the youth and families in the community, engage in, and participate at all levels of the County System of Care.

- Leadership Teams offer trainings and resources in CLC to help ensure that the staff of county services and supports effectively represent the communities they serve.

- Leadership Teams ensure that services and supports are adapted to meet the needs of their county's culturally diverse populations.

Communication and Social Marketing

Communication and social marketing can be central to the success of your system of care's implementation and sustainability efforts. Because you and your staff are already busy creating the programs, services, and partnerships that will improve lives for youth and families, it may seem as though communicating about your work will take too much time. But think of it this way: if no one knows about your important work, it's as if the proverbial tree has fallen in the forest but no one heard it—your programs won't be utilized, your data won't reflect success, and sustaining your efforts will be harder than it might otherwise be.

In order to make the most of limited time and resources for communications, it helps to think strategically. These four questions can help you do just that. They can improve everything from the way you compose a simple email to the way you design and execute a social marketing campaign.

1. What are your goals?

One of the most effective ways to set a goal is to answer this question: *What do we want people to know or do that they don't already know or do?* For instance, do you want to persuade:

- Youth or family members to join your county leadership team?
- Providers to make referrals differently?
- A potential partner to join your CLMT?
- County leadership in funding a program or service?

In each of these examples, you can see that the job is to persuade a person or group of people to take an *action* that they haven't taken before. And the best strategic communication goals often align directly with programmatic goals.

Remember that communication *goals* are not communication *tactics*. If you think that a goal is to "send out an electronic newsletter each month," or "improve our website," know that these are tactics. You may well need to do them, but tactics alone rarely persuade people to take action. When thinking about goals, think about people (or systems) and the change you seek.

2. Whom do you need to reach?

In the world of communications and social marketing, this question refers to your "audiences". What do you know about them? Where do they live, learn, work, and play? How do they like to receive information? What do they value and believe? What keeps them awake at night—and how can your work solve a problem for them? The more you learn about your audiences, the more effective your outreach will be.

3. What message will persuade people to take action?

Because you've learned about your audiences, you're able to craft messages that do more than just inform—they persuade. Do your best to ensure that the language of your message matches the values and beliefs of your audience. Demonstrate how your program or service will improve their lives or, in the case of systems change, will improve the way business is done in your county. Be clear about what action you would like your audience to take.

4. How—and how often—should you deliver your message?

Again, because you've learned about your audience, you'll know what communication tactics will work best. You will probably need to use a combination of these tactics:

> **Communication channels (people, places, and things):** Is your message best delivered by a peer? A trusted authority? Will your message be best received on a flyer at the local laundromat or the public library? Should you deliver your message through social media or traditional media?
>
> **Activities and events:** Are there health fairs or school events at which you should have an information table? Should you make a presentation to county leaders? Is there value to holding a press conference?
>
> **Materials:** Do you need flyers, posters, or brochures about your work? What about a PowerPoint presentation? Perhaps a one-sheet that highlights your data, or a success story about the lives that your work has changed? Will you create these materials, or will you adapt existing materials (e.g., SAMHSA materials)?

Finally, as with all of your programs and services, you'll want to measure your success. Let technology work on your behalf and turn to the measurement tools that are built-in to the web-based platforms you use. For instance, your email host will report the growth of your list, who is opening your emails, and which hyperlinks are getting clicks. Facebook's analytics will give you insights into your visitors and let you know which posts receive the most interaction. Use Google Analytics to look at your website traffic.

Beyond identifying these basic metrics, see if you can draw a connection between your messages and audience actions, e.g., is there a way to determine whether your emails

or social media posts increased enrollment at a training? Or drove more phone calls to a hotline? In other words, are your messages getting through—and making a difference?

Successful communication and social marketing are never an afterthought. Find a way to build these efforts into the larger fabric of your work by, for instance, embedding it into your strategic plan or creating a subcommittee dedicated to outreach. To support your communication and social marketing efforts, please see both the Resources section and Appendix N of this toolkit.

Evaluation, Quality Assurance, and Improvement

System of Care aims to help families function better at home, in school, in the community, and throughout life by finding out what they truly need and providing the appropriate care. This worthwhile work is worth measuring.

If grant funds are available to support your SOC, you will naturally follow all grant guidelines for data collection and reporting. In the absence of grant funding, however, we urge you to build an evaluation component into your system of care as part of your commitment to SOC Core Values. Collecting data from youth and families in your county will offer essential insight into individual outcomes, satisfaction, and progress of youth and families who are enrolled in designated services and processes. This will allow your decisions to be data-driven—relying on concrete information rather than personal feelings, anecdotal, or historical experience.

Data—both quantitative and qualitative—is particularly important for sustaining and expanding your efforts. If you hope to persuade decision-makers and legislators to support your work, they will need to be convinced of its value. As you plan for evaluation, think about what data these groups might need to see. While they will likely want to know the ROI (return on investment) for your work, bear in mind that they may also be moved by the individual stories of youth and families whose lives have been changed for the better.

Under current SAMHSA funding, counties associated with the PA Care Partnership collect information such as a youth's mental health diagnosis and system involvement. Counties have also collected information related to youth perceptions of their mental health care and their connectedness with people other than their mental health providers. Data has historically been collected every six months from youth still enrolled in a county chosen provider program.

Whether or not your county is able to fund extensive data collection, there are multiple data sources that can provide an important point of departure for robust CLMT discussions and decision-making. We recommend that you and your team regularly look at data together, and the following list of activities and actions can jumpstart your thinking.

Examples of Data-Related Activities and Actions

1. Have a Data and Continuous Quality Improvement (CQI) standing agenda item at each County Leadership Team meeting.

2. Choose a data topic for each meeting.

    - Review relevant data sources at the county, state, and federal levels. (See links to several data sites in the Resources section of this toolkit or visit the evaluation resources on the PA Care Partnership website.

    - Look at census data to get a better sense of your county's minority populations around race/ethnicity/language/culture.
    - Ask a different CLMT member to choose the topic for a monthly meeting and be responsible for bringing some data (a few slides/charts) to discuss.
    - Let the natural discussion of each meeting identify a topic for the following month.
    - Allow curiosity/questions to arise first and allow the group to identify the data that can help to answer the question or illuminate the discussion.
    - Develop a list of important topics and schedule them for the next 6 months of meetings so that everyone can bring something relevant to discuss.

3. Choose a reason to look at data and how to focus on the discussion.

    - **Strengths-based:** Look at positive data and the possible strengths of your county that may have led to positive results. Celebrate successes around the work that your county has done that to make a difference.
    - **Challenges:** Look at barriers to positive change. Discuss what actions your county might have taken that may have led to the negative results, discuss any possible elephants in the room, and identify areas for improvement.
    - **Outcomes:** Focus on one particular county program, service, support, etc., and look at a small number of outcomes to see how the program is functioning and what is working/not working. Be sure to bring in staff and/or family/youth who have participated to help think about the outcomes.
    - **Confusing/conflicting information:** Spark discussion from different perspectives around the table (family, youth, systems, providers, community, etc.) by asking critical questions and reflecting on why information is mixed or conflicting.

- **Lack of information:** Identify areas where there is a need for more data and brainstorm ways that you could obtain more information about the topic.
- **Sustainability:** Consider the decision-makers, funders, and funding streams that may be in a position to help sustain your work down the road. Try to forecast what combination of quantitative and qualitative data will help these audiences see support as a "win" for them. If you aren't currently collecting this data, see if there is a way you can capture it.

4. Develop a plan for next steps.

    - Identify what you want to do to make sure that the good work continues.
    - Choose and prioritize areas that you want to improve or adjust.
    - Discuss whether you have all the information you need or if you need to brainstorm more ideas/sources of data, etc.
    - Discuss who, what, when, where, how, why the plan will be developed around CQI.
    - Decide when updates will be made to the group and how the group will be informed of progress.

Best Practices for Data-Driven, Quality, and Outcomes Oriented:

- The CLMT, partnering agencies, and/or providers collaborate to gather data for CQI.
- Data is collected and submitted as required by any grant funding available to the CLMT.
- The CLMT collaborates with child-serving systems to reduce barriers related to confidentiality and data sharing between systems.
- The CLMT collaborates with child-serving systems to collect data related to cost-effective services and supports.
- Data is effectively shared/conveyed with stakeholders to demonstrate the value of SOC and make the case for sustainability.

Visit the Resources section of this toolkit for links to several state and federal data resources. We also suggest that you contact other SOC counties across the Commonwealth to learn how they are measuring their efforts (see Appendix E). Also, see Appendix K for more tips on how to use and convey data effectively.

Training and Technical Assistance

When it comes to successfully implementing a system of care, your county will most certainly benefit from training and technical assistance (TA) along the way to identify issues and generate sustainable solutions. The right TA can assist you in areas that need development, such as program implementation and operationalization, partnership development, evaluation, cultural and linguistic competency, communications, and more.

Technical assistance isn't about finding someone to do the work for you—it's about building capacity within your CLMT to accomplish and sustain the work yourselves.

Finding TA to Meet Your Needs: Basic? Or Intensive?

Every CLMT has its unique needs, and no one size fits all. One county may have a strong infrastructure and partners already in place to implement a SOC, while another may be building their SOC from the ground up. Each will need a different *kind* and *level* of TA to succeed. It is wise for you and your CLMT to identify and plan for your TA needs based on your strengths and gaps. Your TA plan will also grow and change over time as your work evolves and new needs arise.

One way to think about the TA you'll need is to distinguish between Basic TA and Intensive TA. In their white paper "Intensive Technical Assistance,"[11] authors Fixsen, Blase, Horner, and Sugai (2009) suggest **Basic TA** as an efficient approach to facilitate change by providing information and support (e.g., materials, summative documents, overview workshops, tools). This approach is most effective when the TA recipients already possess core skill sets and are most in need of timely, accurate, and accessible information and content—in other words, the "what."

Intensive TA, however, is required when new knowledge, skills, and abilities are called for, and changes need to occur at multiple levels to support and sustain a new way of working. Recipients of Intensive TA don't just need information (the "what"); they need to build the skills and competencies necessary to apply this information (the "how"). Intensive TA frequently requires that recipients think quite differently about problems and solutions, and it may challenge current beliefs, assumptions, and attitudes. It is inclusive of all the elements of Basic TA but requires considerable planning, frequent

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[11] Fixsen, D. L., Blase, K. A., Horner, R., & Sugai, G. (2009, February). *Intensive Technical Assistance. Scaling Up Brief #2.* Chapel Hill: The University of North Carolina, FPG, SISEP.

communication, on-site work, collaboration at multiple levels, coaching, and both process and outcome evaluation efforts at several levels to build capacity and achieve systemic change. An overarching outcome of Intensive TA is to ensure that the TA functions and strategies are embedded in the organizations and institutions themselves; this ensures continuous regeneration, improvement, and sustainability.

In summary, TA is defined in a number of ways, but it may be most useful to anchor *your* definition in relation to your intended outcomes. TA to promulgate awareness and encourage changes in attitudes will require different strategies than TA needed to build capacity and create service and system change. TA can and should change over time and across initiatives to match the desired outcomes, from Basic to Intensive TA and back again, and this spectrum from one to the other can be a useful way to analyze what you will need in your own county.

The Core Features of Intensive TA[12]

Clarity:

- A clear understanding of the current context (e.g., system strengths, policies, stressors).
- Agreement on needs, vision, desired changes.
- Mutually clarified roles and responsibilities among all partners.
- Agreement on process for creating change (e.g., communication routines, feedback methods, workgroups).

Frequent communication:

- Regular on-site meetings, telephone, and/or video conferencing to initiate and manage change.
- Frequent cycles of planning, execution, evaluation, and articulation of next steps to move the work forward and solve problems.

Intensity:

- Opportunities for collaborative reflection to guide next steps and to infuse new skills and information into system work.
- Regular coaching and assessments of skill development and overall progress.

Duration:

- Long-term commitment from TA provider to build capacity and achieve system change (2 to 5 years is typical).

Integrity:

- Focus on creating a more integrated and effective system of services and supports through comprehensive work with the whole system
- Commitment to the use of reliable data to inform decision-making

Accountability:

- Responsibility for updates and support to assure that intended outcomes occur.
- Challenges and feedback become opportunities to develop new strategies, bring in new partners, and deepen knowledge, skills, and abilities.
- Impact of benefits to children and their families is measured at multiple levels.
- Full accountability for results and agreed-upon goals rests with the TA Provider.

An extensive list of relevant current TA providers can be found in Appendix J. If you'd like guidance on selecting training programs or providers, or you have needs not identified below, we urge you to contact the PA Care Partnership. You may also wish to speak with other SOC counties; a contact list can be found in Appendix E.

[12] Adapted from *Intensive Technical Assistance.*

Funding

One of the first questions stakeholders in your county will likely ask is, “How much will System of Care cost—and where will the money come from?” The good news is that, here in Pennsylvania, significant funding is already in place through Medicaid. Additional funding streams may also be available, and this section will guide your thinking.

Medicaid Funding for Direct Services

Our state’s mandatory managed care program, HealthChoices, covers both physical and behavioral health benefits for Medicaid eligible residents. Behavioral health is a “carve-out,” designed to improve access to and quality of services. It is funded by the Center for Medicaid Services (CMS) and distributed and monitored by the Commonwealth and Pennsylvania’s Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS) overseeing behavioral health.

Behavioral health services are managed at the county level through Behavioral HealthChoices, and the Behavioral Health Managed Care is administered through the Behavioral Health Managed Care Organization or directly by the county. Either way, service providers may be reimbursed for services to Medicaid-enrolled children with significant behavioral and mental health challenges. Services that may be eligible for reimbursement in your county include:

- Psychiatric outpatient
- Targeted/Intensive case management
- Behavioral health rehabilitation for children and adolescents
- Family-based mental health services
- Partial hospitalization
- Residential treatment facility
- Crisis intervention services
- Inpatient psychiatric hospitalization
- Outpatient drug and alcohol services
- Non-hospital drug and alcohol residential and rehabilitation

Additionally, Medicaid funds may be used for a select number of evidence-based mental health therapies and services, including:

- Multisystemic Therapy
- Functional Family Therapy
- Mobile Psychiatric Rehabilitation Services for Youth and Young Adult
- Parent-Child Interactive Therapy
- Peer Support for Youth and Young Adult

This makes Medicaid a core funding source for every System of Care in Pennsylvania, but it probably won't be sufficient to cover all of the costs associated with your SOC.

Tapping into Leftover Medicaid Funds

At the end of each year, any Medicaid funding that has not been used by your county is divided in three ways. One-third is returned to the state, one-third is returned to the MCO as a bonus for good management, and one-third is returned to the county.

Counties reinvest this "refund" for physical and behavioral health-related programs, services, trainings, and infrastructure, and a SOC may pursue some of this funding to cover its own additional costs, e.g.:

- Evidence-based programs or promising practices not covered by Medicaid
- Trainings
- Staffing
- Outreach

Other Funding Sources

Finding additional funds to support your work requires flexibility and a little creativity. You and your CLMT will want to identify—and braid together—as many funding streams as possible. These funding streams may be public or private, and each will come with its own requirements (e.g., administrative, reporting), but they may be central to your ability to provide a full array of formal services, informal supports, and relevant trainings that best serve youth and family, drive systems change, and sustain your work.

Hold periodic brainstorming sessions with your CLMT, or consider a workgroup or subcommittee dedicated to identifying and pursuing additional funding streams. A few questions to consider include:

- Do we understand how public funding flows in our county (e.g., block grants, matching funds, general revenue)?

- How is money allocated to agencies—including system partners? Could some of that funding be redirected to SOC? How could we frame our ask as a “win-win”?

- Are there available public or private/foundation grant funds to support any element of our SOC or our strategic plan? How will we monitor future grant opportunities and apply for them?

- Is support—either financial or in-kind—available locally (e.g., business organizations like the Chamber of Commerce, service organizations like Kiwanis, faith-based organizations, or area colleges/universities)?

Again, with Medicaid providing the lion’s share of funding for direct services to children, youth, and families, you will be able to turn your attention to additional sources of funding. Flexibility, coupled with creativity, will help you and your CLMT map the right array of funding streams to meet your needs.

For more, visit the Resources section of this toolkit.

Additional Resources to Support Your County System of Care

This array of resources will help you apply the System of Care approach and align with the core values we encourage counties to adopt.

PA Care Partnership Online Tools and Resources

This comprehensive collection includes:

- Multiple guides and manuals
- Reporting forms for PA Care Partnership grant recipients
- Sample forms, job descriptions, and MOUs
- Policy examples and forms for counties (e.g., family stipend, compensation consultation, youth and family CLMT applications)
- Budget and finance forms

More topic-specific resources found on this site are also listed below.

Developing a System of Care

"Building Systems of Care: A Primer," second edition, published by National Technical Assistance Center for Children's Mental Health at Georgetown University Center for Child and Human Development with funding from SAMHSA.

"Toolkit for Expanding the System of Care Approach," published by National Technical Assistance Center for Children's Mental Health at Georgetown University Center for Child and Human Development with funding from SAMHSA. 2015.

"Return on Investment in Systems of Care for Children with Behavioral Health Challenges," published by National Technical Assistance Center for Children's Mental Health at Georgetown University Center for Child and Human Development with funding from SAMHSA. 2015.

"Lessons Learned for Expanding Systems of Care: Analysis of the System of Care Expansion Planning Grant Program," published by National Technical Assistance Center for Children's Mental Health at Georgetown University Center for Child and Human Development with funding from SAMHSA. 2013.

"Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions," SAMHSA Bulletin, May 7, 2013. Focuses on positive impacts on Medicaid programs designed to serve this population.

Engaging Youth

"Youth Voice Tip Sheet: 10 Tips to Improve the Conversation," published by the American Academy of Child & Adolescent Psychiatry, 2012.

"Youth Involvement in Systems of Care: A Guide to Empowerment," published by American Institutes of Research, 2005.

"The Substance Abuse and Mental Health Services Administration's (SAMHSA) Youth Engagement Guide: Strategies, Tools, and Tips for Supportive and Meaningful Youth Engagement in Federal Government-Sponsored Meetings and Events," published by SAMHSA, 2016.

"A Guide to Youth Recruitment," published by SAMHSA in partnership with Youth M.O.V.E. National and The Technical Assistance Network for Children's Behavioral Health.

"Youth Advocate to Advocate for Youth," published by SAMHSA, The National Institute on Disability and Rehabilitation Research, and the U.S. Department of Education in partnership with Youth M.O.V.E. National and the Research and Training Center for Pathways to Positive Futures.

"Strategic Sharing Workbook: Youth Voice in Advocacy!" published by The Research and Training Center for Pathways to Positive Futures, Portland State University. 2012.

"Young Adult Leadership Curriculum," published by the National Resource Center for Youth Development and funded by the Administration for Children and Families Children's Bureau in collaboration with Fosterclub, the National Network for Young People in Foster Care. 2011.

"Youth Advocate-to-Advocate," produced by Youth MOVE National in partnership with the Research and Training Center for Pathways to Positive Futures. Published with support from SAMHSA.

"Building the Foundation for a Youth MOVEment of Peer Support." Slide presentation from Youth MOVE National and National Technical Assistance Center for Children's Mental Health, Georgetown University.

"Youth Peer-to-Peer Support: A Review of the Literature," published by Youth MOVE National with support from SAMHSA. 2013.

Engaging Families

The PA Parent and Family Alliance have produced a comprehensive collection of resources and supports for families on topics such as:

- Different diagnoses
- Statewide services and supportive systems
- Parent chat line
- Parent leadership development

"Meaningful Parent Leadership: A Guide to Success," published by FRIENDS National Resource Center for Community-Based Child Abuse Prevention with support from the U.S. Department of Health and Human Services, Administration for Children, Youth, and Families, Office on Child Abuse and Neglect. 2010.

"Building Communities, Building Hope," published by the Office on Child Abuse and Neglect, U.S. Department of Health and Human Services. 2017.

Cultural and Linguistic Competence

The National Standards on Culturally and Linguistically Appropriate Services (CLAS Standards) help health care organizations and providers make their practices more culturally and linguistically accessible.

"Improving Cultural Competency for Behavioral Health Professionals" is a free online training created by the U.S. Department of Health & Human Services Office of Minority Health.

"Culture Clues" are tip sheets to help clinicians better understand the cultural preferences of their patients. These quick reference guides were developed by the University of Washington Medical Center.

Resources from Mental Health America include support for working with Native American, Latino, LGBT, Asian American, and African American communities.

The National Council for Behavioral Health's "Culturally and Linguistically Responsive Strategies Developed for Certified Community Behavioral Health Clinics."

The "Mental Health Clinician's Guide to Cultural Competency" includes assessment tools, a toolkit, and other resources from Loma Linda University.

SAMHSA's TA Center for Service Members, Veterans, and Their Families (SMVF) offers toolkits, fact sheets, webinars, and more resources for supporting military families.

Trauma-Informed Care

Organizational Self-Assessments:

"Organizational Self-Assessment: Adoption of Trauma-Informed Care Practice," published by National Council for Behavioral Health.

"Creating Trauma-Informed Care Environments" from the University of South Florida College of Behavioral & Community Sciences.

"Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol," adopted from the National Center of Family Homelessness Trauma-Informed Organizational Self-Assessment article by Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.

"Trauma-Informed Care in Youth Serving Settings," published by the Traumatic Stress Institute of Klingberg Family Centers.

Other Trauma-Informed Resources:

"Trauma-Informed Organizational Toolkit," published by The National Center on Family Homelessness and supported by SAMHSA's Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services.

"Understanding Trauma: A Guide for Youth," published by Youth MOVE and the National Technical Assistance Center for Children's Mental Health with support from SAMHSA.

High-Fidelity Wraparound

"Connecting the Dots: A Ten-Year Review 2009-2019" from the Youth and Family Training Institute. This report examines the success of the High-Fidelity Wraparound over time. Outcomes include cost savings, decreased hospitalization, and improved use of community-based services.

Technical Assistance

"Intensive Technical Assistance," Scaling Up Brief #2. Fixsen, D. L., Blase, K. A., Horner, R., & Sugai, G. (2009). Chapel Hill: The University of North Carolina, FPG, SISEP.

Juvenile Justice

"A Family Guide to Pennsylvania's Juvenile Justice System," developed by the Family Involvement Committee of the Pennsylvania Council of Chief Juvenile Probation Officers.

"Pennsylvania's Juvenile Justice System Enhancement Strategy," published by the Pennsylvania Commission on Crime and Delinquency and supported with funds from the U.S. Department of Justice. 2012.

"Building Bridges Between Your Court and Your Community: A Handbook for Juvenile Court Professionals." Includes a handbook for community members. Produced by the Court and Community Collaboration Committee of the Pennsylvania Council of Chief Juvenile Probation Officers with funding from the Office of Justice Programs, U.S. Department of Justice.

Communication and Social Marketing

"Introduction to Strategic Communication Planning," "Developing Your Communication Strategy," and "Moving from Strategy to Action." Three-part interactive, self-paced

learning modules to support program success and sustainability. Produced by AIR and funded by SAMHSA. 2017.

Evaluation

The PA Care Partnership Evaluation Resource page includes tip sheets, PowerPoints, practice activities, and more.

SAMHSA's "Guide to GPRA Data Collection Using Trauma-informed Interviewing Skills." 2015.

County and State Data Sources:

United States Census Bureau allows city and county-level data on populations; demographic information (age, race, ethnicity, language, education, income); geographical mobility/migration; industry and occupations; and, more.

SAMHSA's Data and Dissemination website is a searchable portal for data on mental health and substance abuse. It also includes multiple relevant state-specific reports.

The Annie E. Casey Foundation regularly publishes research and policy reports, including the KIDS COUNT Data Book, based on data featured on its KIDS COUNT Data Center. Users may explore multiple indicators of child well-being and search by demographics, economic well-being, education, family and community, safety, and more.

The Robert Wood Johnson's County Health Rankings and Roadmaps provides a snapshot into how health is influenced by where we live, learn, work, and play.

The Pennsylvania Department of Human Services Data Dashboards provides insights into county-level data.

The Pennsylvania Department of Education collects and analyzes an array of education-related data.

The PennData Special Education Reporting System is sponsored by the Bureau of Special Education in collaboration with Penn State University.

Pennsylvania Juvenile Court Judge's Commission provides juvenile court statistics report to develop long-range plans for future court operations.

The Pennsylvania Commission on Crime and Delinquency's Statistical Analysis Center (SAC) and the Commonwealth's Office of Research, Evaluation, and Strategic Policy Development (ORESPD) serve to evaluate best practices and research trends in the criminal and juvenile justice arenas.

The Pennsylvania Commission on Crime and Delinquency's Evidence-based Prevention and Intervention Support Project (EPIS) offers a menu of proven prevention and intervention programs and conducts research.

The Department of Corrections Bureau of Planning, Research & Statistics assembles data and reports to assist in short- and long-term decision-making.

National Data Sources:

The Data Resource Center for Child & Adolescent Health tracks the prevalence and impact of a wide spectrum of health topics for children aged 0-17. The survey can help states plan and evaluate programs, as well as inform organizations that work directly with children.

The Youth Risk Behavior Surveillance System (YRBSS) monitors priority health-related behaviors and the prevalence of obesity and asthma among youth and young adults. The YRBSS includes a national school-based survey conducted by the Centers for Disease Control and Prevention (CDC) and local surveys conducted by state, territorial, and local education and health agencies and tribal governments.

The National Center for Health Statistics is a rich source of information about America's health. As the nation's principal health statistics agency, they compile statistical information to guide actions and policies to improve the health of our people. They are a unique public resource for health information—a critical element of public health and health policy.

FindYouthInfo.gov was created by the Interagency Working Group on Youth Programs (IWGYP), which is composed of representatives from 18 Federal agencies that support programs and services focusing on youth. The IWGYP promotes the goal of positive, healthy outcomes for youth. This Web page includes resources related to a number of topics affecting America's youth. Many of these resources include data and statistics for proposals, research, presentations, and more. Data are available on general data; bullying; community development; education, employment, and training; health; housing; parenting; substance abuse; teen driver safety; violence and victimization; and more.

CDC's Adolescent and School Health Data and Statistics use three state-of-the-art monitoring systems designed to collect, analyze, and disseminate data on youth risk behaviors and school health policies and practices.

Funding

"Effective Financing Strategies for Systems of Care: Examples from the Field—A Resource Compendium for Developing a Comprehensive Financing Plan." Published by the Research and Training Center for Children's Mental Health and the University of South Florida.

Appendices

Appendix A

The National SOC Model

At the national level, SOC is defined as:

A spectrum of effective community-based services and supports for children, youth and young adults with or at risk for mental health and related challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them function better at home, in school, in the community, and throughout life.

Operates with Core Values:

> Family-driven and youth-guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
>
> Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
>
> Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Is supported by guiding principles:

> Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
>
> Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
>
> Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence to ensure the effectiveness of services and improve outcomes for children and their families.

Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.

Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.

Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.

Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.

Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.

Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.

Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.

Protect the rights of children and families and promote effective advocacy efforts.

Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and services should be sensitive and responsive to these differences.

Source: Stroul, B., Blau, G., & Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health

Appendix B

History of PA CASSP/Systems of Care

1985 Pennsylvania received two federal grants to build CASSP infrastructure across the state, including the county CASSP Coordinator system and the CASSP Advisory Committee Mental Health Association of Southeastern Pennsylvania founded Parents Involved Network

1989 First Children's Interagency Conference Held

1990 Division of Children's Services created in the Office of Mental Health

1991 Bureau of Children's Services established in the Office of Mental Health

1993 PA CASSP Training and Technical Institute created

1995 CASSP Core Principles for Pennsylvania developed and approved by the CASSP Advisory Committee

1997 Last state hospital unit for children closed Office of Mental Health was renamed the Office of Mental Health and Substance Abuse Services, as part of this reorganization, the Bureau of Children's Services was eliminated and its functions integrated into other Bureaus

2002 Performance Expectations and Recommended Guidelines for County CASSP Bulletin issued to guide interagency work for children, youth and families, and promotion of broader adherence to the CASSP principles

2003 Bureau of Children's Behavioral Health Created

2004 Pennsylvania Families Incorporated (PFI) developed which helped the family movement in PA take a major step forward with the receipt of a federal grant from SAMHSA

2007 The Youth and Family Training Institute was established, and the CASSP Institute was disbanded

2008 Implementation of High-Fidelity Wraparound begins

2009 Pennsylvania receives SAMHSA cooperative agreement to fund System of Care through 2015.

2017 The PA Care Partnership receives expansion grant funding from SAMHSA to build on previous SOC work

Appendix C

Why the PA Care Partnership Values Matter

The PA Care Partnership has developed eleven (11) Core Values, which are the foundation of a system of care. Additionally, the Values have been vetted and approved by the TA Network, part of the University of Maryland School of Social Work, the national technical assistance provider for System of Care grants, has detailed core System of Care Values. These values transition System of Care toward a public health framework. The focus is not only on treatment for individual children with serious behavioral health conditions but also on addressing promotion, prevention, early intervention, and education to improve total health—physical, oral, developmental, and behavioral—for identified populations of children and youth.

