BRIEF

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System of Care Governance

The Role of Governance within Systems of Care

Building Systems of Care: A Primer defines a system of care as:

> "A broad flexible array of effective services and supports for a defined, multi-system-involved population, which is organized into a coordinated network, integrates care planning and care management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and with youth at service delivery, management, and policy levels, has supportive management and policy infrastructure, and is data-driven." [1]

This definition reflects the need for organized leadership, decision-making, and oversight provided through a group effort comprised of those persons who hold a shared vision for what needs to be done and have the ability and resources to make those things happen. This, in its simplest form, is what system of care governance <u>is</u> and what it <u>does</u>.

The *Primer* defines system of care governance as "decision-making at a policy level that has legitimacy, authority, and accountability." [2] The *Primer* also offers this very important distinction. "*Governance*—policy-level decision making and oversight—should not be confused with system management. These are two distinct functions. Governance has to do with policy-making and oversight. System management has to do with day-to-day operational decision-making.

The System of Care Non-Categorical Population Focus

Individual child-serving systems, such as child welfare, education, juvenile justice, and behavioral health hold mandated responsibilities to meet certain needs related to specific populations, while a system of care must carefully define a population focus for its work where the responsibilities of these systems intersect. System of care governance focuses on all of the areas where individual (categorical) systems do not have the capacity to act independently to achieve desired results. Policies set by system of care governing bodies need to promote collaborative practices at both policy and front-line levels across those partner systems. Collaborative decision-making among discrete systems requires structure and process, as well as clarity about the population(s) of focus.

Systems of care, as they are designed and built in different states and locales, do not serve a universal, homogenous population. Rather, each system is designed to address particular populations carefully defined by system stakeholders in response to functional needs that cross categorical system boundaries. A driving force behind the development of systems of care has been the experience of families caught in the gaps between individual system mandates and authorities. Individual system mandates, eligibility, tools, and

resources are narrowly defined, while the realities of families' lives often lie outside those narrow definitions and, as a result, the care and guidance many families receive can be confusing and conflicting. Systems of care are highly effective when designed to address those gaps. As the Primer states, "Developing a clear population focus does not mean that one must adopt either a narrow or a broad 'population focus.' Either is possible, or something in between. What it does mean is that system builders need to agree upon and articulate who the children and families are for whom the system is being built."[3]

Authority and Structure for System of Care Governance

Authority and structure for the governance of systems of care at the state level may be established in several ways: by a governor through an executive order, by the legislature through statute, by a cabinet secretary to whom most child-serving systems report, or through Memoranda of Agreement (MOA) or Memoranda of Understanding (MOU) established among child-serving systems. Generally, these authorizing mechanisms define: 1) the governance authority for the system of care; 2) the governance participants; 3) the population focus; 4) the types of strategies through which the group can assert its authority; and 5) the purpose and goals. Regardless of what mechanism is used to establish system of care governance, it is the ongoing commitment of leadership that is most essential and their recognition that they hold a <u>shared accountability</u> for the effectiveness of the system of care.

Louisiana has a governance board established by Executive Order BJ11-05. The Coordinated System of Care (CSoC) Governance Board is comprised of the Secretaries of the Departments of Children & Family Services and Health and Hospitals, Superintendent of the Department of Education, and Deputy Secretary of the Department of Public Safety and Corrections, Youth Services, Office of Juvenile Justice, or their designees, as well as a representative from the Governor's office and family, youth and advocacy representatives. The CSoC Governance Board has authority to establish policy, define focus populations, direct funding, and monitor quality and cost. The Executive Order is available at: http://www.doa.louisiana.gov/osr/other/bj11-05.htm.

It is important to note that governance bodies, which hold authority and provide accountability, are not the same as advisory groups, which may be formed through formal mechanisms such as executive orders and statutes or informally through mutual commitment to identified goals. A group of stakeholders brought together to raise issues and suggest solutions can play a vital role in ensuring a relationship between system of care governance and the community(ies) it serves, but without authority to implement changes, an advisory group does not provide governance.

Arkansas is an example of a state with an advisory group established by statute. The Arkansas Code Title 20, Chapter 47-604(b) authorizes the Children's Behavioral Health Care Commission, a stakeholder group appointed by the Governor to provide guidance to the Department of Health and Human Services and other child- and family-serving state agencies on the most effective methods for establishing a system of care approach. Chapter 47-605 sets forth that the Department's responsibilities are to be conducted with advice from the Children's Behavioral Health Care Commission, assuring that stakeholder input will be provided to the Department without giving the Commission authority to govern the system of care. For more information, visit: https://ardhs.sharepointsite.net/ARSOC/default.aspx.

