System of Care Readiness and Implementation Measurement Scale[1] (SOC-RIMS)

Lenore B. Behar, Ph.D. & William M. Hydaker, MA

What is Readiness and Implementation Measurement? As you begin planning for the implementation of a system of care, it is important to understand what essential characteristics of a system of care are in place in your communities, fully or partially, and what elements need to be created. A good way to make these determinations is to ask the broad array of stakeholders who will participate in the planning how they assess your community's current capacity for a system of care. Determining what is in place and what is needed is important in planning technical assistance, training, and the development of a logic model and an implementation plan. Measuring capacity also provides a baseline against which you can measure progress. Although there are several ways to assess community readiness and progress with implementation, this scale offers an efficient method that is grounded in research specific to systems of care.

How was the scale developed? The System of Care Readiness and Implementation Measurement Scale was developed specifically for use in implementing a system of care. Behar & Hydaker developed the instrument through a national study in 2008. The Child, Adolescent and Family Branch funded this study to further the understanding of the community and systems factors that underlie the development of a system of care. The national study used a web-based method of collecting data as developed by Concept Systems, Inc. CS Global© system[2] which allowed for data analysis using multidimensional scaling and cluster analyses and resulted in a detailed, statistically-based

[1]Formerly the Community Readiness Assessment Scale

[2]Concept mapping analysis and results were conducted using The Concept System© software: Copyright 2004-2007; all rights reserved. Concept Systems Inc.

description of the community's capacity. The study produced 109 action statements, which the 223 participants believed to be the essential characteristics of a system of care. These 109 statements have been organized into eight domains/clusters, to include:

- Families & Youth as Partners
- Plan to Expand Services
- Evaluation
- Collaboration
- Network of Local Partners
- Shared Goals
- Accountability
- Leadership

The domains/clusters are used in the analysis of the data to understand where the current community is in comparison to the "ideal" established in the national study. The scale has been designed to measure progress, using the first measure as a baseline and a follow-up measure 6-12 months later.

The SOC-RIMS has excellent psychometric properties, with a reliability score of .92 and validity scores from .89-.98, depending on the method. This statistically-based assessment strategy allows a large number of community stakeholders to rate their own readiness to develop a system of care.

The System of Care Readiness and Implementation Measurement Scale (SOC-RIMS) is also available in Spanish. There is a version that is compatible with the structure of Native American tribal sites.

How do you administer the System of Care Readiness and Implementation Measurement Scale (SOC-RIMS)? The project

leadership selects the community stakeholders who are asked to rate the capacity of the community to implement a system of care. The project staff, usually the Project Director or Evaluator, asks the stakeholders to rate each of the 109 items, using a five- point scale, ranging from “Least Ready” to “Most Ready.” It takes 30-40 minutes to complete the rating scale.

The scale can be administered during a community meeting or it can be sent as an e-mail attachment, which can be completed online. Combining these methods of data collection allows those who did not attend the meeting to be included. Complete instructions are provided during a phone consultation and in writing.

How do you use the findings? The data collected by the project staff is submitted to the consultants who analyze the data and provide a report in four to six weeks. The report provides

- An overall readiness score;
- Ranking of specific items in terms of those where the community is most ready and least ready; and
- Ranking of clusters/domains for Readiness and compared with Importance and Difficulty of Implementation that was determined in the earlier study. This information provides specific guidance for planning and technical assistance. By sharing the report with the stakeholders, they can see how the community “voted” and the findings can provide a basis for discussion about how to move forward with the system design.

  Other uses might include 1) determining which local sites are more ready than others to “go first” with local implementation; 2) using the information from the report to prepare for a grant application; 3) developing a logic model and implementation plan;

and 4) serving as a basis for comparison at a later date to measure progress.

Attached is a copy of the scale. Also attached is a report, "An Analysis of Readiness in System of Care Communities" submitted to the Child, Adolescent and Family Branch in 2012. See too the articles describing the national study and subsequent work to refine the scale. See:

Behar, L.B. & Hydaker, W.M. (2009). Defining community readiness for the implementation of a system of care. Administration and Policy in Mental Health and Mental Health Services Research. Volume 36, Issue 6, 381-392.

Rosas, S.R., Behar, L.B. & Hydaker, W.M. (2014). Community readiness within systems of care: The validity and reliability of the System of Care Readiness and Implementation Measurement Scale (SOC-RIMS). Journal of Behavioral Health Services Research. Mar 14 [Epub ahead of print] (DOI) 10.1007/s11414-014-9401-3.

Behar, L.B., Hydaker, W.M., & Rosas, S.R. (2015). Using concept mapping to assist development of a community-based system of care. In preparation.

Rosas, S.R., Behar, L.B. & Hydaker, W.M. (2016). Community readiness within systems of care: The validity and reliability of the System of Care Readiness and Implementation Measurement Scale (SOC-RIMS). Journal of Behavioral Health Services Research. Volume 43, Issue 1, 18-37.

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System of Care Readiness and Implementation Measurement Scale (SOC-RIMS) Samples

- A Sample of the System of Care Readiness and Implementation Measurement Scale
- The System of Care Readiness and Implementation Measurement Scale for Native American Sites
- The System of Care Readiness and Implementation Measurement Scale in Spanish

An Analysis of Readiness in System of Care Communities

A Report to the Child, Adolescent and Family Branch, Center for Mental Health Services

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This report is also available at:
http://www.tapartnership.org/SOC/newCommunitiesResources.php?id=topic1

Suggested reference: Behar, L.B. & Hydaker, W.M. (2012). *An analysis of readiness in system of care communities. A report to the Child, Adolescent and Family Branch, Center for Mental health Services*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

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Executive Summary

Background

System of care development has evolved over the past forty years, stimulated by the recommendations of the Joint Commission on Mental Health of Children (1969), a congressionally-appointed body, that completed a four-year national study and reported that millions of children were not receiving needed mental health services. More than a decade later *Unclaimed Children,* Knitzer's (1982) national study of mental health services for children and youth, revealed serious deficits in services throughout the country. In 1984, the federal response to these findings launched the first phase of service reform through the Child and Adolescent Service System Program (CASSP), which provided funding to the states to begin restructuring children's mental health services. System of care has become federal policy, promulgated by the Child, Adolescent and Family Services Branch of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. In 1992, the Comprehensive Community Mental Health Services Program for Children and Their Families (2006) legislation began the second phase of systems reform. This Act provides funds to improve/expand community-based systems of care and to address the needs of an estimated 4.5-6.3 million children with serious emotional disturbances and their families. Systems of care are promoted on the premise that the mental health needs of children, adolescents, and their families can be met within their homes, schools, and communities. Since 1993, 173 communities have been funded to develop systems of care, across all 50 states, plus Puerto Rico, Guam, the District of Columbia, and 21 American Indian/Alaska Native tribes or tribal entities. Funding is at the level of approximately $5 million per site over a six-year period. There are additional federal funds for an independent evaluation, technical assistance and training. As of 2011, the federal agency has awarded funds of more than $1.6 billion for the development of systems of care. Clearly, the focus on systems of care represents a major federal policy and a major investment of funds.

The concept of "community readiness" offers an important contribution to improving the planning and implementation process for communities. Being able to understand what factors are important to the successful implementation of a system of care should help communities assess their own strengths and weaknesses and address the areas of weakness. In 2008, with funds from the Child, Adolescent and Family Branch of the Center for Mental Health Services, the authors, Behar & Hydaker, used concept mapping to develop an understanding of the community and systems factors that underlie the concept of community readiness. They chose concept mapping because this method is based on sound research, quantifiable data and statistical analyses. To understand community readiness, information was gathered from a panel of national experts and from representatives of advanced and graduated sites funded to develop systems of care. The goal was to better define the boundaries and elements in this complex area by synthesizing input from stakeholders across the country, as well as from national experts in this content area. Using a concept mapping strategy and Concept Systems, Inc. CS Global© software, the data provided by the national experts has been organized into content areas/domains (clusters) and the information within each cluster has been rated by the site representatives according to importance and difficulty of implementing. The resulting information has identified the concepts that the participants believe to be central to readiness and are the most important and easiest/most difficult to implement. Using multidimensional scaling and cluster analyses, the

authors provided a detailed, statistically based description of community readiness. Community readiness was described by eight clusters:

- Family & Youth as Partners
- Plan to Expand Services
- Evaluation
- Collaboration
- Network of Local Partners
- Shared Goals
- Accountability
- Leadership

Based on these analyses, the authors developed the Community Readiness Assessment Scale (CRAS), composed of 109 statements generated in the first study. These items are to be rated on a five-point scale, ranging from "least ready" to "most ready." This statistically-based assessment strategy allows a large number of community stakeholders to quickly rate their own readiness to develop a system of care. Once the community stakeholders assess their readiness, the resulting information of their strengths and weaknesses should provide direction for their implementation efforts. A follow-up rating after 10-12 months, using the same rating scale would reflect their progress in addressing areas of weakness.

Study of Readiness in 24 Sites

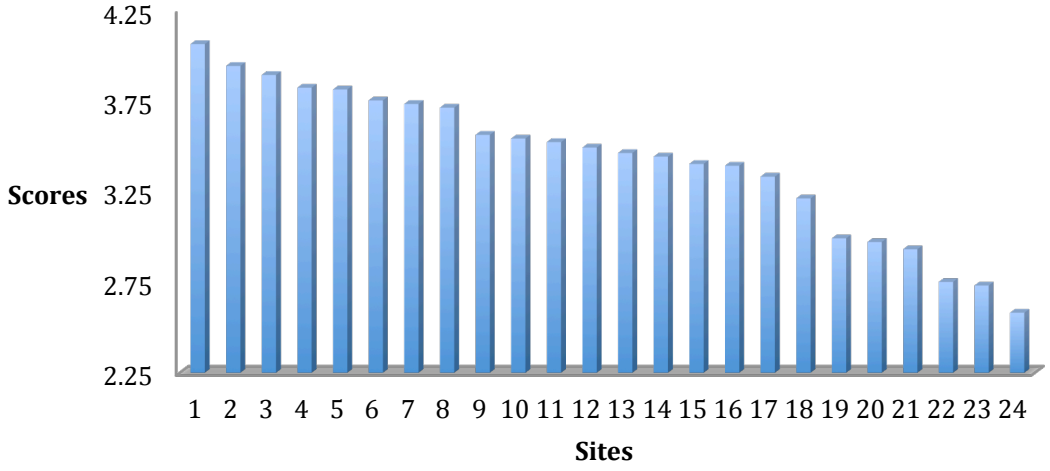
***Participants*:** From 2009-2012, the CRAS was used in 24 newly funded systems of care communities to have stakeholders do an initial assessment of community's readiness to implement a system of care. 506 stakeholders participated in these assessments. Of the 24 sites, two were Native American sites, representing 8% of the site sample. In the 24 sites, data were collected from 530 individuals. The size of the participant population ranged from seven stakeholders at a small single county site to 87 at a statewide site. In all of the sites, there was a representative sample of stakeholders, to include, project leadership, project staff, partner agencies, parents, youth, and community leaders. The distribution of these 530 stakeholders was:

- 16 project leadership (3%)
- 133 project staff (25%)
- 196 partner agencies, including public schools and public child welfare, juvenile justice, health agencies, and private agencies and providers (37%)
- 69 parents (13%)
- 48 youth (9%)
- 47 community leaders (8%)
- 21 other (undefined) (4%)

Almost all of these 530 participants provided data that met the criteria for inclusion in the studies. Data from 24 participants (4.5%) were excluded, either because 1) they did not answer sufficient questions (66% or 72 of the 109 items) or 2) they did not discriminate among the possible responses by answering 80% of the items exactly the same. These 24 individuals were distributed essentially equally across the sites. Thus, the data analyses are based on 506 respondents. These are criteria recommended by Concept Systems, Inc.

Readiness Scores: The readiness score for each site is calculated to reflect the average score for all 109 items. These items were rated on a scale of 1.00 – 5.00, with 1.00 being the "least ready" and 5.00 being the "most ready." The range of scores from the 24 funded sites is 2.58 – 4.06 and the mean is **3.42**. This mean score reflects a fairly high degree of readiness, which is expected, given that these sites were selected for funding based on the amount of readiness for a system of care that they had in place. The range of readiness across the sites is seen in Figure 3. The six sites that scored the lowest were below 3.00, and that is two standard deviations below the mean.

Readiness Scores across 24 Sites



Readiness Ratings by the Federal Project Officers and Regional Technical Assistance: In addition to collecting data from community stakeholders in the 24 sites, ratings of community readiness were gathered from two groups that interact with the sites in a consultative manner. The Federal Project Officers from the Child, Adolescent and Family Branch and the Regional Technical Assistance Consultants from the Technical Assistance Partnership who were responsible for the participating sites were asked to complete a brief rating scale. The average readiness score from the Federal Project Officers (FPOs) and the Regional Technical Assistance Consultants (RTACs) combined is 3.76. The range of scores is 2.44 to 4.33. There was agreement between these two (combined) groups with the community groups that rated readiness at the sites. Among the top six sites as rated by the community, five of them had the top ratings by the FPOs/RTACs. Among the bottom five sites (excluding the one site that was unrated), four were rated the lowest by the FPO/RTACs.

Ranking of the Clusters for Readiness: The 506 participants ranked the clusters as follows:

Collaboration	3.51
Accountability	3.44
Evaluation	3.39
Plan to Expand Services	3.39
Leadership	3.35
Shared Goals	3.25
Network of Local Partners	3.21
Families/Youth Partners	3.13

When considering the most ready areas, the respondents rated the 24 sites highly on Collaboration, Accountability, and Evaluation. Collaboration was also rated highest in the national study, indicating that a broad group of experts considered this most essential to the development of a system of care. This high rating on Readiness represents strength for the 24 sites. The Request for Applications (RFA) for funding emphasized the importance of collaboration and the reviewers of the applications considered community collaboration as they scored the submissions. In the applications, letters of support from the community partners were required to present evidence of community collaboration; sites that were selected had presented this evidence. The ratings by the community stakeholders reinforced the validity of the process.