Our System of Care principles guide and direct how we implement the work we do throughout the Commonwealth of Pennsylvania.

Youth-Driven

Youth-driven is having youth included in decisions that affect their care and well-being. Adults make the conscious decision not to manipulate youth or use them in a way that would suggest tokenism or mere decoration. Youth are trained, supported, have a valued voice, and earn a seat at state and local policy and program tables as their experience, confidence, and voice develops. Participation grows from being assigned and informed and evolves into youth leading and sharing with adults in decision-making.

Youth are supported in various ways as they share their experiences and their opinions. Financial support is given as needed through stipends, transportation assistance, hotels, meals, and childcare, to sustain their input. Opportunities, like youth voice and leadership, are encouraged and made available to youth at county and state level child-serving systems, through the work of System of Care.

Family-Driven

At the individual family level, Family-driven means families have a primary decision-making role in the care of their children. In leadership positions at their county and state, providing input into the policies, procedures, and funding decisions that govern the care of all children in their communities. Family-driven can be realized even within the context of delinquency and/or dependency proceedings, even when there is a feeling that it is not being driven by the family. In some situations, families may not have the opportunity to drive all decisions, but they should have the opportunity to be involved in the decisions.

Home- and Community-Based

A system of care builds on the strengths of the community in which that family lives. Providing community-based services means having high-quality services accessible to families in the least restrictive setting possible. A community-based system of care requires systems to see the home, school, and neighborhood of the family from the perspective of its assets and to identify the natural supports in these familiar surroundings as part of a strengths-based approach.

Community-based care has the culture of the family woven into the services provided. Access to the home, school, and neighborhood is seen as an asset to be used to identify and craft the strengths and quality of the natural supports into the family plan for the highest probability of positive outcomes for all.

Strengths-based and Individualized

Strength-based and individualized practices and processes identify and build on the strengths of the family and child. Families are included and drive the creation of individual plans to provide needed services. Formal and informal supports are used to create services and supports for each child and family. Plans are individualized based on the needs of the youth, young adult, and family. The plan changes frequently based on ongoing individualized assessments of strengths and needs.

Plans are created by teams comprising people who know the child and family, including neighbors; friends; family; and child welfare, mental health, education, substance abuse, and juvenile justice professionals. The team's major task is to create an individualized plan of care that is community and strength-based made up of formal and informal services and supports.

Trauma-Informed

Trauma-Informed Care (TIC) is a holistic, person-centered approach to treatment that understands and incorporates the biological, psychological, neurological, and social impact of trauma on an individual. Implementing trauma-informed practices means that every part of an organization or program understands the effects of trauma on the individuals they serve and promotes cultural and organizational change in responding to the consumers/clients served. By recognizing trauma as an important factor impacting health throughout the lifespan, and by offering trauma-informed approaches and treatments in health care settings, provider organizations can more effectively treat patients, thereby potentially improving health outcomes, reducing avoidable care utilization, and curbing excess costs.

Cultural and Linguistic Competence

Cultural and linguistic competence is the integration and transformation of knowledge, behaviors, and attitudes from and about individuals or groups that enable policymakers, administrators, youth, families, service providers, and system partners to work effectively in cross-cultural situations. Furthermore, linguistic competence is the capacity of policymakers, administrators, youth, families, service providers, and system partners to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. (Goode & Jones, 2006).

Culture is vital to ensuring equity in Systems of Care because it is a set of attitudes, values, beliefs, symbols, and behaviors shared by a group of people, but different for each, and usually communicated from one generation to the next. Cultural and Linguistic Competence supports authentic collaborations between systems and community and natural supports through community partnerships and outreach to ensure youth and families receive culturally responsive care.

Connected to Natural Helping Networks

When working with people, need to ask about those associations and relationships a person has that supports them that are personal, not professional. They are natural helpers, and social supports may be family members, youth, and representatives from culturally diverse neighborhoods, and others who can provide a more "normalized" and enduring form of support to families and youth that can use formal services. Natural helping networks may include groups such as faith-based organizations, neighborhood watch groups, or informal social groups such as a neighborhood scrapbooking club.

Data-driven, Quality, and Outcomes-Oriented

System of Care aims to help families function better at home, in school, in the community, and throughout life by finding out what they truly need and providing the appropriate care. Collecting data from youth and families in a community allows decisions to be data-driven – relying on concrete information, rather than personal feelings, anecdotal, or historical experience. Data collected includes information such as a youth's mental health diagnosis and system involvement as well as information related to the youth's perception of his/her mental health care and his/her connectedness with people other than their mental health providers. Data is collected every six months from youth still enrolled in a county chosen provider program and ultimately provides an objective picture of what works and what doesn't work locally and nationally.

County Leadership and Governance Teams

Leadership Teams and Governance Boards may look and run in many different ways across Pennsylvania Ultimately, Leadership/Governance Board is comprised of an equitable partnership of System, Family and Youth leaders who work together to assure that the System of Care Values and Principals are incorporated in the framework of how decisions are made, policies are made and how services are planned and delivered.

Multi-System Integration

Integrated serving systems ensure that services and supports are integrated at the system level, with linkages between the child and transition-aged serving agencies and programs across administrative and funding boundaries and mechanism are established for system-level management, coordination, and integrated care management. The mission, vision, and desired outcomes of each system are incorporated in a person-centered approach that meets the needs of the youth and family's social, emotional, and physical health care needs. Utilizing natural and community supports and services available to the youth and family in the county they reside.

Youth and Family Services and Supports Planning Process

The youth and family-driven model that facilitates integrated services and supports planning among youth, families, and key child-serving systems. These services and supports processes have staff who are trained to deliver the process; there is a clearly defined engagement process and assesses the youth and family individual needs. These are performed in the least restrictive settings, have required data collection and outcomes bases. To have supportive processes, youth and family have supports (peer) available as needed.

Appendix D

State Leadership and Management Team Resources

Roles and Responsibilities (as of 2020)

Pennsylvania's State Leadership and Management Team (Youth, Family, and Systems members) strives to represent the diversity of Pennsylvania, including different ages, genders, ethnicities, socioeconomic backgrounds, and geographic locations. Our members include:

Youth Partners (voting members)

- Anyone (ages 16-28) who is currently managing his/her own behavioral health recovery and has current, or past, experience with the educational, child welfare, behavioral health, co-occurring, and/or juvenile justice, drug and alcohol systems can apply to be on the SLMT. Preference will be given to youth with experience participating in other state or local advisory boards, youth leadership teams, or youth advocacy groups.

Family Partners (voting members)

- Anyone who recently had or is currently raising a child(ren)/youth with behavioral health concerns (or needs) and past/current experience with the educational, child welfare, behavioral health, and/or juvenile justice, drug and alcohol systems can apply to be on the SLMT. Preference will be given to family partners with experience participating in other state or local advisory boards, family leadership teams, or family advocacy groups. Family partners should also have a variety of experiences in navigating the behavioral health system in combination with educational, child welfare, drug and alcohol, and/or juvenile justice systems.

System Partners (voting members)

- These are key leaders or representatives at a state level from the following agencies: Education, child welfare, juvenile justice, drug and alcohol systems, behavioral health, physical health, early intervention, intellectual disabilities, and the courts. Demonstration of knowledge/experience and/or interest related to services addressing children/youth's behavioral health and wellbeing in Pennsylvania. System Partners are requested upon need to fill vacancies for needed representation in specified departments.

    - **Community Partners** may include but not be limited to social service organizations, community organizations (i.e., United Way, Big Brothers Big Sisters, YMCA, YWCA), faith-based organizations, or other providers or services that are not traditionally funded by medical assistance or county funds.
    - **Provider Partners** are those who provide direct services to family, children, youth, and young adults (direct services for mental health, Child Welfare, Juvenile Justice, Drug and Alcohol, and in the education setting). The direct services may include but

not be limited to mental health, drug and alcohol providers, family preservation, High Fidelity Wraparound or Joint Planning Team, Family Group Decision Making (Conferencing), Strengthening Families, Open Table, and MST- Multi-systemic Therapy, Case Management, Psych Rehabilitation, Mobile Psych Rehabilitation, and other agencies that receive funding from Medical Assistance or the County/State to provide a service.

Non-Voting Members

- We delineate between voting and non-voting members to ensure that youth and family voices are equally weighted in decision making with system partners. Therefore, based on the number of youth and family representatives on the SLMT, a percentage of community and provider partners are not given voting status.

- Non-voting members are encouraged to participate fully in agenda development, discussions, and other SLMT activities. Additionally, grant staff (including contractors and consultants), may be invited to attend SLMT meetings.

Roles and Responsibility of SLMT Members

	Tri-Chair	Voting Member	Non-Voting Member
Works collaboratively with other youth, family partners, and system partners to advise the development of the grants.	X	X	X
Represents yourself and your organization to help shape the decisions that impact SOC goals and activities.	X	X	X
Is willing and able to participate on, or provide guidance and feedback to, one subcommittee.	X	X	X
Identifies the needs of children, youth, and families across the Commonwealth.	X	X	X
Develops strategies that meet the priorities of all grant initiatives.	X	X	X

	Tri-Chair	Voting Member	Non-Voting Member
Brings issues that impact youth, families, and community to the table for information and or discussion.	X	X	X
Determines ways to individually or through agency support specific SLMT strategies.	X	X	X
Suggests new, creative ways to collectively address priority issues with given resources.	X	X	X
Reviews family and youth serving systems and advocates for improvements.	X	X	X
Monitors program and community level trends and outcomes.	X	X	X
Recommends policy change based on data, program, and systems review.	X	X	
Creates or co-creates agenda items for the SLMT.	X		
Gets feedback and thoughts from system partners, youth, and family on the activities for meetings.	X		
Puts self-interest aside for the betterment of the community. Commits to learning the processes and models used for data-driven decision making.	X	X	X
Works in partnership to sustain System of Care programs and activities.	X	X	X
Attends and actively participates in the monthly meetings.	X	X	X
Reviews meeting materials before meetings.	X	X	X

	Tri-Chair	Voting Member	Non-Voting Member
Carefully considers and votes on SLMT issues, policies, plans, and proposals. Represents their constituency in matters of discussion and voting.	X	X	
Gets relevant issues/ information on SLMT agendas in advance of meetings.	X	X	
Volunteers for leadership positions.	X	X	X
Lends expertise and/or resources needed by the program or organization.	X	X	X
Reviews family and youth-serving systems and advocates for improvements.	X	X	X
Represents the viewpoint of the identified member role.	X	X	X
SLMT OPERATIONS OUTSIDE OF MEETING	**Tri-Chair**	**Voting Member**	**Non-Voting Member**
Becomes familiar with all SLMT and Grants initiatives and work plans.	X	X	X
Attends and participates in all training/education related to the Partnerships.	X	X	
Establishes and executes a statewide agenda through a strategic plan.	X		
Serves as an ambassador for SLMT and its mission.	X	X	X
Attends special events and SLMT-supported community activities. Provides leadership when appropriate.	X	X	X
Presents appropriate agenda items one week in advance of meeting dates.	X		

SLMT DATA AND EVALUATION	Tri-Chair	Voting Member	Non-Voting Member
Reviews data and benchmarks, identify trends, sets priorities, and develops strategies to address the agreed-upon priorities.	X	X	
Shares outcomes and data with partners.	X	X	
SLMT TIME COMMITMENT	**Tri-Chair**	**Voting Member**	**Non-Voting Member**
Two hours of initial training.	X	X	X
Six-eight hours of meetings monthly.	X	X	X
Participates in special events.	X	X	
Attendance at 75% of the monthly meetings.	X	X	

SLMT Operating Guidelines and Bylaws

Article I. NAME AND DESCRIPTION

Section I.1 The name of the organization is the State Leadership and Management Team (from now on referred to as “SLMT”).

Section I.2 The SLMT State Leadership and Management Team is comprised of youth and family leaders working in partnership with state-level system leaders. (System leaders are defined as leaders or representatives from such state offices as the Office Mental Health and Substance Abuse Services, Office of Child Development and Early Learning, Department of Drug and Alcohol Programs, Juvenile Court Judges Commission, Office of Children, Youth and Families, PA County Commissioners Association, PA Training and Technical Assistance Network, PA Department of Education, and the Bureau of Autism.) It is responsible for the development and implementation of the Pennsylvania Partnership.

Article II. MEMBERSHIP

Section II.1 The voting members of the SLMT shall be made up of youth and young adult partners, family partners, and system partners.

Section II.2 Youth partners must be between the ages of 16-28 and been involved in the behavioral/mental health system and one other child-serving system. An application for youth under 18 must include evidence of support from caregivers regarding meeting attendance.

Section II.3 Family partners must have had a child or young Adult involved in the behavioral/mental health system and one other child-serving system.

Section II.4 System partners must represent one or more state or county level child or young adult serving system.

Section II.5 Grant staff (including contractors/consultants) cannot serve as SLMT voting members.

Section II.6 Principle Investigators, for which the SLMT provides grant guidance to may be allowed to be a voting member of the SLMT if they are a representative or voting designee of a department listed in section 4.11.

Section II.7 SLMT members will have the following expectations:

Section II.8 Attend all meetings and SLMT related events.

Section II.9 Serve on SLMT committees when appropriate (Committees include: Cultural and Linguistic Competence, Evaluation, Social Marketing, and more as developed)

Section II.10 The SLMT members will be familiar with the strategic plan to assist in their ability to identify and prioritize opportunities, issues, needs, and challenges that need to be addressed. The SLMT will be strength-based and solution-focused in their approach. Please refer to Article 4, Section 4.6

Section II.11 If an SLMT member is unable to attend a regularly scheduled monthly SLMT meeting, they may appoint a non-voting representative to fill their seat during their absence.

Section II.12 SLMT members will identify and share local, state, and/or national opportunities/ resources with the SLMT.

Section II.13 SLMT members will identify and share local and state barriers with the SLMT that hinder the work counties associated with the system of care grant to identify solutions to remove the identified barriers.

Section II.14 SLMT members will promote the grant under their guidance with their respective communities, organizations, systems, etc.

Article III. OFFICE AND GRANT YEAR

Section III.1 **Office Location.** The registered office of the Grant is 303 Walnut St, 11th Floor, Harrisburg, PA 17101, and located in the Office of Mental Health and Substance Abuse Services, Bureau of Children's Behavioral Health Services.

Section III.2 Grant Year.

(a) The grant year begins September 30th and ends September 29th each year for the PA Care Partnership Cooperative Agreement.

Article IV. GOVERNANCE AND STRUCTURE

Section IV.1 The organizational and governance structure of the SLMT shall be divided into a Tri-Chairs, which shall have full power to manage and control the meetings, agenda items, and information requests. The SLMT which shall, among other things, provide programmatic and strategic direction to the grants and to fulfill the general mission and purposes of the grants, as more specifically set forth herein below in Article VIII, and such advisory committees and action teams as shall be appointed by the SLMT from time to time.

Section IV.2 Youth partners comprise a minimum of 25% and a maximum of 33% of the SLMT membership.

Section IV.3 Family partners comprise a minimum of 25% and a maximum of 33% of the SLMT membership.

Section IV.4 System partners will comprise no more than 50% and no less than 33% of the SLMT membership.

Section IV.5 **Qualification and Selection.** Each SLMT member must either live in or work in Pennsylvania.

Section IV.6 Each group of partners (youth, families, systems) will select one SLMT member to serve as a Tri-Chair of the SLMT. The selection will occur in December of each year.

Section IV.7 **Election.** At each December meeting or Special Meeting of the SLMT Membership duly called for this purpose, successors to SLMT Members or Tri-Chairs whose terms expire shall be elected by a simple majority of members present and entitled to vote

Section IV.8 Tri-Chair terms begin January 1st and end on December 31st.

Section IV.9 A Tri-Chair serves a minimum of a one-year term, not to exceed three consecutive terms, with one year off before being able to be elected to the Tri-Chair position again.

Section IV.10 **Number and Term of Office.** The SLMT shall consist of at least 12, but no more than 28 members. Each member shall hold office for three years and until his successor shall have been elected and qualified or until his earlier death, resignation, or removal. Each SLMT member may serve multiple terms, but not more than three consecutive (3) year terms. If the end of the 3rd year of the 3rd consecutive term of an SLMT member shall cause undue hardship and or disruption to organizational functioning, final terms may be extended one year at a time, for not more than three years. The extension(s) must be documented as to the reason, and the estimated length of time in SLMT minutes and approved by a majority vote of the current SLMT.

Section IV.11 The SLMT voting members shall consist of the following Members:

(a) Department of Education

(b) Department of Human Services, The Bureau of Autism.

(c) Department of Human Services, Office of Child Development and Early Learning

(d) Department of Human Services, PA Department Drug & Alcohol Programs

(e) Department of Human Services, Office of Mental Health and Substance Abuse Services

(f) Juvenile Court Judges Commission

(g) Children and Youth in the Courts

(h) Department of Human Services, Office of Children, Youth, and Families

(I) Youth Partner

(j) Family Partner

(k) Department of Health

(l) Additional voting members may be added based on the needs of the grants and SLMT.

Section IV.12 Oversight of all personnel matters shall be the responsibility of UPMC, the Office of Mental Health and Substance Abuse Services, and contracted providers.

Section IV.13 **Resignations.** An SLMT member may resign at any time and must give written notice of resignation to the Tri-Chair(s). The resignation shall take effect at the date of receipt or a date specified in a resignation letter. The acceptance of such registration shall not be necessary to make it effective."

Section IV.14 **Removal.** An SLMT member may be removed, without cause, as determined by a two-thirds (2/3) vote of the SLMT present at any meeting at which there is a quorum. Also, any member of the SLMT may be removed for substantial cause by the majority vote of the SLMT present at any meeting at which there is a quorum.

Section IV.15 **Vacancies**. Any vacancy or vacancies in the SLMT because of death, resignation, removal in any manner, disqualification, an increase in the number of SLMT members, or any other cause, may be filled by the majority vote of SLMT; and each person so elected shall be an SLMT member to serve for the balance of the unexpired term.

Article V. MEETINGS

Section V.1 The SLMT meets at least once a month in person and/or by phone/web

Section V.2 Members may decide to hold additional or extended meetings as necessary; these may be in person, by phone, or via the web.

Section V.3 The SLMT membership receives notice of the scheduled meetings at least one week before the meeting, and each member RSVPs to indicate whether he/she or a designee will attend.

Section V.4 An emergency meeting can be called by consensus of the Tri-Chairs with notice of 24 hours.

Section V.5 SLMT members who have three (3) consecutive absences from either in-person meetings, conference calls, or video chat meetings or absent for six meetings within a calendar year will be contacted by the affiliated SLMT Tri-Chair about their continued participation.

Section V.6 The SLMT uses the strategic plan as a guide to identify and prioritize opportunities, issues, needs, and challenges to be addressed. It deliberates and makes decisions in equal partnership when all voices have been heard.

Section V.7 **Place of Meeting.** Meetings of the SLMT may be held at such place within or outside of Pennsylvania as said SLMT might from time to time appoint, or as may be designated in the notice of the meeting.

Section V.8 **Regular Meetings.** Regular meetings of the SLMT shall be held at such time and place as shall be designated from time to time by resolution of said SLMT. At such meetings, the SLMT shall transact such business as may properly be brought before the meeting. Notice of regular meetings need not be given unless otherwise required by law or these by-laws.

Section V.9 **Special Meetings**. Special meetings of the SLMT shall be held whenever called by the Tri-Chairs, who also is serving on the SLMT. Notice of each such meeting shall be given to each SLMT member by telephone or in writing at least twenty-four hours (in the case of notice by telephone) or forty-eight hours (in the case of notice by email) or five days (in the case of notice by mail) before the time at which the meeting is to be held. Every such notice shall state the time and place of the meeting

Section V.10 Meeting Feedback and Input. At times, there will be requests or attendees of a State Leadership and Management Team meeting to provide feedback in the form of voting. These votes are not to determine policy or actions to be taken by the voting members of the SLMT, but for feedback and input.

Article VI. QUORUM AND VOTING

Section VI.1 A quorum is at least 50% of the total SLMT voting member and must include at least two members from each of the three SLMT voting partner groups (youth, family, and system partners).

Section VI.2 A quorum includes voting members attending by phone or WebEx.

Section VI.3 Designees may be voting members.

Section VI.4 **Voting.** Whenever a vote of the membership is taken, each member that is an individual shall be entitled to one (1) vote, and each "member" that is an organization or entity shall be entitled to one (1) collective vote for the organization or entity, regardless of the number of representatives in attendance. No individual has more than one (1) vote.

Section VI.5 **Quorum, Manner of Acting, and Adjournment.** The presence of a majority of the SLMT in a meeting, provided 50% of those present are SLMT members shall constitute a quorum for voting purposes. In the absence of a quorum, a majority of the SLMT present and voting may adjourn the meeting from time to time until a quorum is present.

Section VI.6 Voting electronically is allowable and may take place through a variety of ways including but not limited to email, surveys, online polling, digital polling, etc.

(a) When requesting an online vote, a minimum of 72 hours will be provided to respond to the vote.

Article VII. DECISION MAKING

Section VII.1 All decisions will require a majority vote at a meeting in which a quorum has been reached.

Section VII.2 Consensus can be reached between scheduled meetings when necessary through discussion and consensus-building by email with all members.

Article VIII. COMMITTEES

Section VIII.1 **Committees and Action Teams.** The SLMT may establish one or more other sub-committees, practice groups, or action teams, each sub-committee, practice group, or action team to consist of one or more members of the SLMT. The Chairperson of each sub-committee, practice group, or action team, or his or her designee, shall sit on the SLMT. The SLMT may designate one or more of its members as alternate members of any committee or action team, who may replace any absent or disqualified member at any meeting of the committee or action team. Each sub-committee or action team of the SLMT shall serve at the pleasure of the SLMT. A Practice Group may fall outside of the purview of the SLMT and can and should exist beyond the SLMT.

(a) Each committee and action team shall keep regular minutes of its proceedings and report such proceedings periodically to the SLMT.

Section VIII.2 The SLMT will utilize subcommittees to support the work of the group. Standing committees will include Evaluation / Continuous Quality Improvement and Cultural and Linguistic Competence.

(a) Evaluation / Continuous Quality Improvement: This committee makes decisions about how to collect valid and meaningful data that measures outcomes for youth and families enrolled in Systems of Care. The data informs: national, state, and local SOC leaders to support the development and continuous improvement and to impact Congressional decision-making in the allocation of Children's Mental Health Initiative funding.

(b) Cultural and Linguistic Competence Committee: This committee develops and supports processes and structures at the state and local levels that respect the cultural and linguistic considerations of every youth and family and engage and value their community and natural supports. This committee also seeks to decrease disparities between cultural groups in 1) access to appropriate and effective services and supports and 2) positive outcomes

(c) Social Marking and Communication Committee:

(d) Other Committees to be determined by the SLMT

(e) Community of Practice – How and should we add this to the bylaws. The idea would be to have the information from the COP shared back to the SLMT.

Section VIII.3 At least one SLMT member must serve on each subcommittee and act as the liaison to the SLMT. Additional members can be recruited from outside of the SLMT.

Section VIII.4 Ad Hoc committees can be utilized as needed to support the work of the SLMT. A Membership Committee will be convened as needed to develop member recruitment, interviews, and orientation.

Section VIII.5 AMENDMENTS

Section VIII.6 Section 9.01 The Operating Guidelines can be amended by a majority vote at a scheduled meeting, with changes to be effective the first of the following month.

Section VIII.7 The SLMT can waive a specific section of the Operating Guidelines with a majority vote, meeting quorum requirements.

Appendix E

County Leadership and Management Team (CLMT) Resources

System of Care Grantees and Grant Directors

Pa Care Partnership (Grant Active 2017-2021)
Mark Durgin, Director
PA Care Partnership
Email: durginm@upmc.edu
Email: info@pacarepartnership.org
Website: https://www.pacarepartnership.org/
Facebook: https://www.facebook.com/PACarePartnership
Phone: (717) 678-9166

Alleghany County System of Care (Grant Active 2020-2021)
Linda Kuster, System of Care Project Director
Alleghany County Human Services
Email: Linda.Kuster@AlleghenyCounty.US
Website: http://www.bc-systemofcare.org/
Phone: 412-350-7397

Beaver County System of Care
Kimberly Hall, Project Coordinator
Dear Mind; Pathways to Wellness
Email: kimberlyhall@etc-pa.com
Website: http://www.bc-systemofcare.org/
Facebook: https://www.facebook.com/beavercounty.soc
Phone: (412) 244-1244

Behavioral Health Alliance of Rural PA (BHARP) System of Care (Grant Active 2020-2024)
Christine Kruis, System of Care Project Director
Behavioral Health Alliance of Rural PA
Email: ckruis@bharp.org
Website: https://bharpsystemofcare.org/
Facebook: https://www.facebook.com/BHARPSYSTEMOFCARE%20/
Phone: (814) 380-4262

Blair County (Grant Active 2017-2021)
Jennifer Stubbs, System of Care Coordinator
Blair County HealthChoices
Email: jstubbs@blairhealthchoices.org
Phone: (814) 599-6679

Carbon, Monroe, and Pike Counties (Grant Active 2017-2021)
Larissa Kimmel, System of Care Coordinator
Carbon, Monroe and Pike Counties HealthChoices
Email: Larissa.kimmel@cmpsystemsofcare.org
Facebook: https://www.facebook.com/cmpcares
Phone: (570)350-0585

Crawford County (Grant Active 2017-2021)
Joe Barnhart, System of Care Manager
Crawford County Human Services
Email: jbarnhart@co.crawford.pa.us
Facebook: https://www.facebook.com/CrawfordCountySOC
Phone: (814) 333-7300 ext. #3698

Delaware County (Grant Active 2017-2021)
Laura Kuebler, Acting Delaware County Human Services
Email: KueblerL@delcohsa.org
Website: http://delcohsa.org/systemofcare.html
Facebook: https://www.facebook.com/delcosystemofcare
Phone: (610) 713-2387

Erie County System of Care (Grant Active 2016-2020)
Nicole Wells, System of Care Project Director
Achievement Center
Email: nicolewells@achievementCtr.org
Website: https://www.systemofcareerie.org/
Facebook: https://www.facebook.com/systemofcareerie
Phone: (814) 460-2115

Greene County (Grant Active 2017-2021)
Melanie Trauth, CASSP Coordinator
System of Care Coordinator
Greene County Human Services
Email: metrauth@co.greene.pa.us
Facebook: https://www.facebook.com/Greene-County-System-of-Care-1016493795200011
Phone: (724) 852-5276 ext. 509

Luzerne-Wyoming Counties System of Care (Grant Active 2020-2024)
Joseph Kloss, Project Director
Luzerne-Wyoming Counties System of Care
Email: Joseph.Kloss@luzernecounty.org
Website: https://www.luzernecounty.org/945/Luzerne-Wyoming-Counties-System-of-Care-
Facebook: https://www.facebook.com/LWSOCI
Phone: (570) 408-1332

Philadelphia County (Grant Active 2020-2020)
Catherine Bracaliello, Project Manager DBHIDS / SOC
Philadelphia Department of Behavioral Health and disAbility Services
Email: Catherine.Bracaliello@phila.gov
Website: https://psoc.dbhids.org/
Facebook: https://www.facebook.com/PhilaSOC Phone: (267) 602-2295

Venango County (Grant Active 2017-2021)
Loni Beer, System of Care Coordinator
Venango County Human Services
Email: lbeer@co.venango.pa.us
Website: https://co.venango.pa.us/162/System-of-Care
Facebook: https://www.facebook.com/VENCOHS
Phone: (814) 432-9725

York County (Grant Active 2017-2021)
Colleen Igo, System and Community Initiatives Manager
York County System of Care
Email: CIgo@YorkCountyPA.gov
Website: https://yorkcountypa.gov/county-human-services/human-services-department/york-county-system-of-care.html#:~:text=York%20County%20System%20of%20Care%20%28SOC%29%20is%20a,they%20serve%20are%20being%20served%20effectively%20and%20appropriately.
Facebook: https://www.facebook.com/YorkCountyHumanServices
Phone: (717) 324-1012

Sample Packet for Interested Youth and Family Partners

This language, taken from the Delaware County System of Care County Leadership Team, may be adapted to suit your county's needs.

SYSTEM OF CARE OVERVIEW

System of Care is a philosophy about how care should be delivered to youth and families. In Pennsylvania and [COUNTY NAME], System of Care seeks to transform the way services and supports are provided to children, youth, and families who have complex mental health challenges and involvement with the systems they encounter, such as child welfare or juvenile justice.

[COUNTY NAME] enrolled as a System of Care County on [DATE] and formed a System of Care County Leadership Team with equal representation from youth, families, and county system partners. We work as equal and trusted partners to provide comprehensive and effective care to empower youth, families, and all child-serving systems to be responsible and accountable for positive outcomes that support health and wellness.

Vision: Every youth and family in [COUNTY NAME] will be able to easily access a collaborative network of systems and supports that partners with youth and families to reach their goals.

Mission: Our mission is to ensure that System of Care principles are standard practice in [COUNTY NAME] and that youth and family voices are valued, respected, and welcomed. Our System of Care will be responsible and accountable for positive outcomes that support health and wellness.