Some states use a governor's cabinet or children's cabinet structure, which is generally comprised of appointed heads of the various child- and family-serving agencies within state government structures. In this model, most or all of the members of such cabinets operate under the authority of the governor, allowing the governor substantial influence over the areas of focus and the impact attained by the cabinet. A particular challenge for this model of governance is the incorporation of voices outside of the administration, most especially the voices of families and youth/young adults. Generally, states have rejected the inclusion of these voices or other non-governmental voices in a cabinet council with

the primary argument that appointed officials have fiduciary and mandated program responsibilities to taxpayers that cannot be delegated to or shared with others. Instead, many states have formed stakeholder advisory groups to offer input to cabinet council processes.

An example of an advisory group established through the mutual commitment of multiple child- and family-serving state agencies rather than an executive order or authorizing legislation is the North Carolina Collaborative for Children, Youth and Families, which serves as a neutral forum for family members, child-serving agencies, provider groups, university researchers, advocates and others interested in children and families to have conversations about North Carolina's system of care. While the Collaborative has no legal authority to make decisions, it is a forum for decision makers, representing a range of state and local agencies, to work together with families and advocates to better meet the needs of children and families. In other words, this group is deliberately designed to be a safe place to raise issues and explore a range of solutions in partnership with decision makers with the intent of influencing governance decisions. For more information, visit: http://www.nccollaborative.org/.

Maryland is an example of a state with a governor's children's cabinet and an advisory group. The Maryland Children's Cabinet in its current form was created by Executive Order in 2005 and amended in 2006 (Executive Orders 01.01.2005.34 and 01.01.2006.03; available at http://www.dsd.state.md.us/comar/comarhtml/01/01.01.2006.03.htm).

In 2006, the Maryland Legislature established the Advisory Council to the Children's Cabinet (Maryland Annotated Code, Human Services Article, secs. 8-201 through 8-202) and set a mandate for that group "to recommend how to create more capacity to serve youths in their communities; reduce reliance on institutions as a primary intervention for at-risk youth offenders; promote positive outcomes for youth; fund best practices to deter juvenile crime and delinquency; and reduce the disproportionate confinement of minorities." This language gives the Advisory Council, comprised of appointed stakeholders and advocates, as well as ex officio state agency representatives, a clear imperative to offer guidance in these important, defined areas. For more information on Maryland's Children's Cabinet and Advisory Council, visit: http://msa.maryland.gov/msa/mdmanual/08conoff/cabinet/html/child.html.

Other states use a state interagency council structure that includes the executive heads of the child- and family-serving state agencies along with other appointed persons. These additional seats might be designated for other system of care stakeholders, such as parent and/or youth representatives, local system representatives, advocacy organizations, statewide professional organizations, or university research and/or training programs. Some states that have established governance using the interagency council model, with its more expansive membership, have migrated towards using these groups in an advisory role, with less or no explicit authority – a trade-off that is not uncommon in state-level councils that include substantial consumer and/or advocacy voices. However, the clout of these additional stakeholders and their ability to advocate with state agency decision makers, legislators, governors' staff, and others can help to mitigate this concern.

Arizona is an example of a state with interagency council structure established by an MOU that includes additional stakeholders on subcommittees. The Arizona Departments of Health Services, Economic Security, Education, and Juvenile Corrections, the Health Care Cost Containment System, and the Administrative Office of the Arizona Supreme Court formed the Arizona Children's Executive Committee, charged with ensuring that behavioral health services are provided to children and families according to the Arizona vision and twelve principles, which are highly aligned with the system of care principles. While the MOU refers to the Children's Executive Committee as an advisory committee, it is comprised of agency heads with the authority to implement individual state agency policies and practices agreed upon by the Committee. Subcommittees on family involvement, clinical/substance abuse, training, and information sharing are comprised of Committee participants, family members and other representatives from state agencies, behavioral health authorities and family-run organizations. For more information, visit: http://www.azdhs.gov/bhs/children/ACEC.htm.