The least ready areas of Shared Goals, Network of Local Partners and Families & Youth as Partners indicate that the next steps, deeper steps, in the collaborative process will require strengthening and broadening local partnerships with agencies, providers, families and youth; and one of the first steps in enhancing collaboration should be to ensure a good understanding of the project and clarify what is expected of local partners (Shared Goals). As Network of Local Partners, was also rated in the national study as the second most difficult to achieve and Shared Goals, third, these clusters of action steps represent an important and somewhat difficult challenge for the stakeholders across the 24 sites. The items within these clusters that will strengthen the Network of Local Partners will need the most attention by the sites as they implement the systems of care.

Now pay particular attention to the lowest ranking cluster of Families & Youth as Partners. A review of the scores across the 24 sites indicates that this low score reflects a consistent pattern of low scores for this cluster—not just a few sites with very low scores to pull down the average. Of the 24 sites, 22 scored lowest in this area. The importance of family and youth involvement was highlighted in the national study, as this area of focus scored second highest behind collaboration with community partners (which also included some items about collaboration with families). Family and youth involvement is also a highly emphasized area in the federal policy guidance for the preparation of the application for funding and for the implementation of a system of care. This is the area of least readiness of the sites. The explanation seems rather clear—it is the area where there is a major gap in usual and customary community services and therefore a challenge to the sites—and perhaps best said as the area where federal funding can make the biggest difference, helping communities move from little involvement of families and youth to major involvement in system design, participation on governing boards, participation in evaluation, and participation in the design of their own services.

Results of the Ratings of Statements across Clusters: The purpose of presenting the ratings of statements is to highlight specific areas of strength and areas that need attention to improve. The ratings of the items are presented without considering the clusters in which they are arranged.

The Ten Statements Rated as Most Ready[1]

#	Statement	Score
16	There is a felt need for services within the community by the stakeholders.	4.22
64	There is a commitment to measurement of progress and outcomes.	3.92
88	There is agreement to have family advocates on staff.	3.87
93	There is a willingness to work in a fair, inclusive, and open manner.	3.86
31	There is a strong collaborative group of service providers already engaged in discussion about mutual goals.	3.73
30	There are committed community stakeholders, which include child-serving systems, providers, families, youth and community members.	3.72
22	There is commitment to evaluation and data based decision-making.	3.70
86	The community partners are willing to have open discussions and come to agreement on what some of the barriers and obstacles are to making the changes necessary to have a system of care.	3.69
37	There are strong relationships and commitments to collaboration among community partners.	3.68
54	There is a core, committed group with strong leadership that couples vision with concrete strategy and practical know-how.	3.68
45	There is intent to provide training in and utilization of specific evidence-based practices with justification based on clinical characteristics of population of focus.	3.66

The ten "most ready" statements reflect adherence to the Core Values and Guiding Principles promulgated by the funding agency, the Child, Adolescent and Family Branch of the Center for Mental Health Services and discussed above on page 4. These values and principles were articulated in the Request for Applications. Essentially, the sites were selected because they demonstrated in their applications that these requirements were in place. The policies were then emphasized to the funded communities through written communications, webinars, and meetings. The ratings by the respondents in the 24 sites reflect that these requirements are almost in place.

Looking at specific items, it is clear that these items reflect commitments/willingness/ agreements to plan, develop, evaluate, discuss, work together, and collaborate. The communities indicate that there is leadership with a vision to get the work done. These 11 items reflect optimism and trust that the job of building a system of care will get done, which is certainly an excellent foundation on which to build. The areas of most readiness still reflect work to be done, as none were scored as fully complete. This information can be useful in planning technical assistance and training, as all sites appear to need work in strengthening their relationships with local partners and, most importantly, in developing partnerships with families and youth.

[1] 11 statements are presented, as there is a tie for ninth place.
[2] 13 statements are presented, as there are three ties.
[3]The study to define community readiness was completed under Contract 280-03-4200, Task Order Number 280-03-4200, funded by the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. A full report of the findings is available at www.lenorebehar.com

Note that the items rated as "most ready" do not reflect actual accomplishments in these areas; the accomplishments are presumably yet to come. Looking at Table 4 below, the 13 statements of the "least ready" items reinforce this interpretation. The "least ready" items are not items of hope or intent; they are items of action and accomplishment. Note that six of these items address family involvement (#107, #82, #78, #50, #1, #5). Five items address broader community involvement (#107, #99, #29 #13, #5). And four items address financing issues (#82, #41, #39, #102). **These items and similar ones appear in the "least Ready" lists of all 24 sites**, indicating that family issues, financing issues, and broader community involvement are the part of systems development that are not initially in place and also that these are areas, most likely, where technical assistance and training should be focused. In essence, these are the areas that the federal funding is designed to address, with the expectation that these elements will be built during the life of the cooperative agreement between the site and the federal agency.

The Ten Statements Rated as Least Ready[2]

#	Statement	Score
32	Young people are being provided support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	3.01
107	An advisory or leadership board has been established that has at least 1/3 parent participation and they have input on the design and implementation of the project.	2.98
82	There is a plan for substantial financial support for family involvement, controlled by families being served.	2.98
78	Families are willing to take on a lead role in taking the vision to reality.	2.96
41	There has been an analysis about those service components that will require more support in order to implement them.	2.96
39	The community partners have a clear understanding of how services are financed and their limitations on flexibility	2.94
50	Training has been provided to parents to help them feel more confident advocating for themselves and others in the community.	2.92
99	There is a plan for volunteer development.	2.91
1	Families are provided with support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	2.84
102	The community is being made aware of the potential services in order to be willing to support additional funding.	2.79
29	Community organizations such as faith-based groups have participated in the planning process.	2.77
13	There is strong inclusion of elected officials on the local and state level.	2.77
5	Everyone--community partners, leaders, families, and youth--understands the principles on which the new system will be built and share the same values.	2.73

Preliminary Findings of the Follow-Up Assessments: Of the 24 sites studied, nine have participated in follow-up assessments to date. There were 116 respondents in these nine

[2] 13 statements are presented, as there are three ties.

communities. The findings are that all nine sites that completed follow-up assessments have shown positive changes. The average readiness score of these eight follow-up sites is 3.77, compared to an average score of 3.33 at their initial assessment. The average change is .47; the range was .09 – .72. The timeframe for the follow-up assessments ranged from 14 months to 25 months, with an average of 19 months. There is a consistent pattern among the nine sites that the longer the time period between the initial assessment and the follow-up, the greater the gain. This finding suggests that positive change continue over time, with the sites making greater progress as time goes on. Note that the six sites that scored considerably lower than the others, at two standards deviations below the mean, have not participated in follow-up studies.

Conclusions: The study of community readiness in 24 sites, funded by the Child, Adolescent and Family Branch of the Center for Mental Health Services, indicates the 24 communities have much in place on which to build a system of care. The overall rating of readiness of 3.42 across the 24 sites, out of a possible 5.00, is quite positive. Further, the areas that are rated to have the most readiness are those of Collaboration and Accountability, elements that are stressed in the federal policy guidance and in the requirements of the Request for Applications (RFA).

The perceptions of the respondents also identify areas important to system of care development that need attention as planning and implementation efforts move forward. In terms of what needs to be done next, it seems important to focus on the areas that are rated as least ready, that is Families and Youth as Partners and Network of Local Partners, especially focusing on the 'non-traditional" partners, such as parents, advocates, community leaders, and volunteers.

It is not a surprising finding that Families and Youth as Partners and Network of Local Partners are the two areas where most work is needed. These two conceptual areas are fundamental to system of care philosophy and essential for a successful system of care and these two conceptual areas are usually not in place in communities that have not yet focused on system of care development. In some sense, developing these conceptual areas, which are described in the Families and Youth as Partners and Network of Local Partners clusters, is a major purpose of the federal funding. Note that in the national study, Families and Youth as Partners was rated as only moderately difficult to achieve, so addressing these activities should be only moderately challenging. However, the activities related to the Network of Local Partners was rated as the second most difficult to achieve in the national study, so this is an area of substantial challenge.

Focusing on statements, rather than clusters, the statements/action steps presented in Table 3 indicate the strengths of the communities. The ten "most ready" statements reflect adherence to the Core Values and Guiding Principles promulgated by the funding agency, the Child, Adolescent and Family Branch of the Center for Mental Health Services and discussed above on page 4. These values and principles were articulated in the RFA. Essentially, the sites were selected because they demonstrated in their applications that these requirements were in place. The policies were then emphasized to the funded communities through written communications, webinars, and meetings. The ratings by the respondents in the 24 sites reflect that these requirements are almost in place.

Looking at specific items, it is clear that these items reflect commitments/willingness/ agreements to plan, develop, evaluate, discuss, work together, and collaborate. The communities

indicate that there is leadership with a vision to get the work done. These 11 items reflect optimism and trust that the job of building a system of care will get done, which is certainly an excellent foundation on which to build. The areas of most readiness still reflect work to be done, as none were scored as fully complete. This information can be useful in planning technical assistance and training, as all sites appear to need work in strengthening their relationships with local partners and, most importantly, in developing partnerships with families and youth. Note that the items rated as "most ready" do not reflect actual accomplishments in these areas; the accomplishments are presumably yet to come

Of the 24 sites studied, nine have participated in follow-up assessments to date. There were 116 respondents in these nine communities. The findings are that all nine sites that completed follow-up assessments have shown positive changes. The timeframe for the follow-up assessments ranged from 14 months to 25 months, with an average of 19 months. There is a consistent pattern among the nine sites that the longer the time period between the initial assessment and the follow-up, the greater the gain. The results suggest that the support provided to the sites by the Federal Project Officers, Regional Technical Assistance Providers, evaluation efforts, consultants and a myriad other means improves implementation over time. The Community Readiness Assessment Readiness Scale quantifies this progress and provides a clear focus for "next steps."

An Analysis of Readiness in System of Care Communities
Lenore B. Behar, PhD and W.M. Hydaker, MA

Introduction

System of care development has evolved over the past forty years, stimulated by the recommendations of the Joint Commission on Mental Health of Children (1969), a congressionally-appointed body, that completed a four-year national study and reported that millions of children were not receiving needed mental health services. More than a decade later *Unclaimed Children,* Knitzer's (1982) national study of mental health services for children and youth, revealed serious deficits in services throughout the country. In 1984, the federal response to these findings launched the first phase of service reform through the Child and Adolescent Service System Program (CASSP), which provided funding to the states to begin restructuring children's mental health services. Descriptions of the evolving reform efforts can be found in the writings of Behar (1985, 2002), Friedman (2005a, 2005b), Lourie (2002), Stroul and Friedman (1986, 1996, and 2011). The reports of the Surgeon General (1999) and the New Freedom Commission (2003) emphasized the value of this reform in improving services to children with mental health disturbances and their families. System of care has become federal policy, promulgated by the Child, Adolescent and Family Services Branch of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

In 1992, the Comprehensive Community Mental Health Services Program for Children and Their Families (2006) legislation began the second phase of systems reform. This Act provides funds to improve/expand community-based systems of care and to address the needs of an estimated 4.5-6.3 million children with serious emotional disturbances and their families. Systems of care are promoted on the premise that the mental health needs of children, adolescents, and their families can be met within their homes, schools, and communities. In 1986, Stroul and Friedman published the first monograph that described the theoretical framework, the values, and principles for a system of care, which they described as a "comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families" (Stroul & Friedman, 1986; updated, Stroul & Friedman, 1996; Stroul, B., Blau, G., & Sondheimer, D., 2008). In these publications, the authors provided guidance to communities about the implementation of the system of care.

The Act offers a philosophy that includes four elements: 1) the mental health service systems should be driven by the needs and preferences of the child and family and addressed through a strength-based approach; 2) the focus and management of services should occur within a multi-agency collaborative environment and should be grounded in a strong community base; 3) the services offered, the agencies participating, and the programs generated should be responsive to the cultural context and characteristics of the populations served; and 4) families should be lead partners in planning and implementing the system of care.

As systems of care have been designed and implemented over the past 20 years, the foundation on which systems of care are to be built have been articulated further, as guidance to communities. In their 2011 publication, Stroul and Friedman provided a summary of the system of care approach, as follows:

Definition

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 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

Systems of care are:

1. 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
2. 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
3. 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

Guiding Principles

Systems of care are designed to:

1. Ensure availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children and their families that addresses their physical, emotional, social, and educational needs, including traditional and nontraditional services as well as informal and natural supports
2. Provide individualized services in accordance with the unique potential 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
3. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate
4. 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 communities, states, territories, tribes, and Nation
5. Ensure cross-system collaboration, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management
6. Provide care management or similar mechanisms 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
7. Provide developmentally appropriate mental health services and supports that promote optimal social and emotional outcomes for young children and their families in their homes and community settings
8. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult-service system as needed
9. Incorporate or link with mental health promotion, prevention, and early identification and intervention 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

10. Incorporate continuous accountability 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
11. Protect the rights of children, youth, and families and promote effective advocacy efforts
12. Provide services and supports without regard to race, religion, national origin gender, gender expression, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; services should be responsive to these differences.

Since 1993, 173 communities have been funded to develop systems of care, across all 50 states, plus Puerto Rico, Guam, the District of Columbia, and 21 American Indian/Alaska Native tribes or tribal entities. Funding is at the level of approximately $5 million per site over a six-year period. There are additional federal funds for an independent evaluation, technical assistance and training. As of 2011, the federal agency has awarded funds of more than $1.6 billion for the development of systems of care. Clearly, the focus on systems of care represents a major federal policy and a major investment of funds.

The federal agency responsible for managing the Comprehensive Community Mental Health Services Program for Children and Their Families is the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. This agency provides communities with funding, policy and practice guidance, and technical assistance to improve and expand community-based services into coordinated systems of care. Such community transformation is a complex process that involves many stakeholders, including those from public agencies such as mental health, schools, public health, child welfare and juvenile justice, private providers of health and mental health services, families and youth, and community leaders. Recognizing the complexities of the change process, the federal agency develops cooperative agreements with each community for a six-year period. The first of these years is a planning year, during which the community partners develop the groundwork for systems change. From the inception of the program, the Child, Adolescent and Family Branch has sought to identify strategies and processes that enhance successful implementation and support positive outcomes for children and their families. Ongoing evaluation of these programs by Macro International (Manteuffel, Stephens, & Santiago, 2002; Manteuffel, Katana, Petrila, Rosales-Elkins, & Stroul, 2006; Manteuffel, B., Stephens, R., Brashears, F., Krivelyova, A., & Fisher, S., 2008) indicates that although some programs do quite well, others struggle in terms of their capacity to coordinate and integrate services across community agencies, the number of children and families they serve, and the progress these children make.

