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Collaboration Strategies for Reforming Systems of Care
A Toolkit for Community-Based Action

ABSTRACT: The mental health delivery system in the United States is fragmented and disorganized resulting in inappropriate and inconsistent care. The cost of mental illness has led to devastating effects on personal lives at an enormous financial cost. Successful community collaboration efforts are worth forming to enhance public health systems. Key stages of successful collaboration include identifying stakeholders, defining a shared vision, implementation, and developing momentum. Reforming systems of care begins at the local level as community collaboratives begin to develop their status in the community, become an important stakeholder voice, and promote action.

The Mental Health System Is in Disarray

The mental health service delivery system in the United States continues to be characterized by fragmentation and disorganization that create barriers to appropriate and consistent mental health treatment resulting in enormous personal and financial costs. The President’s New Freedom Commission Report [1] acknowledges the grave problems in the community mental health system and calls for a seamless, consumer-driven approach to mental health treatment. The report identifies the following six goals in transforming the mental health system:

1. Americans understand that mental health is essential to overall health;
2. Mental health care is consumer and family driven;
3. Disparities in mental health services are eliminated;

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4. Early mental health screening, assessment, and referral are common practice; 
5. Excellent mental health care is delivered and research is accelerated; and 
6. Technology is used to access mental health care and information.

A critical strategy for reforming community systems of mental health care is 
grassroots activism and coalition building. Grassroots community-based reform 
strategies are effective because they draw on first-hand knowledge and experience 
of consumers and providers currently engaged with systems of care resulting in 
more pragmatic and realistic solutions. In addition, they provide a base for ongo-
ing advocacy related to monitoring systems of care for quality assurance and ser-
vice improvement, and they offer a forum for developing innovative collaborative 
solutions, including public–private partnerships.

The purpose of this paper is to discuss effective collaboration strategies for 
transforming local community systems of care for people with mental illness. First, 
the paper briefly provides statistics related to prevalence and cost of mental illness 
as indicators of breadth and depth of the personal and financial impact of un-
treated mental illness. Next, it describes examples of community-based grassroots 
efforts to reform public health systems. The paper subsequently outlines the stages 
of the collaboration process and action steps associated with each step followed by a 
discussion of the factors associated with successful coalitions. The author concludes 
with special considerations for mental health coalition advocacy to provide further 
guidance on questions around coalition formation and collaborative efforts.

**Mental Health Disorders Are Very Pervasive and Costs Are High**

The experience of mental illness is nearly universal for American families. Be-
tween 20 percent and 25 percent of adults have some type of mental illness, and 
between 9 percent and 13 percent of children experience serious emotional distur-
bances depending on the poverty level of the children [2]. Consequently, millions 
of Americans experience mental illness first-hand, and most Americans are touched 
by it. In addition, untreated mental illness has devastating effects on personal lives 
and an enormous financial cost.

- The U.S. Department of Health and Human Services [1] showed that ineffi-
cient systems of care create barriers to appropriate and consistent treatment, 
which may ultimately lead to homelessness, unemployment, school disrup-
tion, and incarceration, all of which have untold personal and financial costs 
implications.
- The Surgeon General’s report on mental health [2] cited indirect costs of 
mental illness in the United States as approximately $79 billion, including 
the loss of productivity, premature death, and incarceration due to illness.
- In 1996, direct costs for the diagnosis and treatment of mental illness were 
estimated at $69 billion [2].
Responding to the Problem: Public Health Advocacy as a Model

Recent public health reform movements provide examples of effective community-based activism inspired by concerns about service delivery similar to those expressed about the mental health service delivery system. In 2004, the Institute of Medicine held a conference of national health experts and leaders from 15 communities to develop a strategy for public health service delivery systems reform [3]. Driven by research that has reported the extensive and overwhelming problems in the health-care delivery system, conference participants were invited to develop strategies to address the “quality chasm” in health care within five priority areas: asthma, depression, diabetes, heart failure, and pain control in advanced cancer. Participants identified community coalition building as a key component to transforming local systems of care, and several community coalitions shared their successes and lessons learned during the conference. Three examples of successful community coalition efforts to enhance public health systems are as follows:

- In 1996, Friends of Health, a coalition of hundreds of organizations and county residents, organized by the Champaign County Health Care Consumers in Illinois, successfully advocated for the establishment of a county health department to ensure the provision of basic public health services to the community. Their advocacy included initiating and securing passage of a voter referendum for a county health department followed by 3 years of advocacy to ensure its proper implementation [4].

