School Based Approaches

Chapter 4

The School and Community Study: Summary of Preliminary Baseline Data

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Introduction

Children who have serious emotional disturbances have been described as an underserved and ineffectively served group of youngsters with disabilities (Koyanagi & Gaines, 1993). Year after year "The Annual Report to Congress on the Implementation of the Education of Handicapped Children's Act" prepared by the Office of Special Education and Rehabilitation Services (OSERS) has documented the low number of children identified and served and the poor outcomes for those who are served in the special education system (see, for example, U.S. Department of Education, 1990). This report indicates that less than one percent of the school age population has been identified as seriously emotionally disturbed while conservative prevalence estimates range from three to five percent (Knitzer, 1982; Koyanagi & Gaines, 1993). Further results from the report indicate that children who have serious emotional and behavioral disorders have lower grade point averages and graduation rates and fewer attend post-secondary schooling as compared to all students who have a disability as well as students in general.

During the past 10 to 15 years, the special education community began a series of reform initiatives, responding to a number of annual reports to Congress documenting poor outcomes for children with disabilities (see, for example, U.S. Department of Education, 1995). These reforms focused on normalizing the experience of exceptional learners by increasing

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their contact with non-exceptional students. Models were developed to increase mainstreaming (Wang & Birch, 1984); to integrate regular education and special education (Will, 1986); and to completely include children with disabilities in all aspects of a totally comprehensive school (Sailor et al., 1989). At present, the reform literature, though extensive, is lacking on several counts. It is normative rather than empirical, and it lacks a comprehensive theoretical framework. In addition, there is no clear explication of which reform mechanisms, if any, contribute to positive outcomes for children who have emotional and behavioral disabilities. Furthermore, there are several different foci and combinations of reforms that could be occurring in a particular school.

The School and Community Study (SACS) has been designed to examine the various processes of reform in regular education, special education, mental health, and child welfare in terms of how these reforms contribute to improved outcomes for the children and families served. Specifically, this study will identify successful school-based models, explicate the interventions used, and demonstrate that there are efforts that are community-based, family-focused, and child-centered that contribute to improved outcomes for children and youth.

In order to produce a systematic and rich description of schools and communities that are effective in restructuring and improving outcomes for all children, including those who have emotional and behavioral disabilities, the study employs a multi-level model of reform. As presented in Figure 1, a school is the basic unit of analysis, while state and local mandates and initiatives serve as a context for the reform activities at the building level. A goal of this study will be to link these reform activities to improved outcomes for children who have emotional and behavioral disabilities.

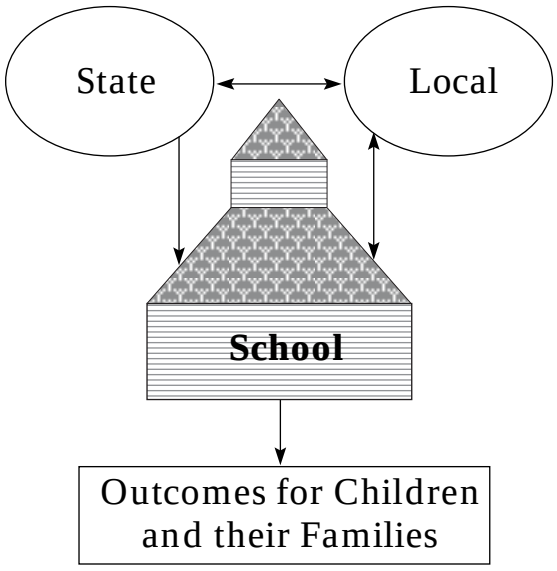
A sample of children who have emotional and behavioral disabilities was identified at each school in the study and will be followed longitudinally for two years. Data were collected from state administrators, social service providers, school staff, and children and their families. The following discussion summarizes the information gathered at baseline from the students at the schools in Phase I of the study. In Phase II, additional students will be recruited from a new sample of schools who have been nominated for their successful efforts in serving children who have emotional and behavioral disabilities.

Method

Subjects

Of the four public schools that comprise Phase I, two are located in Kentucky and two are in Vermont. From the four schools' total enrollment of 23 students formally identified with an emotional or behavioral disability, informed consent for 19 of these students was obtained from their parents or

Figure 1
Effects of Restructuring and Reform on Outcomes for Children and Families



caregivers. The study's sample of 19 students was representative of the schools' total enrollment of 23 students with respect to age, gender, race, and cost of school meals. The students in the sample were an average of 10 years old, mostly male (79%), Caucasian (95%), and receiving free or reduced price school meals (74%).

Instruments and Measures

A variety of data collection methods were used including surveys, semi-structured interviews, and reviews of student records by study staff. In addition, standardized instruments used in the study include the Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1997), Child Behavior Checklist (CBCL; Achenbach, 1991), Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990), Child and Adolescent Services Assessment (CASA; Ascher, Farmer, & Burns, 1996), Client Satisfaction Questionnaire (CSQ; Attkisson & Zwick, 1982), Wide Range Achievement Test (WRAT; Jastak & Wilkinson, 1984), and the Slosson Intelligence Test (SIT; Slosson, 1984).

Procedure

The identification of successful school-based models for inclusion in the study was achieved through a multi-method site selection process, consisting of a national call for nominations, an examination of responses to two surveys, and a site visit. Through a selection process, 81 nominated schools were winnowed down to six schools who were invited to participate in the study. Two schools were unable to continue in the study, resulting in 4 schools comprising Phase I of the study.

Preliminary baseline data collection was completed during the spring and summer of 1996. Data were collected from individuals at multiple organizational levels including state officials, local community leaders, members of local interagency committees, school personnel, parents, and the children themselves. Study staff traveled to the state and local government offices and the four schools to conduct interviews with representatives from these agencies. Visits to the schools also were used to review the students' records and administer the WRAT and SIT, only if the student's most recent intellectual assessment was more than two years old.

Results & Discussion

State and Local

The study attempted to assess the adherence to principles of a coordinated, community-based system of care operating in both Vermont and Kentucky. Through interviews with state and local officials and questionnaires completed by members of local interagency teams, it was evident that both states have had a long history of building community-based services for children with emotional and behavioral disabilities and their families. State and regional interagency committees were active in building coordinated and community-based services for children and state legislation supported their efforts. The strengths of the service system in Vermont were parent involvement and a commitment to coordinating services across agencies. The strengths of the service system in Kentucky were the interagency structure at the state and local level, state legislation, and having family members as equal partners in the treatment process.

School

Since the school level data are from just four schools, it must be considered preliminary. However, patterns emerged in the areas of school governance, curriculum and instructional factors, accountability, and parent involvement. The schools have adopted various methods to ensure diverse input for decision making and indicate a movement toward a site-based approach of governance. While they have diverse instructional methods, curriculum content, and

special education procedures, the schools have a clear plan to assess the outcomes of these efforts. There has been a high degree of involvement of parents who have children with emotional and behavioral disabilities.

Student

A third of the students had been retained at least once, and their IEPs had multiple objectives for reading, math, and written expression as well as social skills and on-task behavior. High rates of absenteeism were not a problem for the majority of this sample, and even though numerous discipline incidents were documented in school records, the most common consequences for these offenses were time out and warnings / reprimands.

For the most part, students were included in the regular activities of the school. Most spent the majority of their school day in a general education setting, used regular transportation, and had their school-wide testing results included in school progress reports. While individual and group counseling were the most common services received by the students, less than one quarter received these services from non-school based service providers in the school facility during the school day.

Scores on intellectual assessments were in the Low Average range (M = 86.6, SD = 14.7). Slightly lower achievement test scores were found for subtests of Reading (M = 80.1, SD = 14.3) and Math (M = 77.4, SD = 16.4). Achievement test results for about three quarters of the participants were below their grade level.

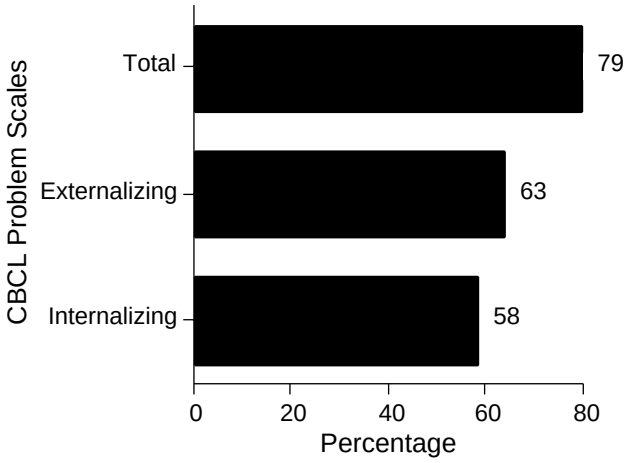
Parent-Reported

Emotional and behavioral problems were first noticed at an average age of 4.9 years, while the average age of first help / intervention was 6.9 years. Most parents described the first problem as hyperactivity (21%) or aggressive behavior (37%) and reported counseling or evaluation as the first service received.