The concept of "community readiness" offers an important contribution to improving the planning and implementation process for communities. Being able to understand what factors are important to the successful implementation of a system of care should help communities assess their own strengths and weaknesses and address the areas of weakness. Further, such understanding could support technical assistance efforts by helping to determine areas of focus.. There is a meager but growing body of knowledge that is applicable to understanding the complex factors that contribute to the successful development of systems of care for children and

adolescents with serious emotional disturbances. Behar, Friedman & Lynn (2005) used a case study method of nine successful sites and identified nine important factors, to include: transformational leadership, strong foundation of values and principles, a clear description of the local population, a clear and widely held theory of change, an implementation plan, family choice and voice, individualized, culturally competent and comprehensive approaches/ interventions, and an effective governance system. Similarly, Hodges, Ferreira, Israel, and Mazza, (2007a, 2007b) used intensive case studies over a six-year period to identify factors that contribute positively to the development of systems of care, to include: shared values, willingness to change, shared accountability, delegation of authority, strategic use of resources, family empowerment, and information-based decisions. Over the past three years, Friedman, Greenbaum, Kutash, Boothroyd & Wang (2009) and Boothroyd, Greenbaum, Wang, Kutash & Friedman (2011) have developed and reported on a survey instrument based on a conceptual model of 14 factors, built upon the nine factors developed by Behar et al (2005) considered important to successful implementation of systems of care. Their factors include: family choice and voice, individualized treatment, outreach and access to care, transformational leadership, theory of change, implementation plan, local population of concern, interagency collaboration, values and principles, comprehensive financing, skilled provider network, performance measurement, provider accountability, management and governance. They are in the process of conducting a large sample, county-based study to test these factors. Other researchers, Edwards, Jumper-Thurman, Plested, Oetting, & Swanson (2000) and Staley & Edwards (2006) point out that, "Communities are at many different stages of readiness for implementing programs, and this readiness is a major factor in determining whether a local program can be effectively implemented and supported by the community." Their Community Readiness Model was developed to provide communities with a theoretical framework, a process, and specific tools to facilitate readiness. Other efforts to develop readiness assessments include 1) Osher and Huff's (2007) *Family Driven Care and Practice System Self Assessment Tool* and *The Community Readiness and Assessment Tool*, which includes a readiness component that taps participant's perceptions of the role of families Reports relevant to systems change, but not focusing directly on readiness, are based in other public systems and focus on implementation strategies. Chinman, Inn & Wandersman (2004) have developed guidance for implementation of substance abuse prevention programs and focus on the gap between the positive outcomes of prevention science and the more limited outcomes of prevention practice. They have developed a manual of implementation strategies for "Getting to Outcomes" which offers promise for improving practice. Later work on this topic includes ten principles of empowerment evaluation (Fetterman & Wandersman, 2005), which focus on improving implementation and evaluation. These include: improvement, social justice, inclusion, democratic participation, capacity building, organizational learning, community ownership, community knowledge, evidence-based strategies, and accountability. Wandersman (2009) has translated these principles to systems of care implementation.

Another approach to systems change includes a focus on state level changes for building sustainable improvements in public health (Padgett, Bekemeir, & Berkowitz, 2005). These authors used a qualitative, case study design to analyze strategies used by Turning Point (a Robert Wood Johnson initiative). The strategies included: institutionalization within government, establishing "third sector" institutions, cultivating relationships with significant allies, and enhancing communication and visibility among multiple communities.

A Study to Define Community Readiness[3]

In 2008, the authors, Behar & Hydaker, used concept mapping to develop an understanding of the community and systems factors that underlie the concept of community readiness. They chose concept mapping because this method is based on sound research and statistical analyses. To understand community readiness, information was gathered from a panel of national experts and from representatives of advanced and graduated sites funded to develop systems of care. The goal was to better define the boundaries and elements in this complex area by synthesizing input from stakeholders across the country, as well as from national experts in this content area. Using a concept mapping strategy and Concept Systems, Inc. CS Global© software, the data provided by the national experts has been organized into content areas/domains (clusters) and the information within each cluster has been rated by the site representatives according to importance and difficulty of implementing. The resulting information has identified the concepts that the participants believe to be central to readiness and are the most important and easiest/most difficult to implement. The findings are derived from multidimensional scaling and cluster analyses, resulting in a detailed, statistically based description of community readiness.

Concept Mapping

The technique of concept mapping was developed in the 1970's (Novak, 1998) as a way to visually present the ideas of groups on a topic of interest to them. Concept mapping has evolved through the efforts of social scientists and there are many methods now available to collect and analyze information. The method designed by Concept Systems, Inc. (Kane & Trochim, 2007; Trochim, 1989a; Trochim & Linton, 1986) is a mixed-methods (Greene & Caracelli, 1997) planning and evaluation approach that integrates familiar qualitative group processes (brainstorming, and sorting and rating of statements) with multivariate statistical analyses to help a group describe its ideas on any topic of interest and represent these ideas graphically through maps. The process typically requires the participants to brainstorm a large set of statements relevant to the topic of interest, individually sort these statements into piles of similar ones, and rate each statement on one or more dimensions. Concept Systems, Inc. has developed a research-based methodology to analyze the data obtained from this process. This approach is a "next generation" tool that uses sound methods of analysis of the data gathered, so that the end result is an unbiased and fair description of the input of the participants.

The analyses include multidimensional scaling (MDS) of the sort data, hierarchical cluster analysis of the MDS coordinates, and computation of average ratings for each statement and cluster of statements. These data are then used to generate the maps, which show the individual statements, with more similar statements located nearer each other and grouped into clusters. The Concept Systems, Inc. approach has been used effectively to address issues across a wide range of fields, including public health, human services, higher education and industry (Kane & Trochim, 2007; Trochim, Milstein, Wood, Jackson, & Pressler, 2003; Trochim 1989b; Trochim, 1993). Data obtained through concept mapping has also been used to develop rating scales (Rosas, 2008). Samples of groups using concept mapping include the Center for Disease Control

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[3]The study to define community readiness was completed under Contract 280-03-4200, Task Order Number 280-03-4200, funded by the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. A full report of the findings is available at www.lenorebehar.com

and Prevention, the National Cancer Institute, the United States Department of Labor, the Hawaii Department of Health, the Mississippi Department of Mental Health, University of North Carolina School of Public Health, Delta Airlines, Nortell, Citgo, Motorola, and Hallmark. System of care sites using concept mapping for planning, development of logic models, and evaluation include "commUNITYcares" in Mississippi, "Circle of Hope" in Missouri, and "Integrating Families, Communities, and Providers (IFCAP)" in Florida[4].

Study Sample

Two groups were invited to participate in this study. The first group consisted of the 27 grant communities in the 5th and 6th year of funding from the Center from Mental Health Services, Child, Adolescent and Family Branch. Those invited included project directors, principal investigators, clinical directors, lead family coordinators, youth coordinators, cultural and linguistic coordinators, technical assistance coordinators, and social marketers. The second group was comprised of a panel of national experts, selected by the investigators. The experts included people from graduated sites and those who have served as consultants, evaluators, trainers, and leaders in the design and development of systems of care. The investigators sent invitations directly to these individuals.

Procedure

Using the Concept Systems, Inc. web-based CS Global© system, input about indicators of community readiness was obtained from the participants described above. The two-part process took place during the period of April 24, 2008 – August 17, 2008. Participants' input was collected in two phases. Phase 1 consisted of brainstorming, and involved generating a list of community and systems factors. Phase 2 consisted of organizing those factors (sorting) and rating them for Importance and Difficulty of Implementation (rating). The Concept System computer software version 4.175 (Concept Systems, 2010) was used for the analysis and generation of the cluster maps.

Phase 1 (Generating Statements). This first part of the study was completed from April 24 - May 30, 2008. Members of Group 1 and 2 were asked to participate; and 115 completed the task. Using the web-based program for the brainstorming activity, participants were asked to complete the following focus statement by typing statements into a text box: **"To be ready to develop a system of care, the following specific characteristics and functions are essential to be in place before an application for funding can be completed."** The group produced 275 statements. The investigators separated those that contained more than one idea, resulting in 336 statements. The 336 statements were reviewed for duplication, resulting in 109 statements, which are presented as the Community Assessment Rating Scale in Appendix A.

Phase 2 (Organizing and Prioritizing Statements). The second part of the study was completed during the period of June 30 – August 17, 2008. Using the web-based program, Group 1 was asked to rate the 109 statements by their Importance and Difficulty of Implementation. Group 2 was asked to sort the 109 statements into categories of similar statements and to provide their own labels for those categories. Group 1 and Group 2 were created because the investigators

[4] The first three of these sites are funded by the Center for Mental Health Services, Child, Adolescent and Family Branch; the three sites in Florida are funded by Health Resources and Services Administration, Maternal and Child Health Bureau.

thought that it was too much to ask participants to do both tasks, as the ratings took 30 – 40 minutes; the sorting took 45 minutes to one hour. Responses were anonymous.
Rating. Group 1 participants rated each of the 109 statements first on the dimension of Difficulty of Implementation and second on Importance. The ratings were based on a five-point scale with 1 indicating *very easy to implement* and 5 indicating *extremely difficult to implement* or 1 indicating *not at all important* and 5 indicating *extremely important*. This task took on average 30-40 minutes. There were 69 people who completed the first rating task (Difficulty of Implementation), and 65 completed the second rating task (Importance). For these tasks, there was representation from 25 of the 27 program sites.
Sorting. Each of the Group 2 participants was presented with a list of the 109 statements and was instructed to sort the statements by grouping them into categories of ideas that were similar to each other. The participants were asked to label the categories. This task took on average 50-60 minutes. There were 36 people who completed the sorting task.

Findings of the Study to Define Community Readiness
Results of the Sorting Process. The results of the sorting process of the 109 statements yielded the eight clusters. The Group 2 participants were asked to provide a name for each of their groupings of statements. The Concept Systems, Inc. software generates cluster labels based on an analysis of frequency and similarity of the names selected by the participants. The eight clusters are:

- Family & Youth as Partners
- Plan to Expand Services
- Evaluation
- Collaboration
- Network of Local Partners
- Shared Goals
- Accountability
- Leadership

These clusters are consistent with system of care principles and policy promulgated by the Child and Family Services Branch of the Center for Mental Health Services. The clusters created through sorting are similar to the concepts that are a part of technical assistance and training for system of care development. The clusters are similar to the common factors that others have identified in reviews of systems of care sites. Hodges, Ferreira, Israel, and Mazza, (2007a, 2007b) used intensive case studies over a six-year period to identify factors that contribute positively to the development of systems of care, to include: shared values, willingness to change, shared accountability, delegation of authority, strategic use of resources, family empowerment, and information-based decisions. Over the past three years, Friedman, Greenbaum, Kutash, Boothroyd & Wang (2009) and Boothroyd, Greenbaum, Wang, Kutash & Friedman (2011) have published information on their survey instrument, which is based on a conceptual model of 14 factors, built upon the nine factors developed by Behar, Friedman & Lynn (2005). Behar et al used a case study method of nine successful sites and identified nine important factors, to include: transformational leadership, strong foundation of values and principles, a clear description of the local population, a clear and widely held theory of change, an implementation plan, family choice and voice, individualized, culturally competent and comprehensive approaches/ interventions, and an effective governance system. The study to

define community readiness provided new information and validated the earlier findings using measurable/quantifiable concepts. The Concept Systems, Inc. methodology provided for statistical analyses of data, going a step beyond the earlier studies that were based on summaries from interviews and observation.

Results of the Rating Process for the Ranking of Clusters. Group 1 rated the statements on a five-point scale for Difficulty of Implementation and Importance. The average Difficulty of Implementation or Importance rating for a cluster is the average of the statements within the cluster. It is the ratings of the items that determine the rankings of the clusters. Therefore, the clusters that contain more statements and higher averages are the clusters that were rated as more important or harder to implement. Table 1 shows the ratings of the clusters, in descending order, indicating the highest to the lowest average rating. Note that it is the rating of the items (action steps) within the clusters that form the basis for the ranking of the clusters.

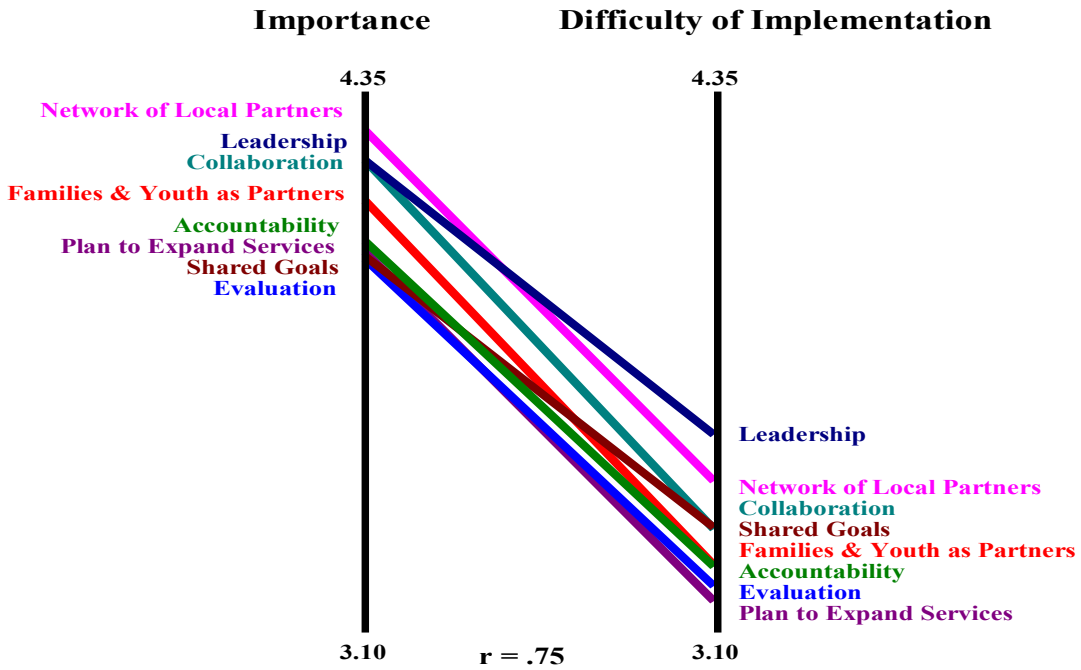
Table 1
Cluster Rating for Importance and Difficulty of Implementation

Difficulty of Implementation		Importance	
Cluster	**Rating**	**Cluster**	**Rating**
Leadership	3.54	Network of Local Partners	4.32
Network of Local Partners	3.42	Collaboration	4.24
Shared Goals	3.30	Leadership	4.24
Collaboration	3.29	Families & Youth as Partners	4.14
Families & Youth as Partners	3.21	Accountability	4.03
Accountability	3.20	Plan to Expand Services	4.01
Evaluation	3.15	Shared Goals	3.99
Plan to Expand Services	3.11	Evaluation	3.99

This same information concerning the agreement between the cluster rankings for Difficulty of Implementation and Importance can also be presented using a consensus pattern match (ladder graph), which is generated based on correlations between the two dimensions. The ladder graph compares the participant responses of each of the two dimensions, Difficulty of Implementation and Importance. The relationship between the two dimensions is represented by a correlation coefficient, which ranges from -1.00 to +1.00, with negative numbers indicating degrees of disagreement and positive numbers indicating degrees of agreement.