- Through collaboration with multiple stakeholders, the Greater Flint Health Coalition was able to engage hospitals, physicians, clinicians, and administrators to develop better systems for increasing patient compliance with evidence-based interventions for managing heart disease. The coalition’s initiative resulted in a “22% increase in counseling for smoking cessation, 15% increase in appropriate prescribing of cholesterol-lowering drugs, and a 24% increase in prescribing ACE inhibitors” [3, p. 82].

- Motivated by the opportunities presented through the multistate tobacco settlement, the Massachusetts Public Health Association, the American Cancer Society, and Health Care for All, formed a coalition of 100 organizations to develop an advocacy campaign to engender support for the broad principle that all funding received from the settlement would be spent on new health initiatives. After success with this campaign, the Massachusetts Public Health Association continued its advocacy to ensure that the dollars were indeed focused on health initiatives prioritized by the local community [5].

Developing a Collaboration Involves Key Stages

Community-based collaborative processes, as those previously described, typically go through a series of stages that include:
1. Identify relevant stakeholders;
2. Define a shared vision; and
3. Implement the vision and maintain (or grow) the stakeholder group.

Each of these stages is described in more detail in the following discussion.

Stage 1: Identify Relevant Stakeholders

Stakeholders are individuals, groups, and organizations who are invested—or have a stake—in the issue being addressed. Because of their diverse representation and perspectives, coalitions that are a mix of consumers, families, service providers, and advocates have the greatest potential to establish legitimacy and leverage power. Such coalitions can ground their advocacy agenda in the expertise of consumers and families interacting with the current system of care. Service providers can offer their own expertise and lend tangible organizational resources to coalition activities. Professional advocates can offer technical expertise in law, regulations, or other technicalities associated with a coalition’s campaign while also providing more concrete resources to the campaign. Typical steps used in identifying relevant stakeholders include:

Step 1. Generate a list of people who could form an advisory body to help plan a “convening event” or a series of convening events to begin the conversation about how people from different perspectives experience the issue (e.g., mental health service delivery) and how they want to address it. Participants in this advisory body may include representatives from:

- Local chapter of the National Alliance for the Mentally Ill and other consumer groups,
- Community mental health service providers,
- Local community leaders;
- Local health activists;
- Religious organizations;
- Hospitals;
- University professors;
- State mental health agencies;
- State substance abuse treatment and prevention agencies;
- State human services agencies; and
- Legal aid and protection and advocacy service providers.

Step 2. Plan the convening event or series of events with careful attention given to the invitation process, selection of speakers, the event’s objectives, and staffing follow-up activities. Many coalition efforts begin with a convening event or series of events (e.g., town hall meetings, summit, or conference) that help to identify additional stakeholders to frame a more specific action agenda. For example, the Institute of Medicine’s Crossing the Quality Chasm Summit served as a springboard for several community-based reform initiatives in public health. In fact, one
of its stated objectives was “to stimulate and further local and national quality improvement efforts” [3, p. 3].

Step 3. Create an initial stakeholder list from the names of the event participants for participation in future meetings designed to define and operationalize a shared vision systems reform.

Stage 2: Define a Shared Vision

It is important to build on the momentum from the convening event by facilitating a process that engenders collective visioning and crafting of specific tasks that will help bring about a shared vision. In building consensus around the shared vision and its associated goals and tasks, Strauss [6] suggests exploring the following questions:

- Is there a problem? How do you feel about it?
- What is the problem? What are its limits or boundaries?
- Why does this problem exist? What are its causes?
- What are some possible solutions to the problem?
- What criteria must a good solution meet? Which alternatives are better or more acceptable than others?
- Which solution can we agree on? Which alternative can we commit to implementing?

Prior to working toward consensus on the vision and work plan for the collaborative effort, Strauss [6] recommends developing a set of ground rules, an agenda, roles, desired outcomes, and timeframe to establish parameters. He also introduces the notion of using a facilitator to help new stakeholder groups move through this process. The benefits of using a neutral facilitator allows full participation of all stakeholders rather than having one stakeholder assume the role of facilitator, thus making the individual less able to fully participate in the process. Strauss has also found that a neutral facilitator ensures that all participants can fully express their ideas, help members understand each other, address group conflicts, and thereby more effectively engage stakeholders in clarifying and operationalizing their vision. In the absence of a facilitator, it is up to the competent leader to help stakeholders work through this process.