The majority of children had experienced severe emotional and behavioral problems in the past, with the most frequent behaviors being hyperactivity, difficulty getting along with peers, academic problems, excessive worrying, and extreme difficulty getting along with family members. At the time of the study, these children had serious emotional and behavioral disabilities with 79% of the participants scoring in the borderline or clinical range for the total problems scale of the CBCL (see Figure 2). Parents also reported that their children exhibited intrapersonal strengths (e.g., identifies own feelings) and affective strengths (e.g., asks for help). The results of the CAFAS are shown in Figure 3 and indicate that more than half had moderate or severe functional impairment in the domains of Behavior Toward Others (79%), Moods / Emotions (58%), and Role Performance at Home (63%) and School (79%).

The majority of participants had used a variety of services for their emotional and behavioral problems. For example, all participants had used at least one service within the professional help category (e.g., school-based related services). Parents were highly satisfied with educational services, but less

Figure 2
Percentage of Students in the CBCL's Clinical or Borderline Ranges

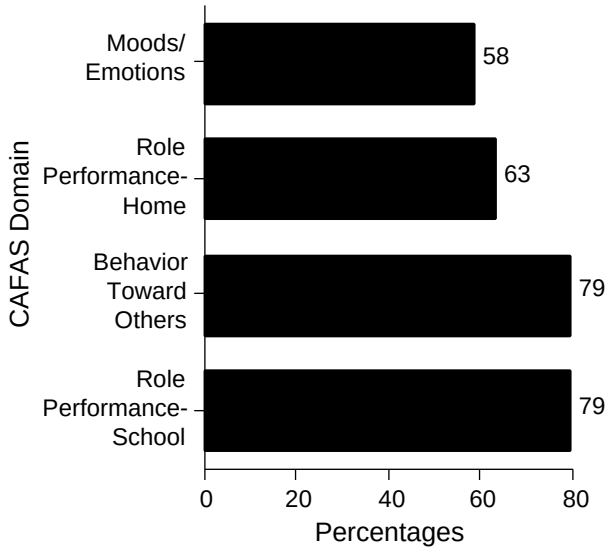


so with related services. Further, parents were highly involved in school functions and in the special education process.

Conclusion and Future Directions

This paper summarized the information gathered at baseline in Phase I of the study from state and local officials, school staff, parents / caregivers, and students at four schools in Vermont and Kentucky. Follow-up data on the 19 students will be collected at 12 and 24 months. In Phase II, additional students will be recruited from a new sample of schools who have been nominated for their successful efforts in serving children who have emotional and behavioral disabilities.

Figure 3
Percentage of Students in the CAFAS' Moderate or Severe Ranges



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P.A.S.C.O. Wraparound: A Collaborative Effort for Middle School Students

Introduction

Planning and Assistance to Schools and Communities to Organize (P.A.S.C.O.) Wraparound has offered support to middle school students and their families since 1994, through a collaborative effort between the administration and staff at the Thomas E. Weightman Middle School (TEWMS), the University of South Florida (USF), community members, and the students and their families. P.A.S.C.O. Wraparound is a school-based model of planning in which the integrated strengths of the students, their families, and community service systems and resources serve as a foundation for the development of goals to overcome barriers to the learning process.

In addition to using strengths to bring about change, P.A.S.C.O. Wraparound is based on shared responsibility among the student, family, school, and community. The students and parents are key in planning and decision-making related to the development and review of student/family support plans. These strength-based plans focus on all of the ecological systems surrounding the student. Students in both regular education and special education classes participate in plan development and review. Systemic and individual change have occurred as a result of P.A.S.C.O. Wraparound. This summary describes the implementation of this initiative.

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Note: A 3-year federal NIDRR grant was awarded in August 1997 to further investigate and quantify child outcomes related to this project.

Method

P.A.S.C.O. Wraparound is an extension of the on-going collaborative relationship between USF in Tampa, Florida and TEWMS. As a USF Professional Development School, TEWMS is committed to developing and implementing alternative approaches to the training of educators and school-based research programs focused on issues central to improving instruction. TEWMS began serving students in the 1991-1992 academic school year. The school's 1,200 student population, in grades six to eight, are 80% Caucasian, 10% Hispanic, 9% African American, and 1% Asian. Thirty-five percent of these students receive special services through either exceptional education (20%), drop-out prevention (12%), or the English as a Second Language program (3%).

In 1993, TEWMS was designated a site for a local Child and Adolescent Service System Program (CASSP) grant. Through the CASSP grant, parental involvement in the school was increased, especially in relation to students identified as emotionally handicapped (EH) and seriously emotionally disturbed (SED). Before the grant ended in 1995, P.A.S.C.O. Wraparound was introduced to continue to increase parental involvement as well as to initiate a school-based collaboration of systems.

A consultant from USF has served as a coordinator for the P.A.S.C.O. Wraparound project. The coordinator and other partners have provided training and informational presentations about the P.A.S.C.O. Wraparound process to the staff of TEWMS and community members. Parents have been included in educational forums on behavioral issues commonly described by families and teachers, such as stealing, gangs, and drugs, which have been set up as an adjunct to the Wraparound process.

The active participants in P.A.S.C.O. Wraparound include: TEWMS administrators (principal and assistant principal); TEWMS student support staff (guidance counselors, social workers, and psychologists); TEWMS teachers (regular and special education); and TEWMS students and their families (regular and special education). Equal partners in the process also include: local mental health agencies; social services, juvenile justice, family friends, USF, neighborhood groups, and other community resources. A parent from the community serves as a Parent Advocate, providing additional support to the students and families.

Strength-based plans are developed or reviewed in collaborative meetings that include the student; their parent(s) or guardian(s); TEWMS staff who are familiar with the child; community agency personnel working with the family; and community members who bring knowledge of available community resources. The student / family support plan identifies strengths, needs, barriers, outcomes, and responsibilities across life domain areas. The plans are reviewed at least once a month and are revised based upon input received through the planning process. Individual plans may include some of the following activities: tutoring, anger management group meetings, psychiatric and medication evaluations, counseling, and other specialized ways to meet the needs of the student.

Each student has a case manager, known as the student / family plan coordinator, who is responsible for the integration of services. To-date, TEWMS staff at every level have shared the role of plan coordinator. The roles of all participants in the Wraparound meeting include:

- equal acceptance and valuing of all participant partners;
- integrate multiple perspectives in plan development and implementation;
- establish communication links between the family, school, and community;

- share relevant information to allow family to make informed choices about supportive services;
- foster a climate of trust;
- practice the principles of confidentiality; and
- share responsibility for goal attainment.

Outcomes

P.A.S.C.O. Wraparound participants view the process as an intervention which can address concerns before problems have reached a level of persistence and severity sufficient to warrant consideration of residential placement. They have expressed that they view P.A.S.C.O. Wraparound as an alternative resource, not just a change in procedure. Further, participants in P.A.S.C.O. Wraparound have identified strengths of the process as the built-in flexibility for staff, students, and families and a sharing of different perspectives resulting in new strategies to address concerns of the student, family, school, and community as strengths of the process.

To date, impressions of the success of P.A.S.C.O. Wraparound are based on anecdotal information and observations of the USF staff based at TWEMS in relation to the following outcomes:

- an increase in school personnel sharing strategies which have been effective in the classroom with one another and with students' parents;
- positive change in student behavior, both in school and at home;
- greater completion of academic goals by students;
- increased parent involvement and parent/school collaboration;
- effective role changes for school personnel, i.e., serving as plan coordinators;
- increased family trust in the school system; and
- flexible resource availability, including funding.

As P.A.S.C.O. Wraparound continues at TEWMS, qualitative measures as well as quantitative outcome measures will be studied, including discipline referrals, absenteeism, changes in academic achievement, and participant analysis of the process. The possibility of expanding P.A.S.C.O. Wraparound into other schools in the local area is also being considered.

Working Together: Mental Health and Special Education Collaboration in Florida

Introduction

Teachers of students with emotional/behavioral disorders will at some time have contact with members of the mental health system. Psychologists, social workers, and counselors often provide much needed services to students with emotional disturbance. Interagency collaboration can be viewed as a necessity in order to meet the demands for the range of services needed. The Child and Adolescent Service System Program (CASSP) has been instrumental in the development of inter-agency collaboration models across the nation (Coleman, 1996).

As agencies work together to provide appropriate services for students with emotional disturbance, the need for effective communication skills among professionals is apparent. Mental health professionals are called upon to transmit their knowledge and expertise to non-mental health professionals as peers in cooperative endeavors (Bower, 1990). The mental health worker must find ways of effectively helping teachers work with students with emotional disturbance.

Feedback from teachers of students with emotional disturbance for mental health professionals is valuable yet lacking in the literature. In order to help bridge the gap between mental health professionals and teachers and to provide specific feedback to mental health professionals, a survey was distributed to 76 contact persons for programs for the emotionally handicapped in the state of Florida.