Priority Population: Children and youth ages 8-21 years old who are receiving mental health services and who have involvement with Children and Youth Services and/or Juvenile Court and Probation.

[COUNTY NAME] System of Care Values:

- Youth Guided/Driven
- Family Driven
- Home and Community Based
- Strengths-Based and Individualized
- Trauma-Informed
- Culturally and Linguistically Competent
- Connected to Natural Helping Networks
- Data-Driven, Quality and Outcomes Oriented
- County Leadership and Governance Teams
- Multi-System Integration
- Youth and Family Services and Supports Planning Processes

What is the System of Care County Leadership and Management Team (CLMT)?

The CLMT plays the lead role in making System of Care successful in [COUNTY NAME]. It is comprised 25% youth partners, 25% family partners, and 50% system and community partners who work as equals. System partners represent the child-serving systems including, but not

limited to, mental health/behavioral health, child welfare, and juvenile court and probation. The CLMT develops and makes recommendations for implementing the System of Care strategic plan based on our System of Care values. The CLMT utilizes information, training, and data to inform our decisions regarding policies, regulations, and recommendations, and we provide oversight and evaluation of the System of Care.

Who can become a Family or Youth Partner on the County Leadership and Management Team (CLMT)?

Any family or youth member who has the following lived experiences can apply to be a member of the County Leadership Team.

A family member is defined as a person who has or has had direct experience and the primary responsibility for raising a child or children with behavioral health issues and/or experience with child welfare or juvenile justice.

A youth member is defined as a person ages 16-28 who has direct experience accessing services and supports in the behavioral health system, child welfare, and/or juvenile justice.

How do youth and family partners become members of the County Leadership and Management Team (CLMT)?

If you are interested in becoming a youth or family partner on the County Leadership Team please fill out the attached application and send it to:

[INSERT CONTACT NAME, ADDRESS, AND EMAIL]

You may also express your interest to any CLMT member or contact us for additional information and to receive an application. Applications will be reviewed by the SOC Coordinator and the CLMT leadership. They will evaluate each applicant based on pre-determined criteria and make a recommendation to the wider CLMT, who will vote on the applicant. All information contained in the application is kept confidential and will not be shared with anyone outside the CLMT.

You may then be contacted to schedule a time to meet with the accepted youth and family partners. They will answer any questions, provide an orientation to SOC and the CLMT, and discuss the role and expectations of youth, family, and system partners.

What are the Expectations for Youth and Family Partners on the CLMT?

Youth and Family Partners on the CLMT should strive to contribute their voice and expertise and provide feedback to the team, other youth and family partners, and the coordinator. All youth and family partners are encouraged to ask for support and additional training when needed.

Members of the CLMT are expected to read and respond to e-mails outside of meetings and read any relevant materials to contribute to CLMT discussions. Members are asked to take responsibility for action items identified at the CLMT meetings. Members are also expected to:

- Attend most CLMT meetings
- Partner with the system and community partners to improve services and supports to youth and families.
- Be champions for System of Care within their communities and organizations
- Help recruit other youth and family leaders to become involved in System of Care.

How are Youth and Family Partners Oriented, Trained, and Supported on the CLMT?

Youth and Family Partners are chosen for the County Leadership Team and meet with the SOC Coordinator or a CLMT chair who:

- Provides history and philosophy of System of Care
- Reviews our Vision and Mission
- Explains the core SOC Values on which our work is based
- Provides a contact list for all CLMT members
- Provides updates on the current work of the CLMT
- Provides any relevant paperwork (e.g., stipend information and IRS 1099 form, timesheet, expense form).

In addition to this in-person orientation, new members are encouraged to further orient themselves by exploring the [COUNTY NAME] Human Services website at [INSERT URL]. Youth and family partners are also encouraged to attend [LIST RELEVANT AND AVAILABLE TRAININGS].

Youth and Family Partners are required to obtain Background Clearances before joining the County Leadership and Management Team.

Effective January 1, 2015, revisions to a Pennsylvania child protection law requires volunteers (any adults serving in unpaid positions) who are individually responsible for the welfare of a child or children, or who will have direct contact with a child or children, to have the background clearances. We will process the background clearances, free of charge, for Youth and Family Partners selected for the CLMT, and this must be done before new members can formally join the CLMT.

Sample CLMT Member Letter of Agreement

As a member of [COUNTY NAME] Leadership and Management Team (CLMT), I agree to the best of my ability to attend monthly meetings, as well as complete additional work between meetings when necessary.

I understand that my voice, expertise, and experience are valued and respected as I work in partnership with the other CLMT members.

I will treat all members of the governance body with respect as we work hard to develop recommendations and plans that are strengths-based, culturally competent, and in the best interest youth and families.

I understand that open discussion by a governing body is crucial to the decision-making process.

I understand that any information acquired from open discussions concerning counties that are contracted with the PA Care Partnership or those counties that are applying for or requesting technical assistance from the PA Care Partnership is to be kept confidential unless the CLMT agrees that the information should be shared.

I understand that any personal information that I learn about other CLMT members will not be shared outside of the group.

I understand that I may need to recuse myself from certain discussions/decisions if another member or I find that I may have a conflict of interest related to the issue at hand.

I understand that failure to follow the agreed-upon terms of this agreement may limit or eliminate my participation on this Advisory Board.

_____ _____

Signature of County Leadership Team Member Date

_____ _____

Signature of Witness Date

Sample CLMT Confidentiality Pledge

As a member of the [COUNTY NAME] Leadership and Management Team, I understand and promise that all information revealed concerning any individual and/or family made known during System of Care meetings through formal or informal channels is confidential. I promise to use information only for designated organization purposes and not disclose the information to any other person or agency unless specifically authorized. This confidentiality pledge shall be valid for 365 days.

_____ _____

NAME (Please Print) NAME (Signature)

_____ _____

POSITION DATE

Sample CLMT Meeting Agenda

Date:
Start Time to End Time:
Physical Location:
Call-in/Video Conference Information:

AGENDA

- **Welcome and Introductions (5 minutes)**

- **Review of minutes from last meeting (5 minutes)**

- **Ground Rules (10 minutes)**
  - Develop List
  - Barriers to Enforcing
  - Agreement of List
  - Permission to Enforce Rules

- **Vision Review (20 minutes)**
  - Review Current Vision
  - Changes to Current Vision
  - Agreement of Vision

- **Needs (40 minutes)**
  - Current Needs Known
  - Additional Needs
  - Linking Needs to Vision

- **Community Links (5 minutes)**

- **Next Meeting (20 minutes)**
  - Review Ground Rules
  - Successes Since the Last Meeting
  - Priority Needs
  - The Goal of Planning for Needs
  - Identify Action Steps
  - Who Can Help?

- **Evaluation of Meeting/Check-in (5 minutes)**

- **Next Meeting: Date, Time and Location**

Sample CLMT Meeting Minutes Template

Attendees:	Date: Time: Location: Facilitator:

Agenda Item	Time Tracker	Discussion	Follow Up
Welcome and Introductions	5 min		
Review of minutes from the last meeting	5 min		
Culture/ Community Building Questions	15 min		
Discussion of CLMT meeting dates, times, location, and structure • Other barriers to participation such as transportation • Open/closed Meetings • Minutes • Meeting facilitation	10 min		
CLMT Membership • New member recruitment and interested youth	10 min		
Adoption of proposed Policies/Guidelines	5 min		
Discussion of CLC Pilot • Assessment/Survey- Review Draft • Plan • Webinar/Workshop • Cultural Brokers • Forum • Funding Request	25 min		
Discussion of communications and outreach	10 min		

Training • Cultural and Linguistic Collaborative • LGBTQIA • Youth Mental Health First Aid • SOC County Collaborative and Learning Institute • FEST	10 min		
System Assessments	15 min		
Community Links	10 min		
Next Meeting:	5 min		
Evaluation of Meeting/ Check-in	5 min		

Sample Post-CLMT Meeting Evaluation

By offering a quick follow-up survey to CLMT members, you will learn how effective your meetings are—and where they can be improved. Surveys can easily be set up using Survey Monkey or Google Forms. Be sure to share results at the next CLMT meeting.

	1 (Strongly Disagree)	2 (Disagree)	3 (Neutral)	4 (Agree)	5 (Strongly Agree)
The meeting met my expectations.					
I will be able to apply the knowledge learned.					
The objectives were identified and followed.					
The presentation met the needs of a variety of learning styles.					
The content was organized and easy to follow.					
The materials distributed were useful.					
Participation and interaction were encouraged.					
Adequate time was provided for questions and discussion.					
I felt engaged during the meeting.					
I liked the meeting overall.					
The conversation was youth-friendly.					
The conversation was family-friendly.					
I felt prepared for today's agenda.					
I felt that my voice was heard.					

OPEN-ENDED QUESTIONS:

1. What was most helpful?
2. What needs to be improved?
3. Additional comments?

Appendix F

County Conversations: Common Threads and Unique Solutions

This resource was developed in conversation with PA Care Partnership's SOC counties in 2019. It demonstrates some of the ways in which the common goals of SOC can be implemented with unique solutions across the Commonwealth.

County Conversations:

Common Threads and Unique Solutions for Pennsylvania's System of Care Counties

In 2019, the PA Care Partnership reached out to six counties that have embraced the System of Care (SOC) philosophy and values (Crawford, York, Venango, Pike, Carbon, and Monroe), to conduct online video conversations with local staff and partners. The six counties represent different regions and county structures, and they also provide fresh insight into the differences between implementing and sustaining this work.

As a result of these conversations, the state better understands:

- Common denominators between counties
- Successes and challenges faced by each county
- Unique, localized solutions that reinforce the truth that "one size does not fit all"
- Opportunities to support these—and future—SoC counties in the Commonwealth

Below is a summary of key findings and highlights, and the wisdom shared by these counties will be integrated into the state's forthcoming strategic plan.

A Commitment to System of Care Values in Action

A first—and critical—common denominator that revealed itself in county interviews was a shared commitment to this work, grounded in the SoC values. Energy and enthusiasm were evident in local leaders, staff, providers, and stakeholders, and counties were able to identify and articulate positive change. They consistently reported that the SoC approach encourages them to be more intentional, moving from "transactional to transformational" experiences with the people they serve. In almost every interview, participants tied their work directly to the language of SoC values, particularly: trauma-informed practices; cultural and linguistic competency; natural networks; and, youth- and family-driven.

While their successes may be directly traced to each county's specific approaches and solutions (see select highlights below), the results across the state are increasingly engaged partners, communities, and a shift in the way systems function together to serve youth and families—even in those counties which have only recently joined the family of SoC counties in the Commonwealth.

Common Goals, Unique Solutions

Breaking silos, integrating systems

Building on the strength of existing coalitions, collaborations, and structures has been a model for success, no matter how long a county has been under the SoC umbrella. This success is usually connected to strong, trusted relationships that have been established over time. Counties report that the SoC model has helped partners and stakeholders gain awareness of silos that need to be broken, and where "walls" remain between siloed systems, these walls have become increasingly permeable.

Pike, Carbon, and Monroe counties (new to the PA Care Partnership in July 2018), each kicked off their efforts with two early leadership meetings under the direction of their shared SoC Coordinator, Larissa Kimmel. Even though these are neighboring counties in northeastern Pennsylvania, each has its unique partners and processes. Therefore, the first meetings employed large post-it notes that helped long-standing community partners gain new insight into how they each perceive their county, their work, their partners, and the people they serve. Second meetings were used to establish initial strategic goals in the areas of leadership, systems change, and youth and family engagement. This shared process allowed each county to hit the ground running—even though their early goals are different.

For instance, Monroe County is expanding the work of the county's long-standing Children's Roundtable—a program housed in the court system and available to counties across the Commonwealth. A particularly robust collaborative in Monroe, the Children's Roundtable convenes stakeholders and volunteers who are invested in the goal of reducing the number of youth who end up in placement. The Children's Roundtable has given the county's SoC a "running start;" system partners already know and trust each other, understand the barriers and challenges, and are now ready to work with greater efficiency and effectiveness.

> "This isn't a group that's trying to replace anything. This is a group that's trying to make everything a little bit better."
>
> *– Ken Gustafson, Monroe County*

Venango County, which first embraced System of Care seven years ago but only joined the PA Care Partnership last October, has a substantively different structure. A true human service model, all services for this rural county in northwestern Pennsylvania are housed under one roof. As one participant put it, they can "force collaboration," noting that it is remarkably easy to get every system partner in the same room to collaborate. A local service provider applauded this approach and expressed the ease with which she can now get questions answered.

> "Sitting around the table are people are funded to stay in their silos, yet here we are trying to find ways to overcome some of those barriers."
>
> *– Bruce Harlan, Crawford County*

Crawford County—one of the original counties under the PA Care Partnership SoC umbrella—continues to build on its long-standing success, noting concrete ways in which silos have been dissolved and "business as usual" has changed. For instance, trauma counselors are now embedded in schools, staff are shared, and High-Fidelity Wraparound programming is now embedded in Human Services.

York County, the other original SoC county in the PA Care Partnership family, recently launched a school collaborative to bring the county's diverse districts together to share their experiences in implementing trauma-informed work. Building on strong existing relationships with area schools, York is now able to act as a convener; 11 of the county's 16 school districts, as well as one charter school, participated in this new group's first meeting.

Building well-trained, trauma-informed communities from the bottom-up and top-down

Each county expressed a deep commitment to building genuinely trauma-informed communities through trainings, community conversations, events, and more.

Indeed, Crawford County demonstrates its commitment to trauma-informed work in everything it does. For example, in collaboration with a neighboring county, they will hold their sixth annual conference for partners, families, and youth this coming October. The strong desire for this important event is evidenced by increased attendance over the years—now maxed out at 300 participants. Their long-standing commitment to community outreach also includes informal conversations with the public through their Mental Health Cafes and Courageous Conversations. As a consequence, residents of Crawford County increasingly realize that "it's okay not to feel okay," and support is available.

York County takes a three-pronged approach, providing customized trainings to a) internal human services staff; b) school districts; and, c) community members. They are mindful of the groups with which they work (e.g., consumers of services, homeless providers, foster care parents, faith-based community), and they look forward to providing training to law enforcement in the near future. When asked if it was hard to encourage participation, they noted that organizations and individuals are clearly hungry for training. As one person said, "It's not a hard sell at all."

Venango has provided staff trainings for several years, including trauma, Mental Health First Aid for children, and now, the Coach Approach. A next step is to provide culture and poverty training for staff. In Pike, Monroe, and Carbon, early trainings also include trauma-informed practices, Coach Approach, and Mental Health First Aid. Thus far, outreach to partners and the community to encourage participation has focused on word-of-mouth and Facebook page announcements.

> "I'm definitely a big proponent of Train the Trainer. I see how much that investment in me has paid off because I can go and spread that knowledge to so many more people."
>
> *– Larissa Kimmel, SoC Coordinator for Carbon, Monroe & Pike counties*

Successful outreach meets audiences where they are

In addition to the strong outreach efforts of Crawford County (see above), other counties note the importance of outreach that meets people where they are to raise awareness of mental health, reduce stigma, encourage conversations, and learn about accessing local resources.

In May 2019, York County's 2nd annual "Light the Way 4 Mental Health Campaign" reached well into the community and schools with a cohesive set of events and activities. The month kicked off with more than 200 people walking to raise awareness of Mental Health Awareness Month. Participants wore green, and businesses and communities were also encouraged to use green light bulbs throughout the month to continue drawing attention to mental health, start conversations, and reduce stigma. Teams of students across York's school districts participated in county-wide contests, creating public services announcements, hosting special events, and more.

Perhaps the most important event of York's month, however, came at the end of a minor league baseball game for the York Revolution team when dozens of family members who have been impacted by mental illness or lost loved ones to suicide took to the field after the game with green lights in hand. As SoC staff noted in our conversation, this event publicly demonstrated that people are willing to talk about mental health in new ways. They are interested in learning about available services and resources, and many individuals made a point of expressing thanks for this event. To watch a video of the event and learn more about this year's activities, please visit York County Human Services.

While York and Crawford have been conducting community outreach for several years, newer SoC counties understand the need for outreach and are taking early action. Carbon, Pike, and Monroe counties plan to establish a presence at popular community events as a critical first step in reaching people where they are. For instance, Monroe County Community Night (May 7), provided an opportunity to join over 100 area nonprofits in providing information to community members, and the county's SoC team sponsored a well-attended pre-event concert that included an open mic for the very kinds of youth voices that the county hopes to engage in its work.

Venango County is meeting audiences where they are in a completely different way—through their smartphones. Their free app, “Venango County HS to Go,” is available through Apple or Google Play and provides coordinated information on county services and systems 24/7. The app has been promoted through social media, billboards, doctors’ offices, and more. By investing in this ubiquitous technology, Venango is helping to overcome the lack of area transportation. Learn more here.

Engaging Families: A Common Challenge for Newer Counties and Solutions from Established Counties

While the first year of implementing a SOC approach may be well spent on engaging system partners, each county is acutely aware of the need to attract, engage, and retain family members with lived experience as equal partners in decision-making. Additionally, system partners already at the table must learn to make equal room for family voices that have never been invited to participate in this work. Newer counties are coming to grips with the reality that genuine family engagement can be challenging.

Pike, Monroe, and Carbon are taking a “first, listen” approach. As one participant noted, counties have been making assumptions about the populations they serve—albeit thoughtful assumptions—and it’s time to listen more purposefully. Each county will be surveying families and promote this opportunity through word of mouth, social media, flyers, service providers, and other channels still TBD. Among other things, counties hope to learn what it will take to make services more welcoming to families. From this survey, and through community connections, these counties hope to attract their first family voices to the table. Newer SoC counties are also exploring methods for demonstrating to families that their voice is valued, including gas stipends, or gift cards/incentives.

These counties may benefit from the work already done in the established counties of York and Crawford. Both have achieved inroads in this area by building trusted, long-standing, and intentional relationships, and their approaches might be adopted elsewhere.

In Crawford County, family partner Gloria McDonald runs support groups that empower family members to use their voice, and “do for, do with, cheer on” is the approach that forms the basis of family work in the county. She keeps a watchful eye open to identify family members who are “looking to be leaders.” When asked how she is able to identify these individuals, she shared that if an individual has a lot to say to her, there is an excellent chance that they have a lot to say to others.

In York County, family partner Lisa Kennedy has long-standing relationships with family members in the community. She nourishes those relationships—both figuratively and literally—through an informal grassroots community group that meets monthly for dinner at a local restaurant. Members choose a topic for discussion, and Lisa comes prepared with relevant resources and questions to spark conversation. Lisa also teaches families and recently completed a 7-month set of parent classes that included topics such as understanding trauma, self-care, communication, and navigating systems. She describes the county's work with families today as "intentional" and believes families must see evidence that their voices are truly heard—and valued.

> "It has been valuable to show appreciation [to families] through allowing the evaluation data they provide to drive most of what we do."
>
> *– Lisa Kennedy, York County*

Engaging Youth: A Common Challenge for All Counties

The challenges associated with identifying, engaging, and retaining youth was a common theme running through every county conversation. Similar experiences were shared, regardless of how long a county has been with PA Care Partnership:

- Youth who emerge from systems have little desire to remain connected to them. One participant suggested, "It's the last thing they want to do."
- Youth want to "be normal" and move on with life—finish school, work, and enjoy time with friends. As one person noted, "Who wants to be defined by their illness?"
- Many youth may have important lived experience but lack the skills that their county wishes they would have. Conversely, those with strong skills want to move on with their lives and use those skills elsewhere.
- Between school, jobs, and other commitments, youth schedules are often a limiting factor as well.

The challenge is real, but every county is looking for solutions that will work for them. In Crawford, for instance, they recognize the need to meet youth "where they are"—both physically and emotionally. They are considering outreach to youth through a partnership with universal youth-serving organizations like 4-H, and they are also connected to a group of teens who have established a teen lounge at a local church. These examples extend beyond the youth voice that has traditionally been involved in SoC work, but Crawford would like to hear from youth who may not receive a high tier of services but would still benefit from support systems.

York County has seen some success when they "chunk" their work with youth. For example, they were able to schedule a series of back-to-back speaking engagements for youth leaders at area schools, thereby working within the parameters of youth schedules. Nonetheless, York acknowledges that they may need to shift their expectations about what youth engagement can realistically look like. Going forward, their goal is to include a true youth voice in their work while still understanding the demands on youth and their priorities.

Newer counties are still in the planning stages for engaging youth and are looking at collaborations with schools and partners to help identify potential youth voices. A Pike County participant suggested a future goal of a youth and family peer mentoring program to help identify new leaders. Regardless of the paths that these counties take, however, each is committed to more than lip service, and they know that the SoC values and philosophy they have adopted will hold them to account.

Other Challenges

Other challenges shared by the six counties tended to fall into the following categories:

- **Time.** Everyone could use more time to plan or attend events, deliver trainings, conduct outreach, etc.
- **Trust.** Families who have been in systems may not trust systems enough to want to engage.
- **Cultural and linguistic competence.** Even in counties with predominantly white, rural populations, participants expressed a need to better understand things like generational poverty and a culture of "learned helplessness" so that they can help empower the people they serve.
- **System partner challenges.** More than one county shared that not all system partners are anxious to collaborate or share data or resources—they are quite comfortable in their silos. Select system partners and providers may also have a bias against youth/family, and counties expressed concern that these essential voices will not feel welcomed "at the table."
- **Staff turnover.** Venango County, in particular, noted that providers are leaving the region.
- **Bureaucracies.** As an example, Carbon County employees require extensive approval to participate in trainings—a process that can take six weeks—and is a barrier that SoC staff must now be mindful of.

Looking Forward

We asked each county to share what they would like to see happen in the next year—and beyond. Unsurprisingly, their answers often revealed the distinctions between implementation and sustainability efforts that expand and embed SoC in systems and communities.

Newer PA Care Partnership Counties

Each of the four counties that joined the PA Care Partnership in 2018 ranked engaging family and youth as equal partners as a priority for the coming year. Beyond this critical work, each county has its own unique focus:

- Venango County, the newest SoC county interviewed, is invested in attracting new partners to the county's work, including schools, the faith-based community, and business. Their goal is to ensure that these new community voices get equal representation in meetings and decision-making.
- Carbon County plans more trainings and is looking at implementing the Handle with Care program—a low-cost initiative started in West Virginia that links law enforcement, schools, and providers to support children who have experienced a traumatic event. They see programs like this as an important way to break down silos between systems and build trusted partnerships.

> "We're driven. We want this to be successful... and accessible. We want to have a fully-functioning community."
>
> *– Ashley Nichols, Venango County*

- Monroe County will focus on trauma in the coming year and continue to train as many people as possible (including Train the Trainer events). They would also like to focus on enhancing the quality of services and supports, reducing stigma, and improving coordination and service delivery between system partners.
- Pike County, which recognizes that transportation is a barrier to services for many residents, has a long-term goal of establishing "ambassadors" throughout the county who can bring coordinated services directly to families and youth living in smaller communities. In the near term, they look forward to working with the faith-based community to establish an Open Table program.

Established PA Care Partnership Counties

York County will continue its trauma-informed practices with an eye towards establishing policies and procedures that will permanently embed this work in systems across the county. They are also hard at work—and in collaboration with families—to create a collection of materials that will empower families to navigate systems and ask for what they need. These may include a family folder with valuable templates and fact sheets as well as a broader family toolkit with critical resources.

Crawford County intends to complete a strategic plan that will guide their efforts going forward. Among the issues that the county hopes to address are policy change to make the inclusion of youth and family voices permanent; a trauma-informed court system; communities of practice at the local level; ongoing data collection; and, sustaining/expanding a data mapping project to pinpoint hotspots and availability of services. They are also identifying how they might better

tailor and streamline support services to specific populations such as grandparents and women escaping domestic violence.

One More Common Goal for the Future: Keeping Youth Out of Systems

While not the focus of SoC, the majority of counties included prevention services as an important addition to their work with the long-term goal of keeping youth out of systems altogether. As one participant said, “In a perfect world, I wouldn’t need to be employed anymore.”

Appendix G

System of Care Rating Tool 2.0

On the next several pages, you will find screenshots of the System of Care Rating Tool provided for your review.

For more information and guidance on using this tool, or to take the assessment on behalf of your county, please contact the PA Care Partnership's System of Care Implementation Team.

SYSTEM OF CARE RATING TOOL

System of Care Rating Tool 2.0

Introduction

Purpose of the Rating Tool

The Rating Tool for Implementation of the System of Care Approach© is designed to **assess progress in a geographic area, typically a community or region, in implementing the system of care approach** for children, youth, and young adults with behavioral health challenges and their families. It provides information to determine the level of implementation of the system of care approach and to inform the allocation of resources and technical assistance aimed at improving service delivery and outcomes.

A system of care is: *A spectrum of effective, home and community-based services and supports for children and youth with or at risk for behavioral health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.* Core values for systems of care specify that they are community based, family driven, youth guided, and culturally and linguistically competent. Guiding principles call for a broad array of treatment services and supports, individualized care, evidence-informed services, and coordination across child-serving systems.

The Rating Tool is designed to provide a picture of implementation of the key elements of the system of care approach at a point in time. In addition to assessing these elements, the tool offers a method for deriving an **estimate of the overall "level" of implementation** of the system of care approach at one of **five levels**:

1. Little or No Implementation

2. Some Implementation

3. Moderate Implementation

4. Substantial Implementation

5. Extensive Implementation

How to Use the Tool

At the **community or regional level** the Rating Tool can be used as a measure of the level of system of care implementation. It can be used as an initial **baseline assessment** at a point in time when efforts are underway to develop or improve the system of care. The tool can then be used subsequently at **regular intervals** to assess progress over time. Use of the tool can help a community or region to **determine areas needing attention** while implementing the system of care approach. The ratings on each element provide a method for identifying the need for investment or resources, training, and technical assistance.

The Rating Tool can also be used by **states, tribes, or territories** with multiple communities or regions to **assess progress throughout their jurisdictions** in implementing the system of care approach. They can use the tool to obtain a **baseline rating and subsequent ratings** of progress that are tied to their efforts to implement, sustain, and expand the approach across all communities, regions, or other types of subdivisions in accordance with the structure of their service systems. Communities or regions complete the tool, and the state, tribe, or territory can then determine the **percent of its communities or regions that have achieved each of the five levels of implementation** of the system of care approach. Repeated use of the tool annually or at other intervals can provide a measure of progress throughout the state, tribe, or territory based on comparisons of the percent of communities or regions at each level of implementation over time. Further, the average ratings on each element across communities or regions provide a method for identifying the need for **investment of resources and technical assistance**.

Areas of Assessment

The Rating Tool explores **5 major domains** of system of care implementation:

1. Strategic plan for the system of care approach

2. System of care principles

3. Services and supports

4. System of care infrastructure

5. Commitment to the system of care approach

Respondents

The Rating Tool is designed for completion by **ten or more respondents per community or region**. The number and types of respondents can be **customized** based on the key individuals in the community or region, with the requirement that they fulfill specific types of roles related to children with behavioral health challenges in their areas, and that they are sufficiently **knowledgeable about the system of care** to be able to make a reliable assessment. The scores of these respondents are averaged to determine the ratings for that area. Responses are **confidential**, and no individual respondent is identified in any report related to the Rating Tool.

Completing the Rating Tool

Use the **unique URL link** emailed to you to access and complete the Rating Tool.

You may complete the Rating Tool in **one sitting or over multiple sessions**. Use the same **unique URL link** emailed to you to re-access the assessment at the point where you stopped. To store responses on a page, please click "next." To go back to a previous page to change a response, please click "prev." You may change your responses at any point before you submit your assessment.

You are encouraged to complete every item in the Rating Tool. However, if you do not have sufficient knowledge to respond to a particular item, skip the item and continue completing the Rating Tool.

SYSTEM OF CARE RATING TOOL

System of Care Rating Tool 2.0

Informed Consent

You are invited to complete a Rating Tool to assess children's behavioral health services entitled "Rating Tool for Implementation of the System of Care Approach." The purpose is to assess progress in a community or region implementing the system of care approach for children, youth, and young adults with behavioral health challenges and their families. Results from the Rating Tool will provide guidance about areas needing attention and technical assistance to increase alignment with the system of care approach.

Participation in this assessment is entirely voluntary. You may choose not to participate at all or to leave the survey at any time. Regardless of your decision, there will be no effect on your relationships with local or state agencies or any other consequences.

The Rating Tool is designed to be completed by multiple respondents to obtain an integrated perspective on progress in implementing the system of care approach. You are being asked to take part because of your involvement and understanding of the services being provided in the community or region being assessed. Your individual responses will be completely confidential. All data will be reported in aggregate. The community or region will receive reports of the results of the survey that contain average responses for each question. No one will be able to link your name and your responses.

If you agree to participate, you will be asked to complete one electronic survey with questions related to several major implementation areas of the system of care approach. This online survey should take around 20 minutes to complete.

If you agree to take part in this assessment, there will be no direct benefit to you. However, the assessment may help to set goals and priorities, identify opportunities for improvement, and celebrate successes in implementing the system of care approach in the community or region.