The ladder graph in Figure 2 offers a pictorial display of the information in Table 3. The level of agreement between the two dimensions is +.75, meaning that the participants had 75% agreement in the order of their rankings of the clusters (based on their rating of the items) for Difficulty of Implementation and Importance. Perfect agreement would be +1.00 or 100%, meaning that the average rating for every item on Difficulty of Implementation was exactly the same as the average rating for Importance. A rating of +.75 is considered to be positive.

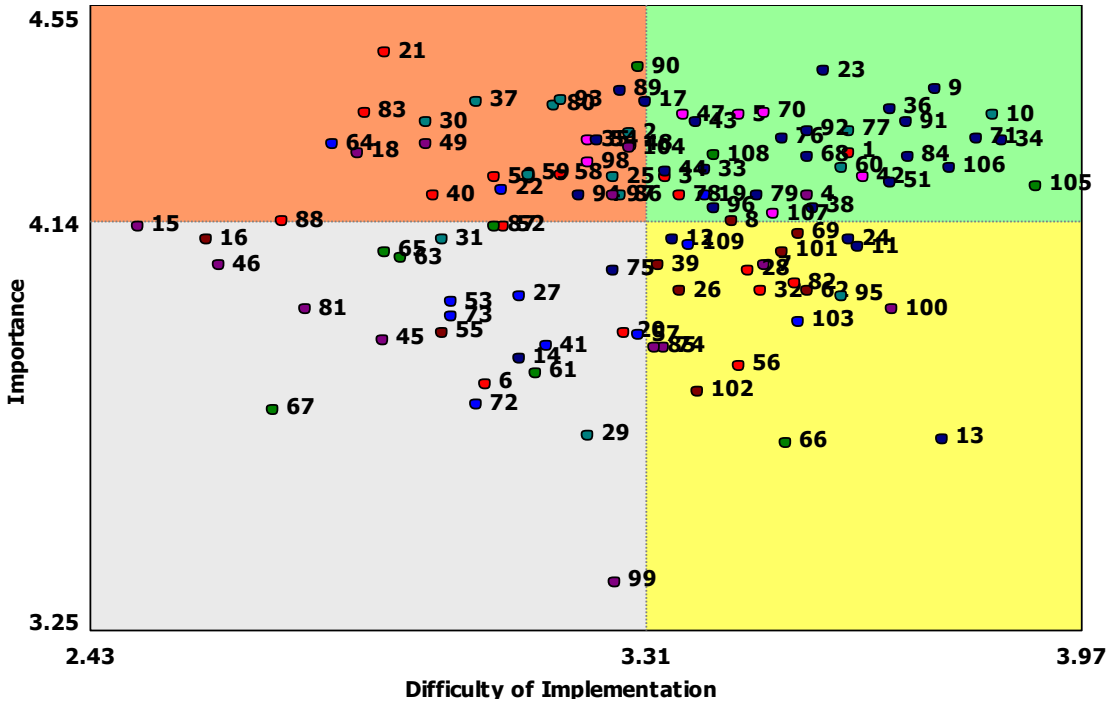
Figure 1
Comparison of the Clusters for Importance and Difficulty of Implementation



Results of the Process for the Ranking of Items. The 109 statements generated in the brainstorming session were rated on a five-point scale for Importance and Difficulty of Implementation. The statements receiving high ratings on Importance reflect higher priorities for action, and therefore the most important steps for action. However, if the concept of difficulty of implementation is also considered, the priorities for focusing action are changed, as they are tempered by what will require more effort. The areas that would be most essential to pursue, that is, the areas that will require the most attention and effort are those judged both important and difficult to implement.

A way to depict the most important and most difficult next steps is to use a "focus zone" map as shown in Figure 3. This method of mapping, which is part of the Concept Systems, Inc. data outputs, divides the items into four quadrants and displays the relationship between Importance and Difficulty of Implementation. The numbers on the map are the numbers of the 109 statements. The upper right quadrant is considered the major "focus zone," and includes items that the participants considered to be most important yet the most difficult to implement. These are the items that will require the most attention in preparing the community to implement a system of care.

Figure 2
Map of Items in Focus Zones



The rating of items for Difficulty of Implementation has yielded new information, as the dimension of Difficulty of Implementation had not been addressed in earlier studies. The practical implication of rating both Importance and Difficulty is that communities can understand where the greatest amount of effort should be expended—on those actions that are most important and most difficult to implement. As an example, the three statements with the highest combined rating on these two dimensions are:

1. The community partners have a willingness to share resources: knowledge, staff, dollars, with the understanding that it is through joint investment that joint success is achieved.
2. The concept of permanent system change needs to be understood and accepted as the end goal.
3. There must be a commitment from state and local policy makers and funders of services to participate in developing a viable system of care and revamping how services are provided and funded.

Useful Guidance and a Way to Assess Communities

The findings of the study to define community readiness were intended to be useful to communities as they plan to develop systems of care, whether they are at the stage of writing an application for funding or in the early stages of implementation. The clusters that resulted from the study define the domains/factors where efforts should be made. Within those domains, there are specific action steps (statements) that guide what needs to be done. The action steps were rated by the participants in the original study for how important they are to the successful implementation of a system of care. The action steps were also rated for how difficult they are to implement.

The list of statements generated in the first study has provided a basis for the Community Readiness Assessment Scale (CRAS). This statistically-based assessment strategy allows a large number of community stakeholders to quickly rate their own readiness to develop a system of care, whether they are in the pre-application stage or in the stage of being funded and in the planning phase. The input can be statistically analyzed quickly to provide a report on a community's readiness. Once the community stakeholders assess their readiness, the resulting information of their strengths and weaknesses should provide direction for their implementation efforts. A follow-up rating after 10-12 months, using the same rating scale would reflect and quantify their progress in addressing areas of weakness.

A Study of Readiness in New System of Care Communities

Cross-Site Analysis Plan

The cross-site analysis was designed to provide information about community readiness, from the perspective of the community stakeholders and from their Federal Project Officers (FPO) and the Regional Technical Assistance Coordinators (RTAC). This analysis was to address the following questions:

- Does the readiness score reflect the readiness of the site, as rated by the community stakeholders, the FPOs and RTACs?
- How do the sites compare on readiness scores, that is, what is the range of scores and how are the sites' scores distributed along a continuum?
- Is the timing of the assessment related to the overall readiness score? Does the readiness scores increase overtime as sites move forward with implementation? For example, is a site that participates in the first 9 months of funding more likely to have a lower score than one that is completed after the 15th month?
- What are the clusters that are scored highest and lowest across the sites? How do these compare to the ranking produced in the national study?
- What are the ten action steps (items) that are scored highest and lowest across the sites?
- Do the follow-up assessments show progress?

This proposed cross-site analysis represents a "first look" at the data. More extensive analyses are possible given the volume and type of data available.

Method

Description of Sites: From 2009-2012, the CRAS was used in 24 newly funded systems of care communities to have stakeholders do an initial assessment of their community's readiness to implement a system of care. 506 stakeholders participated in these assessments. Of the 24 sites, two were Native American sites, representing 8% of the site sample. There were 30 participants at the Native American sites, representing 6% of the total number of participants

There are three types of funded sites that have been assessed:

1. A single entity, such as a state, county, community mental health center, Indian Reservation, or other local entity that applied directly for funding for its entire area (8 sites in the sample);
2. A state that applied for funding on behalf of a designated local site or group of local sites (5 local sites in the sample); and
3. A state that applied for funding and then issued a request for proposals (RFP) to fund local sites. (14 sites in the sample).

Of the 24 sites, there were nine follow-up assessments completed thus far using the same instrument, to measure progress. The remaining sites are due to have follow-up assessments during the coming year, which would be 12-14 months after the initial assessment. This report covers the initial assessments at 24 sites and provides more limited analyses for the follow-up assessments at nine sites. The findings for the initial assessments and the follow-up assessments are presented separately below.

***Data Collection at the Sites*:** Beginning with communities that were funded in October 2009, the authors approached the site leaders, offering to do community readiness assessments. The intent was to conduct the assessments toward the end of the planning year, that is, at the end of the first year of funding. For sites that agreed to participate, discussions were held with site leaders about how to administer the Community Readiness Assessment Scale (CRAS). The following points were addressed:

- The site leaders were encouraged to reach as broad a group of stakeholders as possible. They were encouraged to recruit a group of 20-35 participants, representing different aspects of their community.
- It was explained that the assessment could be done face-to-face in a group, by e-mail distribution, or via a web-based program. Responses are easy for participants and the scale takes 20-30 minutes to complete. Sites were encouraged to do the assessments face-to-face in a group meeting to increase the likelihood of getting completed ratings from all the participants. They were told that additional participants could be recruited by e-mail, if they were not at the meeting.
- The Community Readiness Assessment Scale has also been translated into Spanish and this version was available to the sites, with accompanying instructions.
- A demographic form was developed with the site leaders to ensure that that the names of community agencies were appropriate and that all groups of stakeholders were listed. See Appendix B for a sample of the demographic form.

Data were mailed to the authors, who analyzed it and prepared a report for the system of care community within 30 days. The report was provided to the project leadership for review and comment, a final version was then created and sent to the site leadership for distribution. This information was to be used as the leadership and the community stakeholders mapped out the activities for the coming year. The assessments provide direction for implementation efforts. Follow-up assessments were completed after 12-14 months. Thus, follow-up studies have been completed for 8 sites, with several coming due in the next six months, so limited analyses have been done comparing initial assessments to follow-up assessments.

Participation from the Sites: In the 24 sites, data were collected from 530 individuals. The size of the participant population ranged from seven stakeholders at a small single county site to 87 at a statewide site. In all of the sites, there was a representative sample of stakeholders, to include, project leadership, project staff, partner agencies, parents, youth, and community leaders. The distribution of these 530 stakeholders was:

- 16 project leadership (3%)
- 133 project staff (25%)
- 196 partner agencies, including public schools and public child welfare, juvenile justice, health agencies, and private agencies and providers (37%)
- 69 parents (13%)

- 48 youth (9%)
- 47 community leaders (8%)
- 21 other (undefined) (4%)

Almost all of these 530 participants provided data that met the criteria for inclusion in the studies. Data from 24 participants (4.5%) were excluded, either because 1) they did not answer sufficient questions (66% or 72 of the 109 items) or 2) they did not discriminate among the possible responses by answering 80% of the items exactly the same. These 24 individuals were distributed essentially equally across the sites. Thus, the data analyses are based on 506 respondents. These are criteria recommended by Concept Systems, Inc.

***Timing of Assessments*:** The plan was to complete assessments toward the end of the first year of funding, that is, toward the end of the planning year and for most sites, this was accomplished. In a few sites, start-up was delayed, with delays in getting contracts to the sites established, staff hired, or community meetings held. For sites that were established through a Request for Proposal (RFP) process or through a contract between the site and the state office, the timing was calculated from when the local site was funded. Using these parameters, the range of timing of assessments was two months to 16 months from the beginning of the planning year, with a mean of 7.3 months.

It should be noted that the timing of start-up versus readiness was also affected by the history of the site. Some sites had either state, foundation, or federally funded grants prior to this initiative; some states had legislation regarding system of care in place; and some sites were selected by their state office based on need rather than readiness to move forward.

Participation by the Federal Project Officers and Regional Technical Assistance Consultants: In addition to collecting data from community stakeholders in the 24 sites, ratings of community readiness were gathered from two groups that interact with the sites in a consultative manner. The Federal Project Officers (FPOs) from the Child, Adolescent and Family Branch and the Regional Technical Assistance Coordinators (RTACs) from the Technical Assistance Partnership who were responsible for the participating sites were asked to complete a brief rating scale. This scale assessed their perceptions at the time of the first federal site visit, which was usually at the end of the first year of funding. See Appendix C for this rating scale.

The FPOs and the RTACs have a good understanding of how the sites listed as types 1 and 2 above are progressing (Type 1: A single entity, such as a state, county, community mental health center, or other local entity that applied directly for funding for its entire area; and Type 2: A state that applied for funding on behalf of a designated local site or group of local sites.); For category 3, they are familiar with only one site (Type 3: A state that applied for funding and then issued a request for proposals (RFP) to fund local sites.). In the other 14 sites, they are familiar with only some of the local sites, as their site visits could not include visits to all local sites. For the states where these raters are not familiar with the local sites, the data was collapsed into a state-level data set.

All the FPOs and RTACs responsible for the sites were asked to provide ratings. All did not reply, but the responses from these two groups covered all but one site. Neither the Federal Project Officer nor the Regional Technical Assistance Consultant provided ratings for the one

site that had the lowest ratings by its community partners. For the remaining 23 sites, there were 21 ratings by the FPOs and 14 ratings by the RTACs. There were seven sites where both groups provided ratings.

Findings of the Initial Assessments

***Native American Sites*:** Examination of the findings from the Native American sites in the areas listed above indicates that their responses are similar to those of the other sites. The data indicate that there is no reason to analyze these data separately. Therefore, the data from all 24 sites have been combined.