Authority for system of care governance at a local level may be established by the legislature, an elected or appointed municipal or county executive or board of commissioners, or by local agency heads. System of care governance at the sub-state level (county, parish, municipal, etc.) is most effective when it aligns with state-level system of care governance goals. Local governance must deliberately be embedded within and use the tools and resources made available to it through the individual partner systems participating in the system of care, as well as through system of care structures at the state level. In some states, legislation has created state-level interagency bodies and regional or local interagency bodies that mirror the purpose and scope of the state body.

> *The Mississippi Code of 1972 Title 43-14-1 establishes the Interagency Coordinating Council for Children and Youth (ICCCY) to oversee the State's system of care. The ICCCY's statutory membership includes all of the relevant state agencies <u>and</u> the executive director of Mississippi's Families as Allies (a family-run advocacy group), a family member of a child or youth served by the system of care, a youth in the population served by the system of care, a member of a local Multidisciplinary Assessment, Planning and Resource (MAP) Team, a child psychiatrist, an early childhood education expert, an advocate for disabled citizens, and a faculty member of a state university specializing in training professionals who work in the system of care. The ICCCY is charged with overseeing all of the local MAP teams across the state, overseeing a pool of funds that can be accessed by the MAP teams to meet family needs that cannot otherwise be met, and members "may provide input to one another relative to how each agency utilizes its federal and state statutes, policy requirements and funding streams" relative to the system of care. Nothing in this statute compromises the authorities held by the individual state agencies but creates a formal process for ensuring cross-system and stakeholder input into the decisions that determine how the system of care operates within the state. Mississippi's ICCCY statute is available at:*
> *http://www.lexisnexis.com/hottopics/mscode/.*

> *The Ohio Revised Code Title 1, Chapter 121.37 (A)(1) authorizes the Ohio Family & Children First Cabinet Council, comprised of the Directors of all of the state agencies providing services to children, adolescents, and their families, and in part (B)(1) also establishes a County Family & Children First Council to be appointed by the board of county commissioners in each of Ohio's 88 counties. Part (B)(2) states that "the purpose of the (county) council is to streamline and coordinate existing government services for families seeking services for their children." This statute establishes a reporting relationship between the state and county councils, while also assuring that the overall mission at both levels is aligned. For more information, visit: http://www.fcf.ohio.gov/.*

> *Maryland's Local Management Boards (LMBs), authorized under Title 8 of the Human Services Article of the Maryland Annotated Code, are established in each of the State's 23 counties and Baltimore City. LMBs serve as the coordinator of collaboration for child and family services and are comprised of child-serving agencies, local child providers, families, and other community representatives. The Governor's Office for Children (GOC) partners with LMBs to plan, coordinate, and monitor the delivery of integrated services at the local level. The GOC Executive Director chairs the Children's Cabinet ensuring alignment between local and state priorities. For more information, visit: http://goc.maryland.gov/lmb/.*

Governance Body Membership

Core members of a system of care governance body are the leaders who hold decision-making authority within the individual systems that are brought together by a common purpose into a system of care. For these leaders, the governance body provides a collaborative forum through which they can: 1) understand how their individual system policies and implementation strategies intersect and interact with other systems; 2) build cross-system support to solve complex challenges; 3) access expertise not available within their own system; 4) resolve conflicts that may arise between systems; and 5) gain leverage by pooling resources for a greater impact on sub-populations that cross agency boundaries.

It is important for individual service system leaders to participate directly in the system of care governance process. The authorizing legislation for cabinets or councils in many states includes the specific requirement that the executive heads of agencies participate on the councils. As discussions

at that table take place, it is critical that the participants be empowered to make decisions and commitments on behalf of their respective systems, rather than engaging in discussions that end only in a promise to go back and discuss the issue with others who hold the actual authority. Effective system of care leaders use this collaborative table to advocate for fulfilling their own system's mandates more effectively, to use their system's resources to help partner systems succeed in meeting their mandates, and, at its heart, to drive system of care reforms.

It is also very important to bring families and youth representing the diversity of those served by the system or in need of those services and supports to the governance table. Some states have enacted statutes or issued executive orders that specifically include representation of the *family and/or youth voice* on state-level councils, and most of the states with state-level councils and correlated local/regional councils mandate family and youth involvement at that local/regional level. These individuals may be appointed by someone at the state level, designated based on the fact that they are the head of a state or local family-run or youth-run organization or elected by the governance entity members following a nomination process.