* **1. Indicate whether or not you agree to participate in this survey.**

I understand all of the information in this Informed Consent.
I freely and voluntarily agree to participate in this survey.

- ◯ Yes
- ◯ No

Click "next" below to begin completing the tool.

SYSTEM OF CARE RATING TOOL

System of Care Rating Tool 2.0

Respondent Information

* **2. Indicate the name of your community or region.**

Area Served

Area Served

* **3. Indicate your primary role in relation to services for children, youth, and young adults with behavioral health challenges and their families. (Select the choice that best describes your role)**

- [ ] Community-Level or Regional-Level Director or Manager of Services for Children with Behavioral Health Challenges
- [ ] Lead Provider Agency Director or Manager of Services for Children with Behavioral Health Challenges
- [ ] Clinician or Care Manager
- [ ] Family Organization Director or Family Leader
- [ ] Youth Organization Director or Youth Leader
- [ ] Community-Level or Regional-Level Director or Manager of Services for Children with Behavioral Health Challenges in a Partner Child-Serving System (e.g., Child Welfare, Juvenile Justice, Education, Health, Substance Abuse, etc.)
- [ ] Other

Other (Please Specify):

SYSTEM OF CARE RATING TOOL

System of Care Rating Tool 2.0

I. Strategic Plan for the System of Care Approach

Assess the existence and use of a strategic plan for implementing, sustaining, and expanding the system of care approach in the community or region during the past 12 months.

4. Indicate the extent to which the community or region has developed and used a strategic plan to guide the implementation, sustainability, and expansion of the system of care approach during the past 12 months.

	No plan exists	Informal unwritten plan exists	Formal written plan is under development	Formal written plan exists but is not used	Formal written plan is sometimes used to guide implementation	Formal written plan is used extensively to guide implementation
Existence of a strategic plan for implementing, sustaining, and expanding the system of care approach	○	○	○	○	○	○

SYSTEM OF CARE RATING TOOL

System of Care Rating Tool 2.0

II. System of Care Principles

The principles that comprise the system of care philosophy and several indicators for each principle are listed below. For each indicator, rate the extent to which it has been implemented in the community or region during the past 12 months.

5. Individualized, Wraparound Approach to Service Planning and Delivery

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Individualized child and family teams are used (including family, youth, providers, etc.) to develop and implement a customized service plan	○	○	○	○	○	○
Individualized assessments of child and family strengths and needs are used to plan services and supports	○	○	○	○	○	○
Individualized service plans are developed and implemented for each child and family that address multiple life domains	○	○	○	○	○	○
Services include informal and natural supports in addition to treatment	○	○	○	○	○	○
Flexible funds are available to meet child and family needs not financed by other sources	○	○	○	○	○	○

6. Family-Driven Approach

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Families have a primary decision making role in service planning and delivery	○	○	○	○	○	○
Family strengths are incorporated in service planning and delivery	○	○	○	○	○	○
Families have a choice of services and supports	○	○	○	○	○	○
Families have access to peer support	○	○	○	○	○	○
A family organization exists and supports family involvement at the system and service delivery levels	○	○	○	○	○	○

7. Youth-Guided Approach

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Youth are active partners in service planning and delivery	○	○	○	○	○	○
Youth strengths and interests are incorporated in service planning and delivery	○	○	○	○	○	○
Youth have a choice of services and supports	○	○	○	○	○	○
Youth have access to peer support	○	○	○	○	○	○
A youth organization exists and supports youth involvement at the system and service delivery levels	○	○	○	○	○	○

8. Coordinated Approach

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Intensive care coordination with a dedicated care coordinator is provided to high-need youth and families	○	○	○	○	○	○
Basic care coordination is provided for children and families at lower levels of service intensity	○	○	○	○	○	○
Care is coordinated across multiple child-serving agencies and systems	○	○	○	○	○	○
One overall plan of care is created across child-serving agencies and systems (there may be more detailed plans for individual systems as part of the overall plan)	○	○	○	○	○	○

9. Culturally and Linguistically Competent Approach

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Culture-specific services and supports are provided	○	○	○	○	○	○
Services and supports are adapted to ensure access and effectiveness for culturally diverse populations	○	○	○	○	○	○
Providers represent the cultural and linguistic characteristics of the population served	○	○	○	○	○	○
Providers are trained in cultural and linguistic competence	○	○	○	○	○	○
Specific strategies are used to reduce racial and ethnic disparities in access to and outcomes of services	○	○	○	○	○	○

10. Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Evidence-informed practices are implemented within the array of services and supports to improve outcomes	○	○	○	○	○	○
Providers are trained in specific evidence-informed practices and/or evidence-informed practice components	○	○	○	○	○	○
Best practice guidelines, clinical protocols, and manuals are provided to practitioners	○	○	○	○	○	○
Fidelity to evidence-informed practices and outcomes is measured	○	○	○	○	○	○

11. Least Restrictive Approach

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Utilization of home and community-based services is increased	○	○	○	○	○	○
The number of children who are served in settings more restrictive than necessary is reduced	○	○	○	○	○	○
Utilization of inpatient hospitalization is decreased and it is primarily used for short-term, acute treatment and stabilization when necessary and appropriate	○	○	○	○	○	○
Utilization of residential treatment is decreased and it is primarily used for short-term lengths of stay to achieve specific treatment goals when necessary and appropriate	○	○	○	○	○	○

12. Service Array

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Broad array of home and community-based services and supports is available	○	○	○	○	○	○
Array includes or is linked to services and activities to identify behavioral health problems at earlier stages and at earlier ages (e.g., screening in primary care, schools, child welfare, etc.)	○	○	○	○	○	○
Array includes developmentally appropriate services for young children and their families	○	○	○	○	○	○
Array includes developmentally appropriate services for youth and young adults in transition to adulthood	○	○	○	○	○	○

13. Data and Accountability

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Data are collected regularly on the utilization of children's behavioral health services and supports, quality, outcomes, and costs and are used for continuous quality improvement	○	○	○	○	○	○
Electronic health records exist	○	○	○	○	○	○

SYSTEM OF CARE RATING TOOL

System of Care Rating Tool 2.0

III. Services and Supports

For each of the following services, indicate the extent to which it has been available in the community or region during the past 12 months.

14. Home and Community-Based Treatment and Support Services

	Not at all available	A little available	Somewhat available	Moderately available	Substantially available	Extensively available
Screening for behavioral health needs (e.g., in early care, education, primary care, child welfare, and juvenile justice settings)	○	○	○	○	○	○
Assessment and evaluation	○	○	○	○	○	○
Individualized service planning (e.g., wraparound process)	○	○	○	○	○	○
Intensive care coordination	○	○	○	○	○	○
Service coordination for youth at lower levels of service intensity	○	○	○	○	○	○
Outpatient individual therapy	○	○	○	○	○	○
Outpatient group therapy	○	○	○	○	○	○
Outpatient family therapy	○	○	○	○	○	○
Medication treatment/management	○	○	○	○	○	○
Crisis response services, non-mobile (24 hours, 7 days)	○	○	○	○	○	○
Mobile crisis response and stabilization services (24 hours, 7 days)	○	○	○	○	○	○

	Not at all available	A little available	Somewhat available	Moderately available	Substantially available	Extensively available
Intensive in-home services	○	○	○	○	○	○
School-based behavioral health services	○	○	○	○	○	○
Day treatment	○	○	○	○	○	○
Intensive outpatient substance use treatment	○	○	○	○	○	○
Therapeutic behavioral aide services	○	○	○	○	○	○
Behavior management skills training	○	○	○	○	○	○
Tele-behavioral health services	○	○	○	○	○	○
Youth peer support	○	○	○	○	○	○
Family peer support	○	○	○	○	○	○
Youth and family education	○	○	○	○	○	○
Respite services	○	○	○	○	○	○
Therapeutic mentoring	○	○	○	○	○	○
Mental health consultation	○	○	○	○	○	○
Supported education and employment	○	○	○	○	○	○
Supported independent living	○	○	○	○	○	○
Transportation	○	○	○	○	○	○

15. Out-of-Home Treatment Services for Short-Term Treatment Goals that are Linked to Home and Community-Based Services and Supports

	Not at all available	Available, but not used appropriately and not linked	Available, but rarely used appropriately and rarely linked	Available, somewhat used appropriately and somewhat linked	Available, moderately used appropriately and moderately linked	Available, mostly used appropriately and mostly linked
Therapeutic foster care	○	○	○	○	○	○
Therapeutic group home care	○	○	○	○	○	○
Crisis stabilization beds	○	○	○	○	○	○
Medical detoxification	○	○	○	○	○	○
Substance use residential treatment	○	○	○	○	○	○
Residential treatment	○	○	○	○	○	○
Inpatient hospitalization	○	○	○	○	○	○

SYSTEM OF CARE RATING TOOL

System of Care Rating Tool 2.0

IV. System of Care Infrastructure

This section lists components that comprise the infrastructure for a system of care. For each component, indicate the extent to which the component has been implemented in the community or region during the past 12 months.

16. Infrastructure Components

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Point of accountability structure for system of care management and oversight	○	○	○	○	○	○
Financing for system of care infrastructure and services	○	○	○	○	○	○
Structure and/or process to manage care and costs for high-need populations (e.g., care management entities)	○	○	○	○	○	○
Structure and/or process for interagency partnerships and agreements	○	○	○	○	○	○
Structure and/or process for partnerships with family organization and family leaders	○	○	○	○	○	○
Structure and/or process for partnerships with youth organization and youth leaders	○	○	○	○	○	○
Defined access/entry points to care	○	○	○	○	○	○
Extensive provider network to provide a comprehensive array of services and supports	○	○	○	○	○	○

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
Structure and/or process for training, TA, and workforce development	○	○	○	○	○	○
Structure and/or process for measuring and monitoring quality, outcomes, and costs (including IT system) and for using data for continuous quality improvement	○	○	○	○	○	○
Structure and/or process for strategic communications/social marketing	○	○	○	○	○	○
Structure and/or process for strategic planning and identifying and resolving barriers	○	○	○	○	○	○

SYSTEM OF CARE RATING TOOL

System of Care Rating Tool 2.0

V. Commitment to the System of Care Approach

For each of the following groups, indicate your assessment of the extent to which there has been buy-in and commitment to the system of care approach in the community or region during the past 12 months.

17. Child-Serving Systems

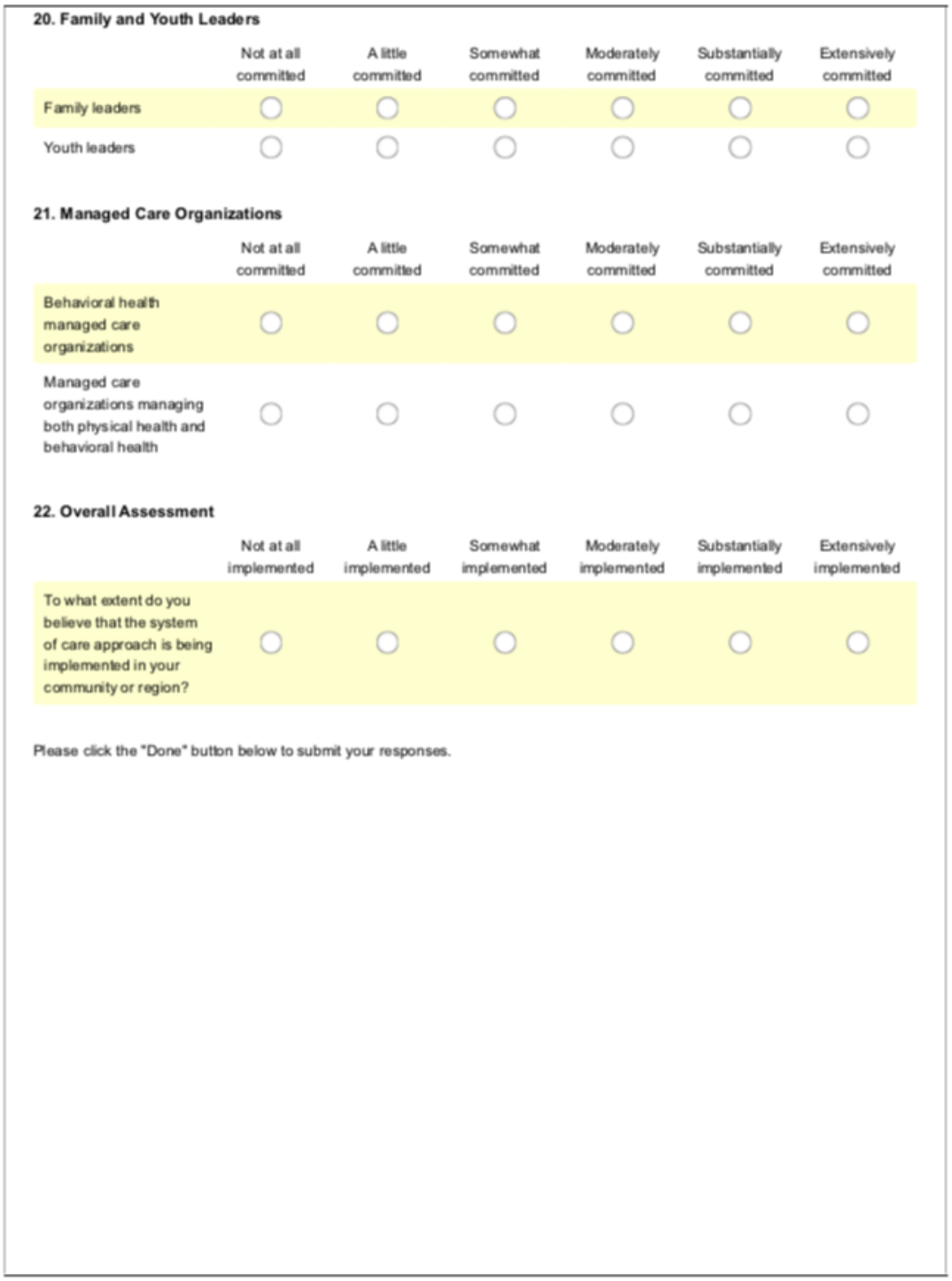
	Not at all committed	A little committed	Somewhat committed	Moderately committed	Substantially committed	Extensively committed
Mental health system	○	○	○	○	○	○
Child welfare system	○	○	○	○	○	○
Juvenile justice system	○	○	○	○	○	○
Education system	○	○	○	○	○	○
Health system	○	○	○	○	○	○
Substance use treatment system	○	○	○	○	○	○
Courts/judiciary system	○	○	○	○	○	○
Medicaid system	○	○	○	○	○	○

18. Policy and Decision Makers

	Not at all committed	A little comitted	Somewhat committed	Moderately committed	Substantially committed	Extensively committed
High-level policy and decision makers at the local community or regional level	○	○	○	○	○	○

19. Providers

	Not at all committed	A little committed	Somewhat committed	Moderately committed	Substantially committed	Extensively committed
Provider agency administrators and mid-level managers	○	○	○	○	○	○
Direct service providers (clinicians and others)	○	○	○	○	○	○



20. Family and Youth Leaders

	Not at all committed	A little committed	Somewhat committed	Moderately committed	Substantially committed	Extensively committed
Family leaders	○	○	○	○	○	○
Youth leaders	○	○	○	○	○	○

21. Managed Care Organizations

	Not at all committed	A little committed	Somewhat committed	Moderately committed	Substantially committed	Extensively committed
Behavioral health managed care organizations	○	○	○	○	○	○
Managed care organizations managing both physical health and behavioral health	○	○	○	○	○	○

22. Overall Assessment

	Not at all implemented	A little implemented	Somewhat implemented	Moderately implemented	Substantially implemented	Extensively implemented
To what extent do you believe that the system of care approach is being implemented in your community or region?	○	○	○	○	○	○

Please click the "Done" button below to submit your responses.

Again, for additional information and guidance on using this tool, or to take the assessment on behalf of your county, please contact the System of Care Implementation Team.

Appendix H

Youth and Family Partner Resources

Preparing to Recruit Family and Youth Members

You will want to focus on finding family and youth members for you CLMT who have lived experience and would like to make a positive difference for others. These members bring knowledge and personal experience that will inform and enrich your CLMT's important decisions. Because youth and family have probably not been invited into this kind of decision-making process before, it makes sense to talk openly with system partners about the opportunities that will open up.

Questions to consider prior to engaging family and youth:

- What concerns do you have about having family and youth working with all of you in this decision and policy making process?
- What are the reasons families and youth would want to work with the county system partners?
- What knowledge and skill sets do they need to have to be able to participate in a valuable way to the discussion and decision-making process?
- Are you willing to ensure that families, other caregivers, and youth are full partners in all aspects of the planning?
- Do you need to clarify how you will function as a collaborative team of equal members?
- What do you believe family and youth could bring to the county leadership team?

Opportunities for Family and Youth Beyond the CLMT

Counties may also consider identifying additional family and youth who may be a good fit in other systems in your county or on community boards. Be prepared to recommend other places where their voice and experience is needed so that the family and youth perspective is not coming from the same few family and youth. You may also want to develop education programs for family and youth that detail other systems and agencies.

Sample Youth and Family Partners Policy and Procedures

This sample policy document was created by the Delaware County System of Care County Leadership Team.

DELAWARE COUNTY SYSTEM OF CARE
COUNTY LEADERSHIP TEAM (CLT)
YOUTH AND FAMILY PARTNERS POLICY AND PROCEDURE

How are Youth and Family Partners Recruited and Chosen for the CLT?

There are numerous and varied ways youth and family partners can be recruited to be involved with Delaware County System of Care and for consideration as youth and family partners on the County Leadership Team. These include, but are not limited to:

- Recommendations from County Leadership Team members
- Recommendations from youth and family-run organizations and training programs such as:
    1. Parents Involved Network (PIN) and the Parent Empowerment Through Advocacy and Knowledge Program (PEAK)
    2. The Youth Advisory Board and Independent Living Program of Children and Youth Services
    3. Magellan Leaders Inspiring Future Empowerment (MY LIFE)
    4. PRYSM Youth Center for LGBTQQIA Youth
    5. Bully Free Friends (BFF)
- By contacting the SOC Consultant or Coordinators in response to our SOC recruitment brochure
- Recommendations from Delaware County Human Services agencies and Juvenile Court and Probation
- Recommendations from schools and the Delaware County Intermediate Unit
- Recommendations from community events and the Family Engagement Workgroup
- Recommendations from cultural and faith-based organizations
- Recommendations from community organizations serving youth and families such as:
    1. High Fidelity Wrap Around
    2. Community Mental Health Providers
    3. Community Drug and Alcohol Treatment Providers
    4. Family Centers
    5. Transition to Independence Process (TIP)

Recommendations for potential youth and family partners for the County Leadership Team should be given to the SOC Coordinator(s) who will supply the individual with an application. Applications will be reviewed by the SOC Coordinators and the CLT tri-chairs. All information contained in the application is kept confidential and will not be shared with anyone outside the selection committee. They will evaluate each applicant based on pre-determined criteria and make a recommendation to the County Leadership Team. The CLT will vote on new members following the CLT process for making decisions.

One of the SOC Coordinators will schedule a time to meet with the referred member to build a relationship, provide an orientation to SOC and the CLT, and discuss the role and expectations of youth, family, and system partners on the CLT, and train them how to submit the youth and family partner timesheet, expense form, and check request.

How are Youth and Family Partners Oriented, Trained, and Supported on the CLT?

Youth and Family Partners are chosen for the County Leadership Team and meet with the SOC Coordinator(s) or a CLT chair who:

- orients them to the history and philosophy of System of Care
- reviews the Vision, Mission, and Guiding Principles of Delaware County System of Care
- explains the PA and Delaware County SOC Standards
- provides a list and contact information for all CLT members
- provides updates on the current work of the County Leadership Team
- orients them to the stipend process and paperwork

The tri-chairs and Coordinator(s) support the youth and family members by continually checking in regarding their experiences, thoughts, and recommendations and providing additional preparation, support, and training as needed. CLT members are provided a TIP Sheet on "How to make Youth and Family Members Feel Comfortable at Meetings and Events" that was developed by the Youth and Family Training Institute. We provide regular check-in times and have a "no-acronym rule" at County Leadership Team meetings to allow for questions, clarification, and common understanding.

The County Leadership Team has a tri-chair leadership structure with a youth partner tri-chair, a family partner tri-chair, and a system partner tri-chair supported by the SOC Coordinators. Tri-chairs are available to support youth and family partners. The tri-chairs are available to meet with their respective partners 30 minutes prior to the CLT meeting to review the agenda and documents as well as any other suggestions, thoughts, and concerns.

In addition to the orientation provided by the SOC Consultant and the CLT chairs, CLT members are encouraged to further orient themselves by exploring the websites for Delaware County Human Services and Delaware County Juvenile Court and Probation. To learn more about Delaware County's System of Care, Child-serving Systems, and many community providers, youth and family partners are encouraged to attend the Parent Empowerment through Advocacy and Knowledge (PEAK) training offered by Parents Involved Network, the Delaware County Multi-Systems Training, and the Youth Mental Health First Aid Training. All of these trainings are offered at least once a year.

How do Youth and Family Partners get approved for continuing education and training directly related to the 8 PA System of Care Standards?

Youth and Family partners may attend the monthly PA SOC Partnership Go To Meetings, the PEAK and Multi-Systems training, and any training sponsored by the Delaware County System of Care. The PA SOC Partnership Go To Meetings are offered once a month.

If youth and family partners are interested in attending other trainings related to the PA SOC Standards, they can submit a "County Leadership Team Training Request" to the SOC Coordinator(s). If they are attending non-local trainings or conferences, the SOC Coordinators can help you to submit the necessary paperwork and documentation. The County Leadership Training request form is attached.

How are Youth and Family Partners compensated for their involvement on the CLT?

Delaware County System of Care has adopted the PA SOC Partnership rate for supporting youth and family partner involvement on the County Leadership Team. This rate is dependent on available funds. All youth and family partners must fill out and submit an IRS 1099 form to be paid.

Rate of Pay Per Meeting or Training	
1-4 hours	$25
4plus-6 hours	$50
7 plus	$75

Youth and Family partners can also be reimbursed for expenses, including mileage, parking, tolls, and childcare to attend County Leadership Team Meetings, CLT workgroups, and approved trainings. Youth and Family partners who take public transportation can be provided with tokens that can only be used for travel to and from County Leadership Team meetings, CLT workgroups, and approved trainings. If the youth and family partner is away at a conference, they can also be reimbursed for meals not provided at the conference. Meals may be reimbursed up to $7 for breakfast, $9 for lunch, and $14 for dinner. Original receipts must be attached to the expense form.

Youth and Family Partners submit their timesheets, expense forms, and check request to the SOC Coordinator(s) for approval. It generally takes a month for the first check to be issued. A schedule is attached that outlines the dates for submitting timesheets and the dates the checks are mailed. It is recommended that all youth and family partners keep a copy of their submitted timesheet and notify the SOC Coordinator(s) promptly if the check is not received by three days after the date the check is mailed.

How do Youth and Family Partners obtain Background Clearances to participate on the CLT?

Effective January 1, 2015, revisions to a Pennsylvania child protection law will require volunteers (any adults serving in unpaid positions) who are individually responsible for the welfare of a child or children, or who will have direct contact with a child or children, to have the background clearances. On Wednesday, June 10, 2015, Governor Wolf announced that the State will waive fees for the Pennsylvania criminal record check and child abuse clearance for volunteers working with children. The fee waiver of $10 per clearance will be effective on July 25, 2015**.**

Family Engagement Checklist for Schools

This tool comes from the NH Center for Effective Behavioral Interventions and Supports (NH-CEBIS).

Family Engagement Checklist

Muscott & Mann, 2004
Adapted from Epstein (2003) and Fullen (1991)

School: _____ Team: _____ Date: _____

STATUS: **In place** **Partially in place** **Not in place**	**TASK**	**PRIORITY:** **High** **Medium** **Low**
	Climate	
	1. There is a process for assessing how welcomed, valued, and satisfied parents are in and with the school.	
	2. There is a plan for addressing ways to help families feel welcomed and valued.	
	3. There is a plan for training all staff to work collaboratively and respectfully with families.	
	4. Plans for addressing ways to help families feel welcomed and valued address diverse families, including those with students in the universal, targeted, and intensive levels of PBIS.	
	Parent Involvement in Learning Activities at Home	
	5. There is a process for assessing parents' opinions about their own involvement in learning activities at home.	
	6. There is a plan or set of activities for helping families to support their child's learning at home.	
	7. The plan includes activities for helping diverse families, including those with students in the universal, targeted, and intensive levels of PBIS, support their child's learning.	
	Communication with Parents/Families	
	8. There is a process for assessing parents' opinions about how well schools communicate with them.	
	9. There is a plan for communicating with families in varied and helpful ways.	

Parent/Family Mandates

Developed by PA Families Inc. This document may also be downloaded from the PA Care Partnership website here.

1. We, the Parents/Family, love our children and will work to keep them safe.

2. We, the Parents/Family, have our children's health, well-being, and safety at the forefront of our concerns.

3. We, as the Parents/Family, do the best we can; we are not perfect but are willing to learn.

4. We, the Parents/Family, cannot provide the therapeutic home 24/7, and we should not be expected to.

5. We, the Parents/Family, know our children and families better than anyone, and our perspectives should be heard and respected.

6. We, the Parents/Family and youth, feel it is necessary for early and appropriate transition services.

7. We, the Parents/Family, believe that any and all barriers that still exist in the system need to be torn down.

8. We, the Parents/Family, believe that ALL systems should be able to inform parents and families about ALL programs and natural supports available. ALL systems partners should support the choices of the family and youth.

9. We, the Parents/Family, should be supported in our decisions and not be shunned if our child needs to leave our home, whether that be temporary or permanent.

10. We, the Parents/Family, know that post-secondary education should be seen as an option and encouraged. We do not want our children to be under-educated, underemployed, and unemployable.

11. We, the Parents/Family, know that our children's physical health (e.g., obesity, dental care), must be considered equally when assessing our children for strengths, needs, and concerns. System partners should provide information and resources to parents and families.

12. We, the Parents/Family, expect that system partners will not force families to adapt to system culture. We encourage systems to ask us about our culture and beliefs so that

they can provide access to culturally-appropriate resources that serve the family interest.

13. We, the Parents/Family, live with guilt, and we do not need our system partners to re-enforce the blame.

14. We, the Parents/Family, believe that parent/family-supported transition services for our children into the adult population are a requirement for successful living. We want our children to be productive members of the community.

15. We, the Parents/Family, know that systemic extensive MH/BHRS services, as well as OCYF, JJ, and D/A that are state-mandated and consistent from county to county (hassle-free services) are needed for efficient, successful outcomes.

16. We, the Parents/Family, realize that early intervention is essential if we are to stop the flow of our children into Children, Youth and Family Services, Juvenile Probation, and Drug and Alcohol.

17. We, the Parents/Family, are prepared to be at the table and fully embedded in the decision-making process on behalf of our children to promote transparency.

18. We, the Parents/Families, need systems to welcome us to the table and embed us in all levels of the decision-making process (county and state) to establish transparency in the system from theory to budget.

19. We, the Parents/Family, need access to services during times that are not standard business hours.

20. We, the Parents/Family, should be treated with respect from all levels of our system partners.

21. We, the Parents/Family, need to have freedom from fear of retaliation from all system partners.

22. We, the Parents/Family, know that respite care is a prevention and intervention. It needs to be provided on a routine basis.

23. We, the Parents/Family, should not have to struggle with education. There should be respect and follow through with 504 or the IEP process.

24. We, the Parents/Family, should not be hindered in finding available treatment for our children because of a lack of transportation.

25. We, the Parents/Family, need family peer and educational advocates who can accompany and support us at all meetings.

26. We, the Parents/Family, believe that our children are entitled to community integration in all ways.

27. We, the Parents/Family, should be equal members of their children's team; all team discussions should be approached from a position of common interests and strengths.

28. We, the Parents/Families, need effective parenting programs, such as realistic, evidence-based education on parenting children with behavioral challenges.

29. We, the Parents/Family, feel accountability is a requirement of all.

30. We, the Parents/Family, need and welcome high-quality, evidence-based services/processes for our children; we usually are not clinicians or experts.

31. We, the Parents/Family, expect improvements after a reasonable time with any system partner. If not, we will seek another system partner.

32. We, the Parents/Family, expect equality of treatment no matter what our income, culture, race, religion, sexual orientation, or insurance.

33. We, the Parents/Family, expect full disclosure of valuable information from all team members.

34. We, the Parents/Family, need to know our rights, including what they are when attempting to manage a child or teen exhibiting challenging behaviors.

35. We, the Parents/Family, need to understand our legal rights in every system.

36. We, the Parents/Family, expect systems to coordinate services into a single plan.

37. We, the Parents/Family, did not choose to have children with mental health problems. We did not cause this but are doing our best to raise our children.

38. We, the Parent/Family, want to eliminate the stigma of children and families with behavioral health problems.

39. We, the Parents/Family, know that adoptive parents or foster parents need ongoing support. It can take years for the family system to be stressed to the point of fracture.