Stage 3: Implement the Vision and Develop the Stakeholder Group

After the stakeholders have developed and operationalized a vision, the coalition undertakes continued growth and begins to further develop and implement a strategy for achieving its goals. The key tasks are as follows.

Step 1: Formalize the coalition structure. Many collaborative processes start out with a loose governing structure comprising a strong leadership core that informally assigns tasks. But collaborations whose goals lend themselves to more permanence
tend to gravitate to more structure, which begins by forming work groups or committees around particular action items (e.g., improving outreach to the homeless, streamlining services to children, increasing access to psychotropic medication) or by functions (e.g., media, documentation, advocacy, information systems, etc.).

**Step 2: Identify and coordinate member resources.** One of the benefits of coalition membership is the ability to share and leverage resources. Specific resources and tasks that organizations can take responsibility for include:

- Staff time, often used for participating in meetings, researching issues, and planning and coordinating committee work;
- Taking notes and facilitating follow-up tasks;
- Copying and distributing materials;
- Identifying and securing facility space and food;
- Providing computer and other technology support;
- Providing logistical support in specific campaigns;
- Conducting training and support for developing skill and knowledge to new members and people in the community;
- Engaging with media and promoting issue; and
- Actively participating in one or more committees, whose tasks vary depending on the committee function.

**Step 3: Develop Momentum.** Dluhy [7] recommends the following ten practice guidelines for working in coalitions which should be considered at each stage of the collaborative process:

1. Find a place for everyone in the coalition. Identifying meaningful formal and informal roles for coalition members is an important strategy to engender ongoing participation in coalition efforts.
2. Avoid elitism in governance. Participatory management practices that equally include and invite the voices of all members is crucial to sustaining broad-based coalition membership and minimizing risk of being perceived as an “exclusive” organization with narrow interests.
3. Keep issues in front of the members and have no hidden agendas. Maintain clarity about the purposes of coalition actions and resist temptations to pursue “opportunities” that creep up without fully vetting it with the coalition membership.
4. Avoid organizational rigidity and do not become too formalized. Too much formalization can impair a coalition’s ability to respond to crises and may also impede the emergence of new leaders during a campaign.
5. Rotate leadership positions or use a small but representative steering committee. Rotating leadership has a number of benefits, including preventing real or perceived consolidation of power among a few members, preventing leadership burnout, bringing new energy to coalition work, and developing a predictable leadership succession schedule to facilitate the grooming of emerging leaders.
6. Use periodic retreats and other self-assessment techniques. Time for reflection on coalition work is an important element to bring meaning, renewal, and sustenance to coalition activities.

7. Do not waste members’ time and stress tasks with clear payoffs: Remember that coalition participation is typically voluntary and is often a task added to regular job responsibilities. Therefore, respectful coalition leaders prepare in advance for meetings and give serious attention to balancing the process and task functions of coalition meetings to maximize use of time.

8. Stress organizational credibility above all else and downplay individual personalities. Coalition members must work together to ensure that the goals and objective of the coalition transcend and overcome tensions among coalition members based on egos, turf issues, or interpersonal conflicts.

9. Design political strategies that allow maximum participation among members and encourage multiple rather than single strategies. Members must be comfortable with political strategies to be willing to participate in or support them.

10. Openly discuss covert political action in which members may be asked to participate but may find objectionable. For example, before engaging in disruptive tactics, such as civil disobedience, the coalition must fully process each step of the action, discuss any reservations held by coalition members and be prepared to temporarily abandon disruptive tactics based on discussion among coalition members.

Know the Factors That Lead to Success

From their research examining the dynamics, operations, and outcomes of 40 coalitions in the New York and New Jersey area, Mizrahi and Rosenthal [8] identified four factors associated with successful coalitions. These factors are essential for coalitions to successfully move through each stage of the collaborative process. The factors are competence, commitment, contributions, and conditions. The first three factors speak to the capacity of coalitions to successfully pool resources for a common purpose. The last factor (i.e., conditions) primarily refers to the external political and economic environments that are more or less favorable to supporting a social change agenda. All of the factors are interrelated and influence the success and shape of the others. In forming a collaborative effort whose purpose is to transform community systems of care for people with mental illness, it is important to be aware of how these factors interplay with each stage of the collaborative process.