Other voices important to consider might be representatives of provider organizations, business representatives, advocates, university trainers, leaders within racially and ethnically diverse communities, and representatives of local faith communities. Due to potential conflicts of interest, providers pose a challenge to include in governance – the experience and knowledge they bring may be invaluable in finding solutions to complex issues, but their presence on a body that may influence how funds are allocated raises potential conflict of interest issues. Inclusion of family and youth organizations that provide peer support services can be particularly challenging. Generally, providers serve in advisory role in state-level bodies. While they are sometimes represented on local- or regional-level governance bodies, providers may be prevented from bidding for locally distributed funds unless there are processes put in place for recusal on procurement related discussions. Inclusion of business leaders and other advocates at the local level ensures meaningful linkages between system of care governance and the community at large.

Cultural and Linguistic Competency Considerations

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care present specific standards for health care organizations that system of care governance should adopt. These standards include governance and leadership that promote CLAS and health equity through policy, practices, and allocated resources; recruitment, promotion, and support of culturally and linguistically diverse governance, leadership and workforces; and ongoing education and training of governance, leadership, and workforces in culturally and linguistically appropriate policies and practices.[4] Systems of care also should consider incorporating CLAS standard language into authorizing mechanisms including executive orders, legislation, and MOAs/MOUs.

Considerations of Size

The size of a system of care governance body must be balanced against its functionality. Systems of care are participatory systems with multiple stakeholders, and it is important to try to include all key voices in decision-making processes. However, large groups are not especially adept at implementing complex processes or making clear decisions. Therefore, governance bodies must have enough members that all necessary perspectives are represented, while remaining small enough to accomplish the tasks of governance. Generally, statutorily comprised system of care governance bodies contain between 9 to 15 members and most consider this to be a fairly functional size. State and local governing bodies may supplement the formal members of the governance group with *ex officio*

Family & Youth Leadership in System of Care Governance

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It is important for family organizations, parents, and youth to be reflective of the population, including underserved populations, to serve in system of care governance structures. Parents are especially effective partners in helping to share direct experiences about accessing services and supports, reviewing and interpreting data, and promoting quality assurance. Some system of care governance structures have appointed parent leaders to serve as co-chairs and even implemented policies to have at least 51% family and youth participation in the governance body.
In order to achieve strong family and youth participation in governance bodies, systems need to build a supportive structure to recruit families and youth and ensure opportunities for involvement, informed decision-making, and leadership development. System of care initiatives may contract with family-run organizations to provide supports, and ongoing training and coaching opportunities for families and youth serving on their state and local governance bodies.

Parent Engagement & Participation
All system of care partners need to work together to develop focused strategies to recruit family members to participate in governance body activities. Some system of care initiatives contract with family organizations to hire parent leaders to conduct parent recruitment activities in partnership with service delivery providers and parent advisory groups, drawn especially from parents who are being, or have been, served by the system of care service delivery system. For example, the Rhode Island Department of Children, Youth, and Families (DCYF) contracts with Parent Support Network of Rhode Island to support the recruitment, participation, and leadership of families and youth to serve on State and Regional Family Community Advisory Boards.

Training & Mentorship
All governance body members will benefit from ongoing training and leadership development. Some system of care state initiatives have contracted with family organizations to offer parent leadership training and certification opportunities focused on knowledge of system of care, guidelines of governance board operation, service delivery, empowerment, facilitation, policies and procedures, quality assurance, conflict resolution, and advocacy. Some system of care communities have hired parent leaders to serve as role models and provide ongoing mentorship. For example, the North Carolina System of Care Collaborative operates under bylaws that require a parent co-chair and parent co-vice-chair (who will succeed the co-chair) at all times in order to offer the opportunity for parents to develop functional leadership capabilities.

Participant Supports
System of care partners have learned that families and youth may need participant supports in order to attend ongoing governance meetings. Flexible meeting times and family friendly meeting locations have increased family and youth participation. Transportation and child care have been identified by many parents as necessary supports for participation. Family organizations may help coordinate rides, organize onsite child care, and provide gas cards to support active participation. In addition, some system of care communities provide cash or gift card incentives. For example, Rhode Island DCYF and regional Family Community Advisory Boards provide stipends for the families and youth who attend any meetings. System of care communities have reported that when they stopped providing parent involvement incentives, their parent participation decreased.