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Method

Subjects/Sites

The Florida Department of Education supplied a list of contact persons for programs for the emotionally handicapped. Surveys were sent to all contact persons primarily working in direct service. The list includes:

63 School districts listing one contact person.

4 Districts listing two contact persons.

1 Principal.

Of the 72 surveys sent out, 50 were returned for analysis. The Florida Department of Education classifies school districts as very large / large, medium, medium / small, or small. Eighteen percent of survey respondents were from very large / large districts, 22% from medium districts, 22% from medium / small districts, and 38% from small districts. The majority of respondents were district level administrators.

Survey Instrument

Respondents were asked three open-ended questions regarding service provision by mental health professionals. Specifically, respondents were asked:

1. What benefits do mental health professionals provide to the teachers / students in your district?
2. What difficulties have resulted during interactions between mental health professionals and educators in your district?
3. What advice would you offer to mental health professionals for improving service provision?

Analysis

Answers to questions 1 and 2 regarding benefits and difficulties stemming from mental health service provision were typed in a list format. Counts were taken of the number of respondents listing each benefit or difficulty. Benefits and difficulties were listed in order of greatest frequency to lowest frequency reported by respondents.

Answers to question 3 regarding advice to mental health professionals were analyzed using a content analysis procedure. Responses were typed in a list format and were grouped according to the following categories: (a) knowledge of school policies and procedures, roles and responsibilities; (b) communication with educators; (d) collaboration with educators; and (e) making service provision more beneficial.

Results

Seventy-one percent of respondents reported that contact time between teachers of students with behavioral disorders and mental health professionals was not enough, while only 29% reported contact time to be satisfactory. No one reported that contact time between teachers and mental health professionals was more than necessary.

When asked "what benefits do mental health professionals provide to the teachers / students in your district," respondents reported as shown in Table 1.

When asked what difficulties resulted during interactions between mental health professionals and educators in your district, respondents reported as shown in Table 2.

When asked what advice respondents would offer to mental health professionals for improving service delivery, respondents reported:

Knowledge of school policies and procedures.

- Learn the law (IDEA), especially regarding IEP decision making.
- Become familiar with the referral and evaluation process.
- Understand the culture of the school community.

- Meet the key players.
- Sign in and sign out; call if you are absent.

Roles and responsibilities.

- Set your job parameters from the very beginning so there are no misunderstandings later on.
- Be flexible in service delivery hours; begin service delivery with the start of the school year and maintain a consistent schedule.
- Mental health professionals should know what it's like to be educators and educators should know what it's like be to mental health professionals.

Communication with educators.

- Bring your expertise, experience, and an open mind when meeting with educators.
- Schedule times for regular and frequent communication with educators.
- Share treatment plans and offer feedback to teachers after working with students.
- Listen to teachers' concerns for students;
- meet with school personnel prior to service delivery.

Collaboration with educators.

- Find a common ground and be willing to try new, uniquely designed strategies that are a result of disciplines collaborating into a new identity.
- Individual contacts are the key. Good friendships make good working relationships.

Making service provision even more beneficial.

- Use Medicaid funding as much as possible; identify more stable funding sources.
- Spend more time in the schools: have supervisors lower caseloads.
- Provide ongoing staff development activities and on-site services in schools.
- Reduce the turnover rate so quality services can consistently be provided.
- Collaborate more services between homes and schools.
- Deliver what you promise; never promise what you can't deliver.
- Focus on prevention and early intervention.

Table 1
Benefits Endorsed by Teachers (*N* = 50)

# Respondents Listing Benefit	Benefits Listed
38	Service provision to students (e.g., counseling, crisis management).
27	Consultation, training, or support to school staff.
26	Behavioral observations, assessments.
19	Consultation, training, counseling to parents.
9	Membership on school teams (e.g., Child Study).
5	Advocacy, referral to outside agencies.
5	Case management.

Table 2
Difficulties Listed by Teachers (*N* = 50)

# Respondents Listing Difficulty	Difficulty Listed
16	Differences in treatment philosophies, role responsibilities
13	Lack of communication, collaboration
10	Conflicts in scheduling appointments, meetings, etc
8	Limited resources, lack of service provision.
4	Frequent changes in mental health personnel.
3	Lack of knowledge regarding school procedures, laws, etc.

Discussion

Results of a survey of district level contact persons for programs for students with emotional disturbance indicate more contact time is needed between mental health professionals and teachers of students with emotional disturbance. Benefits provided by mental health professionals include: service provision to students, consultation, training, and support to school staff, and conducting educational assessments. Difficulties resulting from interactions between mental health professionals and educators include: differences in treatment philosophies, lack of communication, and conflicts in scheduling appointments and meetings. In order to improve service delivery, respondents suggest mental health professionals know school policies and procedures, delineate roles and responsibilities, communicate and collaborate with educators, and maintain a consistent staff providing quality services to students, their families, and school personnel.

Psychologists, social workers, and counselors provide much needed services to students with emotional disturbance. As agencies work together to provide appropriate services for students with emotional disturbance, the need for effective communication skills among professionals is apparent. Mental health professionals must find ways of effectively helping teachers, students, families, and school personnel work with students with emotional disturbance.

Successful collaboration among professionals requires effective communication, time management, and interpersonal skills. Educators and mental health professionals should plan collaboratively to meet the needs of students with emotional disturbance. Regularly scheduled meetings should allow professionals to discuss concerns, share treatment plans, and offer feedback on current interventions. By sharing a common ground and integrating disciplines, educators and mental health professionals can improve service provision and offer greater benefits to consumers.

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Supporting Students with Serious Emotional Disturbance in Rural Schools and Communities

Introduction

Bridges (Best Practice-Based Services For Including Students with Serious Emotional Disturbance in General Education, Their Local Schools and Communities) is a three year grant funded by the U.S. Department of Education. The dual purpose of this Outreach Project is to build the capacity of rural public schools to fully include students with severe disabilities and severe emotional disturbance within general education and community settings, and to provide support for their families. The project and institutes were based on several interacting elements: (a) best practices for educating students, including those with serious emotional disturbance, within their local schools; (b) the Responsive Classroom (Northeast Foundation for Children, 1994) curriculum for strengthening teaching practices, and developing innovative classroom and school programs; (c) a School-Community and Model School planning team model, with school, family, student, other agency and community involvement for increasing the availability of best practices for children and adolescents in the school and community; and (d) an Individual Student Planning Team model for including students with serious emotional disturbance in general education settings and activities in their local school and community.

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Bridges Web Site:
http://www.uvm.edu/~uapvt/programs/bridges.html

Method

Subjects and Site

One rural Vermont K-8 school is participating as the model school site, and approximately 20 teams from other rural states across Vermont and the nation will participate in two national institutes. Montgomery Elementary School was chosen as the model site based on the following criteria: administrative commitment at the district and building level for providing educational services for all children within the general education setting; willingness to engage in community and school-wide planning (Fox & Williams, 1991); willingness to develop individual student support teams (Hamilton, Welkowitz, Mandeville, Prue & Fox, 1995); openness to involve parents in all aspects of their student's program; and commitment to collaborate with other agencies.

Within the model school site, 12 students, in grades K through 8, have had individual student support teams formed to assist in problem-solving and developing appropriate educational services.

Intervention

A collaborative approach between the community and school, as well as an individualized approach for students, was emphasized. A School-Community Team and Model School Team were developed. The teams consisted of representation from the school faculty, administration, community businesses, parents and students. The School-Community Team was formed in an effort to strengthen the communication between community members, parents and the school, stressing the value of input from everyone involved in the education of children. The Model School Team was formed to assist the school in coordination of federal, state and local initiatives, provide problem-solving supports for the school overall, and identify the most effective educational practices to support all students in the areas of school and classroom structure, climate, curriculum, assessment, and instruction. Finally, the Individual Student Support Teams were set up to address the specific needs of students who are experiencing unique challenges. The outcome of this intensive level of teaming has been the inclusion and provision of appropriate educational plans for every child, regardless of their type of disability.

As a model school, Montgomery Elementary School will be sharing its experiences and approaches with other teams from other small rural schools in the United States. Teams of teachers, parents and community members will provide mini workshops and conference presentations, and facilitate team planning with the visiting schools.

Evaluation

The project used quantitative and qualitative methodology to evaluate preliminary outcomes. Semi-structured interviews are conducted at the beginning and end of each school year with the students with SED, their peers, their parents, and their regular and special education teachers.

Surveys and their corroborating questionnaires were completed by the student's family, his or her peers' families in the model school site, the school administrator, regular and special education teachers, and a representative sample of students in K through 8 during the first year of the grant, and will be re-administered in Year 3. Questionnaires assessing team functioning were completed by members of the students' individual support team, the School-Community Team and Model School Team, and were administered at the beginning and end of each school year. T-test analyses were conducted for each question of the Team Assessment to determine whether the participant's response prior to participation in the project was significantly different from their response following participation, support, and training. This same analyses will be done with remaining questionnaires; however, means are currently determined for each question of the premeasures.