Timing of the Assessments: Recall that the point of funding was calculated from when the site received the funds. As explained on the previous page, there were many variations as to how funds were distributed to the sites, which influenced the starting dates. The timing of the assessments did seem to make a difference. The average time for sites to complete the Community Readiness Assessment from the start of their funding was 7.88 months. The range was two months to 17 months. There were 12 sites that completed the assessment within six months of funding and 12 sites that completed it within 10-17 months. The sites that completed the readiness assessment early clearly did better than the sites that completed it late. The average readiness score for the 12 sites funded less than six months was 3.54; for the 12 sites that completed the readiness assessment after 10 months, the average score was 2.75.

Of the 12 higher scoring sites, ten were selected by an RFP process in states where system of care approach was strong. In these states, there were other sites historically funded with state, federal or foundation grants and there was legislation that addressed the system of care as the desired approach for service organization. Of the other two, one was a statewide program and one was a community that had applied on its own. The latter "independent site" was also in a state where system of care was emphasized by the state office. From working with the 12 sites in the "six months or less" group that used the RFP process, the authors' interpretations of this finding are that 1) the RFP process that was used gave sites time to organize and prepare and the process gave the states sound information to use in the selection process; 2) the states that used the RFP process were states where substantial work on system of care development had already been done prior to the states' being funded; and 3) those states selected the local sites based on readiness as described in their responses to the RFP. It also seemed clear that, for the two sites not involved in an RFP process, state involvement/leadership was very strong. In the 12 sites that completed the assessment after ten months, three used the RFP process. Of these 12, five were sites that involved states applying on behalf of specific local sites; the site selection was not competitive and was based on need, on the sites that were behind, or for other reasons other than readiness. In these sites, there were problems with 1) directing the money to the local level; or 2) changes in state leadership which delayed the process. Another four were sites that applied on their own, without direct state involvement.

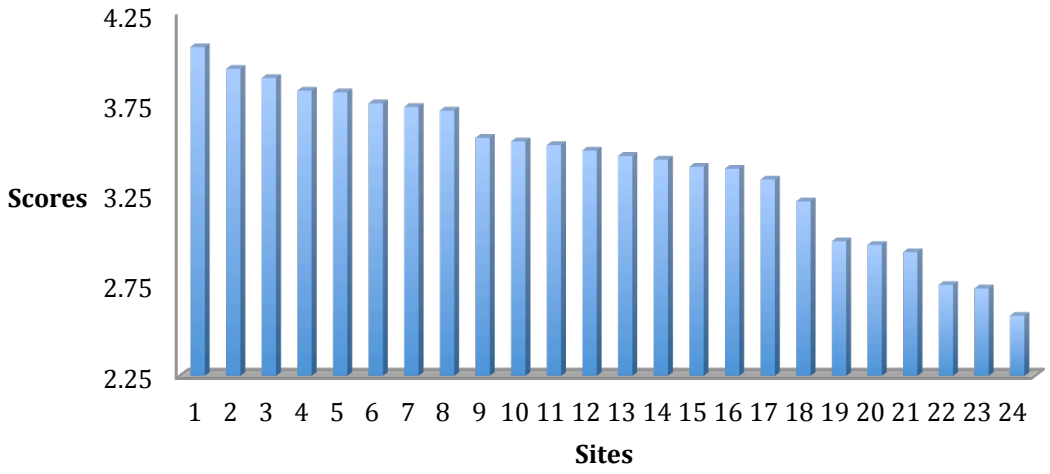
Analysis of Data from the Community Readiness Assessment Scale: Data have been analyzed to provide information in the following areas:

- Readiness Scores, an overall index of readiness and Readiness
- Ratings by the Federal Project Officers and Regional Technical Assistance Coordinators,

- Cluster Rankings: a comparison with the findings in the national study regarding the importance of the items and the difficulty of implementation, indicating readiness; data are presented by clusters/domains;
- Analysis of Items: information about the specific actions for which the sites are most ready and least ready, that is, areas that have not been addressed and will need attention to successfully implement systems of care;
- Concerning the Cluster Rankings and Item Rankings, a comparison of the low ranking sites and the high-ranking sites (those that are 2 standard deviations above and below the mean on Readiness scores);
- A listing of most ready and least ready items by cluster; and
- A limited comparison of initial assessments to follow-up assessments.

Readiness Scores: The readiness score for each site is calculated to reflect the average score for all 109 items. These items were rated on a scale of 1.00 – 5.00, with 1.00 being the "least ready" and 5.00 being the "most ready." The range of scores from the 24 funded sites is 2.58 – 4.06 and the mean is **3.42**. This mean score reflects a fairly high degree of readiness, which is expected, given that these sites were selected for funding based on the amount of readiness for a system of care that they had in place. The range of readiness across the sites is seen in Figure 3. The six sites that scored the lowest were below 3.00, and that is two standard deviations below the mean.

Figure 3
Readiness Scores across 24 Sites



Readiness Ratings by the Federal Project Officers and Regional Technical Assistance Consultants: The average readiness score from the Federal Project Officers (FPOs) and the Regional Technical Assistance Coordinators (RTACs) combined is 3.76. The range of scores is 2.44 to 4.33. There was agreement between these two (combined) groups with the community groups that rated readiness at the sites. Among the top six sites as rated by the community, five of them had the top ratings by the FPOs/RTACs. Among the bottom five sites (excluding the one site that was unrated), four were rated the lowest by the FPOs/RTACs.

Cluster Rankings: The eight clusters or domains used in assessing readiness were determined in the earlier national study. The data from the community readiness assessments provided

rankings of the clusters compared with the rankings from the national study. Table 2 presents the average rankings of Readiness from the 24 sites with the earlier rankings for Importance and Difficulty of Implementation.

Table 2
Cluster Rankings of Site Readiness Compared with Importance and Difficulty of Implementation

Importance	Score	Readiness	Score	Difficulty of Implementation	Score
Collaboration	4.32	Collaboration	3.51	Leadership	3.54
Plan to Expand Services	4.24	Accountability	3.44	Network of Local Partners	3.42
Families/Youth Partners	4.24	Evaluation	3.39	Shared Goals	3.30
Leadership	4.14	Plan to Expand Services	3.39	Collaboration	3.29
Accountability	4.03	Leadership	3.35	Families/Youth Partners	3.21
Shared Goals	4.01	Shared Goals	3.25	Accountability	3.20
Evaluation	3.00	Network of Local Partners	3.21	Evaluation	3.15
Network of Local Partners	3.99	Families/Youth Partners	3.13	Plan to Expand Services	3.11

When considering the most ready areas, the respondents rated the 24 sites highly on Collaboration, Accountability, and Evaluation. Note that Collaboration was rated highest in the national study, indicating that a broad group of experts considered this most essential to the development of a system of care. This high rating on Readiness represents strength for the 24 sites. The Request for Applications (RFA) for funding emphasized the importance of collaboration and the reviewers of the applications considered community collaboration as they scored the submissions. In the applications, letters of support from the community partners were required to present evidence of community collaboration; sites that were selected had presented this evidence. The ratings by the community stakeholders reinforced the validity of the process.

The least ready areas of Shared Goals, Network of Local Partners and Families & Youth as Partners indicate that the next steps, deeper steps, in the collaborative process will require strengthening and broadening local partnerships with agencies, providers, families and youth; and one of the first steps in enhancing collaboration should be to ensure a good understanding of the project and clarify what is expected of local partners (Shared Goals). As Network of Local Partners, was also rated in the national study as the second most difficult to achieve and Shared Goals, third, these clusters of action steps represent an important and somewhat difficult challenge for the stakeholders across the 24 sites. The items within these clusters that will strengthen the Network of Local Partners will need the most attention by the sites as they implement the systems of care.

Now pay particular attention to the lowest ranking cluster of Families & Youth as Partners. A review of the scores across the 24 sites indicates that this low score reflects a consistent pattern of low scores for this cluster—not just a few sites with very low scores to pull down the average. Of the 24 sites, 22 scored lowest in this area. The importance of family and youth involvement was highlighted in the national study, as this area of focus scored second highest behind collaboration with community partners (which also included some items about collaboration with families). Family and youth involvement is also a highly emphasized area in the federal policy

guidance for the preparation of the application for funding and for the implementation of a system of care. It is an important focus of technical assistance and training for the funded sites. From all considerations, it is important, even essential, to the successful implementation of the system of care. However, it is the area of least readiness of the sites. The explanation seems rather clear—it is the area where there is a major gap in usual and customary community services and therefore a challenge to the sites—and perhaps best said as the area where federal funding can make the biggest difference, helping communities move from little involvement of families and youth to major involvement in system design, participation on governing boards, participation in evaluation, and participation in the design of their own services.

Results of the Ratings of Statements across Clusters: The purpose of presenting the ratings of statements is to highlight specific areas of strength and areas that need attention to improve. The ratings of the items are presented without considering the clusters in which they are arranged. The data by cluster will be presented later. (The list of statements by ranking is presented in Appendix C.) Those items that the participants rated as most ready and those that they rated as least ready are presented in Tables 3 and 4.

Table 3
The Ten Statements Rated as Most Ready[5]

#	Statement	Score
16	There is a felt need for services within the community by the stakeholders.	4.22
64	There is a commitment to measurement of progress and outcomes.	3.92
88	There is agreement to have family advocates on staff.	3.87
93	There is a willingness to work in a fair, inclusive, and open manner.	3.86
31	There is a strong collaborative group of service providers already engaged in discussion about mutual goals.	3.73
30	There are committed community stakeholders, which include child-serving systems, providers, families, youth and community members.	3.72
22	There is commitment to evaluation and data based decision-making.	3.70
86	The community partners are willing to have open discussions and come to agreement on what some of the barriers and obstacles are to making the changes necessary to have a system of care.	3.69
37	There are strong relationships and commitments to collaboration among community partners.	3.68
54	There is a core, committed group with strong leadership that couples vision with concrete strategy and practical know-how.	3.68
45	There is intent to provide training in and utilization of specific evidence-based practices with justification based on clinical characteristics of population of focus.	3.66

The ten "most ready" statements reflect adherence to the Core Values and Guiding Principles promulgated by the funding agency, the Child, Adolescent and Family Branch of the Center for Mental Health Services and discussed above on page 4. These values and principles were articulated in the RFA. Essentially, the sites were selected because they demonstrated in their

[5] 11 statements are presented, as there is a tie for ninth place.

applications that these requirements were in place. The policies were then emphasized to the funded communities through written communications, webinars, and meetings. The ratings by the respondents in the 24 sites reflect that these requirements are almost in place.

Looking at specific items, it is clear that these items reflect commitments/willingness/ agreements to plan, develop, evaluate, discuss, work together, and collaborate. The communities indicate that there is leadership with a vision to get the work done. These 11 items reflect optimism and trust that the job of building a system of care will get done, which is certainly an excellent foundation on which to build. The areas of most readiness still reflect work to be done, as none were scored as fully complete. This information can be useful in planning technical assistance and training, as all sites appear to need work in strengthening their relationships with local partners and, most importantly, in developing partnerships with families and youth.

Note that the items rated as "most ready" do not reflect actual accomplishments in these areas; the accomplishments are presumably yet to come. Looking at Table 4 below, the 13 statements of the "least ready" items reinforce this interpretation. The "least ready" items are not items of hope or intent; they are items of action and accomplishment. Note that six of these items address family involvement (#107, #82, #78, #50, #1, #5). Five items address broader community involvement (#107, #99, #29 #13, #5). And four items address financing issues (#82, #41, #39, #102). **These items and similar ones appear in the "least Ready" list of all 24 sites**, indicating that family issues, financing issues, and broader community involvement are the part of systems development that are not initially in place and also that these are areas, most likely, where technical assistance and training could be helpful. In essence, these are the areas that the federal funding is designed to address, with the expectation that these elements will be built during the life of the cooperative agreement between the site and the federal agency.

Table 4
The Ten Statements Rated as Least Ready[6]

#	Statement	Score
32	Young people are being provided support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	3.01
107	An advisory or leadership board has been established that has at least 1/3 parent participation and they have input on the design and implementation of the project.	2.98
82	There is a plan for substantial financial support for family involvement, controlled by families being served.	2.98
78	Families are willing to take on a lead role in taking the vision to reality.	2.96
41	There has been an analysis about those service components that will require more support in order to implement them.	2.96
39	The community partners have a clear understanding of how services are financed and their limitations on flexibility	2.94
50	Training has been provided to parents to help them feel more confident advocating for themselves and others in the community.	2.92

[6] 13 statements are presented, as there are three ties.

99	There is a plan for volunteer development.	2.91
1	Families are provided with support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	2.84
102	The community is being made aware of the potential services in order to be willing to support additional funding.	2.79
29	Community organizations such as faith-based groups have participated in the planning process.	2.77
13	There is strong inclusion of elected officials on the local and state level.	2.77
5	Everyone--community partners, leaders, families, and youth--understands the principles on which the new system will be built and share the same values.	2.73

Adjusted Ratings: To understand the adjusted ratings, it is important to understand the national study of readiness completed in 2008. The study is discussed on pages 6-13. In this study, 223 experts in systems of care identified 109 characteristics considered essential to the development of a system of care. These 109 items became the Community Readiness Assessment Scale. The expert panel also rated each item on a five-point scale as to its importance in developing a system of care. In the current study of 24 sites, the respondents' ratings are adjusted to the national study's findings of which items are most important. The comparison addresses the items rated highest and lowest on Readiness, compared to the ratings on Importance (Tables 5 and 6). Table 5 presents a list of the items rated as most important and most ready. Table 6 presents a list of the items that are rated as most important and for which the community is least ready. These are the items on which to focus next efforts.

Table 5[7]
Five Most Ready and Most Important Items

#	Statement	Rank
93	There is a willingness to work in a fair, inclusive, and open manner.	1
64	There is a commitment to measurement of progress and outcomes.	2
90	Sustainability of services developed is part of the discussions beginning in the 1st year not waiting until the end.	3
30	There are committed community stakeholders, which include child-serving systems, providers, families, youth and community members.	4
37	There are strong relationships and commitment to collaboration among community partners.	4
89	There is a commitment from policy makers, community leaders, partners, and staff to the system of care values and principles.	5

Note that five of the six statements rated as most ready among those considered as most important tend to reflect a focus on commitment to the important elements in the development of a system of care, but not the actual implementation of those. It is also important that the community understands the importance of sustainability (#90). These are important items, as identified in the national study and this implies that, according to the perceptions of the participants, the 24 sites have good foundations in place on which to build a system of care,

[7] Six statements are presented, as there is a tie for 4th place.

moving from commitment to actualization. Having these elements of the system of care mostly in place should serve the communities well as they design their next steps.