40. We, the Parents/Family, should be included in cross-system training available to our system partners.

41. We, the Parents/Family, feel childhood is a precious time of life and that our children deserve a happy childhood. We feel a unique sense of loss and urgency, and when our children are placed in a holding pattern as a matter of systemic habit, we know that the earlier the intervention, the better the outcome for our children and families.

PA Families Inc. would like to thank the parents and families that participated in the creation of these the PA Family Mandates.

Checklist for Family Partners on State and County Leadership and Management Teams

☐ **I have a clear understanding of my role on the County Leadership Team.**

As a parent, you see through the eyes of a parent. That is your line of sight. You have a different way of seeing and understanding issues and end results. This may or may not lead you to the same decisions that a system partner would make. As time goes on, your role and contributions to the team will not be static or always exactly the same. Like everyone else on the team, you will see your role expand and contract.

☐ **I am happy to promote System of Care Values.**

Make sure you have a copy of the SOC Values. If you do not understand any of them or want to discuss them, be sure to ask your CLMT contact person for help.

☐ **I am willing to represent a broad group of families by seeking input from diverse groups.**

We can't possibly understand the needs of every family in every situation. And we probably aren't experts on the different cultures, faiths, and demographics of families in our communities. This requires us to be willing to listen, learn, and ask for guidance when we're unsure of how to best represent others.

☐ **The Family Partner commitment (e.g., time, travel, and training) has been clearly explained to me.**

For instance, do you know:

- How much time will each meeting take?
- Are there other times you may be needed?
- When and where will meetings be held?
- Will you be reimbursed for mileage or gas?
- What if you cannot make a meeting?
- Will there be notes/minutes sent to you by email, mailed, or posted on a website?

☐ **I can rely on strong self-care skills and natural supports.**

Do you have family or friends to help and support you in this endeavor? Is there someone you can talk to about your challenges with your personal life and your work on this team?

☐ **I have an understanding of these entities, areas of interest, and systems.**

Remember that no one knows it all, but a basic understanding of the structure and mission of a system is helpful. Below are some common systems that might be part of a leadership team. Never hesitate to ask for help to better understand the systems in your county.

- Mental Health
- Drug and Alcohol
- Children and Youth Services
- Juvenile Justice
- Education
- Managed Care
- Behavioral Health Organization
- Medicaid
- Social Security/ Disability
- Support Groups
- Diagnosis
- Medications
- Early Intervention
- Intellectual Developmental Disabilities

☐ **I feel confident that I understand how the public policy processes of each system functions.**

If you do not understand how different systems set and enact policies, ask for information and/or training. Systems enjoy helping people learn about them, but many system staff members understand only their piece and not any other. See if there is a specific person who can help you understand this area. Ask for any fact sheets, websites, or other materials that can help you. Remember that this is new information you wouldn't normally know, so it's normal to ask for help.

☐ **I have an understanding of, and am also willing to, develop the following leadership skills.**

As a member of your CLMT, you should have access to many trainings that can benefit you personally and professionally. Skills are learned, and If you feel you could use some training on the skills listed below (or others), just ask for it! You may discover that, like many of us, you already have stronger skills than you realized.

- Communication skills
- Conflict Resolution
- Public Speaking
- Facilitation
- Cultural and Linguistic Responsiveness
- Learning Styles
- Advocacy
- Self-confidence skills
- How to mentor other families
- Funding
- Serve on Committees
- Legislative Issues
- Legal Issues
- Individualized Education Plan/504
- Lead a Group
- Serve on Governance boards
- Serve on Advisory Boards

☐ **I can and will share the information that I learn with others who need it.**

People facing issues similar to yours will be grateful to hear what you know. Just a few of the ways to find them are among your family and friends, your church family, the newspaper, a support group, or a Facebook group. Brainstorm other ideas and tell us, too!

Tips for Family/Caregivers Involved with Child Welfare

Working with Child Welfare can feel so complicated. How can you remember it all? Get a planner to help keep track of your case and keep it (and a pen) with you at all times.

Include the following information in your planner:

1. Appointments
2. Phone calls made and received
3. Action was taken/dates of action
4. Questions you have
5. Contacts

Then, get a folder/binder to keep important documents organized in one place. Attach an envelope or paper clip for business cards.

Helpful Hints for Working with Caseworkers:

- Make sure you have your caseworker's work address, email address, and phone number. Find out if your caseworker has an assigned day at the office, as this will be the best day to reach the caseworker by phone. You may also ask for the caseworker's supervisor's contact information.
- If you are having trouble reaching your caseworker or getting your calls returned, keep a record of where and when you left messages. Try emailing your caseworker. If all attempts are unsuccessful, call or email his/her supervisor. You can also speak with another caseworker in an emergency.
- Share important information about your child with your caseworker (e.g., routines, medical history, school, important contacts).
- Participate in creating your family service plan and your child's/youth individual service plan.
- Make sure your caseworker has documentation that you are participating in services offered to you.
- If certain agency expectations may seem unrealistic for you, your family, or the child, ask the caseworker to work with you to make another plan.
- Keep all the appointments that you have made. If you are unable to get to a meeting or unable to get there on time, be sure to call your caseworker or the caseworker's supervisor. Leave a message if the caseworker is not available. Also, contact the day-in or on-call caseworker if one is available.
- Ask how visitation with your child will happen and participate in visitation. Always confirm your visits in advance.
- Advocate for visits supervised or unsupervised.

- Make sure you have your assigned attorney's contact information (phone number, address, and email) so that you can contact them as issues arise.

Tips for Visitation

- Confirm scheduled visitation the day before or that morning and check to see what the caseworker may require.
- Try to arrive 10-15 minutes early to your visit to plan how your visit will be.
- Bring some of your child's/youth favorite toys, games, books, crayons, and paper.
- Bring healthy snacks (such as fruits, crackers, rice cakes, cheese sticks, and/or juice), as well as occasional treats. If the child is an infant/toddler, bring items needed for changing diapers and bottle feedings.
- Plan for fun activities that allow you to laugh with your child, be silly, and enjoy your time together.
- If it is near your child's/youth birthday, bring a special card and/or gift or a special treat if you can.
- You may be sad but put on a happy face for your child/youth. Try to make the visit with the child/youth a pleasant experience.
- Stay calm when visiting your child.
- If there is a court case, don't talk about the court case in the presence of your child/youth.
- Be honest with your child/youth, and remember that it's okay to say, "I don't know."
- You may want to ask a family member, friend, or another support person to attend your meetings with Children and Youth Services.

We want to thank Child Welfare Resource Center Family and Communities for their work on these tips, as well as members of The Child Welfare Resource Center Diversity Task Force members for updating the information.

Breaking Down a Complicated Barrier

Developed by the PA Care Partnership in collaboration with the Team Up for Families Project of Melton Hill Media.

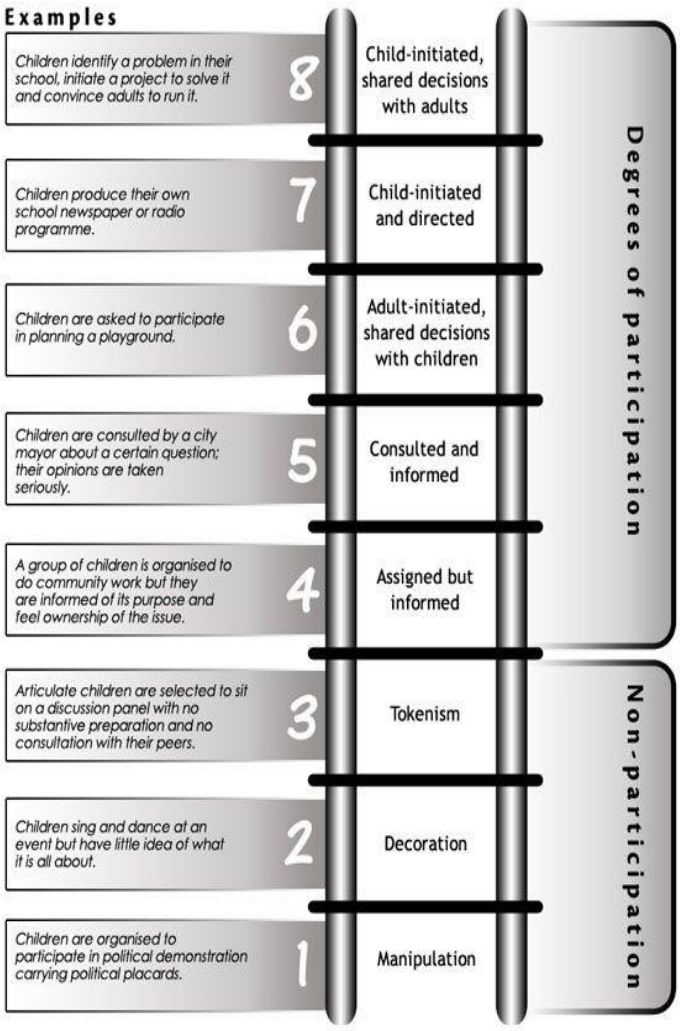
This tool is designed to help families solve problems they encounter when navigating systems. A problem that feels overwhelming often seems so complicated that a person does not know where to start. Cutting the problem into smaller pieces or "chunking up" the problem cuts it down to size and allows solutions to emerge.

As you begin to utilize these problems solving skills, even at the outset (when things seem bleak), it helps to know that as families work their way through difficulties, they almost always find useful strategies to share with others who find themselves in the same boat.

1. What do I need most from this system right now?
2. What strengths and assets do I bring to the table?
3. What challenges and barriers do I face?
4. What's my role in this system as a parent/caregiver?
5. What do I need to know about how this system works to solve the problem?
6. What strategies have worked for other families?
7. What have I learned so far that I might want to share with others?

Hart's Ladder for Youth Participation

Hart's Ladder of Participation is a model that can be used when developing and working on youth participation projects. It aims to enable young people to take an active part in decision making and give them the opportunity to have a voice in society.



Hart states there are eight steps on the "Ladder of Participation." While the first three steps (Manipulation; Decoration; and, Tokenism) do not engage young people in active youth participation, they instead provide a pathway to move up to the other stages of youth participation.

The next five steps explore more active involvement and fuller integration of young people into the decision-making process. In the fourth step (Assigned but Informed), an adult organizes an event or project with the expectation that young people will work on it. Following this step, young people's opinions will have some influence on decisions made, and they will receive feedback on these opinions (Consulted and Informed).

The sixth step involves adults choosing a project and young people taking the steps needed to implement it with their ideas, skills, and organization (Adult-initiated, Shared Decisions with Young People). The penultimate step allows young people to have full control and creative license over their ideas and projects (Child-Initiated and Directed).

The final step is an amalgamation of the last few steps, in that young people launch an idea and invite adults to join in, thus leading to an equal partnership. (Child-Initiated, Shared Decisions with Adults.)

Tip Sheet for a Youth and Family Services and Supports Planning Process

The PA Care Partnership's values include a Youth and Family Services and Supports Planning Process. The intent of this value is to assure that regardless of what planning process model is utilized within a county, that key elements are considered and built into the process. These key elements support the Theory of Change, youth and family engagement, and build upon the PA System of Care philosophy.

Please note the tip sheet is not all-inclusive. It is meant as a guide to start the conversation regarding your current youth and family planning process model, enhancements strategies to meet this core SOC value, or the possibility of developing a new approach for your county.

A. The youth- and family-driven model facilitates integrated services and supports planning among youth, families, and key child-serving systems.

Has your County Leadership and Management Team (CLMT) selected a planning process model that allows the family/youth to express their needs, brainstorm options that will work for them, and have a voice in deciding what supports and services they will want to try?

1. Does the selected process allow for the integration of plans?
2. If not, how will your CLMT support the system work to allow for the integration or sharing of services and plans?
3. Does the selected process support system partner involvement?
4. How will your CLMT support the youth and family-driven nature of the planning process?
5. What enhancements will your planning process need to reach this value?
    a. Longer period of engagement to get to know the youth and family member?
    b. Change in policy to assure integration or sharing of services?
    c. Time for child-serving staff to participate in meetings?
    d. An educational process for youth, families, and system partners on meeting expectations?
    e. A designated facilitator that will have time to engage all the members of the youth and family planning process team meetings? Will this person have time for follow up on plans?
    f. Ability for youth and family partners to support the facilitator?

B. The Planning Model has dedicated and trained staff.

This element considers relevant questions around the staffing for the selected planning model.

1. Are specific staff identified for the model?
2. Have they received training in facilitation skills?
3. Does the staff have time to dedicate to the engagement and prep of youth, family, and system partners?
4. Does the staff understand the Theory of Change? How will staff learn about the Theory of Change?
5. Does the staff have time to follow up to assure that the plans are working for the youth and family?
6. On average, it takes 4-6 hours to engage youth and families in the process. This includes an explanation of/expectations for participating in the process; gathering information from them regarding their needs; understanding the priorities they would like to address; assessing their strengths, establishing how the information will be shared; and, identifying who they would like to have at their meeting. Will there be time dedicated for staff to do this well?

C. The referral process is known and understood by families and systems.

This element refers to ensuring that youth, their families, and the system partners understand how and why a referral is made to the planning process model, what the benefit of the referral will be to them, and how the referral will be shared with others.

1. Does the CLMT approve and support the current referral process?
2. Are there elements of the referral process that can be improved to assure that all parties understand the referral, what the process will be, and who will be aware of the referral?
3. How are youth, family, and system partners educated on the referral process?
4. Does the facilitator of the process model have time to provide education to the process?
5. Do/can youth and families refer themselves?
6. Is the referral easily accessible? (Is it online, is it a paper form, or can a referral be completed by phone?)
7. Is the family referral shared with those who are invited to the meeting? Is there a summary document that describes the family that is shared as well?
8. Are releases clear regarding the sharing of information and confidentiality?
9. Do all possible members understand that youth and families will be decision-makers within the process and that they may invite whomever they feel is helpful to them?

D. The engagement process is clearly defined, and the process is agreed to by families.

This element refers to the working with the family and youth to explore their needs, their strengths, and the goals they would like to reach. It seeks to ensure that the planning process allows time for this engagement and promotes active participation by natural, community, and system partner supports. Time is needed for the youth and family to be prepared and understand their role within the planning process.

1. What time frame does your current model allow for engagement to occur?
2. How does your current model explain the youth and family participation? Is it easily understood?
3. Is there an opportunity to have engagement with invited partners to the team (natural, community, and system partners)?

E. The individual youth and family plans include:

- Assessment of strengths and needs
- Assessment across multiple domains
- Crisis plan
- Cultural and linguistic sensitivity
- Natural and community support
- Plan for self-efficacy

This element examines those areas of youth and family lives that should be considered when a plan is being developed with the youth and family team. The plan must assess strengths and ensure that those strengths are utilized. The strengths should reflect those of the youth and families but can also include the strengths of the systems/services and supports that they have identified.

Needs are not services. What are the needs that are identified by ***all*** members of the team in relationship to the youth and family?

Multiple domains include all aspects of the youth and family lives—the home, community, health, education, and so on. What and where are things going well for them, and where do they possibly need support?

Crisis plans ask you to think outside the box. If there is a clinical crisis plan in place, please review it to see if it reflects the situation across all domains. Does the plan include a crisis prevention plan? Who is helpful to include in the plan?

Cultural and linguistic sensitivity means that the plan accurately reflects and respects how a family identifies itself and that services and supports align with the family's values, beliefs, and lifestyle. Any plan that does not appropriately reflect the family's culture will not work.

Natural and community supports. Does the plan include the use of natural and community supports, and do these take the place of, or supplement, paid services?

Plan for self-efficacy. The Planning Process Model assures the development of skills with the youth and family so that they can manage their planning process, care, and services on their own.

F. Youth will receive services and supports in the least restrictive settings.

This element is familiar to many. The youth and family team that is built on the process model must first consider options for the youth that are within their community. Are there natural supports, community activities, or other options that haven't been tried and may make a difference? Is the youth active in sharing their voice? What might they want or be willing to try to make things better?

1. Does the youth have a friend on the team?
2. Does the family feel comfortable sharing their story with natural supports that may be helpful to the situation?
3. Are the system partners and mandates able to be met within the community?
4. Are system partners educated on the least restrictive services?

G. Youth and family peer supports are available as needed.

Youth and family peer support is a key element to this core SOC value. Youth and family peers are people with lived experiences that may be very helpful and effective supports for youth and families currently being recommended for the planning process. Youth and family peers can bring practical experience, examples, and different ways to navigate the system. They encourage youth and families to use their own voices to share what will make sense for them as they consider services and supports. Youth and family peer support partners are trained to participate in the planning process model. They are teachers, advocates, links to resources, truth speakers, support to other members, and help in exploring outside of the box ideas. They also help others on the team better understand what is happening, gain insight into youth culture, and offer options in the community that may be helpful. They should be available to support the family in preparing for the meeting and will often provide the facilitator with valuable information that will make the meetings more effective.

1. Is your CLMT able to support youth and family peer supports for the planning process model? How can they be funded? Can they be supported in a full- or part-time position?
2. Is there training available for the youth and family peer support? This training should include skill-building on engagement, boundaries, ethics, etc.
3. Is there an understanding of how the youth and family peer partners will work with the facilitator of the selected planning process model? How will information be shared?
4. How will system partners be educated on the roles and responsibilities of the youth and family peer support partners?
5. How will youth and families be notified of the availability of the youth and family peer support partners?

6. Who will supervise the youth and family peer support partners? How will the agency be supported in hiring those with lived experience?
7. What policies and procedures will be used to hire these staff?

H. Process outcomes are collected and monitored.

This element refers to the collection of outcomes based on the results of the planning process model and how the youth and family are progressing. The ultimate goal is for youth and family to have success with the process model, feel better about services and supports, and be able to do this on their own, in time. CLMTs are encouraged to engage in data collection to measure outcomes and success.

1. How will the planning process collect outcomes?
2. Will the CLMT select outcomes to consider?
3. Will the facilitator of the planning process have the time for follow up data collection?
4. How will youth and families be engaged in data collection?
5. How will information be shared?

I. Results are used by the CLMT for continual improvement.

This element correlates directly to the previous element. The data that is collected within the selected planning process must be shared with the CLMT. The information is then used to review current trends, overall needs, services that are effective, natural, and community supports, and more. The CLMT can assess this data in several important ways:

1. Are current services and supports effective for youth and families?
2. Are there natural and community supports that can be built upon for youth and families? Can funding be used to build up a community support program that has been continually identified as helpful to youth and families?
3. Is the planning process effective?
4. Do youth and families report feeling better based on their experience in the planning process model?
5. Is the CLMT able to see a reduction in services and an increase in natural and community supports?
6. How will the CLMT select data elements to review?

Appendix I

Strategic Planning

Strategic Framework for Expanding the System of Care Approach

(Developed by Beth A. Stroul, M. ED. And Robert M. Friedman, Ph.D. Revised 2019. Georgetown University National Technical Assistance Center for Children's Mental Health and the National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program.)

Five Core Strategy Areas and Sub-Strategies

I. Implementing Policy and Partnership Changes	
Making state-level policy, regulatory, and partnership changes that infuse and institutionalize the system of care (SOC) philosophy and approach into the larger service system to support the expansion of the SOC approach.	
Sub-Strategies	• Establishing an organizational locus of SOC policy, management, and accountability at state and local levels • Developing and implementing strategic plans • Developing interagency structures, agreements, and partnerships for coordination and financing • Promulgating rules, regulations, guidelines, standards, and practice protocols • Incorporating the SOC approach as requirements in requests for proposals and contracts • Enacting legislation that supports the SOC approach • Incorporating the SOC approach in protocols to monitor compliance with SOC requirements • Incorporating the SOC approach into data systems for measurement of utilization, outcomes, and cost, and quality improvement • Linking with and building on other system change initiatives (e.g., health reform, parity legislation, reforms in other systems) • Expanding family and youth involvement at the policy level • Improving cultural and linguistic competence at the policy level and incorporating strategies to eliminate disparities

II. Developing or Expanding Services and Supports Based on the SOC Philosophy and Approach	
Implementing the systemic changes needed to develop and expand a broad array of home- and community-based services and supports that are individualized, coordinated, family-driven, youth guided, and culturally and linguistically competent to support the expansion of the SOC approach.	
Sub-Strategies	• Creating or expanding the array of home- and community-based services and supports • Creating or expanding an individualized, wraparound approach to service delivery • Creating care management entities • Creating or expanding care coordination • Implementing family-driven, youth-guided services and expanding family and youth involvement at the service delivery level • Creating, expanding, or changing the provider network with new providers and by retooling and aligning community and residential providers • Creating or expanding the use of evidence-informed and promising practices and practice-based evidence approaches • Improving the cultural and linguistic competence of services • Reducing racial, ethnic, and geographic disparities in service delivery • Implementing or expanding the use of technology (e.g., electronic medical records, telehealth, videoconferencing, e-therapy)

III. Creating or Improving Financing Strategies	
Creating or improving financing mechanisms and using funding sources more strategically to support the infrastructure and services comprising systems of care to support the expansion of the SOC approach.	
Sub-Strategies	• Increasing the use of Medicaid • Increasing the use of Mental Health Block Grants, federal SOC grants, and other federal grants • Redeploying funds from higher-cost to lower-cost home- and community-based services • Implementing case rates or other risk-based financing approaches • Increasing the use of state mental health and substance use funds • Increasing the use of funds from other child-serving systems • Increasing the use of local funds • Increasing the use of federal entitlements other than Medicaid • Accessing new financing structures and funding streams

IV. Providing Training, Technical Assistance, and Workforce Development

Implementing workforce development mechanisms to provide ongoing training, technical assistance, and coaching to ensure that providers are prepared and skilled to provide effective services and supports consistent with the SOC philosophy and approach to support the expansion of the SOC approach.

Sub-Strategies	• Providing training, technical assistance, and coaching on the SOC approach • Creating ongoing training and technical assistance capacity • Providing training, technical assistance, and coaching on evidence-informed and promising practices and practice-based evidence approaches • Implementing strategies to prepare the future workforce to work within SOC framework • Implementing strategies to diversify the workforce by including staff with cultural and language diversity, paraprofessionals, families, and youth

V. Generating Support

Generating support among high-level decision-makers at state and local levels, families, youth, providers, managed care organizations, and other key leaders through strategic communications to support the expansion of the system of care approach.

Sub-Strategies	• Establishing strong family and youth organizations to support the expansion of the SOC approach • Generating support among high-level policy makers and administrators at state and local levels • Using data on outcomes, cost savings, and return on investment to promote expansion of the SOC approach • Cultivating partnerships with providers, provider organizations, managed care organizations, and other key leaders • Generating broad-based support through strategic communications and social marketing • Cultivating leaders and champions for the SOC approach

V. Cross-Cutting Themes Across All Core Strategy Areas

- Family-driven, youth-guided approaches to services and systems
- Cultural and linguistic competence in services and systems
- Cross-system collaboration in services and systems

PA Care Partnership County Action Plan Template

County: _____

The **County Action Plan Template** begins with the development of a Sustained System of Care Vision. The planning development sections are:

- PA Care Partnership System of Care Values
- Key Indicators of Success
- Strategies or Action Steps
- Responsibility
- Timeframe
- Participants

PA Care Partnership Values for counties:

- Youth-Driven
- Family-Driven
- Home and Community Based
- Strength-based & Individualized Practices & Processes
- Trauma-Informed
- Cultural & Linguistic Competence
- Connected to Natural Helping Networks
- Data-driven, Quality and Outcomes-Oriented
- County Leadership Team and Governance Board
- Multi-System Integration
- Evaluation & Continuous Quality Improvement (CQI)

When completing the following Action Plan, please address each of the eleven (11) PA Care Partnership values. Each of the eleven (11) PA Care Partnership standards has lettered subsets. At a minimum, please address 50% of the lettered subsets for each of the eight standards.

County: _____

Plan Date: _____

System of Care Community:

(What is the descriptive name of our system of care community?)

Sustained System of Care Vision:

(What will our system of care look like when it is fully sustained beyond Federal grant funding? Write in the future tense.)

Youth-Driven				
Key Indicators of Success (How will we know when we have gotten there?) Use standard subsets.	**Barriers to Achievement** (What is standing in the way of our progress?)	**Strategies or action steps** (What are the steps?)	**Responsibility** (Who does what step?)	**Timeframe** (Dates?)
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Family-Driven				
Key Indicators of Success (How will we know when we have gotten there?) Use standard subsets.	**Barriers to Achievement** (What is standing in the way of our progress?)	**Strategies or action steps** (What are the steps?)	**Responsibility** (Who does what step?)	**Timeframe** (Dates?)
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Home and Community-Based				
Key Indicators of Success (How will we know when we have gotten there?) Use standard subsets.	**Barriers to Achievement** (What is standing in the way of our progress?)	**Strategies or action steps** (What are the steps?)	**Responsibility** (Who does what step?)	**Timeframe** (Dates?)
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Strengths-Based and Individualized Practices and Processes				
Key Indicators of Success (How will we know when we have gotten there?) Use standard subsets.	**Barriers to Achievement** (What is standing in the way of our progress?)	**Strategies or action steps** (What are the steps?)	**Responsibility** (Who does what step?)	**Timeframe** (Dates?)
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Trauma-Informed				
Key Indicators of Success (How will we know when we have gotten there?) Use standard subsets.	**Barriers to Achievement** (What is standing in the way of our progress?)	**Strategies or action steps** (What are the steps?)	**Responsibility** (Who does what step?)	**Timeframe** (Dates?)
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Cultural and Linguistic Competence				
Key Indicators of Success **(How will we know when we have gotten there?) Use standard subsets.**	**Barriers to Achievement** **(What is standing in the way of our progress?)**	**Strategies or action steps** **(What are the steps?)**	**Responsibility** **(Who does what step?)**	**Timeframe** **(Dates?)**
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Connected to Natural Helping Networks				
Key Indicators of Success **(How will we know when we have gotten there?) Use standard subsets.**	**Barriers to Achievement** **(What is standing in the way of our progress?)**	**Strategies or action steps** **(What are the steps?)**	**Responsibility** **(Who does what step?)**	**Timeframe** **(Dates?)**
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Data-Driven, Quality, and Outcomes-Oriented				
Key Indicators of Success (How will we know when we have gotten there?) Use standard subsets.	**Barriers to Achievement** (What is standing in the way of our progress?)	**Strategies or action steps** (What are the steps?)	**Responsibility** (Who does what step?)	**Timeframe** (Dates?)
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

County Leadership Team and Governance Board				
Key Indicators of Success **(How will we know when we have gotten there?) Use standard subsets.**	**Barriers to Achievement** **(What is standing in the way of our progress?)**	**Strategies or action steps** **(What are the steps?)**	**Responsibility** **(Who does what step?)**	**Timeframe** **(Dates?)**
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Multi-System Integration				
Key Indicators of Success (How will we know when we have gotten there?) Use standard subsets.	**Barriers to Achievement** (What is standing in the way of our progress?)	**Strategies or action steps** (What are the steps?)	**Responsibility** (Who does what step?)	**Timeframe** (Dates?)
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Youth and Family Services and Supports Planning Process				
Key Indicators of Success (How will we know when we have gotten there?) Use standard subsets.	**Barriers to Achievement** (What is standing in the way of our progress?)	**Strategies or action steps** (What are the steps?)	**Responsibility** (Who does what step?)	**Timeframe** (Dates?)
❑				
❑				
❑				

The permanent presence of youth and families in every process is required.

Participant List:
As members of the community, we actively participated in completing the [COUNTY] Action Plan.

Name	Agency Affiliation or Family/Youth member	Date
Name	Agency Affiliation or Family/Youth member	Date
Name	Agency Affiliation or Family/Youth member	Date
Name	Agency Affiliation or Family/Youth member	Date
Name	Agency Affiliation or Family/Youth member	Date
Name	Agency Affiliation or Family/Youth member	Date
Name	Agency Affiliation or Family/Youth member	Date
Name	Agency Affiliation or Family/Youth member	Date
Name	Agency Affiliation or Family/Youth member	Date

Appendix J

Training and Technical Assistance

Currently Recommended T&TA Resources

You may already have excellent providers to support your training and technical needs, but if you are in search of new/additional providers, then the table below describes currently recommended training and technical assistance resources. Please note that these are current prices and are subject to change.

If you'd like guidance on selecting training programs or providers, or you have needs not identified below, contact the PA Care Partnership at info@pacarepartnership.org.