A behavior checklist was also completed at the beginning of the school year and at the end of the school year by the student with SED (YSR; Achenbach, 1991b) if over 10 years of age, his or her teachers (TRF; Achenbach, 1991a), and his or her parents (CBCL; Achenbach & Edelbrock, 1983). *T*-test analyses were conducted to determine whether the *T* scores are significantly different for each of these measures following training, support and participation in the project.

Results

Results suggested that the project has had some initial impact upon all students in the model school, their parents, educational and related service providers, community based service providers and businesses, and other community members.

Surveys and Checklists

Means were determined for each question of the General Education Teacher, Special Education Teacher and Administration Survey, and the Parent Survey (see Tables 1 and 2, respectively). Overall, the responses of the educators and administration indicated strong support for providing educational services for all children in the regular classroom environment; while parents did not strongly agree or disagree. The parents, however, did feel strongly that education programs should address more than just academics, and the local school should provide for all of their children.

There were several statistically significant differences for the team members' responses between the first and second administration (see Table 3 and 4, respectively) of the School-Community Team Assessment and the Model School Team Assessment. Factors related to collaboration which achieved statistical significance have an asterisk.

Semi-Structured Interviews

The students primarily focused on how they handled stressful situations within the classroom and school, or how they help other students. The students who experienced behavioral difficulties reported fewer coping strategies and described responses to difficult situations that were often ineffective. The educators focused on the quality of education for the students; awareness and concern for individual student differences; needs and styles of teaching required; and the need for flexibility in order to manage stress and the changing workload. The parents of children with SED identified three themes: (a) appreciation for meaningful involvement in their children's education; (b) in addition to academic priorities, the importance of social and emotional educational opportunities; and (c) concern for their children's development and their changing role as parents with each passing year.

Discussion

These preliminary findings– despite the small sample size–continue to support prior research in regard to the inclusion of children with severe emotional disturbance within the regular classroom, school and community environments (Hamilton, Broer, & Welkowitz, 1995; Hamilton, Welkowitz, Topper, & Inatsuka, 1993). With adequate school, community-wide planning and access to training, and use of an individual student support planning team process, educators, administrators, students and families are accepting of children with SED in the general education classroom in their local public school. It is expected that the two national institutes will be an effective training vehicle for exposing these components and strategies to other rural schools and communities.

Table 1
General Education Teacher, Administration, and Special Education Teacher Survey

Don't Know	Strongly Disagree					Agree				Strongly Agree		
0	1	2	3	4	5	6	7	8	9	10		
											Mean	***N***
1.	"I would refuse having _____ in my class if I had a choice."										1.37	8
2.	“I have not been involved in developing the educational program for _____ ”										2.13	8
3.	" _____ 's presence does not interfere with my ability to address the educational needs of my other students".										4.8	8
4.	"I always have the nagging feeling I'm not doing enough to include _____ ."										3.75	8
5.	"Initially I didn't know much about how to deal with _____ and how to respond to him / her and interact with him / her. I was afraid."										4.25	8
6.	"Having _____ in my general education class is having a positive social / emotional impact on the nondisabled students."										5.38	8
7.	I believe any teacher (given support), can teach any child in his / her general education classroom".										6.25	8
8.	"I don't think I really have developed a relationship with _____ compared to my relationships with other students. I still haven't really connected with her / him."										2.25	8
9.	"Getting to know kids with emotional difficulties is not very different than getting along with a whole lot of other people in life."										7.63	8
10.	"I feel very comfortable with _____."										7.13	8
11.	"I don't think anybody really knows what to do with _____. Specialists come in, but nobody really gives me any suggestions of what to do."										4.71	7
12.	I feel like I am not getting any support".										3.5	8
13.	The paraprofessionals assigned to my class have received adequate training.										4.57	7
14.	"Given appropriate supports, I would welcome a student with serious emotional difficulties in my class in the future."										8.86	7

Table 2
Parent Survey

Don't Know	Strongly Disagree					Agree				Strongly Agree		
0	1	2	3	4	5	6	7	8	9	10		
											Mean	***N***
1.	My child feels comfortable interacting with children who have emotional difficulties.										6	19
2.	My child feels more comfortable interacting with people who have emotional difficulties than I did when I was a youngster.										5	18
3.	The opportunity to interact with a classmate who has emotional difficulty has had a positive impact on my child's social/emotional growth.										6	17
4.	My child feels positively about having a classmate who has emotional difficulties										6	16
5.	Having a classmate with emotional difficulties has interfered with my child receiving a good education										6	18
6.	Overall, I feel that having a classmate with emotional difficulties has been a positive experience for my child.										5	17
7.	Having a classmate with emotional difficulties has enhanced my child's education.										3	16
8.	Having a classmate with emotional difficulties has increased my child's perception of differences in others.										8	17
9.	I am accepting of different kinds of people.										9	24
10.	I feel that our local school provides educational programs for all of our children.										8	23
11.	I feel that educational programs should address:											
	A. only academic skills										5	24
	B. social interactions and interpersonal skills										9	24
	C. self-control and self-management skills										9	23
	D. vocational skills										8	24
	E. self-care skills										8	22

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Table 3
School Community Team Assessment
(Paired Samples *t* - Test, *N* = 7)

1 2 Definitely Not True	3 4 Probably Not True	5 6 Sometimes True	7 8 Probably True	9 10 Definitely True

Safety	*T* = -2.076	*p* = .093
Decision-Making	*T* = -2.887	*p* = .028*
Trust	*T* = -1.865	*p* = .121
Ability to Resolve Conflict	*T* = -2.414	*p* = .052
Productivity	*T* = -4.347	*p* = .005*
Community	*T* = -1.814	*p* = .129
Cohesiveness	*T* = -4.000	*p* = .010*
Equality of Members	*T* = 1.429	*p* = .203
Commitment of Team	*T* = -1.890	*p* = .108
Ownership	*T* = -2.048	*p* = .086
Common Goals	*T* = 1.726	*p* = .135
Sharing	*T* = -2.198	*p* = .070
Brainstorming	*T* = -1.901	*p* = .106
Action	*T* = -2.500	*p* = .047*
Processing	*T* = -2.772	*p* = .032*

Table 4
Model School Team Assessment
(Paired Samples *T* - Test, *N* = 9)

1 2 Definitely Not True	3 4 Probably Not True	5 6 Sometimes True	7 8 Probably True	9 10 Definitely True

Safety	*T* = -4.733	*p* = .002*
Decision-Making	*T* = -6.928	*p* = .000*
Trust	*T* = -5.715	*p* = .000*
Ability to Resolve Conflict	*T* = -2.490	*p* = .038*
Productivity	*T* = -3.087	*p* = .015*
Sense of Community	*T* = -2.066	*p* = .073
Cohesiveness	*T* = -7.426	*p* = .000*
Equality of Members	*T* = -2.530	*p* = .035*
Commitment of Team	*T* = -2.081	*p* = .071
Ownership	*T* = -4.041	*p* = .004*
Common Goals	*T* = -2.987	*p* = .017*
Sharing of Roles	*T* = -7.778	*p* = .000*
Brainstorming	*T* = -3.900	*p* = .005*
Action	*T* = -4.406	*p* = .002*
Processing	*T* = -5.160	*p* = .001*

*Significant at .05

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Implementation and Outcome Evaluation of Statewide School-Based Family/Youth Services

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Introduction

School-based family resource and support programs assume that socially disintegrative factors that affect families attenuate the ability of children to fully profit from their educational experiences. The primary focus of these programs is to enhance the participation of families in the educational process and to strengthen the capacity of families to enable children's readiness for learning. Broadly, this is to be achieved by empowering families to access a variety of services and resources, and to forge cooperative links among families, schools, and communities. The purpose of this study was to evaluate the degree and quality of program implementation and educational outcomes associated with program participation of a statewide school-based family support initiative.

Method

Program

Kentucky's Family Resource and Youth Service Center program (FRYSC) is an essential component of the Kentucky Education Reform Act (KERA). Modal staffing of centers consists of a coordinator, an assistant, and various adult and student volunteers. Consistent with other family support programs, their general mission is to reach out and establish connections with families and students, schools, and community agencies; and to establish links or bridges among them, particularly to increase

the involvement of families and the community with schools. They are supposed to carry out their tasks by adapting their services and approaches to local characteristics and resources; to, whenever possible, broker or mobilize community resources, rather than provide direct services; and, to empower families to identify and utilize formal and informal resources to meet their own needs. Family Resource Centers (FRC) serving elementary schools and Youth Service Centers (YSC) serving secondary schools proliferated rapidly to 560 centers in the 1995-96 school year.

Measurement

Qualitative and quantitative methods were used to evaluate these programs. The qualitative methods consisted of half-day site visits to centers that included interviews of coordinators, staff, principals, and parents; observation of center operations; and review of center workplans and other materials. Quantitative methods included teacher surveys, and a computerized management information system that permitted coordinators to collect data on who was served, what services were provided, and what outcomes were associated with participation. Outcomes used in this study were teacher pre-post ratings of the performance of student program participants on 18 educational variables, as well as student progress on KERA levels of academic proficiency.