Table 6
Five Least Ready and Most Important Items

#	Statement	Rank
5	Everyone--community partners, leaders, families, youth--understands the principles on which the new system will be built and share them, share the same values.	1
1	Families are provided with support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	2
3	There is training and support to help teach and educate families and professionals how to work together and respect and value each other's expertise.	3
84	Agreements between the state and local agencies are in place so that changes in administrations midway through the 6 years of funding don't derail the momentum and progress of the project.	4
47	There is active participation from families, youth and front-line workers from public and private sectors in the implementation of the system.	5

It is apparent that important next steps are to fully implement the commitments to the values and principles of system of care development. It is important to note that four of the five "least ready" items among the most important focus on actual involvement of families, not just commitment to such involvement (#5, #1, #3, #47). As noted above, every one of the 24 sites had family issues among the "least ready" items. In Table 6, comparing the readiness areas of the 24 sites with the areas found to be most important in the national study emphasizes this point. The one issue, #84, surprisingly also appears in most of the 24 sites, regardless of the role that the state played in the application process—that is whether or not the state was the applicant. The issue of agreements to support continued development of a system of care was considered very important in the national study. Evidently, such agreements are lacking in the sites, which threatens sustainability. The areas of family involvement and assurances of ongoing state support represent the biggest challenges, challenges that will be necessary to address as the implementation of the systems of care move forward.

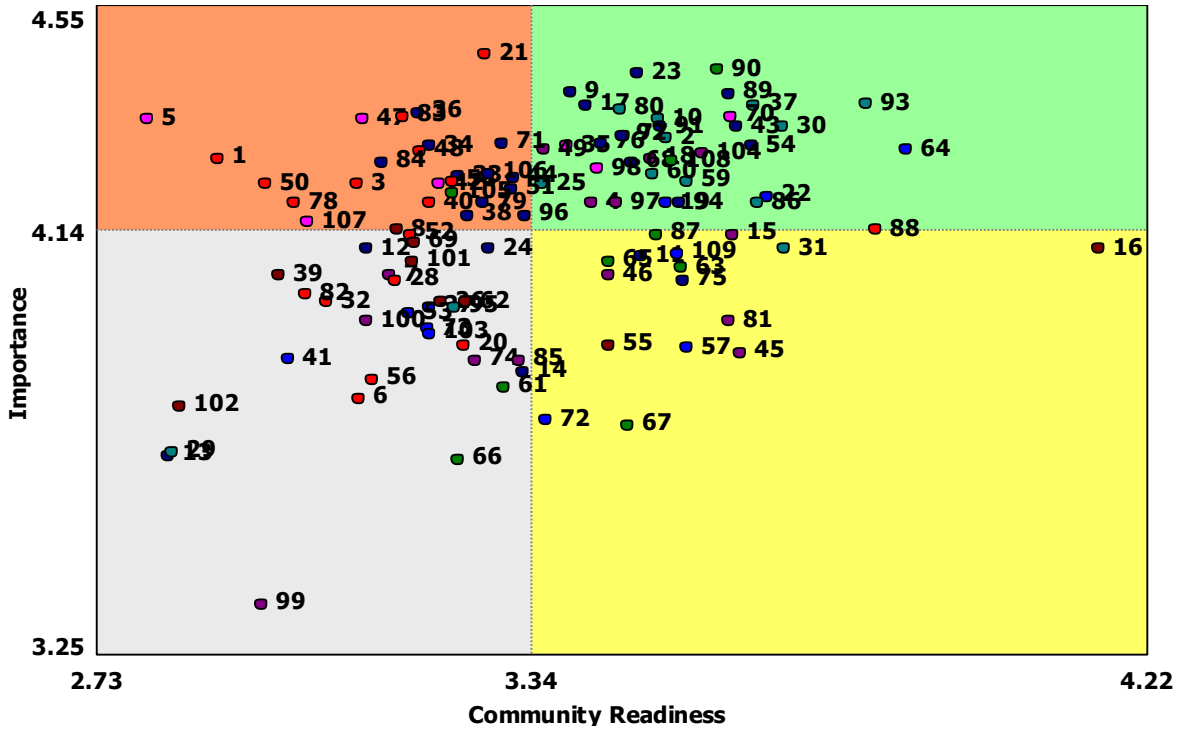
Focus Zone Maps: Another method of looking at these comparisons is by creating a Focus Zone map. The map below displays the readiness ratings of the statements compared with the importance ratings of those statements (Figure 4), which is a visual representation of Tables 5 and 6. The Focus Zone map shows, in addition to the comparisons of Readiness to Importance, the scatter of the items—how broad a range the scores of the items cover. The placement of the items on the map is derived from the average scores of each item. The numbers on the maps are the statement numbers from the CRAS.

In Figure 4, the upper right quadrant (green) contains those statements rated highest on both Readiness and Importance, reflecting the best readiness in relation to importance and the area where the easiest work might be. The upper left quadrant (orange) contains those items that are

considered to be of high importance and low readiness, representing items that should be addressed next. The lower right quadrant (yellow) contains those items on which there are high ratings of readiness, even though they were not considered to be among the most important statements. The lower left quadrant (gray) contains those items, which were rated as less important and for which there is less readiness. The lower two quadrants contain items to be addressed in the future.

Figure 4

A Focus Zone of the Ratings for Importance and Readiness



In Figure 4, which depicts Tables 3 and 4, there are more items in the upper right quadrant (green) than the upper left quadrant (orange). These placements of items convey that the 24 sites are scored higher by their communities on readiness for the important items than lack of readiness for these items. This interpretation of the graph is consistent with the high average readiness score of 3.42 and a range of scores from the sites reaching 4.06, out of a potential perfect score of 5.00. Most of the items in the upper left quadrant (orange) are bunched toward the midline, suggesting that on these items, the respondents rated the communities as moving towards readiness or just about ready, but with more progress needed. Some of the items in the upper right quadrant (green) are bunched at the midline also. These items near the midline in both quadrants are the items where much of the work needs to be done to implement the system of care, as these are items that were rated high on importance in the national study. Items that need the most work are on the outer side of the upper left quadrant, as they are important items not yet accomplished. By their placement on the left side of the graph, items #5, #1, #50, #47 #3, and #84, appear as least ready among the most important items. These are the same six items that are listed in Table 6, which reflects the Least Ready and Most Important items.

Results of the Ratings for Items within Clusters: The analysis of items within clusters based on the rating by community respondents provides interesting information and guidance. The discussion above used the ratings of the items, independent of the clusters. In the national study, the experts placed the items in eight clusters (conceptual areas). An analysis of how the respondents from the 24 sites ranked the items within clusters is presented in Table 7 below, focusing on the items that were rated as most ready and those that were rated as least ready. The presentation of six items for each of eight clusters includes 48 items, that is, 44% of the total 109 items. Some communities have created work groups based on the clusters. Looking at the responses of items by cluster has helped those communities decide which issues to address. The "most ready" items need some additional work and the "least ready" items are important for the longer range.

Table 7
Ranking of Items within Clusters

Families & Youth as Partners

Most Ready

88 There is agreement to have family advocates on staff.
21 There has been input from youth and families to determine the needs in the community.
20 There is an adequate budget to provide skill-building activities for youth.

Least Ready

78 Families are willing to take on a lead role in taking the vision to reality.
50 Training has been provided to parents to help them feel more confident advocating for themselves and others in the community.
1 Families are provided with support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.

Plan to Expand Services

Most Ready

45 There is intent to provide training in and utilization of specific evidence-based practices with justification based on clinical characteristics of the population of focus.
15 The community has identified a population of initial focus for its system transformation efforts.
81 The staff and the community partners have a demonstrated knowledge of characteristics of the population to be served.

Least Ready

7 The community is being provided with examples of what following the values and principles of the system of care looks like in order to understand what a shift in thinking and practice it is from how they currently serve children and families.
100 The community has dedicated sufficient resources to support cultural and linguistic proficiency.
99 There is a plan for volunteer development.

Evaluation

Most Ready

64 There is a commitment to measurement of progress and outcomes.
22 There is commitment to evaluation and data based decision-making.
57 The community partners have a commitment to ongoing evidence-based practice with fidelity monitoring and feedback.

Least Ready

73 There has been a study that provides insight into the barriers to change within the community.

53 There has been a comprehensive assessment within the community of where the gaps are in terms of resources.

41 There has been an analysis about those service components that will require more support in order to implement them.

Collaboration

Most Ready

93 There is a willingness to work in a fair, inclusive, and open manner.

31 There is a strong collaborative group of service providers already engaged in discussion about mutual goals.

30 There are committed community stakeholders, which include child-serving systems, providers, families, youth and community members.

Least Ready

25 The community partners have an understanding of their specific contribution to collaborative efforts.

95 The school district and medical professionals are in the collaborative agreement.

29 Community organizations such as faith-based groups have participated in the planning process.

Network of Local Partners

Most Ready

70 There is a commitment from leadership at major child serving systems that a family-driven, youth-guided system of care is essential to success.

98 There is a fully functioning advisory board or other group that represents key program partners, families, and youth.

35 All partners have a sense of community identification and buy-in to the system of care values and principles.

Least Ready

47 There is active participation from families, youth and front-line workers from public and private sectors in the implementation of the system.

107 An advisory or leadership board has been established that has at least 1/3 parent participation and they have input on the design and implementation of the project.

5 Everyone--community partners, leaders, families, and youth--understands the principles on which the new system will be built and share the same values.

Shared Goals

Most Ready

16 There is a felt need for services within the community by the stakeholders.

55 The child-serving agencies have been meeting regularly along with family/youth participation to review children with serious emotional disturbances in their community and in need of more intensive community resources.

62 There is a process to learn about and better understand the realities of each of the major stakeholders so system change can occur by devising win-win situations rather than relying on good will alone.

Least Ready

8 Key budget staff is working with partners on funding issues, requirements, restrictions, and

how to resolve the issues.

39 The community partners have a clear understanding of how services are financed and their limitations on flexibility

102 The community is being made aware of the potential services in order to be willing to support additional funding.

Accountability

Most Ready

90 Sustainability of services is part of the discussions from the beginning, not waiting until the end of the funding period.

63 The agency that received the funds has a history of positive audits and has disclosed any fiduciary or subcontracted agent that will manage funds.

108 There is an agreement to share information across child-serving systems.

Least Ready

61 There are partnerships with colleges and universities for research and/or evaluation purposes.

66 The fiscal agent is independent of any and all of the partner agencies so as not to appear to have control over the budget.

105 There is an understanding of blended or braided funding and the willingness among the community agencies to share resources.

Leadership

Most Ready

54 There is a core, committed group with strong leadership that couples vision with concrete strategy and practical know-how.

43 The project leaders have the ability to bring resources to the table or leverage resources (not necessarily money but also human capital and political will).

89 There is a commitment from policy makers, community leaders, partners, and staff to the system of care values and principles

Least Ready

84 Agreements between the state and local agencies are in place so that changes in administration midway through the 6 years of funding don't derail the momentum and progress of the project.

12 There are clearly defined decision-making processes and communication pathways across stakeholders.

13 There is strong inclusion of elected officials on the local and state level.

Preliminary Findings of the Follow-Up Assessments

Of the 24 sites studied, nine have participated in follow-up assessments to date. There were 116 respondents in these nine communities. The findings are that all nine sites that completed follow-up assessments have shown positive changes. The average readiness score of these nine follow-up sites is 3.77, compared to an average score of 3.33 at their initial assessment. The average change is .47; the range was .09 – .72

The timeframe for the follow-up assessments ranged from 14 months to 25 months, with an average of 19 months. There is a consistent pattern among the nine sites that the longer the time period between the initial assessment and the follow-up, the greater the gain. This finding

suggests that positive change continue over time, with the sites making greater progress as time goes on.

Note that the six sites that scored considerably lower than the others, at two standards deviations below the mean, have not participated in follow-up studies.

Conclusions

The study of community readiness in 24 sites, funded by the Child, Adolescent and Family Branch of the Center for Mental Health Services, indicates the 24 communities have much in place on which to build a system of care. The average rating of readiness of 3.42 across the 24 sites, out of a possible 5.00, is quite positive. Further, the areas that are rated to have the most readiness are those of Collaboration and Accountability, elements that are stressed in the federal policy guidance and in the requirements of the Request for Applications (RFA).

The perceptions of the respondents also identify areas important to system of care development that need attention as planning and implementation efforts move forward. In terms of what needs to be done next, it seems important to focus on the areas that are rated as least ready, that is Families and Youth as Partners and Network of Local Partners, especially focusing on the 'non-traditional" partners, such as parents, advocates, community leaders, and volunteers.

It is not a surprising finding that Families and Youth as Partners and Network of Local Partners are the two areas where most work is needed. These two conceptual areas are fundamental to system of care philosophy and essential for a successful system of care and these two conceptual areas are usually not in place in communities that have not yet focused on system of care development. In some sense, developing these conceptual areas, which are described in the Families and Youth as Partners and Network of Local Partners clusters, is a major purpose of the federal funding. Note that in the national study, Families and Youth as Partners was rated as only moderately difficult to achieve, so addressing these activities should be only moderately challenging. However, the activities related to the Network of Local Partners was rated as the second most difficult to achieve in the national study, so this is an area of substantial challenge.

Focusing on statements, rather than clusters, the statements/action steps presented in Table 3 indicate the strengths of the communities. The ten "most ready" statements reflect adherence to the Core Values and Guiding Principles promulgated by the funding agency, the Child, Adolescent and Family Branch of the Center for Mental Health Services and discussed above on page 4. These values and principles were articulated in the RFA. Essentially, the sites were selected because they demonstrated in their applications that these requirements were in place. The policies were then emphasized to the funded communities through written communications, webinars, and meetings. The ratings by the respondents in the 24 sites reflect that these requirements are almost in place.