Training Name	Description	Provider	Length	# Per Class	Cost Per Class	Grant Funded	County/ Provider Cost	Total Est. Cost	Train the Trainer Available
Lakeside Global Trauma Workshop 101	Trauma 101: An Overview of Trauma-Informed Care In this two-hour workshop participants will: • Enhance and enrich your knowledge of trauma • Be introduced to the Adverse Childhood Experiences Study • Discover the basics of brain growth and the impact of toxic stress • Understand four components of trauma-informed care • Be inspired by reasons for hope	Lakeside Global	2 Hours	50	$1,500.00 or two sessions same day $2,700	Yes, with available funding. Partnership payer of last resort for grant-funded counties.	Facility, Catering, light refreshments, and snacks (if desired)	$1,500-$1,700 Per Training	Yes
Lakeside Global Trauma Workshop 102	Trauma 102: Basic Skills of Trauma-Informed Care In this two-hour workshop participants will: • Recognize the value of Dr. Bruce Perry's 3 R's • Equip participants with the resources to develop Personal Safety Plans for themselves and others • Be introduced to a key trauma-sensitive communication skill • Explore the power and impact of intentional breathing • Appreciate the definitions of epigenetics and trans-generational legacies	Lakeside Global	2 Hours	50	$1,500.00 or two sessions same day $2,700	Yes, with available funding. Partnership payer of last resort for grant-funded counties.	Facility, Catering, light refreshments, and snacks (if desired)	$1,500-$1,700 Per Training	Yes
Lakeside Global Trauma Workshop 103	Trauma 103: Recognizing Vicarious & Secondary Trauma for Caregivers In this two-hour workshop participants will: • Identify and distinguish between the various ways trauma impacts caregivers • Recognize the signs and symptoms of secondary traumatic stress	Lakeside Global	2 Hours	50	$1,500.00 or two sessions same day $2,700	Yes, with available funding. Partnership payer of last resort for grant-funded counties.	Facility, Catering, light refreshments, and snacks (if desired)	$1,500-$1,700 Per Training	Yes

	• Practice self-care exercises								
Lakeside Global Trauma Workshop 105	Trauma 105: An Introduction to Trauma for Parents & Caregivers In this two-hour workshop participants will: • Develop Personal Safety Plans • Learn why people behave the way they do • Gain some basic information about trauma • Understand Dr. Perry's 3 R's • Explore three styles of leadership as a Parent or Caregiver • Relate to key trauma-sensitive communication skills	Lakeside Global	2 Hours	50	$1,500.00 or two sessions same day $2,700	Yes, with available funding. Partnership payer of last resort for grant-funded counties.	Facility, Catering, light refreshments, and snacks (if desired)	$1,500-$1,700 Per Training	Yes
Lakeside Global Trauma Workshop 106	Trauma 106: An Introduction to Trauma for Youth In this two-hour workshop participants will: • Learn why people behave the way they do • Gain some basic information about trauma • Identify some basics of brain structure • Discover positive and future self through strengths activity	Lakeside Global	2 Hours	50	$1,500.00 or two sessions same day $2,700	Yes, with available funding. Partnership payer of last resort for grant-funded counties.	Facility, Catering, light refreshments, and snacks (if desired)	$1,500-$1,700 Per Training	Yes
Lakeside Global Enhancing Trauma Awareness	Enhancing Trauma Awareness Goals for the course include: • Exploring the nature and related principles of trauma. • Exploring practical applications of ICAPS (information, concepts, approaches, principles, and skills). • Promoting a passionate sense of urgency with regard to dispersing key principles to those who work with children/adults, parents/caregivers, families, and others. • Encouraging professionals to gain awareness and appreciation for the importance of being self-protective when exploring the subject of trauma and to be advocates for the self-protection of others.	Lakeside Global	*First in trauma series 15-hour course (2.5 hours per session) for 15 participants.*	15		Yes, with available funding. Partnership payer of last resort for grant-funded counties.	Facility, Catering, light refreshments, and snacks (if desired)		No
Family Road Map	Workshop Road Map ® is a peer-led, interactive, six-hour curriculum created by the Team Up for Families (TUFF) National Learning Collaborative to help family caregivers' partner more effectively with health professionals, school staff, insurers, and social agencies. The curriculum is available in English and Spanish. Educational Objectives: Finding the right services for children with special needs can feel overwhelming to family caregivers. Community health centers, schools, and social agencies have complicated procedures with bewildering jargon. Each provider may only see a small part of the total problem. Road Map ® offers a	PA Care Partnership	6-hour	10-30	One book per attendee @ $19.00 $5.00 per attendee for material $24.00 per attendee	Yes, with available funding. Partnership payer of last resort for grant-funded counties.	Facility and Catering (if desired)	Up to $500-$1,200	Yes, by completing Facilitator Training

	step-by-step guide to coordinating a child's services.								
	Coaches Road Map ® Training is a peer-led, interactive, six-hour certification training created by the Team Up for Families (TUFF) National Learning Collaborative for Educators, case managers, peer support, counselors, therapist, social worker, advocates, and family members who work with families of children experiencing behavioral, developmental or other special needs. The training integrates the "Start Here → Get There" Strategy Session curriculum covering all parts of the Family Road Map. This curriculum provides a simple step-by-step path to self-reliant problem management and effective communication skills, as well as strategies for managing specific problems.	PA Care Partnership	1 Day or 6 hours	10-30	One book per attendee @ $19.00 $5.00 per attendee for material Certificate Fee $TBD $__.00 per attendee	Yes, with available funding for trainers and books. Grant provides up to 5 books per trainee. A certificate is the responsibility of the trainee.	Facility and Catering (if desired)	To be Determined.	Yes, by completing Facilitator Training
		Family Road Map Institute		25	$350.00 per person for Training and Certificate. (Includes 5 Books)	No			
	Facilitator Road Map® Training - This 2-Day, 14-hour Facilitator Certification Training is for Educators, case managers, peer support, counselors, therapist, social worker, advocates, and family members who work with families of children experiencing behavioral, developmental or other special needs. This training includes the Coaches Training and equips Facilitators to run interactive Road Map workshops and provide one-on-one coaching to clients and family members.	PA Care Partnership	Two Days or 14 hours	10-30	One book per attendee @ $19.00 $5.00 per attendee for material Certificate Fee $TBD $__.00 per attendee	Yes, with available funding for trainers and books. Grant provides up to 5 books per trainee. A certificate is the responsibility of the trainee.	Facility and Catering (if desired)	To be Determined.	Yes, by completing Facilitator Training
		Family Road Map Institute		25	$475.00 per person for Training and Certificate. (Includes 10 Books)	Yes, with available funding for trainers and books. Grant provides up to 5 books per trainee. A certificate is the responsibility of the trainee.	Facility and Catering (if desired)	To be Determined.	Yes, by completing Facilitator Training
Youth and Young Adult Roadmap	Youth and Young Adult Roadmap (YYARM) training and coaching are available to help youth and young adults navigate the changes needed to move into the adult living, enhancing their existing skills. We can train people to use the Roadmap tool and to train others on its use. We will provide you with the Roadmap books. These are used by the youth/young adult participants and remain with them. The cost is approximately $24.00 per book. Coaching can also be provided, which is working directly	Youth M.O.V.E. PA	6 hours for coaches training 12 hours for Facilitator	30	One book per attendee $40.00 per attendee - Membership fee to Family Road Map Institute	Portions of training can be grant-funded, but the Family Road Map Institute Membership Fee is not.	Facility and Catering (if desired)	Working on details	Yes

	with a small group, preferably 6 to 8 young people, in order to work through the Roadmap tool.								
PMHCA/Youth M.O.V.E. PA Drexel Youth Leadership Training	PMHCA/youthMOVE-pa/Drexel BHE youth leadership training was developed collaboratively, using Youth MOVE lived experience and Drexel Behavioral Health Education's curriculum writing expertise. To encourage leadership opportunities for youth, this training shares perspectives, advice and strategies gathered from young adult leaders with disabilities, families, school staff, and other leadership experts on what makes someone a leader and how best to support leadership development in youth. This is a one-day training that can be delivered either in a full day framework or in two half-days. It will be presented by people with lived experience.	Youth M.O.V.E. PA	6 hours	30	Review cost after pilot	Review cost after pilot	Facility and Catering (if desired)	Review cost after pilot	No
Question Persuade Refer	QPR stands for "Question-Persuade-Refer" and is an evidence-based "gatekeeper" training on suicide prevention. Gatekeepers can be anyone, including parents, friends, neighbors, teachers, nurses, etc. in a position to recognize a crisis and/or warning signs in someone that may be thinking about suicide. The gatekeeper learns to recognize early suicide warning signs, question their meaning to determine suicide intent or desire, persuade the person to accept or seek help, and refer the person to appropriate resources. QPR is an evidence-based training that has been recognized by SAMHSA and the Suicide Prevention Resource Center (SPRC). The following are key components covered in QPR training, which generally lasts between 1 and ½ to 2 hours (please visit the QPR Institute for additional information): • How to question, persuade, and refer someone who may be suicidal • How to get help for yourself or learn more about preventing suicide • The common causes of suicidal behavior • The warning signs of suicide	Garrett Lee Smith Suicide Prevention Grant As well as other entities. Becoming Certified Trainer	1.5 hours to 2 hours for training		Online Gatekeeper Training $29.95 per. Or 250-500 pre paid @14.95 per person. Trainer Cost $495.00	Through various grants and can be written into local grant budget	$14.95 to 29.95 per person for online. Face to face varies. For face to face: Facility	$14.95 and up.	Yes
Youth Mental Health First Aid	Youth Mental Health First Aid® USA is in-person training program — like traditional First Aid or CPR — designed to give participants who interact with young people the skills to help adolescents age 12-18 who are developing a	Mental Health First Aid https://www.mentalhealthfirstaid.org/take-a-	8-hour evidence-based in-person training program		Varies, but can be found at $0.00 to attend as a	Could be written into local grant application.	$0.00 to $2,000 per person depending on training. Must include travel	Varies depending on course	Yes Onsite training for large group $21,500

	mental health problem or experiencing an emotional crisis. The course uses role-playing and simulations to demonstrate how to recognize and respond to warning signs and connect young people to professional, peer, social, and self-help care. Participants do not learn to diagnose, nor how to provide any therapy or counseling – rather, they learn to support youth by applying a five-step action plan, "**ALGEE**:" ♣ Assess for risk of suicide or harm ♣ Listen nonjudgmentally ♣ Give reassurance and information ♣ Encourage appropriate professional help ♣ Encourage self-help and other support strategies	course/find-a-course/ Instructor Training: https://www.mentalhealthfirstaid.org/become-an-instructor/certification-process			single person. For Mental Health First Aid Adult cost is $0.00 to $119.00 per person Instructor Training starts at $2,000		and mileage if needed.		to $36,200
Coach Approach to Adaptive Leadership	The Coach Approach to Adaptive Leadership was developed to support health and human services organizations in building coaching skills as core skills for adaptive leadership. This connects coaching as a daily approach for how to respond to complexity in times of constant uncertainty. This approach is important to be adopted and modeled by leaders/managers who are responsible for orchestrating all types of organization, culture, and systems change, and can ultimately be learned and used by all members within the organization or setting. Training is customized to the audience.	Coach Approach Partners	Two Days	Up to 40	Valued at $13,500 to $15,000 + Expenses for two senior instructors from the Coach Approach Partners (pricing may vary depending on organization size and available funding) Valued at $10,000 + Expenses for PA Certified Instructors (pricing may vary depending on organization size and available funding)	Yes, with available funding. Partnership payer of last resort for grant-funded counties. If pricing is discounted, entity may be able to use the difference in price as in-kind.	Facility and Catering (if desired, but recommended), color printing of material, possible	$15,000 to $17,000 $11,500 to $12,000	Yes
Adaptive Leadership for System Change	This tailored leadership training will address the framework, skills, and tools necessary to support families, peers, and professionals in their roles as leaders in systems change. The strategies and tools will significantly enhance your ability to facilitate collaboration and transformation in your settings/communities. The curriculum is designed to provide the opportunity to engage	Coach Approach Partners	Two Days	50	$15,000 to $24,000 + Expenses. (pricing may vary depending on organization size and available funding)	Yes, with available funding. Partnership payer of last resort for grant-funded counties. If pricing is discounted, entity may be able to use the difference in	Facility and Catering (if desired, but recommended), color printing of material, possible	$17,000 to $26,000	No

	in a dynamic and honest conversation about the nature and role of leadership in our often complex and difficult environments – when there is no road map to follow. This experience will provide an overview and hands on opportunities to deepen skill sets that are needed to strategically mobilize, support, and sustain change. Training is customized to audience.					price as in-kind.			
Parent Cafe	Parental Survival Series: Adolescence and falling in love. To create a sense of community and foster respectful communication in order to have conversations that matter in an emotionally safe environment; while building and raising awareness of the five protective factors.	Strengthening Families	2 1/2	15	To Be Determined	Yes, with available funding	Facility and Catering (if desired, but recommended)	To Be Determined	Yes
Introduction to High Fidelity Wraparound	Provides an overview of the HFW theory of change, principles and phases	Youth and Family Training Institute	3-4 hours	No limit	N/C	yes	Facility and catering		No
High Fidelity Wraparound 5-day Team Training	HFW workforce training for coaches, facilitators, family support partners and youth support partners	Youth and Family Training Institute	2 days then 3 days (4-6 weeks in between)	20	N/C	yes	Meals and hotel if staying overnight	Varies for Expenses	No
Intersection of Case Management and High-Fidelity Wraparound	Provides an overview of Case Management and High-Fidelity Wraparound and highlights how the clinical service and planning process complement and enhance the work of both.	Youth and Family Training Institute	3 hours	No limit	N/C	yes	Facility and catering	Varies for Expenses	No
Intersection of Family-Based and High-Fidelity Wraparound	Provides an overview of Family Based and High-Fidelity Wraparound and highlights how the clinical service and planning process complement and enhance the work of both.	Youth and Family Training Institute	3 hours	No limit	N/C	yes	Facility and catering	Varies for Expenses	No
Customized training on HFW principles to meet unique county needs	Will work with partner counties to develop trainings on specific areas of focus based on the HFW principles (i.e. system collaboration, natural supports, engagement, etc.)	Youth and Family Training Institute	variable	No limit	N/C	yes	Facility and catering (if desired)	Varies for Expenses	No
Overview of Family Peer Support Specialist role in PA	Provides an overview of the current and future Family Peer Support Specialist (FPSS) and Supervisors role and training. Includes an overview of the proposed certification process.	Youth and Family Training Institute	2 hours	No limit	N/C	yes	Facility and catering (if desired)	Varies for Expenses	No
Family Peer Support Specialist training	The Parent Peer Support Practice Model (Developed and Licensed by FREDLA) training provides the basic framework for those that are or will be providing Family Peer Support Services in Pennsylvania. The training consists of six modules: • **Connect**- Presenting self as a peer and establishing a role with family. • **Discover** - Focus on understanding family level of	Youth and Family Training Institute	5 days; 40 hours	20	To Be Determined	yes	Facility and catering (if desired)	Varies for Expenses	No

	need, strengths; identify family goals • **Support** – Focus on support of the family across systems • **Empower** -- Focus on empowering families and informing systems around family perspective, family voice and choice, and family-driven services • **Prepare** – Focus on the transition from formal support and develop an ongoing plan **Take Care** -- Focus on self-care and maintaining role								
Family Peer Support Specialist-Training for Supervisors	Family Peer Support Specialist's Supervisor skill sets, developed by FREDLA. Focus is on the skills needed to effectively supervise and support the FPSS role and work. Includes: • Creating a supportive environment • Ensuring fidelity and accountability of the FPSS role Providing opportunities for growth and development	Youth and Family Training Institute	3 days	18	To Be Determined	yes	Facility and catering (if desired)	To be determined	No

Sample Training Request Form

[COUNTY NAME] County Leadership Team Training Request

___System Partner ___ Family Partner ___ Youth Partner

Name_____Date_____

I would like to attend the following training/workshop:

(Give a brief description of the program, including location, dates, and attach brochure)

The relevance of program to Goals & Objectives and Training Plan:

Cost of Program:	Registration	$_____
	Travel	$_____
	Lodging	$_____
	Meals	$_____
	TOTAL COST	$_____

APPROVED_____ NOT APPROVED_____

Reason (s):

Supervisor_____ Date_____

Administrator_____ Date_____

Appendix K

Evaluation Resources

Tip Sheet: Data 101—The Basics

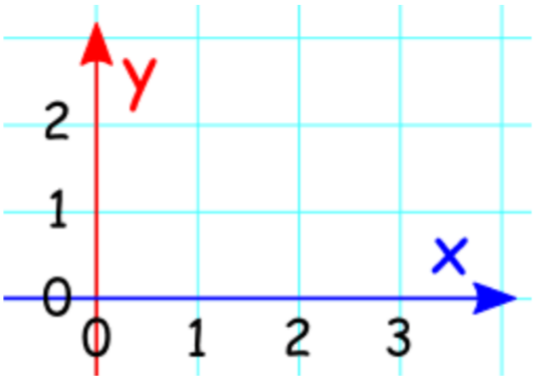
Goal: Learn to speak the language of data and evaluation. Terms defined with simple explanations.

Data is any information you collect: numbers, statistics, or measurements. It can also be words, observations, or any other inputs.

- **Quantitative:** Numbers or things that can be measured or counted. Example: *I paid $3.00 for 12 ounces of coffee that was brewed at 200 degrees.*
- **Qualitative:** Things you can observe but not easily measured or counted such as social interactions, feelings, colors, etc. Example: *My coffee tastes bitter, looks frothy, has a nice aroma, and is in a red cup.*

N = (number) and refers to the total number of people/subjects/items represented in the graph.

Y axis is the vertical (up-down) line on the side of a graph.

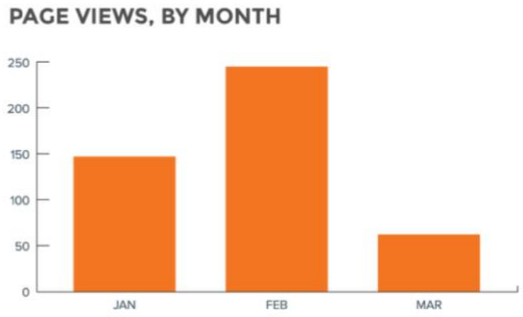


X axis is the horizontal (left-right) line at the bottom of a graph.

Variable: Something that can be measured or counted. It can increase or decrease depending on what/how you are measuring. You can find variables in the titles of the X and Y axes.

Cross-sectional Data is something that is only measured once. It is a snapshot of variables at one point in time.

Longitudinal Data is something that is measured repeatedly over time. You can look at the same variable at different times.



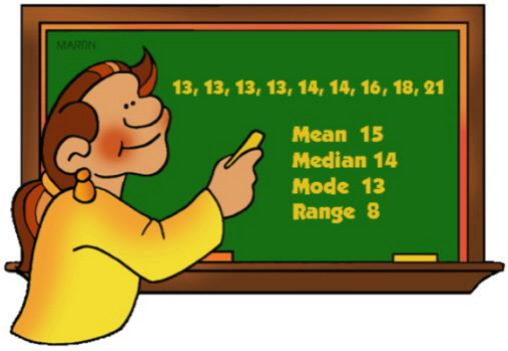
Data Set: A group of variables that can be compared to each other or looked at individually in order to understand how they are related.

Mean: The average, or the sum of all values in a series divided by the number of values.

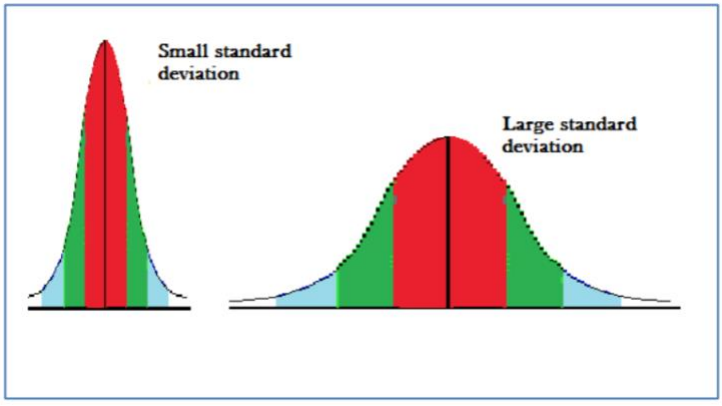
Median: The middle value in a series.

Mode: The most frequent value in a series.

Range: The difference between the highest and lowest values in the series.



Standard Deviation: The measure of how far a variable is from the mean. A small standard deviation shows that the scores are clustered around the mean. A large standard deviation shows that the scores are spread out over a larger range.



Correlation: Two or more variables demonstrate a positive or negative relationship to each other.

- **Positive Correlation:** When one variable goes up the other goes up as well. Example: *The more time you spend running on a treadmill, the more calories you will burn*.

- **Negative Correlation:** When one variable goes up the other one goes down. Example: *The more you exercise, the less you will weigh*.

NOTE: Correlation does not equal causation! It can be just a coincidence that things are related. Example*: There is a strong statistical negative correlation between the increase in lemons imported from Mexico and the decrease in U.S. highway fatalities!*

p value: How likely something is to NOT be true. Example: *a p value of 0.05 means that there is a 5% chance that the result was just a coincidence.* The smaller the p value, the more likely the data results are accurate. ****Look for p values at the bottom of data tables to see how significant the results are.**

Statistically significant: The data presented is probably true (not due to chance). A p value of 0.05 is considered the standard for data to be "significant" but some people prefer a number even lower.

Reliability: The degree that the results are stable and consistent no matter how many times you repeat it.

Validity: The degree to which the data is actually measuring what it claims to measure.

Tip Sheet: How to Use Data

Goal: Use data at the CLMT level to drive decisions, make continuous quality improvement. Make data interesting, relevant, and meaningful to different stakeholders.

1. Have a Data/CQI standing agenda item at each CLMT meeting.

2. Choose a data topic for each meeting.

Tips for selecting topics/data:

- Review relevant data sources at the county, state, and federal levels. (See links to several data sites in the Resources section of this toolkit or visit the evaluation resources on the PA Care Partnership website.
- Look at census (descriptive and demographic) data to get a better sense of your county's minority populations around race/ethnicity/language/culture.
- Ask a different CLMT member to choose the topic for a monthly meeting and be responsible for bringing some data (a few slides/charts) to discuss.
- Let the natural discussion of each meeting identify a topic for the following month.
- Allow curiosity/questions to arise first and allow the group to identify the data that can help to answer the question or illuminate the discussion.
- Develop a list of important topics and schedule them for the next 6 months of meetings so that everyone can bring something relevant to discuss.

3. Choose a reason to look at data and decide how to focus the discussion.

- **Strengths-based:** Look at positive data and the possible strengths of your county that may have led to positive results. Celebrate successes around the work that your county has done that to make a difference.
- **Challenges:** Look at barriers to positive change. Discuss what actions your county might have taken that may have led to the negative results, discuss any possible elephants in the room, and identify areas for improvement.
- **Outcomes:** Focus on one particular county program, service, support, etc., and look at a small number of outcomes to see how the program is functioning and what is working/not working. Be sure to bring in staff and/or family/youth who have participated to help think about the outcomes.
- **Confusing/conflicting information:** Spark discussion from different perspectives around the table (family, youth, systems, providers, community, etc.) by asking critical questions and reflecting on why information is mixed or conflicting.
- **Lack of information:** Identify areas where there is a need for more data and brainstorm ways that you could obtain more information about the topic.

4. Develop a plan about next steps.

- Identify what you want to do to make sure that the good work continues.
- Choose and prioritize areas that you want to improve or adjust.
- Discuss whether you have all the information you need or if you need to brainstorm more ideas/sources of data, etc.
- Discuss who, what, when, where, how, why the plan will be developed around CQI.
- Decide when updates will be made to the group and how the group will be informed of progress.

General tips for presenting data

- Choose data that are relevant and timely to the issues/needs that are current to your stakeholders.
- Stakeholders are more likely to listen to data if it is coming from a peer.
- Provide data in different formats, so there is the ability to multi-task while absorbing information.
- Background information and a key to acronyms and/or definitions are important for the presentation.
- Provide a reference sheet that defines data/evaluation terms and general information to make reading data easier.
- Utilize personal stories and reviews of the program/process to help enhance the numbers/data.
- The role of systems and how they communicate, integrate, use their own language, etc. is often the difficult part to grasp and change for youth/families.

What do youth, family, provider, and system partners look for in data?	
Family	**Youth**
Simple graphs, not lists of numbers, not overly busy with data. Demographics/System involvement: Are these families similar to me and my experience? Clear enough so the untrained eye can easily see the point of the data. Data to show the importance and impact of Family Voice and Choice. Improvement in Family Functioning: How will it make a difference in family life? Education information: Improvement in attendance/performance/discipline. Data to show lower out of home residential placement/youth returning home faster. Family satisfaction: Families found the process helpful and engaging. Good outcomes for youth at home, in school, and in the community.	Simple at-a-glance information, with the choice to dig deeper. Simple graphs, visual elements. The data appeal to a variety of different learning styles. Conveyed through Facebook or other familiar social media platforms. More likely to listen to data if it is coming from a peer. Demographics/System involvement: Are these youth similar to me and my experience? Youth satisfaction: Have other youth found it enjoyable/are they satisfied with outcomes? Good outcomes: How will it make a difference in my life? Will I feel better?
Provider	**System Partners**
Where are referrals coming from? Who is participating in the process/treatment? Can I convince youth/families that they should put the time into the process/treatment? Data to help show youth that were engaged and that it was helpful. Data to show the reduced length of stay in residential placement. Data to show cost savings for providers. Data to convince systems that it is a good investment to increase referrals.	Improved access to care. Lower cost to systems. Data that is tailored to the needs of each system so that the outcomes are meaningful and specific to their needs. Data that they can use to compare to their own system data to increase validity. Cross-system data to show outcomes/cost savings in integrating and coordinating with other systems.

Services Planned / Received Definitions

1. **Modality**

a. ***Case Management****:* Defining, initiating, and monitoring the medical, drug treatment, psychosocial, and social services provided for the client and the client's family.

b. ***Day Treatment****:* A modality used for group education, activity therapy, etc., lasting more than 4 continuous hours in a supportive environment.

c. ***Inpatient/Hospital (other than detoxification)****:* A patient who is admitted to a hospital or clinic for treatment that requires at least one overnight stay.

d. ***Outpatient****:* A patient who is admitted to a hospital or clinic for Treatment that does not require an overnight stay.

e. ***Outreach****:* Educational interventions conducted by a peer or paraprofessional educator face-to-face with high- risk individuals in the client's neighborhood or other areas where clients typically congregate.

f. ***Intensive Outpatient****:* Intense multimodal treatment for emotional or behavioral symptoms that interfere with normal functioning. These clients require frequent treatment in order to improve, while still maintaining family, student, or work responsibilities in the community. Intensive outpatient services differ from outpatient by the intensity and number of hours per week. Intensive outpatient services are provided two or more hours per day for three or more days per week.

g. ***Medication-assisted Treatment:*** Provision of medications for opioid-addicted or alcohol-addicted clients.

For Opioid Addiction

(1) Methadone
(2) Buprenorphine
(3) Naltrexone® (oral)
(4) Vivitrol® (injectable)
(5) Disulfiram®
(6) Acamprosate®

For Alcohol Addiction

(1) Naltrexone® (oral)
(2) Vivitrol® (injectable)
(3) Disulfiram®
(4) Acamprosate® h. *Residential/Rehabilitation*—A residential facility or halfway house that provides on-site structured therapeutic and supportive services specifically for alcohol and other drugs.

i. ***Detoxification****:* A medically supervised treatment program for alcohol or drug addiction designed to purge the body of intoxicating or addictive substances.

(1) ***Hospital Inpatient****:* Client resides at a medical facility or hospital during his/her treatment.

(2) ***Free Standing Residential****:* Patient resides at a facility other than a hospital while treatment is provided.

(3) ***Ambulatory Detoxification****:* Treatment that is performed in a specialized therapeutic environment and is designed to provide both psychological and physiological stabilization to ensure safe withdrawal from alcohol and/or drugs.

j. ***After Care****:* Treatment given for a limited time after the client has completed his/her primary treatment program but is still connected to the treatment provider.

k. ***Recovery Support****:* Support from peers, family, friends, and health professionals during recovery. Includes any of the following: assistance in housing, educational, and employment opportunities; building constructive family and other personal relationships; stress management assistance; alcohol- and drug-free social and recreational activities; recovery coaching or mentoring to help manage the process of obtaining services from multiple systems, including primary and mental health care, child welfare, and criminal justice systems.

l. ***Other*** **(Specify):** Specify any other service modalities to be received by the client.