The goal of the qualitative evaluation was to "open up the black box" and specify program operation variables. Initial impressions of patterns and domains of center programmatic activities evolved into the development of Innovation Components Configuration (ICC) maps (Hall & Hord, 1987) with which we were able to reliably summarize domains of program implementation and levels of implementation in each domain. The domains identified were *Needs Assessment, Relationship With School, Relationship With Community, Relationship With Families, Advisory Council Development, Mission* (improving students' preparedness to profit from their educational experience), *Connectedness,* and *Evaluation*. The first and last domains were not used in this study. Table 1 portrays the Relationship With School domain. By dividing the number of points a center received in a given domain by the total number of possible points in that domain, a domain score was derived. Center implementation could be profiled for each domain and an overall implementation score across domains was also derived for each center. (The complete ICC map and teacher survey are available from the first author).

Subjects/Sites

Twenty centers were visited over a two year period. The centers served approximately 2000 students and their families during this time. This number includes only students and families who were registered as receiving targeted services and does not include families or children who attended one-time programs such as Fall back to school programs, or received one-time referrals. The number of centers and students varied for different analyses as indicated in Table 2.

Analyses

A factor analysis conducted on the 6 implementation domain scores and 11 teacher survey items for each center yielded five factors that accounted for 88.8% of the variance in the 17 constituent variables. The factors are: 1) teacher knowledge / familiarity with center, 2) teacher active involvement with center, 3) center family and community involvement, 4) program mission focus, and, 5) teacher awareness of center mission. These served as our independent variables in prediction equations of the relationship of program implementation to the dependent variables, the 18 educational outcomes. For each of the prediction equations, these latent factors were further condensed into an Overall Implementation

Table 1
Center Relationship With School

1. Connectedness

1. Negative (turf / hostile).
2. Uninformed (inappropriate or no requests / referrals)
3. Customers (school personnel make appropriate requests / referrals; starting to be impressed with center capabilities).
4. Advocate (enthusiastic about center; see it as needed resource / capability of school).
5. Team (school works collaboratively with center; buys into the family involvement education mission).

2. Principal support

1. Negative (either micromanaging or turf / hostile).
2. Laissez-faire
3. Supportive / customer
4. Advocate
5. Involved / collaborative

3. Principal's attitude toward family involvement

1 Not open to it

2 Neutral

3 Appreciates outreach to families

4. Promotes family involvement
5. Has track record and strategies for family involvement.

4. Teacher acceptance of parent involvement

1. None
2. Some (very little)
3. Many (somewhat)
4. Most / all (very much)

5. Teacher interaction with center

1. Refer to center: (3) all, (2) most, (1) some, (0) none. (multiply "1" by (#).
2. Drop by center: (3) all, (2) most, (1) some, (0) none. (multiply "2" by (#).
3. Participate in center programs / activities: (3), (2), (1), (0). (multiply "3" by (#).
4. Assist in center programs / activities: (3), (2), (1), (0). (multiply "4" by (#).

6. Perceived effects on school performance

1. Center is not seen as improving student attendance, classroom performance, or student achievement.
2. School personnel are unsure about the effect of the center on student attendance, classroom performance, or student achievement.
3. Center seen as important, but school personnel unsure of impact.
4. Center is clearly seen as improving student attendance, classroom performance, and achievement.

variable. The relative contribution of each of these factors varied somewhat as a function of the specific educational outcome being predicted. Educational outcomes were computed as a "success rate" for each center, which was a continuous variable consisting of percent of students served by a center who improved on a given educational variable, either by changing yes-no categories in the desired direction or by moving to a higher level in a category. We then applied each of these variables to the data for individuals, grouped by center, and weighted by the number of individuals served by the center. Finally, we assessed the relationship between Overall Implementation and changes in student level of academic proficiency on the KERA tests. For this correlation, we restricted our sample to students who, at intake, were in one of the two lower KERA categories of Novice and Apprentice (accounting for about 80% of the cases) and assessed who moved to either Proficient or Distinguished categories.

Results

The multiple correlations between Overall Implementation and educational outcomes are presented in Table 2. For those variables that are stated in negative terms (e.g. risk, tardiness), the correlation is in a negative direction, as would be predicted. The achievement variable (at / below grade level) is coded inversely, so the correlation is positive. That is, the greater the implementation, the better the gains with respect to achievement. All correlations are significant at the $p < .01$ level. Clearly, the extent to which centers have implemented their programs is positively related to educational improvement among participating students.

The results of the regression equations for each the education variables with the contribution of each of the five factors expressed as beta weights are presented in Table 3. Beta weights are standardized regression coefficients: a measure of how much of a change in standard deviations in the dependent variable is caused by one standard deviation shift in

Table 2
Correlation Between Overall Implementation and Educational Outcomes

Educational Outcome	Multiple *R**	*N* Students	*N* Centers
Classroom Variables			
Remains on task	.692	927	18
Obeys rules	.679	493	18
Follows directions	.666	654	17
Completes homework	.604	799	18
Completes classwork	.541	640	17
Tardiness	-.519	212	14
Attends regularly	.295	238	17
Peer Relations Variables			
Relates appropriately	.810	489	17
Cooperates	.705	428	17
Participates	.702	281	17
Has friends	.564	222	18
Risk Variables			
Drop out risk	-.662	903	18
At risk for retention	-.623	472	18
At risk educationally	-.555	447	17
Global Variables			
Achieve above / below grade level	-.570	1020	19
Retained previously	.475	200	17
Academic proficiency (KERA)	.401	1770	17
Grades	.336	885	18

*All Significant at <.001

the predictor variable. In general, teacher active involvement with the center is the most consistent positive predictor of educational outcomes (13 out of 18 significant beta wts. in the expected direction). Family and community involvement by centers, perhaps a proxy for the degree to which coordinators' efforts are expended in this area, is often inversely related to educational outcomes (7 out of 18 beta wts. inversely related to educational outcomes).

The correlation between Overall Implementation and the net change on academic proficiency was .401 (p<.001), indicating a significant positive relationship between extent and quality of implementation and improvement on KERA scores. Where FRYSC program implementation was less strong, students tended to rise and fall in KERA categorization in equal numbers. Where program implementation quality was stronger, there was a

Table 3
Relationship (beta coefficients) Between Implementation Factors and Educational Outcomes

Educational Outcome	Teacher Knowledge/ Familiarity	Teacher Active Involved	Family & Community Involvement	Program Mission Focus	Teacher Awareness of Mission
Classroom Variables					
Remains on task	-.046	.167***	-.115***	-.068*	-.048
Obeys rules	.065	.189***	-.122**	-.003	-.102*
Follows directions	.003	.180***	-.070***	-.056	-.040
Completes homework	-.090*	.078*	-.135***	-.086*	-.041
Completes classwork	.017	.114**	-.112**	-.018	-.021
Tardiness	-.011	.017	.014	.091	-.159*
Attends regularly	-.015	.056	-.040	.043	.012
Peer Relations Variables					
Relates appropriately	-.016	.204***	-.103*	-.139**	-.164***
Cooperates	.095	.269***	-.020	-.068	-.064
Participates	.144*	.226***	.027	-.055	-.009
Has friends	.185*	.035	-.067	.059	-.035
Risk Variables					
Drop out risk	.093**	-.161***	-.021	.171***	.044
At risk for retention	.032	-.171***	.109*	.037	.123**
At risk educationally	-.029	-.220***	.001	.000	.034
Global Variables					
Achieve above/below grade level	.103***	-.124***	.075	.012	.118***
Retained previously	-.018	-.109	.117	.172	.013
Academic proficiency (KERA)	.051*	-.003	-.008	-.071	.079***
Grades	.019	-.065*	.069	-.128	.075*

Significant at <.05*, <.01**,<.001***

net improvement of about 15% of students moving to a higher ranking. The number of students involved in this calculation was 1771. The factors that made the largest difference in accounting for this finding were Teacher Awareness of Center Mission, Program Mission Focus, and Teacher Knowledge/Familiarity With Center.

Discussion

The ICC map developed for this evaluation grew out of extensive involvement with centers and collaboration with coordinators who helped to develop it. It appears to have captured important components ("active ingredients") of these innovative programs, as does the teacher survey which assesses "market penetration" in the schools. The results provide evidence in support of the premise of family support programs: that addressing the needs of at-risk children and their families may impact on students coming to school more prepared to learn, and thus enhance educational progress. It would appear that an important strategy for these programs is to establish close working relationships with educators and develop coordinated efforts to addressing students' needs. The finding that community involvement is inversely related to educational outcomes may reflect the fact that putting one's efforts into enhancing community supports and family connection with them, rather than spending more time in the school represents a long term strategy that may not show results as immediately as involvement with the school.