Looking at specific items, it is clear that these items reflect commitments/willingness/ agreements to plan, develop, evaluate, discuss, work together, and collaborate. The communities indicate that there is leadership with a vision to get the work done. These 11 items reflect optimism and trust that the job of building a system of care will get done, which is certainly an

excellent foundation on which to build. The areas of most readiness still reflect work to be done, as none were scored as fully complete. This information can be useful in planning technical assistance and training, as all sites appear to need work in strengthening their relationships with local partners and, most importantly, in developing partnerships with families and youth. Note that the items rated as "most ready" do not reflect actual accomplishments in these areas; the accomplishments are presumably yet to come

Of the 24 sites studied, nine have participated in follow-up assessments to date. There were 116 respondents in these nine communities. The findings are that all nine sites that completed follow-up assessments have shown positive changes. The timeframe for the follow-up assessments ranged from 14 months to 25 months, with an average of 19 months. There is a consistent pattern among the nine sites that the longer the time period between the initial assessment and the follow-up, the greater the gain. The results suggest that the support provided to the sites by the Federal Project Officers, Regional Technical Assistance Providers, evaluation efforts, consultants and a myriad other means improves implementation over time. The Community Readiness Assessment Readiness Scale quantifies this progress and provides a clear focus for "next steps."

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Appendix A
The Community Readiness Assessment Scale

Community Readiness for the Implementation of a System of Care[8]

Lenore Behar, Ph.D. & William M. Hydaker, MA

Please rate each item in terms of how ready your community is to implement a system of care, that is, how much your community has accomplished for each item. A rating of 1 indicates "least ready" and a rating of 5 indicates "most ready."

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 1. Families are provided with support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 2. The collaborative is actively involved/committed in developing the application approach/strategies/goals/outcomes.

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 3. There is training and support to help teach and educate families and professionals how to work together and respect and value each other's expertise.

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 4. Well trained culturally competent flexible personnel work in the system.

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 5. Everyone--community partners, leaders, families, youth--understands the principles on which the new system will be built and share them, share the same values.

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 6. Key family contacts and youth leaders have been identified prior to the application submission so that the groups are ready to roll once the funding is received.

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 7. The community is being provided with training and examples of what following the values and principles of the system of care might look like to see what a shift in thinking and practice it really is from how they currently serve children and families.

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 8. There is involvement of key budget staff to work with partners on funding issues, requirements, restrictions, and how to resolve the issues.

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 9. The concept of permanent system change is understood and accepted as the end goal.

☐**1**☐**2** ☐**3** ☐**4** ☐**5** 10. The community partners have a willingness to share resources: knowledge, staff, dollars, understanding that it is through joint investment that joint success is achieved.

☐1☐2 ☐3 ☐4 ☐5 11. There is a strong relationship between the state and the local community receiving the funding.

☐1☐2 ☐3 ☐4 ☐5 12. There are a clearly defined decision-making processes and communication pathways across stakeholders.

☐1☐2 ☐3 ☐4 ☐5 13. There is strong inclusion of elected officials on the local and state level.

☐1☐2 ☐3 ☐4 ☐5 14. There are established relationships among entities to be involved in the system and guidelines for these relationships.

☐1☐2 ☐3 ☐4 ☐5 15. The community has identified a clear population of initial focus for its system transformation efforts.

☐1☐2 ☐3 ☐4 ☐5 16. There is a felt need for services within the community by a variety of stakeholders.

☐1☐2 ☐3 ☐4 ☐5 17. The community understands that the cooperative agreement is not primarily a granting of money but is a partnership with the federal government to accomplish the federal program goals.

☐1☐2 ☐3 ☐4 ☐5 18. There is a clear understanding of the project's population of focus and changes that will be needed to meet the service needs of this population.

☐1☐2 ☐3 ☐4 ☐5 19. The applicant fully understands the magnitude of the evaluation component and the importance of data driven services.

☐1☐2 ☐3 ☐4 ☐5 20. There is a decent budget to provide skill building activities for youth.

☐1☐2 ☐3 ☐4 ☐5 21. There has been input from youth and families to determine the needs in the community.

☐1☐2 ☐3 ☐4 ☐5 22. There is commitment to evaluation and data based decision making.

☐1☐2 ☐3 ☐4 ☐5 23. There is a commitment to the effort from key community stakeholders – people with the ability to influence attitudes and actions of others such as elected officials, community champions, respected individuals, etc.

☐1☐2 ☐3 ☐4 ☐5 24. There is a well developed understanding by the state level personnel with decision making authority.

☐1☐2 ☐3 ☐4 ☐5 25. The community partners have a vision of what is the specific contribution of their collaboration.

☐1☐2 ☐3 ☐4 ☐5 26. There is a clear plan, agreed to by the community partners, for expanding the array of services.

☐1☐2 ☐3 ☐4 ☐5 27. Cultural agents are involved from the early planning stages forward.

☐1☐2 ☐3 ☐4 ☐5 28. There is a strong family organization with resources to fully participate.

☐1☐2 ☐3 ☐4 ☐5 29. Community organizations such as faith based groups were at the table in the application process.

☐1☐2 ☐3 ☐4 ☐5 30. There are committed community stakeholders, which include child-serving systems, providers, families, youth and community members.

☐1☐2 ☐3 ☐4 ☐5 31. There is a strong collaborative group of service providers already engaged in discussion about mutual goals.

☐1☐2 ☐3 ☐4 ☐5 32. Young people are being provided support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.

☐1☐2 ☐3 ☐4 ☐5 33. There is a commitment from partnering agencies about what exactly they will provide to this process.

☐1☐2 ☐3 ☐4 ☐5 34. There is a commitment from state and local policy makers and funders of services to participate in developing a viable system of care and revamping how services are provided and funded

☐1☐2 ☐3 ☐4 ☐5 35. All partners have a sense of community identification and buy in to the System of Care mission and principles.

☐1☐2 ☐3 ☐4 ☐5 36. There is a commitment by the leadership of the community partners in the form of designated funding (match), staffing resources, or track record implementing initiatives that share core SOC values and principles.

☐1☐2 ☐3 ☐4 ☐5 37. There are strong relationships and commitment to collaboration among community partners.

☐1☐2 ☐3 ☐4 ☐5 38. There is cross-system cooperation/ decision-making as well as "vertical" interagency cooperation/decision-making (top-down, bottom-up).

☐1☐2 ☐3 ☐4 ☐5 39. The community partners have a clear understanding of how services are financed and their limitations on flexibility.

☐1☐2 ☐3 ☐4 ☐5 40. The community can show specific ways that family members and youth participate in decision-making for their individual service plans.

☐1☐2 ☐3 ☐4 ☐5 41. There has been an analysis about the service components that will require more support to reduce the problems.

☐1☐2 ☐3 ☐4 ☐5 42. All community partners are working collaboratively to include strong parental engagement, blended and flexible funding, and shared success and liability.

☐1☐2 ☐3 ☐4 ☐5 43. The project leaders have the ability to bring resources to the table or leverage resources (not necessarily money but human capital, political will).

☐1☐2 ☐3 ☐4 ☐5 44. Leadership sharing has been clearly defined.

☐1☐2 ☐3 ☐4 ☐5 45. There is intent to provide training in and utilization of specific evidence-based practices with justification based on clinical characteristics of population of focus.

☐1☐2 ☐3 ☐4 ☐5 46. All those participating in the "big picture" have been educated about the history of the System of Care and the effectiveness of a successful system of care.

☐1☐2 ☐3 ☐4 ☐5 47. There is active participation from families, youth and front-line workers from public and private sectors in the implementation of the system.

☐1☐2 ☐3 ☐4 ☐5 48. Project leaders have identified youth and family members who are able to articulate and to advocate, with support and training, if necessary, to use their stories and voice.

☐1☐2 ☐3 ☐4 ☐5 49. To ensure adequate staffing, there is a realistic plan to hire and train new staff in a timely manner.

☐1☐2 ☐3 ☐4 ☐5 50. Training has been provided in advocacy, leadership, and meeting etiquette to parents to help them feel more confident advocating for themselves and others in the community.

☐1☐2 ☐3 ☐4 ☐5 51. There is buy-in at the state level.

☐1☐2 ☐3 ☐4 ☐5 52. There is a dedicated amount in budget to go to the family organization.

☐1☐2 ☐3 ☐4 ☐5 53. There has been a comprehensive assessment within the community of where the gaps are in terms of resources and needs.

☐1☐2 ☐3 ☐4 ☐5 54. There is a core committed group with strong leadership that couples vision with concrete strategy and practical know-how.

☐1☐2 ☐3 ☐4 ☐5 55. The community can demonstrate that child serving agencies have been meeting regularly along with family/youth participation to review children with serious emotional disturbances in their community and in need of more intensive community resources.

☐1☐2 ☐3 ☐4 ☐5 56. A family organization was developed before funding.

☐1☐2 ☐3 ☐4 ☐5 57. The community partners have a commitment to ongoing evidence-based practice with fidelity monitoring and feedback.

☐1☐2 ☐3 ☐4 ☐5 58. The community can show that family members and youth are active members of a community system of care initiative.

☐1☐2 ☐3 ☐4 ☐5 59. The community partners include the child serving agency stakeholders that have bought into the systems of care and wraparound concept.

☐1☐2 ☐3 ☐4 ☐5 60. Partners that are essential to the system of care are fully on board and officially on board.

☐1☐2 ☐3 ☐4 ☐5 61. There are academic/public (research/practice) partnerships.

☐1☐2 ☐3 ☐4 ☐5 62. There is a process to learn about and better understand the realities of each of the major stakeholders so system change can occur by devising win-win situations rather than relying on good will alone.

☐1☐2 ☐3 ☐4 ☐5 63. The agency that received the funds has had a positive audit with minimal discrepancies for at least three consecutive years; they should spell out precisely if there will be any fiduciary or subcontracted agent that will manage funds, and if so, the subcontractor(s) should also have audits available for review.

☐1☐2 ☐3 ☐4 ☐5 64. There is a commitment to measurement of progress and outcomes.

☐1☐2 ☐3 ☐4 ☐5 65. There is a mechanism for communicating to the community the goals and the progress toward those goals in developing a system of care.

☐1☐2 ☐3 ☐4 ☐5 66. The fiscal agent is independent of any and all of the partner agencies so as not to appear to have control over the budget.

☐1☐2 ☐3 ☐4 ☐5 67. The project leadership understands how a social marketer can help with communication and the role that he/she plays before, during and after the grant period.

☐1☐2 ☐3 ☐4 ☐5 68. There is shared power and decision making among stakeholders.

☐1☐2 ☐3 ☐4 ☐5 69. All community partners have a clear understanding of the required investment, and similar expectations regarding the Return of Investment.

☐1☐2 ☐3 ☐4 ☐5 70. There is a commitment from leadership at major child serving systems that a family-driven, youth-guided care system of care (SOC) is essential to success.

☐1☐2 ☐3 ☐4 ☐5 71. State and/or county support is available - not only to support the proposed service delivery changes, but to support/allow flexibility for larger system change initiatives (proposed changes in funding structure, for example).

☐1☐2 ☐3 ☐4 ☐5 72. The collaborative has validated a needs assessment.

☐1☐2 ☐3 ☐4 ☐5 73. There has been a comprehensive needs assessment that provides insight into the barriers to change within the community.

☐1☐2 ☐3 ☐4 ☐5 74. There are linkages to facilities used for out of home placements and policy of involving parents in treatment and discharge planning.

☐1☐2 ☐3 ☐4 ☐5 75. A strong collaborative team is in place, ideally with some past history and prior success on earlier projects that involve system change.

☐1☐2 ☐3 ☐4 ☐5 76. There is accountability within the collaborative body for follow through and commitment from the boards that control them.

☐1☐2 ☐3 ☐4 ☐5 77. There is a strong trusting working relationship among all collaborating parties.

☐1☐2 ☐3 ☐4 ☐5 78. Families are willing to take on a lead role in taking the vision to reality.

☐1☐2 ☐3 ☐4 ☐5 79. There is a well defined, clear and articulated decision-making structure.

☐1☐2 ☐3 ☐4 ☐5 80. The participants at the planning stage have included parents, providers, advocates, local funders, youth, educators, local leaders, and all those who will be a part of the system of care.

☐1☐2 ☐3 ☐4 ☐5 81. The staff and the community partners have a demonstrated knowledge of characteristics of SED population to be served.

☐1☐2 ☐3 ☐4 ☐5 82. There is a plan for substantial financial support for family involvement - controlled by families being served.

☐1☐2 ☐3 ☐4 ☐5 83. Families have been at the table throughout the visioning process.

☐1☐2 ☐3 ☐4 ☐5 84. Agreements between the state and local agencies are in place so that changes in administrations midway through the 6 years of funding don't derail the momentum and progress of the project.

☐1☐2 ☐3 ☐4 ☐5 85. There are programs in place that address the diverse needs (cultural and linguistic competence) of the population of focus.

☐1☐2 ☐3 ☐4 ☐5 86. Collaborative partnerships have been established within the community and partners are willing to have open discussions and come to agreement on what some of the barriers and obstacles there are to making the systems change necessary to have a good system of care.

☐1☐2 ☐3 ☐4 ☐5 87. There is an understanding of community assets that can be used in building the system.

☐1☐2 ☐3 ☐4 ☐5 88. There is agreement to have family advocates on staff.

☐1☐2 ☐3 ☐4 ☐5 89. There is a commitment from policy makers, community leaders, partners, and staff to the system of care values and principles.

☐1☐2 ☐3 ☐4 ☐5 90. Sustainability of services developed is part of the discussions beginning in the 1st year not waiting until the end.

☐1☐2 ☐3 ☐4 ☐5 91. Leaders are willing to be challenged and are able to experience discomfort when it comes to movement and change.

☐1☐2 ☐3 ☐4 ☐5 92. There is consensus among top level local system leadership on the role of a cooperative agreement.

☐1☐2 ☐3 ☐4 ☐5 93. There is a willingness to work in a fair, inclusive and open manner.

☐1☐2 ☐3 ☐4 ☐5 94. Infrastructure is in place to ensure implementation of major SOC values such as collaboration.

☐1☐2 ☐3 ☐4 ☐5 95. The school district and medical professionals are in the collaborative agreement.