2. Treatment Services

a. ***Screening****:* A gathering and sorting of information used to determine if an individual has a problem with alcohol or other drug abuse, and if so, whether a detailed clinical assessment is appropriate. Screening is a process that identifies people at risk for the "disease" or disorder (National Institute on Alcohol Abuse and Alcoholism, 1990). As such, screening refers to a brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation. In a general population, screening for substance abuse and dependency would focus on determining the presence or absence of the disorder, whereas for a population already identified at risk, the screening process would be concerned with measuring the severity of the problem and determining the need for a comprehensive assessment.

b. ***Brief Intervention****:* Those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his/her substance abuse/mental illness, either by natural, client-directed means or by seeking additional substance abuse treatment/mental health care.

c. ***Brief Treatment****:* A systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. Brief therapies usually consist of more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from one (1) session (Bloom, 1997) to 40 sessions (Sifneos, 1987), with the typical therapy lasting between 6 and 20 sessions. Twenty sessions usually are the maximum because of limitations placed by many managed care organizations. Any therapy may be brief by accident or circumstance, but the focus is on *planned* brief therapy. The therapies described here may involve a set number of sessions or a set range (e.g., from 6 to 10 sessions), but they always work within a time limitation that is clear to both therapist and client.

d. ***Referral to Treatment****:* A process for facilitating client/client access to specialized treatments and services through linkage with, or directing clients/clients to, agencies that can meet their needs.

e. ***Assessment****:* To examine systematically, in order to determine suitability for treatment.

f. ***Treatment/Recovery Planning****:* A program or method worked out beforehand to administer or apply remedies to a patient for illness, disease, or injury.

g. ***Individual Counseling****:* Professional guidance of an individual by utilizing psychological methods.

h. ***Group Counseling****:* Professional guidance of a group of people gathered together utilizing psychological methods.

i. ***Family/Marriage Counseling****:* A type of psychotherapy for a married couple or family for the purpose of resolving problems in the relationship.

j. ***Co-occurring Treatment/Recovery Services****:* Assistance and resources provided to clients who suffer from both mental illness disorder(s) and substance use disorder(s).

k. ***Psycho-pharmacological Interventions****:* The use of any pharmacological agent to affect the treatment outcomes of behavioral health clients.

l. ***HIV/AIDS Counseling****:* A type of psychotherapy for individuals infected with and living with HIV/AIDS.

m. ***Mental Health Services***: The use of any mental health therapeutic approach to affect the treatment outcomes of behavioral health clients.

n. ***Other Clinical Services*** **(Specify)*:*** Other client services the client received that are not listed above.

3. Medical Services

a. ***Medical Care****:* Professional treatment for illness or injury.

b. ***Alcohol/Drug Testing****:* Any process used to identify the degree to which a person has used or is using alcohol or other drugs.

c. ***HIV/AIDS Medical Support and Testing****:* Medical services provided to clients who have HIV/AIDS and their families.

d. ***Other Medical Services*** **(Specify):** Other medical services the client received that are not listed above.

4. Case Management Services

a. ***Family Services (including marriage education, parenting, and child development services)****:* Resources provided by the state to assist in the well-being and safety of children, families, and the community.

b. ***Child Care****:* Care provided to children for a period of time.

c. ***Employment Services****:* Resources provided to clients to assist in finding employment.

(1) ***Pre-employment****:* Services provided to clients prior to employment, which can include background checks, drug tests, and assessments. These services allow employers to "check out" prospective employees before hiring them.

(2) ***Employment Coaching****:* Provides tools and strategies to clients to assist in gaining employment. These strategies include implementing new skills, changes, and actions to ensure that clients achieve their targeted results.

d. ***Individual Services Coordination****:* Services that families may choose to use when they need help obtaining support for their mentally disabled sons or daughters to live as independently as possible in the community.

e. ***Transportation****:* Providing a means of transport for clients to travel from one location to another.

f. ***HIV/AIDS Service****:* Resources provided to clients to improve the quality and availability of care for people with HIV/AIDS and their families.

g. ***Supportive Transitional Drug-free Housing Services****:* Provides rental assistance for families and individuals who are seeking to be drug-free who can be housed for up to two years while receiving intensive support services from the agency staff.

h. ***Care Coordination***: Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people and that this information is used to provide safe, appropriate, and effective care to the patient.

i. ***Other Case Management Services*** **(Specify):** Other case management services the client received that are not listed above.

5. After Care Services

a. ***Continuing Care**:* Providing health care for extended periods of time.

b. ***Relapse Prevention**:* Identifying each client's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs.

c. ***Recovery Coaching**:* Guidance involving a combination of counseling, support, and various forms of mediation treatments to find solutions to deal with breaking the habit of substance abuse.

d. ***Self-Help and Support Groups**:* Helping or improving oneself without assistance from others; and/or an assemblage of persons who have similar experiences and assist in encouraging and keeping individuals from failing.

e. ***Spiritual Support**:* Spiritual/religion-based support for the clients' recovery process.

f. ***Other After Care Services*** **(Specify):** Other after care services the client received that are not listed above.

6. Education Services

a. ***Substance Abuse Education**:* A program of instruction designed to assist individuals in drug prevention, relapse, and/or treatment.

b. ***HIV/AIDS Education**:* A program of instruction designed to assist individuals with HIV/AIDS and their families with HIV/AIDS prevention and/or treatment.

c. ***Other Education Services*** **(Specify):** Other education services the client received that are not listed above.

7. Peer-To-Peer Recovery Support Services

a. ***Peer Coaching or Mentoring**:* Services involving a trusted counselor or teacher to another person of equal standing or others in support of a client's recovery.

b. ***Housing Support**:* Providing assistance for living arrangements to clients.

c. ***Alcohol- and Drug-Free Social Activities**:* An action, event, or gathering attended by a group of people that promotes abstinence from alcohol and other drugs.

d. ***Information and Referral**:* Services involving the provision of resources to a client that promote health behavior and/or directing a client to other sources for help or information.

e. ***Other Peer-to-Peer Recovery Support Services*** **(Specify):** Other peer-to-peer recovery services the client received that are not listed above.

8. Family and Housing Section Living Situations Definitions

a. ***Place not meant for habitation***: Includes living in a vehicle, an abandoned building, bus/train/subway station/airport, or anywhere outside.

b. ***Staying or living with family/friends***: Includes living in the home of a parent, relative, friend, guardian, caregiver, "couch surfing," and foster home. Adolescents living at home are included if they are not paying a standard rental rate to the homeowner. The family may include the caregiver, who is the owner or renter.

c. ***Transition housing***: Includes living in facilities focused on moving the client to a more independent housing arrangement, excludes living in a group home. Often includes rehabilitative services, community reentry training, and aids for independent living.

d. ***Substance abuse treatment facility or detox center***: Includes living in a medically supervised treatment program for alcohol or drug addiction designed to purge the body of intoxicating or addictive substances.

e. ***Residential Treatment***: Includes living in a medically supervised treatment program for alcohol or drug addiction designed to purge the body of intoxicating or addictive substances.

f. ***Therapeutic Community or Halfway House***: Includes living in moderately staffed housing arrangements for clients. Twenty-four-hour supervision is provided with long-term treatment and support.

g. ***Psychiatric Hospital***: Includes living in a hospital for the care and treatment of patients affected with acute or chronic mental illness and a stay in the psychiatric ward of a general hospital. Exclude veteran's hospitals.

h. ***Long-term care facility or nursing home***: Includes a long-term care hospital environment that provides medical and nursing services, long-term veterans, hospice facilities that provide nursing care, and other institutional facilities.

i. ***Hospital or other residential non-psychiatric medical facility***: Living in any hospital environment (state, county, or private) that primarily provides medical services. Do not count veterans or psychiatric hospitals.

j. ***Permanent supportive housing***: Includes housing supported by subsidies provided through the Veterans Affairs Supportive Housing (VASH) program, HUD-funded subsidies (e.g., public housing, Housing Choice Voucher or "Section 8") or other housing subsidy (e.g., state rental assistance voucher).

k. ***Foster care home or foster care group home***: Includes living in moderately staffed housing arrangements for clients. Twenty-four-hour supervision is provided with long-term treatment and support. Also includes living in a standard foster care arrangement with or without a standard treatment component and living in a private home with care provided by foster care parents.

l. ***Jail, prison, or juvenile detention facility***: Living in lockup and/or holding cells in courts or other locations, in addition to living in a juvenile detention center or "youth only" correctional facility with high structure and supervision.

m. ***House owned/rented by client***: Includes living in a house, apartment, room, boarding house, hotel/motel, a room at the YMCA or YWCA, living in an RV or trailer, single room occupancy or single resident occupancy (a multiple- tenant building that houses one or two people in individual rooms). Excludes living in permanent supportive housing.

n. ***Other (Specify)***: Do not simply record the name of the housing situation; instead, describe the type of housing.

Appendix L

Sample Memorandum of Understanding

MOU for County Leadership and Management Team Membership

Memorandum of Understanding for the
County Leadership and Management Team

I. Purpose

The purpose of this Memorandum of Understanding (MOU) is to create a partnership between _____ and the [COUNTY NAME/RELEVANT AGENCY] System of Care (SOC) Partnership for the purposes of establishing a formal relationship as a member of the SOC County Leadership and Management Team (CLMT).

The primary focus of this agreement is to define the mutual roles and expectations of the above-mentioned agency with regard to their membership on the CLMT.

II. Systems of Care Partnership Concept

[COUNTY NAME] SOC committed to the successful implementation, sustainability, and expansion of service to children and youth ages birth to 21 that have behavioral health needs and their families. These youth are also often involved with child welfare and/or juvenile justice and are in or at risk of out of home placement. The SOC philosophy builds on the benefits of systems integration and the strengths of youth and families. It makes youth and families equal partners at the table in every meeting at every level of decision-making. SOC encourages the motto, “nothing about us without us” and fosters youth and family empowerment while valuing natural community supports increasing self-sufficiency, and decreasing dependency.

[COUNTY NAME] SOC Values:

- □ Youth driven
- □ Strengths-based and Individualized
- □ Evidence-based
- □ Trauma-Informed
- □ Data-Driven
- □ Culturally and Linguistically Competent
- □ Family driven
- □ Home and Community-Based
- □ Natural Helping Networks
- □ County Leadership Team
- □ Multi-System Integration

III. County Leadership and Management Team

The County Leadership and Management Team (CLMT) implements its SOC in [COUNTY NAME]. It is made up of an equal number of youth and family members, who are representative of the population of focus. The CLMT also includes leaders from child-serving systems (e.g., Juvenile Justice, Child Welfare, Mental Health, Drug and Alcohol, Education, Physical Health, and Individuals with Developmental Disabilities), as well as adult systems that support transitions to adulthood. The CLMT meets regularly to make decisions and to develop and implement policies that establish and assure the sustainability of the SOC in [COUNTY NAME].

IV. Partnership

System Partner Team members on the CLMT are expected to attend most CLMT meetings, be contributing members, and partner with other systems, community, and family and youth partners to improve services and supports to youth and families. Members of the CLMT are also expected to read and respond to emails outside of the meeting time and read any relevant materials to inform CLMT discussion. Members are also encouraged to assist with any action items identified by SOC CLMT.

Members should be champions for SOC within their communities and organizations by educating others about SOC and the work of the CLMT, representing the strengths, concerns, and recommendations of the youth and family in the organizations and communities in which they are involved.

In addition to the above responsibilities, as a System Partner member of the CLMT, you agree to:

A. Recruit family and youth members for the CLMT
B. Participate in one sub-committee of the CLMT as necessary
C. Support through promotion, participation, and hosting of SOC Partnership efforts such as public awareness campaigns, community and agency-based trainings, and data collection.
D. Have one vote (per agency) as a voting member of the CLMT.
E. Provide PA Childline clearances, FBI clearances, and a criminal background check to the CLMT.

All team members are encouraged to ask for support and additional training when needed.

County Leadership Team meetings are held once per month at [MEETING VENUE AND ADDRESS]. Meetings typically last [XX] hours. In addition to regular monthly meetings, there are occasional opportunities to participate in fairs, forums, trainings, or other SOC-related events.

V. Term of Memorandum of Understanding:

This MOU shall be in effect of a term of [X] years, effective from [START DATE] through [END DATE]. Annually, the CLMT and the above organization will review the progress and success of the MOU and the SOC Partnership initiative to determine whether the MOU will be extended for an additional term. Nothing in the terms of this MOU shall be deemed to create any agency, employer, or officer relationship between the parties. Each party further agrees to indemnify, defend, and save harmless the other, its officers, agents, and employees.

Name & Title	Organization
Signature	Date

MOU Between School District and Youth Mental Health First Aid

[COUNTY NAME] Memorandum of Understanding (MOU)

I. Purpose:

The purpose of this Memorandum of Understanding (MOU) is to create a partnership between the School District of _____ and the [COUNTY NAME] for the purpose of taking a public health approach to the promotion and implementation of Youth Mental Health First Aid (YMHFA) through the school district staff and the communities they serve.

The primary focus of this agreement will be to train a minimum of one school district staff member to be a certified instructor of YMHFA by the National Council for Behavioral Health. These instructors will provide the training to school district staff, parents, and members of the community.

II. Mental Health First Aid Concept:

YMHFA is a groundbreaking early intervention and public education program that teaches community members how to assist a person experiencing a behavioral health problem. YMHFA teaches the skills needed to identify, understand, and respond to signs and symptoms of behavioral health challenges or crises. First Aid is administered until appropriate treatments, and supports are received or until the crisis is resolved. [COUNTY NAME] plans to train 30 individuals with priority being given to the school districts.

The new YMHFA Instructors will be certified to teach the 8-hour course to a variety of audiences, ranging from teachers, counselors, principals, administrators, paraprofessionals, students, coaches, parents, and community members.

III. [COUNTY NAME]

The [RELEVANT COUNT AGENCY] supports people in an environment of recovery, with a focus on prevention, resilience, wellness, and self-determination in order to attain the highest quality of life possible. [AGENCY] is responsible for administering a broad array of treatment, intervention, and prevention programs for children, adults, and families impacted by mental health, substance use, and intellectual disabilities.

System of Care (SOC) is a set of values and principles that help to guide system improvements in partnership with youth and families. [AGENCY] recognizes the importance and value that school districts provide to our youth and families in [COUNTY NAME], with the goal being to expand the partnership with families by working together to promote YMHFA.

IV. Partnership:

In order that the resources of the parties may be coordinated and used to the fullest advantage in promoting and implementing YMHFA in [COUNTY NAME] both organizations have agreed to the following:

[AGENCY]

a. [AGENCY] will fund a training session for selected instructors to be certified by the National Council on Behavioral Health on [DATES OF TRAINING].
b. [AGENCY] will cover the costs for the training materials for each of this first class of instructors' **initial** training session after certification.
c. [AGENCY] will continue to seek funding opportunities to continue to support the YMHFA initiative within [COUNTY NAME] communities and to assist the school district (SD) goals in promoting YMHFA for their employees and parents of students.

School District

a. Instructors will adhere to all the mandates of the National Council for Behavioral Health; including by not limited to maintaining their certification by providing a minimum of three (3) training in one (1) year.
b. Instructors must provide three (3) training within the year of the anniversary date of certification; two (2) of these training will be given to members of the SD community (focus on parents).
c. SD agrees to notify [AGENCY] with a calendar of training dates (4 weeks prior to the scheduled event) and agrees to provide copies of the roster of attendees within 10 days following the training event. These rosters need to identify the participant's name, contact info (telephone, email address) and identify them as either parent, youth, SD employee, or community partner.

V. Term of Memorandum of Understanding:

This MOU shall be in effect for a term of [X] years, effective [START DATE] to [END DATE]. Six months prior to the termination, the parties shall meet to review the progress and success of the MOU and to determine whether MOU will be extended for an additional term. Nothing in terms of this MOU shall be deemed to create any agency, employer, or officer relationship between the parties. Each party further agrees to indemnify, defend, and save harmless the other, its officers, agents, and employees.

Name (for County)	Name (for School District)
Date	Date

MOU Between County Agency and School

[COUNTY NAME] Department of Behavioral Health and Developmental Disabilities

Memorandum of Understanding (MOU)

I. Purpose:

The purpose of this Memorandum of Understanding (MOU) is to create a partnership between the School District of _____ and the [COUNTY NAME] Department of Behavioral Health and Developmental Disabilities for the purpose of taking a public health approach to the promotion and implementation of Youth Mental Health First Aid (YMHFA) through the school district staff and the communities they serve.

The primary focus of this agreement will be to train a minimum of one school district staff member to be certified instructor of YMHFA by the National Council for Behavioral Health. These instructors will provide the training to school district staff, parents, and members of the community.

II. Mental Health First Aid Concept:

YMHFA is a groundbreaking early intervention and public education program that teaches community members how to assist a person experiencing a behavioral health problem. YMHFA teaches the skills needed to identify, understand, and respond to signs and symptoms of behavioral health challenges or crises. First Aid is administered until appropriate treatments, and supports are received or until the crisis is resolved. XYZ County plans to train 30 individuals with priority being given to the school districts.

The new YMHFA Instructors will be certified to teach the 8-hour course to a variety of audiences, ranging from teachers, counselors, principals, administrators, paraprofessionals, students, coaches, parents, and community members.

III. XYZ County Department of Behavioral Health and Developmental Disabilities:

The Department of Behavioral Health and Developmental Disabilities supports people in an environment of recovery, with a focus on prevention, resilience, wellness, and self-determination in order to attain the highest quality of life possible. COUNTY NAME is responsible for administering a broad array of treatment, intervention, and prevention programs for children, adults, and families impacted by mental health, substance use, and intellectual disabilities. COUNTY NAME received a grant from the state to support a System of Care initiative in XYZ County.

System of Care is a set of values and principles that help to guide system improvements in partnership with youth and families. COUNTY NAME recognizes the importance and value the school districts provide to our youth and families in XYZ County, with the goal being to expand the partnership with families by working together to promote YMHFA.

IV. Partnership:

In order that the resources of the parties may be coordinated and used to the fullest advantage in promoting and implementing YMHFA in XYZ County both organizations have agreed to the following:

County Name

a. COUNTY NAME will fund a training session for selected instructors to be certified by the National Council on Behavioral Health on [DATE(S)].
b. COUNTY NAME will cover the costs for the training materials for each of this first class of instructors' **initial** training sessions after certification.
c. COUNTY NAME will continue to seek funding opportunities to continue to support the YMHFA initiative within the XYZ County communities and to assist the SD goals in promoting YMHFA for their employees and parents of students.

School District

a. Instructors will adhere to all the mandates of the National Council for Behavioral Health; including by not limited to maintaining their certification by providing a minimum of three (3) trainings in one (1) year.
b. Instructors must provide three (3) trainings within the year of the anniversary date of certification; two (2) of these trainings will be given to members of the SD community (focus on parents).
c. SD agrees to notify COUNTY NAME with a calendar of training dates (4 weeks prior to the scheduled event) and agrees to provide copies of the roster of attendees within 10 days following the training event. These rosters need to identify the participant's name, contact info (telephone, email address) and identify them as either parent, youth, SD employee, or community partner.

V. Term of Memorandum of Understanding:

This MOU shall be in effect for a term of three years, effective [START DATE] to [END DATE]. Six months prior to the termination, the parties shall meet to review the progress and success of the MOU and to determine whether MOU will be extended for an additional term. Nothing in terms of this MOU shall be deemed to create any agency, employer, or officer relationship between the parties. Each party further agrees to indemnify, defend, and save harmless the other, its officers, agents and employees.

_____	_____
Name (for County)	Name (for School District)
_____	_____
Date	Date

MOA with Youth Mental Health First Aid Trainer

Memorandum of Agreement

This Memorandum of Agreement is made on [DATE] by and between [COUNTY NAME] System of Care (SOC) Initiative and _____ (Youth Mental Health First Aid Trainer/ PA SOC Partnership).

The [COUNTY NAME] SOC whenever, and however, strives to improve the systems, services, and staff for the community's success by facilitating the voices of youth and families in the child-serving system.

Youth Mental Health First Aid (YMHFA) trainers are committed to working with the System of Care to accomplish this goal. Furthermore, a YMHFA trainer agrees to work in partnership with the SOC Initiative, youth and family members toward creating a holistic and barrier-free community for youth and families to succeed and be heard by adhering to the following conditions:

Goals and Objectives:

This Memorandum of Agreement affirms that [COUNTY NAME] SOC Initiative and the YMHFA trainer will collaboratively work on creating a holistic and barrier-free community for youth and families through mental health awareness training/education.

Roles and Responsibilities:

Trainer:

- Trainer will provide two (2) Youth Mental Health First Aid full-day trainings
- Trainer will provide materials, handouts/ books for the training
    - Approved costs associated with the materials will be invoiced to:
      [COUNTY AGENCY]
      ATTN: [CONTACT NAME FOR BILLING]
      Address 1:
      Address 2:
- Trainer will provide Certificates of Completion for the courses.

[COUNTY NAME] SOC:

- SOC Project Director will secure the dates, times and locations as follows:
  Name of Venue:
  Address 1:
  Address 2:
  Time:
- SOC Project Director will market the trainings event throughout [COUNTY NAME] and track registration of participants.

Term:

The term of this Agreement will end upon the completion of the training(s) on [DATE]. It is renewable upon mutual consent.

Statement of Understanding:

As a YMHFA trainer in [COUNTY NAME], I understand that my voice, expertise, and experience are valued and respected as I work in partnership with others. I understand that open discussion by training participants is crucial to the learning process, and I will treat all participants with respect. I understand that any information (personal or professional) acquired from open discussions will be kept confidential.

Trainer Name (printed)	SOC Project Director (printed)
Trainer Name (signature)	SOC Project Director (signature)
Date	Date

MOU Between County Human Services and School District

Memorandum of Understanding Between

[COUNTY NAME] Human Services and [SCHOOL DISTRICT]

The [COUNTY NAME] Human Services Department hereby enters into this *Memorandum of Understanding* with the [SCHOOL NAME], [ADDRESS], hereafter referred to as School District, for the purpose of providing a three-part Trauma-Informed Care Training program, entitled "Neurologic" for school district personnel.

Agreement Date: [DATE]

Background: The [COUNTY NAME] Human Services Department is a current grant recipient for the Systems of Care (SOC) initiative, which has the ultimate goal of improving behavioral health outcomes for children and youth (birth-21). The [COUNTY NAME] SOC has identified the practice of Trauma-Informed Care as a method to improve behavioral health outcomes for youth. Research shows that at least 67% of the population has experienced at least one adverse childhood experience. Trauma-based adversities can lead to a multitude of toxic physical, mental, and social outcomes throughout a person's lifetime. In order to assist [COUNTY NAME] 's education system in understanding Trauma-Informed Care, a three-part training package, entitled "Neurologic" has been designed by the Lakeside Education Network and is being offered to selected school districts through [COUNTY NAME] Human Service's System of Care.

The Neurologic training package will include:

4-Hour Intensive Training: Training will include Brain Basics, Introduction to Trauma, and The Trauma-Informed Classroom. The Brain Basics section will teach participants about the levels of the brain, cortical modulation, and brain plasticity. The Introduction to Trauma will define trauma, Adverse Childhood Experiences (ACE's), and discuss how common they occur. The training will then focus on the impact of trauma and ACE's on students' brains academically, behaviorally, and relationally and why it is important for educators to acknowledge trauma. The Trauma-Informed Classroom will focus on the practicalities of working with those impacted by trauma and ACE's, and will specifically cover areas of regulation, relationships, and reason. [Cost: $4,000.00]

Web-Based Monthly Coaching: The Monthly Coaching sessions will occur remotely, with the coach being projected live for group interaction. During the hour-long session, the coach may teach a brief lesson, review of information, and/or share new interventions and strategies. The session will provide an opportunity for participants to ask questions and discuss specific student issues and scenarios. A maximum of nine (9) sessions, one-hour each session, will be provided. [$500.00 per hour, $4,500.00 maximum]

Pre-Recorded Video Sessions: A series of eight (8), one-hour sessions that will build upon the information from the 4-hour Intensive Training and introduce new strategies and interventions. The videos are designed for small groups but are able to be accessed individually. Each school district will be provided with a username and password that can be shared with staff. [$2500 for package of eight pre-recorded video sessions]

[SCHOOL NAME] has been selected to participate in Neurologic, a Trauma-Informed Care training program designed for schools. [SCHOOL NAME] has demonstrated a commitment to providing the Neurologic curriculum to district personnel and agrees to comply with the requirements outlined below.

[SCHOOL NAME] Agrees to:

1. Designate a contact person that will be responsible for the coordination of the various training components. The designated contact person is: _____ . Email address: _____ Telephone number: _____.
2. Designate a contact person that will be responsible for the reporting requirements described in further detail below. The designated contact person is: _____ . Email address: _____ Telephone number: _____.
3. Participate in a debriefing session with [COUNTY NAME] Human Services after the training package is complete. Topics of discussion will include: Strengths of the Neurologic curriculum, areas of improvement, practice or policy changes that will occur as a result of the program, feedback on the format, etc.
4. Reimburse [COUNTY NAME] Human Services for any costs associated with the various training components enumerated below in the event the training is not delivered in accordance with the agreement.

For the 4-Hour Intensive Training, [SCHOOL NAME] Agrees to:

5. Ensure that no less than 45 employees participate in the training.
6. Require that all participants sign-in for the training and provide [COUNTY NAME] Human Services with a copy of the sign-in form, including name and position, within 72 hours after the completed training.
7. Provide [COUNTY NAME] Human Services with a summary of the training, including the number of attendees, aspects of the training that worked well, and aspects of the training that can be improved. The summary should be sent to Human Services within 72 hours after the completed training.
8. Administer an electronic survey to all training participants within one business day after the training. The survey will be created by [COUNTY NAME] Human Services, and a link to the survey will be provided to the designated School District contact prior to the training date.

For the Web-Based Monthly Coaching, [SCHOOL NAME] Agrees to:

9. Ensure that 15-20 employees participate in each monthly coaching session.
10. Ensure that at a minimum, one [1] Student Assistance Program (SAP) leader will partake in each web-based monthly session.
11. Host monthly web-based coaching calls that will last one (1) hour per each session for a maximum of nine (9) sessions. The dates of the web-based monthly coaching calls will be coordinated by [COUNTY NAME] Human Services with the School District and the Lakeside Education Network.
12. Ensure that required audio/visual equipment will be available and utilized for the web-based coaching sessions and meets minimum specifications as outlined in Attachment A.
13. Require that all participants sign-in for the monthly coaching session via a sign-in form, including name and position, and provide [COUNTY NAME] Human Services with a copy of the sign-in form, including name and position, within 72 hours of the completed training.
14. Provide [COUNTY NAME] Human Services with a brief summary of each session, outlining the number of participants, topics, and solutions discussed during the coaching session within 72 hours of the completed training.
15. Pay any costs over the contracted amount of $500/hour to Lakeside Education Network if the session exceeds the designated time limit of one (1) hour per each session.

For the Pre-Recorded Video Sessions, [SCHOOL NAME] Agrees to:

16. Convene small groups to watch and discuss the eight (8) video sessions.
17. Provide [COUNTY NAME] Human Services with a schedule in which the small groups will convene for each one of the pre-recorded sessions.
18. Ensure that at a minimum 20 staff members watch each pre-recorded video session.
19. Provide [COUNTY NAME] with a sign-in sheet, including name and position, for each small group convened. The sign-in sheet should contain: Video Name/ #, the date, names, and signatures of participants. Provide sign-in sheets to [COUNTY NAME] Human Services on a monthly basis.
20. Track the number of participants who watch the videos on an individual basis. Provide [COUNTY NAME] Human Services with a tracking summary on a monthly basis that includes: Video Name/#, the date it was watched, and participant's name.

[COUNTY NAME] Human Services:

1. Agrees to fund the training program funded in accordance with this agreement.
2. Agrees to designate a lead contact person that will work with the School Districts leads to coordinate scheduling and collect reporting requirements. The designated lead/contact person is: _____. Email address: _____. Telephone #: _____.
3. Will coordinate the 4-Hour Intensive Training, and the Web-Based Monthly Coaching Sessions dates between the School District and Lakeside Education Network.
4. Will provide the School District contact with a link to the survey that will be completed after the 4-hour Intensive Training.

5. Will provide the School District with a username and password for the Pre-Recorded Video Sessions that can be shared with staff.
6. Reserves the right to recoup any training costs from the School District for any part of the training that is not delivered in accordance with the agreement.

[COUNTY NAME] COMMISSIONERS:

_____	_____
[COUNTY NAME] President Commissioner	DATE
_____	_____
[COUNTY NAME] Commissioner	DATE
_____	_____
[COUNTY NAME] Commissioner	DATE
_____	_____
[COUNTY NAME] Administrator/Chief Clerk	DATE

[COUNTY NAME] HUMAN SERVICES:

_____	_____
Executive Director	DATE

SCHOOL DISTRICT SUPERINTENDENT:

_____	_____
Superintendent	DATE

MOA Between County and Lakeside Global

Memorandum of Agreement

This Memorandum of Agreement is made on [DATE] by and between the [COUNTY NAME] System of Care (SOC) Initiative and [COUNTY AGENCY].

The [COUNTY NAME] SOC Initiative is committed to developing a seamless system of care for children, youth, and their families, in collaboration with system partners and provider partners. [COUNTY AGENCY] is committed to working with [COUNTY NAME] SOC to accomplish this goal. The parties will agree to work toward creating unified systems by adhering to the following conditions:

Goals and Objectives

This Memorandum of Agreement confirms that the [COUNTY NAME] SOC and [COUNTY AGENCY] will collaboratively work on building a unified System of Care.

Obligations of the Parties

The [COUNTY NAME] SOC will contract with Lakeside Global to provide ongoing trainings through [DATE]. This Memorandum of Agreement includes:

1. Trauma 101: An Overview of Trauma-Informed Care (2-hour workshop)
2. Trauma 102: Basic Skills of Trauma-Informed Care (2-hour workshop)
3. Trauma 103: Recognizing Vicarious & Secondary Trauma for Caregivers (2-hour workshop)
4. Trauma 105: An Introduction to Trauma for Parents & Caregivers (2-hour workshop)
5. Trauma 106: An Introduction to Trauma for Youth (2-hour workshop)

To ensure that each party's available resources are coordinated to maximize promotion and implementation of Trauma-Informed trainings for [COUNTY AGENCY], County/Agencyboth organizations have agreed to the following:

[COUNTY NAME] SOC Initiative

a. Will fund [X NUMBER OF] training session(s) for Lakeside Global to provide Trauma-Informed Workshops.
b. Will cover the costs for the Trauma-Informed training materials for each training.