As a field study, there are a number of limitations to this evaluation. One is the fact that these are rapidly expanding, full coverage programs that provide a wide variety of wraparound services to self-selected clients. This makes the securing of control conditions difficult and limits the evaluation to a correlational study. However, the strong findings of relationships between implementation and outcome variables is encouraging and suggests the possibility of replicating the essential elements of these programs under more controlled conditions.

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Looking at Success: Experiences of a Select Group of Children and Young Adults with Serious Emotional Disturbance

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Introduction

Children with serious emotional disturbances (SED) meet many obstacles to their social and educational success. Studies indicate that children with SED are less likely than their peers to graduate school and become employed (Davis, Clark, Silver, Smith, & Stoep, 1995). These children also have one of the lowest participation rates in post-secondary education and one of the highest drop-out rates (Silver, Unger, & Friedman, 1993).

While research continues to document similar findings, the Florida Department of Education (DOE) reports a 60% increase in the number of students with emotional disabilities graduating from high school; a 15% increase in the number of students with emotional disabilities in regular classrooms; an 18% reduction in the number of students with SED served outside the public schools; and a 50% decrease in the number of students for whom school districts contracted for residential treatment (SED Annual Report, 1995-96). These statistics are evidence that some students are experiencing "success." However, for many of these students "success" may mean a move to a less restrictive setting, or simply maintaining in their present environment over a period of time.

The Florida DOE Multiagency Network for Students with Serious Emotional Disturbance (SEDNET) requested a study to look at aspects of the community, the individual, and the family that assist a student in becoming a "success." This summary

describes a qualitative study conducted by the Department of Child and Family Services at the Louis de la Parte Florida Mental Health Institute, University of South Florida, that began to describe the characteristics and experiences of youth who had achieved success in several life domains.

Method

This study explored the youths' experiences with the service system within the context of success. The framework of the study was based on the core values of the Child and Adolescent Service System Program (CASSP)– that the child serving system must be child-centered and family-focused, individualized, community-based, integrated / coordinated, culturally competent, and aimed at early intervention / prevention (Stroul & Friedman, 1986). To look at services received by the youth and families in terms of these principles, the review team adapted an interview and case review protocol from the Family Experience Study designed by the Annie E. Casey Mental Health Initiative for Urban Children evaluation team, University of South Florida. In order to systematically discover what has been instrumental to the success of these children, analysis included case descriptions; services received; family involvement, signs of success; and interviewee's and interviewer's perspectives. Considering the exploratory nature of the study, each case was examined against its own light.

SEDNET Project Managers helped to identify two or three children or young adults from their areas of the state who were considered successful. The nominees, six to twenty one years of age, had to have demonstrated success in home, school, and community settings; been identified as having SED; be served in public school settings; and involved in multiple services. Success was defined as (a) remained in the same level of restrictive environment; (b) showed academic gains, (c) improved emotional and behavioral functioning, (d) graduated from high school, and (e) entered the job market.

The evaluation team received twenty eight nominations. Eleven participants completed the study, six males and five females. Seven participants were non-Hispanic Caucasian, three were African-Americans, and one was Hispanic. The median age was 16.6 years, ranging from 7 to 23. Each participant provided names of persons to be interviewed who they felt had been crucial to their success.

Youths were nominated due to a variety of achievements. Of the eleven participants, six had graduated from regular school, received a GED or graduated from a special education program, two of whom graduated with honors; four transitioned to regular classrooms, with two graduating that year; four were living in an apartment on their own or with roommates; six were employed; six were better able to make and maintain friendships. Other characteristics attributed to these "successful" children and young adults were: drug-free, reduced medication, self-motivated, has friends, able to use public transportation; follows directions; and, more respectful of others.

Results

Domains of success. Findings from interviews and case record reviews identified some domains in which success was experienced by the majority of youth. For example, most youth had made gains in their functioning at school; all eleven youths made improvements both in their grades and their behavior in school. A shared domain for youth who were 18 years of age or older was employment. Being employed also helped some of the participants to live more independently. Improved interpersonal / social relationships was also frequently mentioned as a success characteristic for the participants.

Problem history. Study results suggested that this sample of successful youth had experienced a history of problems similar to those found in the population of children with severe emotional disorders, as a whole. In other words, their success did not appear to be related to severity of impairment or circumstance. For the 11 youth, household composition and housing arrangements were mixed. The study found that all the participants came from households in which they faced significant stressors, primarily in the areas of family violence, substance, emotional, physical, and/or sexual abuse. There also were similarities in the behavioral/emotional issues of the participants prior to receiving services. Commonalties reported included depression, aggression, self-destruction, and non-compliance. Many were reported to be withdrawn and to lack self-esteem. A number of the youth used drugs, ran away, and sexually acted out. Others suffered from lack of sleep and auditory hallucinations.

Service history. As a whole, the services and agencies utilized by these individuals were very similar, although the range of mental health services available in the selected communities varied according to the size of the area served and to the special education programs offered by the schools. All had some type of involvement with the mental health system receiving therapy and/or counseling; presently only three participants are receiving services. All youth were involved in an SED program in a special education class or SED center. Eight of the eleven participants had received medication; and, therefore, the services of a psychiatrist for monitoring levels. Five of the eight are still receiving medication. The types of medications distributed to these individuals included two anti-depressants, ritalin, clonodin, busbar, tegretol, decadrine, diatripin, oybutamine, melaril, thorazine, carbamazepine, bactrobar, and duricef. One individual had been on medication for 11 years, beginning at age 3; the longest in our study. The average length of time for receiving services was about 6 years, with a range of three to fourteen years. Three individuals began services at age 3 or 4, seven individuals began at the age of 10-15, and one began during his high school years.

Youth and family strengths. Participants were asked to identify their personal strengths and their families' strengths both prior to and after receiving services. In all cases, participants were able to identify more current strengths than strengths that existed before treatment. Current personal strengths often centered around having goals, such as graduating and becoming employed, being self-motivated and in control of life, able to manage responsibility, and perceiving life more positively. Relatedly, some identified "doing the right thing" as a strength. Some youth also reported increased confidence and maturity, and felt they were more, caring, nurturing and perceptive of others; several mentioned having new friends. When asked to identify family strengths existing prior to services, seven of the eleven individuals reported that their family had been in some way supportive of them. Although family support was consistently identified as a strength by the youth, family involvement in services varied widely; some parents were not at all involved, some inconsistently involved, and some very involved in their child's treatment and services. Only one father was identified as being involved in his child's treatment, and he was the boy's therapist prior to the adoption. When teachers and therapists spoke of strengths, the majority stated that the specific youth was likable, and that they enjoyed spending the extra time with them to develop a supportive relationship. As this strength impacts the way adults interact with youth, it is probable that this group's likability contributed meaningfully to their success.

Goals. The study team identified goals for each individual through interviews and review of either the Individualized Education Plan (IEP) or Family

Service Plan (generated by a multi-agency community-based planning team). For the younger children, the goals centered around developing self control in both the home and social situations and learning appropriate social skills. The goals for many of their mothers focused on learning appropriate parenting skills and how better to manage the child's behavior. Goals for the older youths also focused on appropriate social skills and on achieving their academic potential, whether it was to mainstream into a regular classroom, increase vocational skills, graduate, and/or move onto higher education and becoming employed. Most individuals also worked towards developing more independence, self-reliance and independent living skills. Increasing self-esteem, appropriate work habits and social skills, and developing behavioral control were also important goals.

Coordination and Individualization of Services. A primary focus of interviews addressed the participants' perceptions of their community's service system and the impact services had on their lives. In general, both providers and participants reported services were well coordinated with one another, although it appeared that mental health providers interacted with each other more than with the schools. All but one informant believed that services were provided in the least restrictive environment. In the majority of cases, school placements were reported to be appropriate and helpful. Most families reported that teachers and therapists were accessible, and worked around the family's schedule. The gender or race of provider were important to three of the participants.

Specific interview questions asked families to identify characteristics of services that they felt were particularly helpful; six mothers and one father contributed their thoughts. Notably, while all respondents agreed that respect, acceptance, support and assistance from therapists was invaluable and contributed to success, there was no single recipe for impactful support and service delivery. Instead, different families identified different service characteristics as helpful; the aspects mentioned appeared to be those service features most closely related to unique needs of the child and family. For instance, the school program structure and guidance of the SED teacher were significant to three of the mothers, and mainstreaming was especially important to two of the participants. A few individuals valued the spiritual and religious help they received, and one individual specifically mentioned the support of the church. Five of the participants expressed the value of the support of informal helpers in their community. Being accessible 24 hours a day was mentioned as a help in some cases, and one parent felt that the therapist's knowledge of the juvenile justice system was important. Medication was indicated by two of the parents as making a difference in their child's behavior. The father thought that the fact that his son was ready for change and knew what he wanted was significant in his success.