Factor 1: Competence

Competence refers to the knowledge, skill, and savvy of coalition leadership to balance the needs to accomplish the tasks of the collaborative process to advance their goals and the need to respond to the varied desires of the individual stakeholders to sustain their commitment and contribution to the collaborative effort.
Mizrahi and Rosenthal [8] focus exclusively on the role of competent leadership to balance the complex set of task and socioemotional needs required for coalition success. Others researchers have found that competent leadership is a crucial factor for developing and maintaining collaborative efforts. [7, 9–14]. Libby and Austin [9] stated that the ability to hire a competent leader was critical to raising the status and legitimacy of the coalition so that area providers felt that the only way to stay “relevant” in the service delivery system was to participate in the coalition. Keys and Factor [10] stressed the importance of incorporating local leadership to enhance the legitimacy of the coalition among policymakers as one that is grounded in community and consumer concerns.

The most commonly identified attributes of effective coalition leaders were credibility, dedication and experience, trustworthiness, articulate and persuasive, trained/educated, good strategic/political skills, and organized/good manager [8]. Several authors identified the ability of leaders to foster and build relationships among coalition members as central to coalition success. [7–8, 13]. Knowledge areas for leadership identified by Gentry [15] are group process, the use of power, communication structures, and goal formulation. All of these skills need to be applied to three key tasks associated with the phases of the collaborative process:

1. Identifying stakeholders that would add credibility and power to the collaborative process;
2. Building consensus among stakeholders to clarify vision and identifying tasks that match stakeholder group resources with external factors and conditions; and
3. Fostering greater stakeholder commitment and contribution through careful evaluation of task outcomes and building consensus around new goals and tasks in light of external conditions.

Factors 2 and 3: Commitment and Contributions

The power of stakeholders involved in a collaborative process is related to their commitment to the effort and to the contributions they are able and willing to make. Commitment to a collaborative process is related to an individual or group’s incentives to join and continue their participation in the effort; incentives are typically grounded in ideology, pragmatism or both. Therefore, competent leaders need to address both types of concerns to ensure the continued commitment of members. In Kaufman’s [11] study of 19 organizations, one of the factors predicting membership sustainability was the extent to which members perceived they were receiving benefits.

For collaborative processes to realize the benefit of the pooled resources of the stakeholder group, members need to make contributions. Donaldson [16] found that membership in coalitions was an important enhancement to nonprofit human service agency advocacy behavior, largely due to the benefits of pooling the contributions and resources of participating organizations for a shared purpose. Mizrahi
and Rosenthal [8] identify three types of contributions from which coalitions benefit: resources, ideology, and power. Resources include both tangible (office space, funding, staff support, etc.) and intangible contributions (expertise, access, and information). Dluhy [7] identified the skills as most helpful contributions of coalition members:

- Ability to do homework and be prepared;
- Strong interpersonal skills and work as a team;
- Sense of timing;
- Intense commitment to coalition goals;
- Ability to compromise and negotiate;
- Perseverance and ability to follow-up and follow-through; and
- Patience.

The ideological contributions of individual stakeholders help give energy to the coalition’s work, especially during times when members feel the coalition is stagnating or losing ground on its social change agenda. For a coalition to realize and unleash its potential power, member organizations must be willing to empower the coalition to act on their behalf. To enable coalition members to have trust in the coalition’s representations of the issue and goals, the time-consuming, yet essential groundwork of building relationships, trust, and joint processes for goal formulation and vetting of new developments must occur. Coalition action can get bogged down in such processes, but trust and a degree of autonomy for coalition action is necessary to respond to emerging, crisis-oriented developments.

**Factor 4: Conditions**

The political and economic environments are critical to the success of coalitions. Nelson [17] attributed part of the success of mental health coalitions in Vermont and Connecticut to the existence of a progressive government and a change in mental health commissioner and state agency staff, respectively. Butler and Seguino [18] identified a receptive legislature and general sensitivity by public officials on issues related to low-income families as an important ingredient contributing to their success in amending the Maine Temporary Assistance for Needy Families program.