Privacy & Confidentiality
The governance body needs to define strategies for ensuring appropriate levels of privacy through its bylaws. Governance bodies should use a confidentiality statement that is signed by all members. Parents and youth should be offered supportive training around privacy and confidentiality issues, building trust among partners for including their voice in all discussions and helping them learn how to share lived experiences in a public forum. In New Hampshire, the Granite State Federation of Families *prepares family members to participate in the Collaborative and provides ongoing training to youth on strategic sharing that teaches the youth how to share their lived experience in a safe manner in public forums or board meetings.*

Evaluating Strategies for Family and Youth Involvement
The governance body has the responsibility to evaluate the overall system of care implementation and effectiveness of family and youth involvement within governance and in the broader initiatives. System of care communities can seek the input of family members through focus groups, surveys, advisory councils or committees, as well as through outreach and attendance at support groups and public awareness events that promote social connections. With that input, the governance body can identify strategies to improve the quality of family and youth input in all its functions.

individuals holding specific knowledge or expertise who are present at meetings to provide information and recommendations without having a vote in decisions. Many governance bodies establish committees or work groups that bring additional expertise and perspectives needed to accomplish system of care goals. All recommendations are routed back to the governance body for final decision-making on key issues. As noted earlier, some states and localities have larger advisory bodies that provide recommendations to system of care governing bodies.

Leadership

Two main types of leadership are required to bring systems of care to functionality. *Visionary leadership* opens the pathways at all system levels to move from the status quo to a higher level of functioning needed in effective systems of care, while *process leadership* guides the many interlocking activities that put system of care pieces together into a whole, functional system. Both types are necessary and may, or may not, be provided by the same individual leaders.

Visionary leadership is demonstrated by those individuals on a system of care governing body who recognize the ways in which current system functioning is not successful and imagine the possibilities when functions are organized and/or implemented differently. Visionary system of care leaders understand that "success requires a broad cross section of the community working together to develop clear and measurable plans for change."[5]

Once assembled, effective system of care governance also requires effective *process leadership* in order to implement a shared vision. Strong process leadership includes the ability to bring together and raise diverse perspectives, to focus expertise efficiently, to demonstrate the value of group input, to avoid framing solutions in "right" or "wrong" terms, to communicate clearly, and to respond adaptively to challenges.

System of care governance also needs to pay attention to preparation for and management of leadership transitions. People change and move on to different challenges, and systems of care need to prepare for such changes, not allowing the departure of key players to derail system development. Such preparation includes diversifying and sharing leadership over time, detailing governance commitments through MOAs signed by system and stakeholder leaders, rotating leadership responsibilities on a regular basis across governance body membership, specifying leadership responsibilities in by-laws, and employing training/mentoring processes for new members.

Governance Administration and Initiative Funding

System of care governing entities need funds to support their governance activities – e.g., funds for staff, transportation and stipends for family and youth members, communications, etc. Staff is needed to perform duties that make collaborative decision-making possible, such as gathering and distributing information, setting and arranging meetings, setting agendas, documenting meeting activities, and implementing decisions made by the governance body. It is common for state interagency groups, as well as local system of care governance bodies, to employ an executive director or coordinator. Mid-level managers representing each of the governance body agencies may be charged with meeting regularly to translate policies set by the system executives into actions within each partner system. Often, grant funding is used to support the staffing and operations of governance bodies, which is only a useful strategy while the grant lasts. In the absence of funding earmarked for the governing body, it is common to find that staff are assigned from among governing body membership and the respective

agency heads may utilize their own budgets to support governance operations. Sometimes, Governors' budgets or the legislature will designate funds specifically for governing body administrative functions.

Implementing system of care initiatives and strategies also often require funding. A chief tool used by system of care governance bodies is influencing the impact of system resources on system goals. System resources include the collective competencies of all persons working with or on behalf of the system of care partners, as well as the allocated funding streams that fall under the various system authorities. A primary purpose of governance at the state level is to steadily influence the ways in which these major fund streams are used to accomplish shared, collaborative goals on behalf of children and families, which includes effective governance operations. Major funding streams generally require annual plans and/or budgets which, when prepared collaboratively under the system of care governance authority, can be shaped to direct portions of these funds toward system of care goals and governance. Local system of care governance often has less ability to determine how major funding streams can be utilized because eligible populations, qualified providers, and service parameters are usually set at the state and/or federal levels. However, local governance can set the conditions that allow local systems to maximize the extent to which various funding streams are used synergistically, including for local governance.