Like the families, when asked what made services helpful to families, providers listed aspects of therapist practice that had supported the families' successes. Most providers reported that one-on-one attention, being patient and listening contributed to progress. They also felt it was important to mix structure and consistency in support services with flexibility. Others mentioned having shared interests, honesty, having a sense of humor and making the youth feel welcomed as important in their success. Provider responses also appeared to highlight the effectiveness of individualized services, as different service strategies were identified as impactful for different youth. Some providers indicated specific goals they were working on as helpful, such as building self-esteem, teaching accountability, and working on social and conversational skills and boundary issues. One provider thought the medica-

tion change had a positive influence on the child's behavior, and that teaching parenting skills to the mother helped the child immensely. Another endorsed weekly group meetings as making a difference for the youth.

Future needs. When asked about youths' future needs, the youth, family and providers for each case study tended to agree with each other. For eight of the eleven participants, continued counseling / therapy was identified either by themselves or by others interviewed as a future need, with two needing continued psychiatric medication monitoring. Four of the participants in the study cited continued financial aid as a future need, either for continued schooling or to help pay for housing. Other needs identified included employment and job training. For the younger participant, a continued future need identified by the parent was in parenting skill development.

Discussion

Through this study we learned about services and practices that were considered highly effective by these children and their primary caregivers. This however, does not entitle us to classify them as "best practices" because the study was focused on the children rather than the services received and the agencies providing them. Since this was an exploratory study of a limited number of cases, generalizations cannot and should not be made regarding the success of children with severe emotional disorders. However, what did emerge was a picture of services that were individualized and agreement from the youth, primary caregivers and providers about the needs of the child and family. What we saw was an endorsement from many of the youth that no matter what the involvement was from their family, their family was a strength.

Future research needs to continue looking to "successful" individuals and programs for guidance in the development of services for children with emotional and behavioral disturbances. Finally, based on providers' statements and the reviewers' own qualitative impressions, future studies should address the "likability" characteristic of these "successful" youth, perhaps utilizing social skills battery of tests.

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Education's Role in the System of Care: Student/Family Outcomes

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Introduction

Since July 1990, the Illinois State Board of Education (ISBE) has been redirecting educational dollars to develop enhanced community-based options and supports with the intent of improving student outcomes and reducing the placement of students with emotional and behavioral disabilities (EBD) outside of their homes and communities. In September 1991, six Phase I sites were funded by ISBE to develop community-based supports and services for youth with EBD and their families. In August 1993, five additional sites (Phase II) were funded and a statewide support component was reshaped to coordinate evaluation and technical assistance (TA) for this initiative. This summary provides highlights of the three-year evaluation of student / family outcomes in the Phase II projects. A brief discussion of system change indicators in project sites is included.

Methods

Evaluation data for students and families referred to Phase II projects were monitored from 1993 to 1996. The results reported here are based on information collected on 215 youth and their families from 5 sites across Illinois. All sites received training and technical assistance on implementing system of care approaches. Application of the wraparound process was a prioritized intervention at all sites.

Baseline information was collected at the time of entry to project and every year thereafter. The family information form, collected only at baseline, identified demographic information,

service utilization, and risk factors. A variety of statistical tests were run to examine both relationships between variables and changes over time. Descriptive statistics were used to provide basic information about the data. Relationships between variables were examined using correlational analyses, and cross-tabulation. Differences between groups were examined using independent *t*-tests and cross-tabulation. Changes over time in individuals' clinical scores were analyzed using paired *t*-tests. Changes for groups of individuals in educational placement category or out-of-home placement status were examined by using cross-tabulation. The instruments collected at baseline and every year thereafter are listed in Table 1.

Table 1
Instruments Collected at Baseline and Every Year Thereafter

Restrictiveness of Living Environment Scale (Fabry, Hawkins, Luster & Alameda, 1990)
Child Behavior Checklist (Achenbach, 1991a)
Teacher Report Form (Achenbach, 1991b)
Family Adaptiveness and Cohesiveness Scale (Olson, 1991)
Child and Adolescent Functional Assessment Scale (Hodges, Bickman & Kurtz, 1991)
Educational Information Form

Results

Background Characteristics

Close to half of the youth lived in two-parent households at time of referral. The majority of youth were described by their families as having an emotional or behavioral disorders. Below grade level achievement was the youth risk factor most frequently reported by families. Divorce between parents, history of family alcoholism, and single parent families were the most frequently reported family risk factors. Poverty was the risk factor which correlated with the highest number of other risk factors reported by families. Table 2 provides additional background information on students and families referred to the projects.

Table 2
Background Characteristics & Risk Factors

Living Arrangements (*n* = 215)	**Percent in Placement**
Two-parent household	46.0
One-parent household	40.5
Relative	9.3
Other living arrangement	1.5
Residential school	0.9
Regular foster care	0.5
Disabilities	**Percent with Reported Disability**
Emotional / behavioral disability	86.4
Learning disability	38.8
Psychiatric Hospitalization (*n* = 34)	**Percent Placed in Hosptial**
Placed during past year	17.1
Placed at any time	32.4
Residential Placement (*n* = 214)	**Percent Placed in Residential**
Placed during past year	16.4
Placed at any time	19.6
Risk Factor - Family	**Percent Reported**
Divorce between natural parents	49.0
History of family alcoholism	45.0
Single parent family	45.0
Negative Peer Influences	45.0
Risk Factor - Youth	**Percent Reported**
Below grade level achievement	64.0
Dangerousness to others	34.0
Frequent suspensions / expulsions	31.0

Highlights of Clinical and Educational Data

- Youth who scored within clinical ranges on the CAFAS also scored within the clinical range on the TRF externalizing domain at Time 1 (χ^2= 4.55, p=.03) and Time 3 (χ^2=5.83, p=.02). This relationship was found between the TRF internalizing domain and the CAFAS at Time 1 (χ^2=3.83, p=.05).
- No significant agreement was found between the CBCL and either the CAFAS or TRF.
- There was improvement for youth whose needs fell within the CBCL internalizing domain between Time 1 and Time 2 (t=2.14, p=.04).
- There was an overall increase in emotional and behavioral functioning as measured by the CAFAS from Time 1 to Time 2 (t=1.70, p=.09).
- There was no significant relationship between restrictiveness of educational placement and overall clinical functioning as measured by the combined CAFAS, CBCL, or TRF at time of referral.
- Youth who scored within the clinical range on the TRF internalizing domain were more likely to be placed in more restrictive educational placements than youth who did not rate within clinical ranges (χ^2=20.08, p=.01).
- Youth who scored within clinical ranges on the TRF internalizing domain were significantly more likely to have needs requiring behavioral intervention beyond the normal classroom routine than youth whose did not score within clinical ranges (t=-2.04, p=.05).
- Youth who scored within clinical ranges on the TRF externalizing domain were significantly less likely to complete homework on time (χ^2=13.20, p=.00), engage in socially appropriate behavior in unsupervised settings, (χ^2=14.61, p=.00), engage in appropriate classroom behavior with adults (χ^2=8.21, p=.02), and work to their ability (χ^2=3.51, p=.06). These youth needed significantly more academic assistance (χ^2=8.09, p=.04), and behavioral intervention (χ^2=16.39, p=.00) beyond the normal classroom routine.
- There was a significant decrease for the need of extra academic assistance which interfered with classroom instruction from Time 1 to Time 2 (t=2.19, p=.05).

Educational Placement Changes

The majority of the youth either maintained their current educational placement or moved to less restrictive settings, as summarized in Table 3. Although 33% of the youth moved to more restrictive educational settings, 16 of the 27 students moved up only one level of restrictiveness and maintained placement in their home school. Table 4 summarizes placement changes for youth that moved to more restrictive educational settings.

Out-of-Home Placements

- Thirty-nine percent of the youth had experienced an out-of-home placement at some time in their life (n=203).
- At Time 1, youth who scored within the clinical range on the CBCL externalizing domain were more likely to have experienced an out-of-home placement (χ^2= 7.89, p= .01). There was a similar relationship that approached significance between clinical scores on the CAFAS and out-of-home placements at Time 2 (χ^2= 3.10, p=.08).
- The majority of youth served by the EBD Initiatives maintained placement in their parents' home (χ^2=9.50, p=.00).
- The average number of days spent in a psychiatric facility were significantly reduced from one year prior to services to one year after receiving services, (t=2.96, p=.00).

Family Functioning

- There was a significant increase in adaptability from Time 1 to Time 2 as measured by the Family Adaptability and Cohesiveness Scales (FACES II; t=-14.67, p=.00).

- Family members felt an increased ability to express opinions from Time 1 to Time 2 (t=-2.25, p=.03).

Evaluating System Changes

The most visible system change indicators observed throughout project sites were in the areas of role changes for personnel and resource development. An expanded number of school district personnel began incorporating new roles into current job descriptions. These new roles included facilitating wraparound plans, partnering with other agencies in implementing service options, and direct support for families. Several sites have used the knowledge and interagency partnerships which evolved through the projects as the impetus for grants, co-funding of new positions, increased access of flexible funds, and redirection of resources toward restructured school and community-based options.