Maintaining momentum and pressure refers to implementing the strategies and tactics to achieve the stated goals. Dluhy [7] stated that to have an effective strategy, coalition leaders must have a good understanding of the political environment in which they work, which requires knowing the actors and process in the legislative and executive branches including those who oversee, implement, and give funding for policies and programs. Related to the political conditions of the environment are the economic conditions. The privatization of mental health services has made many members of the stakeholder group agents of the government in service delivery. This funding relationship may affect the participation of individual stakeholders who are also government contractors and the extent to which
they will agree to pursue collaborative versus conflict strategies associated with systems reform. In addition, each locality will have conditions unique to their community that might affect all phases in the collaborative process, including the participating stakeholders, their degree of commitment and contribution, the type of leadership selected, and the vision, goals, and structure of the stakeholder group. Competent leadership that is able to survey the landscape of the service and consumer network and identify and build consensus among relevant stakeholders is the linchpin of a successful collaborative process.

Get Started Now

The President’s Commission report [1] puts a great emphasis on the role of consumers in choosing “who, what, and how” mental health treatment will be provided in an effort to give consumers and their families a meaningful role and more control in selecting among treatment options. Therefore, consumers, families, and advocates of mental health services have the opportunity to seize on the unprecedented attention that mental health services have gained from the Surgeon General and the President’s New Freedom Commission to advance reform in mental health systems in communities across the United States. Although each community needs to identify and prioritize targets of reform in local systems of care, the Commission’s report identified six goals for mental health systems reform around which communities could begin coalescing or at least begin their conversations:

1. Promote greater understanding among Americans that mental health is essential to overall health;
2. Ensure that mental health care is consumer and family driven;
3. Eliminate disparities in mental health services;
4. Make certain that early mental health screening, assessment, and referral are common practice;
5. Guarantee that excellent mental health care is delivered and research is accelerated; and
6. Apply technology to access mental health care and information.

First, sociopolitical trends make the use collaborative processes an increasingly important strategy for social reform. For example, although the devolution of social service policy and budget authority to state and local municipalities squeezes financial resources and makes local system design more vulnerable to shifts in their political environment, it also facilitates the civic engagement and meaningful participation of community groups who are organized and persistent.

Second, the increasing trend to privatize social services and rely more on faith-based organizations to serve vulnerable communities makes the role of community advocacy coalitions even more essential and complex to ensure that services are adequately funded, held accountable, and remain accessible to all consumers at whatever stage in the mental health continuum they need to access services. The
development of Medicaid managed care systems to reduce costs has accelerated
the privatization movement in the behavioral health sectors.

Third, the effects of the terrorist attacks of September 11, 2001, the war in Iraq,
and the unpredictable nature of terrorism within the U.S. borders have strained
mental health service providers on many levels. Money spent on the war on Iraq
and homeland security will likely divert funding from domestic social service pro-
grams to defense and emergency preparedness expenditures. In addition, studies
examining the effects of the September 11 attacks, the Oklahoma City bombing,
and the sarin gas attack in Tokyo [19–27], demonstrate that these types of inten-
tional disasters engender strong emotional, behavioral, and social consequences,
many of which are maladaptive and would benefit from mental health intervention.

As collaborations are successful they will begin to establish their status in the
community, which will enhance their credibility as an important voice on the issue
and thereby make the stakeholder group not only more attractive but also essential to
relevancy in the community. A special consideration for local mental health commu-
nities when forming coalitions is whether to include goals around enhancing and
improving addiction treatment and rehabilitation. Some would argue that due to the
prevalence of co-occurring disorders in addiction and mental illness, advocates would
be making a grave error not to join efforts and speak with a single voice [28]. On the
other hand, some people feel the stigma of addiction is even greater than the stigma
of mental illness and linking one with another in an advocacy campaign would di-
lute the objectives of the mental health reform movement and reduce the chances of
the movement’s success. Some advocates may also suggest an incremental approach
to system reform, starting first with mental health treatment and then joining with
advocates for reform in addiction treatment and rehabilitation.

Conversations around this issue will be subject to balancing the tension be-
tween ideology and pragmatism and will often be guided by factors within the
local communities. In the end, consumers, families, service providers, and advoca-
tes are urged to hold their elected and appointed officials accountable to the call
of the President’s New Freedom Commission [1] to radically transform the mental
health system to achieve the vision of “a future when everyone with a mental
illness at any stage of life has access to effective treatment and supports.”

Note

1. Some collaborative processes formalize in the first phase.

References

1. President’s New Freedom Commission on Mental Health (2003) Achieving the
Available at www.mentalhealthcommission.gov/reports/FinalReport/toc.html,


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