[COUNTY AGENCY]

c. We will recruit and advertise the training in [COUNTY AGENCY to help fill each workshop.
d. As appropriate, we will seek out youth and/or family members to attend trainings.
c. Will provide a room for the training, and offer, if possible, bottled water and light prepackaged snacks (e.g., granola bars, healthy snack packs) for the trainees.
d. Will have each attendee complete a sign-in sheet provided or approved by the [COUNTY NAME] SOC Initiative and returned to [SOC CONTACT NAME] at [SOC CONTACT EMAIL] within 10 business days after the training.
e. Agrees to post-training evaluation as part of a continuous quality improvement program.

Term

The term of this Agreement shall be effective from [START DATE] to [END DATE] and renewable upon mutual consent.

Director, [COUNTY NAME] SOC (printed)	Agency Representative (printed)
Director, [COUNTY NAME] SOC (signature)	Agency Representative (signature)
Date	Date

Appendix M

Sample Policies

Below are two samples of PA Care Partnership policies. For an extensive selection of policy documents, please use the URL links in the Resources section of this toolkit.

PA Care Partnership Consultation Compensation Policy

Pennsylvania (PA) CARE Partnership
Consultation Compensation Policy
Policy #001

Purpose:
The PA Care Partnership (the Partnership), its system partners, and qualified youth and family with lived experience each benefit from a collaborative process in which there is shared participation in program development, implementation, evaluation, learning, and governance. This policy outlines amounts and eligibility for youth and family consultation payments.

Those who are receiving consultation compensation are not employees of the PA Care Partnership, and they will be paid a set amount based on the time at meetings or events in support of the Partnership. Payment will be approved in advance by the Director of the Pennsylvania Care Partnership or designee.

Objective:
The PA Care Partnership encourages youth and family members to be active participants in the development of the Partnership through participation in the State Leadership and Management Team and attendance at meetings, conferences, sponsored events, and interviews. Youth and family involvement is valued because:

- Family members provide expertise about the realities of raising a child or young adult with behavioral health, substance use, or co-occurring issues.
- Youth provide expertise about living with and managing their behavioral health, substance use, and co-occurring issues.
- Mutual sharing and learning among system partners, family members, and youth creates a unique and worthwhile partnership that enhances the work of the Partnership.

Definition:
A Consultation Compensation is a payment provided to a family or youth member as an acknowledgment of the value of their time and expertise. Youth and family members who attend State Leadership and Management Team meetings and/or participate in select committees or other approved activities are eligible to receive a consultation compensation for the time spent in these activities. Family members and youth are not eligible for consultation compensation if their employing organization supports their participation in Partnership activities, and they are receiving their regular wage during this time.

- Meetings: A “Meeting” refers to sitting on a Board/Committee/Workgroup where the individual is assigned/ approved by the Director of the PA System of Care Partnership or designee.
- Trainings: Attending a County/State-sponsored training initiative where the individual is considered a partner, participant, or co-trainer.
- Presentation: A presentation is considered when a youth or family, at the request or for the Partnership, is asked to discuss, share, or express personal or gained knowledge on a subject to a group of individuals.
- The Partnership has the sole responsibility for the implementation of this policy. Payment of the consultation compensations is paid only if funds are available through the PA System of Care Partnership, and the required documentation has been submitted by the youth or family member requesting the consultation compensation.
    - ❖ Required documentation
        - ➢ Completed reimbursement request form
        - ➢ Mapquest or other printable map that will support mileage reimbursement
        - ➢ Receipts for tolls, parking, hotel, meals any costs for which the youth or family member is requesting reimbursement.
- The Partnership will ensure that youth and family members are aware of this policy prior to their participation.
- Youth and family members will complete a letter of agreement (prior to participation), which outlines the expectations and requirements of participating on any committee or for an approved activity that may result in payment of a consultation compensation.
- The process and necessary paperwork for receiving a consultation compensation will be explained to eligible youth and family members. A sample reimbursement form is attached to this policy.
- The Partnership will identify and select youth and family members to participate in related activities, as needed, based on development criteria, interests, and qualifications.
- The Partnership reimbursement of consultation compensation amounts and other reimbursable costs to the youth and family member will be paid after all documentation is completed and approved.
- The Director of the Partnership has the authority to approve or deny payment on consultation compensation.

Approved Youth and Family Involvement activities:

The following activities are considered eligible for reimbursement:

- State Leadership and Management Team (SLMT)
- SLMT subcommittee and ad hoc committee meetings
- Other approved meetings and conferences
- Interviews of candidates for the Partnership positions
- The Partnership training sessions to which SLMT members are invited
- Other committee(s) participation at the description of the Partnership
- If asked to present information or train others about the SLMT or the Partnership
- If asked to attend training sessions on behalf of the SLMT or the Partnership

Other considerations include:

- If Partnership invites the youth or family member to attend/present at a conference or event on behalf of the Partnership, conference/event costs, meals, and travel reimbursement will be provided by the Partnership.

- If the youth or family member receives a scholarship to an approved/relevant conference or event, and the Partnership has funding available, the youth or family member can ask for travel and meal reimbursement.
- If the youth or family member receives a scholarship to a conference or event and is presenting on behalf of the Partnership, a consultation compensation will be given as well as travel and meals.

Exclusions:

The Partnership will not pay a consultation compensation for the following:

- If the youth or family member personally chooses to attend a conference or event, they are not eligible for consultation compensation, conference/event costs, meals, and travel reimbursement.
- Attendance at any meeting, educational event, or support group relating to the family members' own child/children or to the youth's own care/treatment.
- Any meeting or event not pre-approved by the Partnership Director.
- Travel time
- Mealtime (unless a working lunch is part of the agenda)
- Overnight time (if applicable)
- Meetings with legislative representatives and/or their staff
- If the SLMT member is being paid by their supporting employer for eligible time invested.

Consultation compensation amounts:

Based on the availability of funds, consultation compensations will be provided in the following increments:

- **$12** per hour for meetings, trainings, assignments, etc.
- **$20** per hour for presentations on behalf of the PA System of Care Partnership, and presentation preparation

Reimbursements are also available for dependent care and must be pre-approved by the Partnership Director.

- Dependent care is $10.00 (Ten dollars) per hour, with a maximum dependent care consultation compensation of $40.00.

Travel Amounts:

Based on the availability of funds, mileage will be reimbursed based on the current U.S. General Services Administration mileage rate.

Meal Reimbursement:

Based on the availability of funds, reimbursement for meals will be provided.
Meals are reimbursable up to $60.00 a day for overnight travel

- If meals are provided as part of the training or conference, additional meals purchased during the provided meal will not be reimbursed.
- If meals are not provided for a meeting between Monday and Friday, reimbursement is allowable with a receipt at the following rates:
    - Breakfast, Lunch, and Dinner up to $60.00 (sixty dollars) per day.
- Alcohol is unallowable and is not reimbursable.

Lodging Reimbursement and Reservations:
Based on the availability of funds, hotel reservations for meetings and events will be made and paid for by the Partnership.

Taxes:
Youth and family members who accrue more than $600.00 (six hundred dollars) per year in consultation compensations will have a 1099 Tax Form sent to them by UPMC/University of Pittsburgh by January 31 of the following year. Travel reimbursement is not taxable, so it will not be included in the $600.00 maximum to generate a 1099. It is the responsibility of the youth or family member to report this income on their federal, state, or local tax filings as applicable.

Youth and family members can elect to stop receiving consultation compensations at any point during the year before they accrue a total of $600.00 (six hundred dollars) in reportable compensation.

Youth and family members who elect to not receive a consultation compensation from a Partnership activity will still be reimbursed for travel, lodging, and childcare.

Interpretation:
The Partnership is responsible for the official interpretation of this policy. Questions regarding the application for this policy should be directed to the Partnership director.

Authority
The Partnership has sole responsibility for the implementation of this policy. Reimbursement by the Partnership toward childcare cost is dependent on the availability of funds.

Signed: _____
Mark Durgin, Director, Pennsylvania System of Care Partnership

PA Care Partnership Reimbursement Form

PA CARE Partnership Reimbursement Form

Date of Event: _____ Name of Event: _____ Meeting Length: _____

Host of the Event (circle one): PA System of Care Partnership

Type of Event :
☐ Meeting (Face to face) ☐ Conference (In-person) ☐Interview ☐ Presentation

Name: _____

Address: _____
_____
_____

Phone: _____ Social Security Number: _____

Total Miles (with supporting documentation): _____Toll Amounts (with receipts):_____

Parking: _____ Meal Total (receipts must be provided): _____

Dependent Care ($10 per hour, circle one): 1 hour 2 hours 3 hours 4+hours

Consultation compensation for Event (Enter Total Hours): @$12.00/Hr____@$20.00/Hr _____

Signature of Requestor: _____ Date Submitted: _____

WePay Card Admin. Number (back of card lower right): _____ PIN: _____
****** Card Admin Number is required for all reimbursements ******
Card Security Code (3-digit number back of card right of signature):_____

Please note the following:

- All mileage is calculated via MapQuest
- Reimbursement for meals is determined by length of travel
- Dependent care must be pre-arranged
- All reimbursements are based upon available funding and subject to director or designee approval
- Receipts must be submitted for all requested reimbursements. No reimbursement will be paid without a receipt. All receipts must be received within 30 days of the event.

To be completed by event host:
Date Received by Host: _____
Date Processed by Event Host: _____

REIMBURSEMENT FORM INFORMATION

It is important for all the event information and reimbursement requests to be fully completed. This will ensure reimbursement and paying in a timely manner routed and paid. Please submit within 30 days.

PERSONAL INFORMATION

- Address: Requestors home address
- Phone: Best contact phone number
- Social Security Number: Complete number is required

REIMBURSEMENT INFORMATION

Mileage Total: The total miles for which you are requesting reimbursement with MapQuest backup. If you wish to email this, please feel free to do so. Go to MapQuest, click on directions, and enter starting and ending addresses.

Toll Amount: The total amount of tolls, with receipts, for which you are requesting reimbursement.

Dependent Care: The total amount of pre-approved dependent care for which you are requesting reimbursement.

Consultation Compensation for Event: Consultation compensation is determined by meeting time only. Travel time cannot be included.

Meal Total: Total amount of meals for which you are requesting reimbursement. If meals have not been provided, reimbursement up to $60.00 per day is reimbursable for overnight travel Monday – Friday, with receipts. If no meals are provided for overnight travel on the weekend, then breakfast, lunch, and dinner are reimbursable with receipts.

- Will not provide consultation compensation for unapproved conference attendance
- Will not provide consultation compensation for phone calls
- Will not provide consultation compensation for travel time

WEPAY CARD INFORMATION

WePay Card Admin Number: Seven-digit number on the lower right backside of the card (this is required on all forms)

PIN: Four-digit number of the recipient's choice (this is required if being issued a new card).

Card Security Code: Three-digit number to the right of the signature backside of the card (this is required if being issued a new card).

PLEASE NOTE:

- Before submitting a request for reimbursement, please make sure the form has been completed, and the supporting documentation is attached.
- Reimbursements will be made according to the supported items on the request.
- We cannot guarantee reimbursement if requested after 30 days of the event.

Appendix N

Sample Social Media Policies

Adapted from the Substance Abuse and Mental Health Services Administration sample social media guidelines for Mental Health Awareness Day events.

Background

For the purposes of these sample social media guidelines, social media is defined as any online publication and commentary outside of websites and e-newsletters. This includes blogs or social networking sites such as Facebook, Twitter, Instagram, LinkedIn, Snapchat, YouTube, TikTok, etc.

Publication and commentary on social media carries similar obligations to any other kind of organization publication or commentary. These sample social media guidelines are based on best practices and can be customized to meet your unique strategies and needs. Bear in mind that social media platforms regularly update their policies and procedures, and the guidance below may not be up to date.

Digital Team

Your digital team should be the only people with access to (and permission to post to) your social media accounts. List your digital team members' names and roles. You may also want to consider including cell phone numbers for each member of the team so that you can be in contact outside of office hours if the need arises.

Social Media Accounts

Make a list of your social media accounts (Twitter, Facebook, etc.) that includes the profile name and URL for that account, as well as the name of the team member(s) responsible for managing each account. When managing multiple team users, remember that some social media platforms will have one global login/password (such as Twitter and Instagram) while others (Facebook and LinkedIn) allow for personal accounts to be connected under approved roles for the page by the account's existing admins. This means that you will have to share login/password information to your official Twitter and Instagram accounts with your team. However, on Facebook and LinkedIn, your organization's account can be accessed through your team's personal social media accounts, leaving your master login/password known to only a select few.

Tip: Social media publishing tools can also help manage multiple user accounts with different access levels. For example, Hootsuite allows you to have multiple team members access an official account without having to share the login/passwords.

Sample Social Media Guidelines

Opening New Social Media Accounts

Profiles on social media platforms should be connected to and complement your overall web presence and support your communication and marketing strategies and branding.

Adjusting Profile Settings and Passwords

Only members of your digital team can adjust social media account settings or change passwords. Login details and passwords should not be shared with other team members without the written permission of one of the digital team members.

Tip: For social media platforms that require authorized users, it is important to periodically remove individuals from the list who no longer need access.

Disclaimers

It is a good idea to include a disclaimer on your online properties that indicates that your material is not in any way a substitute for obtaining professional help. You also may want to provide additional resources for individuals who may be in crisis or need assistance, such as the National Suicide Prevention Lifeline 1-800-273-8255.

Tip: If your teams are actively and directly engaging with audiences on social media, prepare evergreen messages for seeking help that can be posted for various crisis situations.

Privacy Issues

Social media encourages candid dialogue, but that candor should not imply permission to publish confidential information such as personal details about local youth or any information that might compromise someone's physical, social, or emotional well-being. The protection and safety of youth is paramount. To avoid revealing children's identities, consider using an avatar image online—and never reveal his or her full name. Be respectful of children and youth at all times.

Protecting User Privacy

Privacy settings on social media platforms should be set to allow anyone to see profile information similar to what would be on your website. Other privacy settings that might allow others to post information or see personal information should be set to limit access. Be mindful of posting information that you would not want the public to see.

Copyright Laws

SAMHSA makes many resources copyright free which enables the public to use, publish, and distribute these resources as needed. You might also look at the copyright-free resources available through other federal agencies, state agencies, or national nonprofits.

Other online materials may be covered by copyright, and it is important that you determine whether or not the material you plan to use has been copyrighted, which would preclude using it without permission. This includes videos, print materials, and photos—particularly when used on social media platforms such as Pinterest. Do not quote more than short excerpts of someone else's work, and always attribute such work to the original author/source. It is a good general practice to link to others' work rather than reproduce it.

Developing Messages and Content

To boost interest and engagement in social media, messages should be relevant, short, and simple. Relevance means that your message matters to the audience reading it.

The best way to be interesting, stay out of trouble, and have fun is to write about what you know. There is a good chance of being corrected by an expert if you write about topics you are not knowledgeable about. The speed of being able to publish your thoughts is both a great feature and a great downfall of social media. The time to edit or reflect must be self-imposed. If in doubt about a post, either let it sit and look at it again before publishing it or ask someone else to look at it first.

Remember that quality matters. Use a spell checker before sending out messages. If you include visual images and you're not a strong designer, ask someone with this background for advice on how to improve your visuals. Be mindful of message length. Twitter has a 280-character limit and new allowances for retweeting, tagging photos, and direct replies that don't count against the character count. On Instagram, it is a common practice to use multiple hashtags, each of which can be searched by users. Facebook has very generous character limits, but once over approximately 450 characters, your message will be truncated with a "See more" clickable option. LinkedIn is similar to Facebook in that once you are over approximately 200 characters, your message will be truncated.

Managing Personal and Professional Social Media Accounts

Do not use the same Internet browsers for both professional and personal social media engagement. Mixing professional and personal social media accounts or tools on similar management systems (such as TweetDeck or Hootsuite), devices (smartphone), and web browsers increases the possibility of messages being accidentally sent through the wrong account. For example, use Google Chrome for your organization's accounts and Firefox for your personal accounts. You can also use different social media management systems to keep personal and professional activities separate. For example, use Hootsuite for your organization's social media engagement and TweetDeck for your personal social media engagement.

Community Management and Monitoring Messages

Keeping an eye on the social media conversation is an important part of successful social media engagement and protecting your organization's brand in the social media universe. Because social media is always on, it is important to implement processes and tools to monitor the conversation and direct messages and responses from your followers during the week, evening, and weekends. Consider using an affordable online tool such as Tweetreach or Meltwater. More expensive options are NUVI, Radian6, and Sysomos.

Correcting Errors

Mistakes happen. If you make an error, be upfront about your mistake and correct it quickly. If you choose to modify an earlier post, make it clear that you have done so. If someone accuses you of posting something improper (such as copyright infringement or defamatory remarks), deal with it quickly. Better to remove it immediately, apologize if necessary, and lessen the possibility of legal action.

Responding to Comments and Replies

Your comments should reflect the policies of your jurisdiction as well as the SOC values of being youth-guided, family-driven, and linguistically and culturally competent. Comments should be fact-based and should not disparage any person or entity. Do not use ethnic slurs, insults, or comments that disparage political or religious beliefs. When confronted with a negative public or private post, proceed with respect and caution. Provide factual information when possible and use your best judgment when responding to followers' comments, questions, and posts. If you have any doubt, check with your supervisor or communication officer for review and/or approval of your proposed response. If the comment or message is antagonistic or argumentative, it may be best to not respond, unless that would be hurtful to your brand.

Sharing Links

Retweeting, linking, and “liking” on various social media platforms implies endorsement. Use your best judgment when interacting with organizations and individuals online. When linking to other content, be sure to check the links not only to ensure that they are working, but also to ensure the appropriateness of the content being linked to.

Creating and Leveraging Hashtags

Include relevant hashtags on Twitter, Pinterest, and Instagram messages when appropriate. Look at the hashtags used by accounts you follow and/or conduct a Google search to identify relevant and frequently used hashtags. From there, develop your own list of hashtags to include in your posts. Examples might include:

- #HeroesofHope
- #mentalhealthmatters
- #SAMHSA
- #mentalhealth
- #hope4mh

If you are planning to use a hashtag that is not currently on your frequently used list, make sure to search that hashtag on the social media platform, as well as consult Hashtags.org or Twazzup.com to see how the hashtag is being used and confirm that it will enter the message into relevant conversations.

Tracking and Reporting Engagement

Evaluation is the best way to ensure growth and increased visibility for your content. Work with your digital media team to determine and establish benchmarks prior to your engagement and then use recommended methods of tracking to evaluate engagement and report findings to the team.

Appendix O

Commonly Referenced Acronyms

Below is a list of common acronyms used by child and youth serving systems.

A

ACMH	Association for Children's Mental Health
ACSW	Association of Certified Social Workers
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AFDC	Aid for Dependent Children
AMI	Alliance for the Mentally Ill
AOPC	Administrative Office of Pennsylvania Courts
ASI	Addiction Severity Index

B

BDAP	Bureau of Drug and Alcohol Programs
BDAP CIS	Bureau of Drug and Alcohol Programs' Client Information System
BH	Behavioral Health
BHEF	Behavioral Health Encounter File
BH-MCO	Behavioral Health Managed Care Company
BHRS	Behavioral Health Rehabilitation Services for Children and Adolescents
BIP	Behavior Intervention Plan
BSU	Base Service Unit

C

CAC	Certified Addictions Counselor
CAO	County Assistance Office
CARE	Child and Adolescent Re-evaluation Team
CAS	Children's Aid Society
CASSP	Child and Adolescent Service System Program

CAT	Confrontation Avoidance Techniques
CAU	County Administrative Unity
CCC	Children's Coordinating Council
CCCT	Community Case Coordination Team
CCRS	Consolidated Community Reporting Service (State report)
CCYA	County Children and Youth Agency
CER	Comprehensive Evaluation Record
C/FST	Consumer/Family Satisfaction Team
CIS	Client Information System
CISC	Children in Substitute Care
CLA	Community Living Arrangements
CLC	Cultural and Linguist Competence
CMH	Community Mental Health
CMHS	Center for Mental Health Services
CMHSBG	Community Mental Health Services Block Grant
CMHSP	Community Mental Health Service Provider
CMS	Center for Medicare and Medicaid Services
COB	Coordination of Benefits
COP	Community of Practice
COR/SCRIP	Coordinated School Community Intervention Program
CPA	Commonwealth Prevention Alliance
CPS	Child Protective Services
CQI	Continuous Quality Improvement
CRF	Community Residential Facility
CRR	Community Residential Rehabilitation
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CSI	Consumer Satisfaction Instruments
CSR	Continuing Stay Review
C-STAP	Consumer Satisfaction Team Alliance of Pennsylvania
CSW	Certified Social Worker

D

DAP	Disability Advocacy Program
DASPOP	Drug and Alcohol Service Providers of Pennsylvania
DCH	Department of Community Health
DMIRS	Data Management Information and Retrieval System
DOH	Department of Health
DOI	Department of Insurance
DPH	Department of Public Health
DPW	Department of Public Welfare
DSH	Disproportionate Share
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
DUR	Drug Utilization Review

E

ECC	Electronic Claims Capture
ECM	Electronic Claims Management
ECT	Electro-Convulsive (Shock) Therapy
EI	Early Intervention
EMC	Electronic Media Claims
EMS	Emergency Medical Services
EPDST	Early Periodic Screening, Diagnosis and Treatment
EPS	Extra Pyramidal Side Effects
EVS	Eligibility Verification System

F

FA	Fiscal Agent
FB	Family-Based
FBMHS	Family-Based Mental Health Services
FCN	Family Care Network
FD/FSS	Family-Driven/Family Support Services
FFS	Fee-for-Service
FIA	Family Independence Agency (formerly DSS)
FLP	Family Living Program

FOC	Family Outreach Center
FQHC	Federally Qualified Health Center
FRR	Financial Reporting Requirements
FSIQ	Full Scale I.Q. Test
FSS	Family Support Systems
FST	Family Satisfaction Team
FTE	Full Time Equivalent

G

GA	General Assistance
GAF	Global Assessment of Functioning (Axis of DSM)
GAS	Global Assessment Scale or Goal Attainment Scaling
GPS	General Protective Services
GS	Gifted Support
GTC	General Terms and Conditions

H

HBP	Health Beginnings Plus
HC	HealthChoices
HCCU	Health Care Coordinating Unit
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HEDIS	Healthplan Employer Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payment
HMO	Health Maintenance Organization
HAS	Health Systems Agency

I

IBNR	Incurred but not Reported
ICAN	Involved Consumer Action Network in Pennsylvania
ICC	Interagency Coordinating Council
ICD	International Classification of Diseases

ICF	Intermediate Care Facility
ICM	Intensive Care Management
IEA	Individual Enrollment Assessment
IEAP	Independent Enrollment Assistance Program
IEP	Individual Education Plan
IFA	Individualized Functional Assessment
IMD	Institutions for Mental Disease
I&R	Information and Referral
IOC	Involuntary Outpatient Commitment
IPP	Individual Program Plan
IPS	Individual Plan of Service
ISP	Individualized Service Plan
IST	Instructional Support Team
I-TEAM	Interdisciplinary Team

J

JCAHO	The Joint Commission on Accreditation of Healthcare Organizations
JDC	Juvenile Detention Center
JPO	Juvenile Probation Office

L

LEA	Local Educational Agency/Authority or Law Enforcement Agency
LOC	Level of Care
LOCI	Level of Care Index
LOF	Level of Functioning
LOS	Length of Stay
LRE	Least Restrictive Environment
LS	Learning Support
LSS	Life Skills Support
LSW	Licensed Social Worker
LTC	Long Term Care
LTSR	Long Term Structured Residence

M

MA	Medical Assistance
MAAC	Medical Assistance Advisory Committee
MAID	Medical Assistance Identification Number
MAMIS	Medical Assistance Management Information System
MATP	Medical Assistance Transportation Program
MBD	Minimal Brain Dysfunction
MCO	Managed Care Organization
MDE	Multidisciplinary Evaluation
MDT	Multidisciplinary Team
MH	Mental Health
MHAP	Mental Health Association of Pennsylvania
MHI	Mental Health Inventory (Assessment form used by Base Service Units)
MHPC	Mental Health Planning Council
MI-A	Mentally Ill-Adult
MI-C	Mentally Ill-Child
MI/DD	Mentally Ill/Developmentally Disabled
MIS	Management Information Systems
MISA	Mental Illness/Substance Abuse
MOE	Method of Evaluation
MPL	Minimum Participating Levels

N

NAMI OF PA	National Alliance of the Mentally Ill in Pennsylvania
NCE	Non-Contiguous Eligibility
NDC	National Drug Code
NI	Neurologically Impaired
NMP	Non-Money Payment
NORA	Notice of Recommended Assignment
NPDA	National Practitioner Data Bank

O

OBRA	Omnibus Budget Reconciliation Act
OBS	Organic Brain Syndrome
OCYF	Office of Children, Youth and Families
ODAP	Office of Drug and Alcohol Programs
ODP	Office of Developmental Programs
OIP	Other Insurance Paid
OIS	Office of Information Systems
OMA	Office of Medical Assistance
OMH	Office of Mental Health
OMHSAS	Office of Mental Health and Substance Abuse Services
OP	Outpatient Services
ORC	Other Related Conditions
OSP	Office of Social Programs
OTR	Registered Occupational Therapist
OVR	Office of Vocational Rehabilitation

P

P4P	Pay-for-Performance
PACDAA	Pennsylvania Association of County Drug and Alcohol Administrators
PACT	Program for Assertive Community Treatment
PADOHRIC	Pennsylvania Department of Health Research and Information Center
PAPSRS	Pennsylvania Association of Psychosocial Rehabilitation Services
PARF	Pennsylvania Association of Rehabilitation Facilities
PBM	Pharmacy Benefit Manager
PCACB	Pennsylvania Chemical Abuse
PCAP	Pennsylvania Council on Alcohol Problems
PCBH	Personal Care Boarding Home
PCIS	Patient Census Information System
PCP	Primary Care Physician/Practitioner or Person-Centered Planning
PCPA	Pennsylvania Community Providers Association
PCPC	Pennsylvania Client Placement Criteria
PDDC	Pennsylvania Development Disabilities Coalition

PDE	Pennsylvania Department of Education
PEN	Parent Education Network
PENNFREE	Pennsylvania Drug Free Community Trust Fund
PERT	Program Evaluation and Review Technique
PI	Physical Intervention
PIN	Parents Involved Network
PLF	Private Licensed Facility
PMHCA	Pennsylvania Mental Health Consumers' Association
PMPM	Per Member Per Month
PMU	Psychiatric Medical Unit
PNP	Physical Non-Physical Intervention
POMS	Performance Outcome Measurement System
POSNET	Pennsylvania Open Systems Network
PP&A	Pennsylvania Protection & Advocacy
PPO	Preferred Providers Organization
PRTF	Psychiatric Residential Treatment Facility

Q

QA	Quality Assurance
QAPIP	Quality Assessment and Performance Improvement Program
QARI	Quality Assessment Review Index
QHP	Qualified Health Plan
QI	Quality Improvement
QISMC	Quality Improvement Systems of Managed Care
QM	Quality Management
QMB	Qualified Medicare Beneficiaries
QM/UMP	Quality Management and Utilization Management Program

R

RBUC	Reported but Unpaid Claims
RCT HOME	Residential Community Treatment Home
RMHA	Responsible Mental Health Authority
RPAA	Risk Pool Allocation Amount

RRA	Recipient Rights Advisor
RTF	Residential Treatment Facility

S

SAMHSA	Substance Abuse and Mental Health Services Administration
SAP	Statutory Accounting Principles or Student Assistance Program
SCA	Single County Authority on Drug and Alcohol
SCAN	Suspected Child Abuse and Neglect
SED	Socially and Emotionally Disturbed (Education) or Seriously Emotionally Disturbed (Mental Health)
SHP	Supported Housing Program
SLMT	State Leadership and Management Team
SMH	State Mental Hospital
SMM	State Medicaid Manual
SNU	Special Needs Unit
SOC	System of Care
SPEX	Specific Population Examination
SPMI	Seriously and Persistently Mentally Ill
SPR	Systems Performance Review
SSBG	Social Services Block Grant
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
STD	Sexually Transmitted Diseases
SURS	Surveillance and Utilization Review System

T

TANF	Temporary Assistance for Needy Families
TC	Therapeutic Community
TCM	Targeted Case Management
TCU	Transitional Care Unit
TPL	Third Party Liability
TQI	Total Quality Improvement
TQM	Total Quality Management

U

UM/QM	Utilization Management/Quality Management
UR	Utilization Review

W

WIC	Women, Infants and Children (Program)