Additionally, a number of state legislatures designate funding streams for the collaborative governance bodies they create, such as a governor's children's cabinet. It is common for legislatures to authorize system of care governance bodies to seek, receive, and pool funds from a wide range of sources, such as federal agencies, charitable foundations, or corporations, and to use those funds in support of the system of care goals. Provision is often made for individual partner agencies to contribute categorical resources to the collaborative processes, used for purposes determined by the governance group. Some states or local communities set specific contribution amounts to these funds (often referred to as "pooled" funds) by each partner, although most leave it up to members to determine if and how much they will contribute in any given year. No matter the setup used to direct resources toward specific purposes, it is essential to remember that funding drives all practices, and effective governance requires funding.

Ohio Code authorizes the Ohio Family & Children First Cabinet Council and the legislative budget process allocates annual general revenue funds to the Ohio Department of Mental Health and Addiction Services to administer the Council and support its mandates at the state and county levels. In addition, the Ohio Department of Job & Family Services (responsible for child protective services, as well as other services) has historically contributed a portion of its Federal Title IV-B funds to support the activities of the state and county councils to the extent that they address the needs of children and youth experiencing or at risk for abuse or neglect. For more information, visit:
http://www.fcf.ohio.gov/SharedAccountability/FundingInformation.aspx.

Maryland has a Children's Cabinet Interagency Fund that is overseen by the Governor's Office for Children. Funds support early intervention and prevention programs that reflect the values and priorities of the Governor and Children's Cabinet and include funding to Local Management Boards to support local efforts. Interagency Funds have been used as match for local and state system of care awards. For more information, visit:
http://goc.maryland.gov/ccif/.

Conceptual Priorities for System of Care Governance

At its heart, system of care governance requires ongoing, effective collaboration. Carl Larson, Ph.D. has written a highly informative article, *Building and Sustaining Collaboration, an Introduction*, which serves as the introduction for the State of Colorado's "Collaborative Management Program (CMP) priorities can guide system builders in the early stages of governance development that coincide with

the careful definition of the population of focus, as well as priorities important to sustained collaboration.[6]

- The first and highest priority, according to Larson, is "the problem, the goal, the objective. What the group is trying to accomplish. The change that justifies the time and effort."
- The second priority is to build a credible, open process, with strong process leadership. All stakeholders participating in system-building processes need to understand how and why consensus agreements are reached; they, in turn, become ambassadors to carry that information back to the individuals and groups they represent in planning and implementation processes. This is a reference to the critical *process leadership* described above.
- Larson's third priority is to emphasize the values of inclusiveness and trust. Inclusive partnerships based on trust stand at the very heart of systems of care. In practice, this means reaching out to partners who have not been involved or who have actively criticized past practices to invite them to contribute to identifying and solving problems. It also means respecting the input of stakeholders who may not agree with the majority of other voices in the process. Breadth and diversity of perspectives lend strength to systems of care.
- The fourth priority described by Dr. Larson is a focus on the assessment work and outreach efforts. Both of these dimensions are aimed at maintaining connections with the localities in which the system of care operates, constantly seeking new information, new input, and new partners in system building. These strategies guard against system governance becoming self-contained and closed off to new or contradictory input.
- The fifth priority is to reinforce openness. The governance body cannot assume it knows everything or has all the information it needs to solve the challenges it faces, so it publishes its work and openly seeks input and feedback from local communities itself and from all system stakeholders.
- The sixth and final priority is to celebrate success. Systems of care require a lot of hard, collaborative work; governance success equals system success, which equals success for the population(s) of focus, and all positive outcomes deserve recognition and celebration, setting the stage for optimism about future successes.

Summary

In conclusion, establishing and maintaining system of care governance is often a complex process involving multiple child-serving agencies. Efforts dedicated to setting up a strong structure should include the factors outlined here, such as policy, membership, size, and funding. Governance is key to developing a system of care where diverse voices contribute to the process and aid in guiding decisions. Oversight and accountability through a strong governance body has the capacity to support successful outcomes for children and families and should be considered a necessary component of any current or future system of care configuration.

References

[1] *Building Systems of Care: A Primer (2nd Ed)*, Sheila A. Pires, National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, Washington DC, 2010, pg 8. May be accessed at http://gucchd.georgetown.edu/374615.html

[2] *Ibid.*, pg 64.

[3] Ibid., pg 64.

[4] Think Cultural Health, US Department of Health and Human Services, Office of Minority Health. www.ThinkCulturalHealth.hhs.gov

[5] A Declaration of Hope: Safe Children, Strong Families, Supportive Communities, Casey Family Programs, Seattle, Washington, 2014.

[6] *Ibid.* pages *ii-iv*.

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