☐1☐2 ☐3 ☐4 ☐5 96. There is a governance body that is powerful and independent of any specific provider in the community.

☐1☐2 ☐3 ☐4 ☐5 97. Commitment to ensure that cultural and linguistic competence is represented in both conceptualization and implementation of all activities.

☐1☐2 ☐3 ☐4 ☐5 98. There is a fully functioning advisory board or other group that represents key program partners including youth and family voice.

☐1☐2 ☐3 ☐4 ☐5 99. There is a plan for volunteer development.

☐1☐2 ☐3 ☐4 ☐5 100. The community has dedicated sufficient resources to support cultural and linguistic proficiency.

☐1☐2 ☐3 ☐4 ☐5 101. There is a clear understanding with local community organizations and municipalities of where the community is with a vision of where they want to be within a given period of time.

☐1☐2 ☐3 ☐4 ☐5 102. The lay community is aware of the potential services in order to be willing to provide additional funding.

☐1☐2 ☐3 ☐4 ☐5 103. There is being developed a method of sharing real time useful information to identify important system trends and to provide the requisite information for data based decision making.

☐1☐2 ☐3 ☐4 ☐5 104. Services are being designed to be customer driven and strength and solution focused.

☐1☐2 ☐3 ☐4 ☐5 105. There is an understanding of blended or braided funding and the willingness among the community agencies to share resources.

☐1☐2 ☐3 ☐4 ☐5 106. There is a well developed understanding by the state level personnel with decision making authority.

☐1☐2 ☐3 ☐4 ☐5 107. An advisory or leadership board has been established that has at least 1/3 parent participation and they should have input on the writing of the proposal.

☐1☐2 ☐3 ☐4 ☐5 108. There is an agreement to share information across child-serving systems.

☐1☐2 ☐3 ☐4 ☐5 109. There is an understanding of and buy-in of the use of the research to help address what is working and what can be improved at in the community.

Appendix B

Sample Demographic Form

Community Readiness for the Implementation of a System of Care

Thank you for agreeing to participate and provide your opinions about establishing a system of care in your community. You are being asked to provide your opinions by responding to a rating scale. The rating scale is designed to obtain your opinion about how ready your community is to implement a system of care, that is, how much your community has accomplished for each item listed.

Each item is to be rated on a scale of 1 to 5. A rating of 1 indicates "least ready" and a rating of 5 indicates "most ready." If you do not know the answer to a question, you should leave it blank.

But first, we would like a little information about you.

Name:

Agency/Organization:

Which best describes your role in the system of care:

____ Community leader

____ Parent

____ Representative of community partner agency/service provider

____ System of care project leadership/management team/governing council

____ System of care staff

____ Youth

____ Other (please specify)

Please contact our consultants if you have any questions or comments.

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Appendix C

Rating Scale for the Federal Project Officers and Regional Technical Assistance Coordinators

Assessing Community Readiness
For the Implementation of a System of Care

Site Name

We would like your assessment of the level of community readiness to implement a system of care at the time of the first federal site visit. **These ratings address the eight cluster/domains on the Community Readiness Assessment Scale, plus an overall rating of readiness.**[9] A rating of 1 indicates "not at all ready" and a rating of 5 indicates "very ready."

☐**1**☐**2** ☐**3** ☐**4** ☐**5**	1. Overall readiness to implement a system of care
☐**1**☐**2** ☐**3** ☐**4** ☐**5**	2. Readiness to have families and youth as partners in the system of care
☐**1**☐**2** ☐**3** ☐**4** ☐**5**	3. Readiness with a network of local partners in place
☐**1**☐**2** ☐**3** ☐**4** ☐**5**	4. Readiness for collaboration with community partners
☐**1**☐**2** ☐**3** ☐**4** ☐**5**	5. Readiness with strong leadership
☐**1**☐**2** ☐**3** ☐**4** ☐**5**	6. Readiness with shared goals among community stakeholders
☐**1**☐**2** ☐**3** ☐**4** ☐**5**	7. Readiness with a plan to expand services
☐**1**☐**2** ☐**3** ☐**4** ☐**5**	8. Readiness to implement an evaluation component
☐**1**☐**2** ☐**3** ☐**4** ☐**5**	9. Readiness for accountability for the functioning of the system of care

[9]Note that these eight clusters are only one of the dimensions we study. They represent a summary of the assessment scale. Within each of these clusters, there are 12-20 items, for a total of 109 items. As an example, within the cluster "Families & Youth as Partners" there are several items about youth only and several about parents only. In our report to the site, these items may be discussed separately. We are not asking you for that level of detail.

Appendix D

Statements Listed by Rating

Statements Listed by Rating

#	Statement	Rating
16	There is a felt need for services within the community by the stakeholders.	4.20
64	There is a commitment to measurement of progress and outcomes.	3.92
88	There is agreement to have family advocates on staff.	3.87
93	There is a willingness to work in a fair, inclusive and open manner.	3.82
31	There is a strong collaborative group of service providers already engaged in discussion about mutual goals.	3.75
22	There is commitment to evaluation and data based decision making.	3.73
54	There is a core committed group with strong leadership that couples vision with concrete strategy and practical know-how.	3.70
30	There are committed community stakeholders which include child-serving systems, providers, families, youth and community members.	3.70
37	There are strong relationships and commitments to collaboration among community partners.	3.69
45	There is intent to provide training in and utilization of specific evidence-based practices with justification based on clinical characteristics of the population of focus.	3.67
70	There is a commitment from leadership at major child serving systems that a family-driven, youth-guided system of care is essential to success.	3.65
15	The community has identified a population of initial focus for its system transformation efforts.	3.64
90	Sustainability of services is part of the discussions from the beginning, not waiting until the end of the funding period.	3.63
86	The community partners are willing to have open discussions and come to agreement on what some of the barriers and obstacles are to making the changes necessary to have a system of care.	3.63
57	The community partners have a commitment to ongoing evidence-based practice with fidelity monitoring and feedback.	3.62
59	The child serving agency stakeholders have bought into the systems of care and wraparound concept.	3.61
43	The project leaders have the ability to bring resources to the table or leverage resources (not necessarily money but also human capital and political will).	3.61
81	The staff and the community partners have a demonstrated knowledge of characteristics of the population to be served.	3.60
89	There is a commitment from policy makers, community leaders, partners, and staff to the system of care values and principles	3.59
19	The applicant fully understands the magnitude of the evaluation component and the importance of data driven services.	3.59
104	Services are being designed to be customer driven and strength and solution focused.	3.58
75	A strong collaborative team is in place, ideally with some past history and prior success on earlier projects that involve system change.	3.58
109	There is an understanding of and buy-in of the use of the research to help address what is working and what can be improved at in the community.	3.57
2	The collaborative is actively involved in developing the approach, strategies, goals and outcomes.	3.57

11	There is a strong relationship between the state and the local community receiving the funding.	3.57
60	Partners that are essential to the system of care are fully on board and officially on board.	3.54
94	Infrastructure is in place to ensure implementation of major system of care values such as collaboration.	3.53
10	The community partners have a willingness to share resources: knowledge, staff, dollars, understanding that it is through joint investment that joint success is achieved.	3.50
91	Leaders are willing to be challenged and are able to experience discomfort when it comes to movement and change.	3.50
108	There is an agreement to share information across child-serving systems.	3.49
18	There is a clear understanding of the project's population of focus and changes that will be needed to meet the service needs of this population.	3.49
87	There is an understanding of community assets that can be used in building the system.	3.48
63	The agency that received the funds has a history of positive audits and has disclosed any fiduciary or subcontracted agent that will manage funds.	3.48
67	The project leadership understands how a social marketer can help with communication and the role that he/she plays before, during and after the grant period.	3.48
23	There is a commitment from key community stakeholders â€“ people with the ability to influence attitudes and actions of others such as elected officials, community leaders, and other respected individuals.	3.47
68	The stakeholders share power and decision making.	3.47
92	There is consensus among system leadership about the role of a cooperative agreement.	3.43
76	There is accountability within the collaborative body for follow through and commitment from the boards that control them.	3.43
80	The participants at the planning stage have included parents, providers, advocates, local funders, youth, educators, local leaders, and all those who will be a part of the system of care.	3.43
77	There is a strong trusting working relationship among all collaborating parties.	3.43
55	The child serving agencies have been meeting regularly along with family/youth participation to review children with serious emotional disturbances in their community and in need of more intensive community resources.	3.43
46	All those participating in the "big picture" have been educated about the history of the system of care and the effectiveness of a successful system of care.	3.42
98	There is a fully functioning advisory board or other group that represents key program partners, families, and youth.	3.41
9	The community partners understand and accept the concept of permanent system change as the end goal.	3.40
97	There is a commitment to ensure that cultural and linguistic competence is represented in both conceptualization and implementation of all activities.	3.40
65	There is a mechanism for communicating to the community the goals and the progress toward those goals in developing a system of care.	3.39
4	There are well trained, culturally competent, flexible personnel working in the system.	3.38

61	There are partnerships with colleges and universities for research and/or evaluation purposes.	3.38
35	All partners have a sense of community identification and buy-in to the system of care values and principles.	3.37
17	The community understands that the cooperative agreement is not primarily a granting of money, but is a partnership with the federal government to accomplish the federal program goals.	3.37
25	The community partners have an understanding of their specific contribution to collaborative efforts.	3.36
72	The collaborative has validated a needs assessment.	3.36
51	There is buy-in at the state level.	3.32
14	There are established relationships among entities to be involved in the system and guidelines for these relationships.	3.31
96	There is a governance body that is powerful and independent of any specific provider in the community.	3.31
49	To ensure adequate staffing, there is a realistic plan to hire and train new staff in a timely manner.	3.29
71	State and/or county support is available - not only to support the proposed service delivery changes, but to support/allow flexibility for larger system change initiatives (proposed changes in funding structure, for example).	3.29
85	There are programs in place that address the diverse cultural and linguistic needs of the population of focus.	3.24
20	There is a decent budget to provide skill building activities for youth.	3.24
74	There are linkages to facilities used for out of home placements and policy of involving parents in treatment and discharge planning.	3.24
44	Leadership sharing has been clearly defined.	3.24
21	There has been input from youth and families to determine the needs in the community.	3.23
79	There is a well defined, clear and articulated decision-making structure.	3.23
95	The school district and medical professionals are in the collaborative agreement.	3.22
73	There has been a study that provides insight into the barriers to change within the community.	3.20
24	There is a well developed understanding by the state level personnel with decision making authority.	3.20
36	There is a commitment by the leadership of the community partners in the form of designated funding (match), staffing resources, or a track record of implementing initiatives that share core system of care values and principles.	3.20
33	There is a commitment from partnering agencies about what exactly they will provide to this process.	3.20
38	There is cross-system cooperation and decision-making.	3.20
58	Family members and youth are active members of a community system of care initiative.	3.19
62	There is a process to learn about and better understand the realities of each of the major stakeholders so system change can occur by devising win-win situations rather than relying on good will alone.	3.19
52	There is a dedicated amount in budget to go to the family organization.	3.19
26	There is a clear plan, agreed to by the community partners, for expanding the array of services.	3.19

42	All community partners are working collaboratively to include strong parental engagement, blended and flexible funding, and shared success and liability.	3.18
40	The community can show specific ways that family members and youth participate in decision-making for their individual service plans.	3.17
66	The fiscal agent is independent of any and all of the partner agencies so as not to appear to have control over the budget.	3.16
106	A well developed understanding by the state level personnel with decision making authority is absolutely necessary.	3.16
34	There is a commitment from state and local policy makers and funders of services to participate in developing a viable system of care and revamping how services are provided and funded.	3.16
105	There is an understanding of blended or braided funding and the willingness among the community agencies to share resources.	3.15
103	There are plans to develop a method of sharing real time, useful information to identify important system trends and to provide information necessary for data-based decision making.	3.15
27	Representatives of the community's different cultures have been involved from the early planning stages forward.	3.13
7	The community is being provided with examples of what following the values and principles of the system of care looks like in order to understand what a shift in thinking and practice it is from how they currently serve children and families.	3.12
48	Project leaders have identified youth and family members who with support and training, if necessary, can articulate and advocate using their stories and voice.	3.12
53	There has been a comprehensive assessment within the community of where the gaps are in terms of resources and needs.	3.12
28	There is a strong family organization with resources to fully participate.	3.11
69	All community partners have a clear understanding of the required investment, and similar expectations regarding the return on investment.	3.10
83	Families have been at the table throughout the visioning process.	3.10
101	There is a clear understanding with local community organizations and municipalities of where the community is with a vision of where they want to be within a given period of time.	3.09
8	Key budget staff is working with partners on funding issues, requirements, restrictions, and how to resolve the issues.	3.09
12	There are clearly defined decision-making processes and communication pathways across stakeholders.	3.07
56	A family organization was developed before funding.	3.07
3	There is training and support to help teach and educate families and professionals how to work together and respect and value each other's expertise.	3.06
47	There is active participation from families, youth and front-line workers from public and private sectors in the implementation of the system.	3.04
84	Agreements between the state and local agencies are in place so that changes in administration midway through the 6 years of funding don't derail the momentum and progress of the project.	3.03
6	Key family contacts and youth leaders have been identified prior to the application submission so that the groups are ready to roll once the funding is received.	3.03
100	The community has dedicated sufficient resources to support cultural and linguistic proficiency.	2.99

41	There has been an analysis about those service components that will require more support in order to implement them.	2.98
32	Young people are being provided support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	2.96
78	Families are willing to take on a lead role in taking the vision to reality.	2.95
82	There is a plan for substantial financial support for family involvement, controlled by families being served.	2.94
107	An advisory or leadership board has been established that has at least 1/3 parent participation and they have input on the design and implementation of the project.	2.94
50	Training has been provided to parents to help them feel more confident advocating for themselves and others in the community.	2.93
39	The community partners have a clear understanding of how services are financed and their limitations on flexibility	2.92
1	Families are provided with support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	2.82
99	There is a plan for volunteer development.	2.79
13	There is strong inclusion of elected officials on the local and state level.	2.74
5	Everyone--community partners, leaders, families, and youth--understands the principles on which the new system will be built and share the same values.	2.70
29	Community organizations such as faith based groups have participated in the planning process.	2.66
102	The community is being made aware of the potential services in order to be willing to support additional funding.	2.65