Table 3
Maintenance of Educational Placement or Move to Less Restrictive Placement

Students Who Maintained Educational Placement	
Educational Placement	**Number of Students**
Regular Education 100% of day	1
Regular Education with Consultation	3
Special Education less that 50% of the day	4
Special Education 50-100% of the day	29
Special Public School	4
Private Day School	1
Students Who Moved to Less Restrictive Settings	
Educational Placement	**Number of Students**
Special Education 50-100% of day to Special Education less than 50% of day	3
Private Day School to Special Education 50-100% of day	4
Home-based Instruction to Private Day School	1
Students Who Moved to More Restrictive Educational Settings	
Educational Setting	**Number of Students**
Regular Education 100% to Regular Education with Consultation	1
Regular Education 100% to Special Education less than 50%	3
Regular Education with Consultation to Special Ed. less than 50%	1
Regular Education with Consultation to Special Education 50-100%	3
Special Education less than 50% of day to Special Ed. 50-100%	8
Special Education 50-100% of day to Special Public School	1
Special Education 50-100% of day to Private Day School	1
Special Education 50-100% of day to Residential School	2
Special Education 50-100% of day to Home-based Instruction	3
Special Education 50-100% of day to Hospital-based Instruction	2
Special Education 50-100% of day to Department of Corrections	1

Discussion

An examination of the needs of families from the Phase II sites showed that poverty and having enough income to meet basic needs continue to be issues for a large percentage of the families served by the EBD Initiatives. For example, 29% of the families served by Phase II projects reported income of less than $10,000, and poverty was a risk factor for 23% of the families. Many families also reported not having enough money to meet basic needs (26%), for a phone (23%), and clothing (22%). Further investigation could address the impact of caring for a child with EBD on the socio-economic condition of the family.

Data suggests that teacher rating of emotional/behavioral functioning is closely related to restrictiveness of school placement, and that parent report of emotional/behavioral functioning seems to drive out-of-home placements. The highly significant relationship between parent report of emotional/behavioral functioning and out-of-home placements suggests that the parent perspective is critical in determining the focus of services and supports needed to effectively maintain youth in community-based settings. Similarly, the relationship of teacher ratings to restrictive school placements suggests that classroom teacher needs should be addressed specifically when developing service networks to effectively support students with EBD in school settings. The fact that students with significant EBD are found across all educational settings, including regular education classrooms, has implications for expanding supports, training, and technical assistance across all school settings.

As reported previously, teachers and clinicians agree with each other on the clinical functioning of youth more frequently than they agree with parents. The lack of agreement between parents and teachers is particularly interesting given the fact that the TRF and the CBCL are companion instruments and there is a high degree of consistency among the items. It may be that teachers and clinicians tend to see the same behaviors in youth more often in the school setting (especially if the clinician is school based) and that parents and teachers have different opportunities to observe certain behaviors in youth. This finding is intriguing when coupled with the findings that suggest that teachers' ratings of behavior predict educational placement, whereas parent's ratings of clinical behavior predict out of home placements. This raises questions about type and frequency of communication among teachers, clinicians, and parents. Additionally, there may be implications for allocation of resources that support parent and teacher reported needs.

Table 4
Move to More Restrictive Educational Settings

Educational Setting	Number of Students
Regular Education 100% to Regular Education with Consultation	1
Regular Education 100% to Special Education less than 50%	3
Regular Education with Consultation to Special Ed. less than 50%	1
Regular Education with Consultation to Special Education 50-100%	3
Special Education less than 50% of day to Special Ed. 50-100%	8
Special Education 50-100% of day to Special Public School	1
Special Education 50-100% of day to Private Day School	1
Special Education 50-100% of day to Residential School	2
Special Education 50-100% of day to Home-based Instruction	3
Special Education 50-100% of day to Hospital-based Instruction	2
Special Education 50-100% of day to Department of Corrections	1

Although youth were described as having significant emotional/behavioral needs and high rates of instability in living environments at the time of referral, improvements in emotional and behavioral functioning were noted by families, clinicians, and teachers at Time 2 and 3. The fact that these improvements were captured in one year is important in light of recent findings from the Greenbaum, Dedrick, Freidman, Kutash, Brown, Lardieri, and Pugh, (1996) who observed positive changes in clinical functioning after a seven-year period, and these changes were not found after one year.

Although there continues to be no significant relationship to overall clinical functioning and restrictiveness of educational placement at time of referral, there is a relationship between clinical functioning and changes in educational placement. Students with higher clinical functioning moved to more restrictive educational placements at Time 2. This finding was not evident in the 1994-95 sample. It should be noted that the majority of the students who moved to more restrictive educational placements maintained placement in their current school but began receiving a higher level of special education services (i.e. consultation, resource, or self-contained). Further investigation could explore if these changes indicate more appropriate matching of needs and services with students with EBD.

The role changes for school staff reported in Project sites suggest certain functions are needed to continue implementation of system of care approaches. School personnel incorporating wraparound facilitation into their existing role suggests that different types of meetings are taking place in school settings. Although specific family support activities were documented in most project sites, the progress reports from sites indicate lower outcomes in this area than had been projected. The need for expanded partnerships among families, schools, and community networks has been identified.

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Impact of a Parent Liaison in a Special Day School Setting

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Introduction

The education of children with emotional disabilities is one of the most difficult challenges facing educators today. Many different programs on the continuum, supporting many different philosophies, are in place. Still, many of these children are failing. As a result of school failure and the enduring manifestations of their emotional/behavioral problems, more services and interventions have been attempted.

From an ecological perspective, it is evident that intense family intervention and family involvement are necessary to ensure the success of many children with emotional/behavioral disorders. To promote family involvement, awareness of parent and family needs is crucial, as is understanding of the child's history of problem behaviors and interactions with people from their various environments. Project BRIDGE, a day school program serving children with serious emotional/behavioral disturbances, utilizes a parent liaison to implement its ecological approach to services for students and their families. This summary describes a study of the relationship of parent liaison contact with families and student's classroom behavior and academic achievement.

Method

Participants

A day school setting, Project BRIDGE (Building Relationships is Definitely Good Education) provides academic instruction, counseling, behavior management and parent/guardian support to students in south central Kansas. Students enrolled in the BRIDGE project met federal and state criteria for special education

services and had been placed in the Day School Setting by a special education team. Records provided by medical personnel that had worked with the students within the last eight months indicated that these students had a variety of emotional / behavioral issues. Diagnoses documented included Schizophrenia, Attention Deficit with Hyperactivity Disorder, Conduct Disorder, Post Traumatic Stress Syndrome, Depression, Oppositional Defiant Disorder, Bipolar Disorder, Situational, and Unknown. The mean age of the participants was 12 years and 9 months. Of the 25 students, 22 were male.

Intervention

The project's parent liaison provides informal support, facilitates support groups, teaches parenting classes (Love & Logic), provides resource information, supports parents / guardians in conferences, and produces newsletters. The parent liaison's duties include many contacts with parents / guardians of the students. Support, education and community resources are accessible through phone, office and home visits.

Procedures

Over a period of seven designated weeks, parent liaison contact logs of 25 students were analyzed. The contact logs included the amount of time the parent liaison at Project BRIDGE spent with parents / guardians. Contact logs also included who initiated the contact (parent liaison or parent / guardian); the dates and times of contact; reason for contact; and where the contact took place: telephone, home, office / school or 'other'.

From a review of the documentation, two groups were chosen for this particular study. *Amount of contact time* was the variable chosen to assess the impact of the parent liaison. Two groups, the High Contact Time (HCT) Group and the Low Contact Time (LCT) Group were chosen for comparison.

Behavioral indicators were selected to measure impact of contact time for children in the project. From classroom documentation, the total number of daily points earned for classroom behavior were tallied for the identified students. Also, 'on task' and 'self control' were identified as two specific categories on the point sheet for comparison with the HCT group and LCT group.

Parent / guardian telephone surveys were completed with 21 of the 25 parents / guardians to measure customer satisfaction with the different components of the parent liaison job description. An independent surveyor completed telephone surveys regarding the following parent liaison duties: Newsletter, Individual Support, Parenting Classes, Conferences, and Resources.

Analysis

Data was collected for a total of twenty-five students. The students were rank ordered from highest to lowest on the amount of time that the parent liaison had contact with the parent / guardian. The students were assigned to the HCT group (12 students) or to the LCT group (11 students). Two students, whose contact scores were too close to clearly place them in either group were eliminated from the data analysis. The elimination of these scores created a wider difference between the two groups on the amount of contact time.

The average scores for the HCT and the LCT groups were compared on the following variables: grades; attendance; total daily points; self-control and on-task scores from classroom point sheets; total number of critical incidents; and responses to questions on the parent / guardian survey.

Results

Students were ranked from the lowest to the highest for comparison. The HCT group was assigned capital letters (i.e., A= lowest contact time to L=highest) and the LCT group was assigned lower case letters (i.e., a=lowest to k=highest).

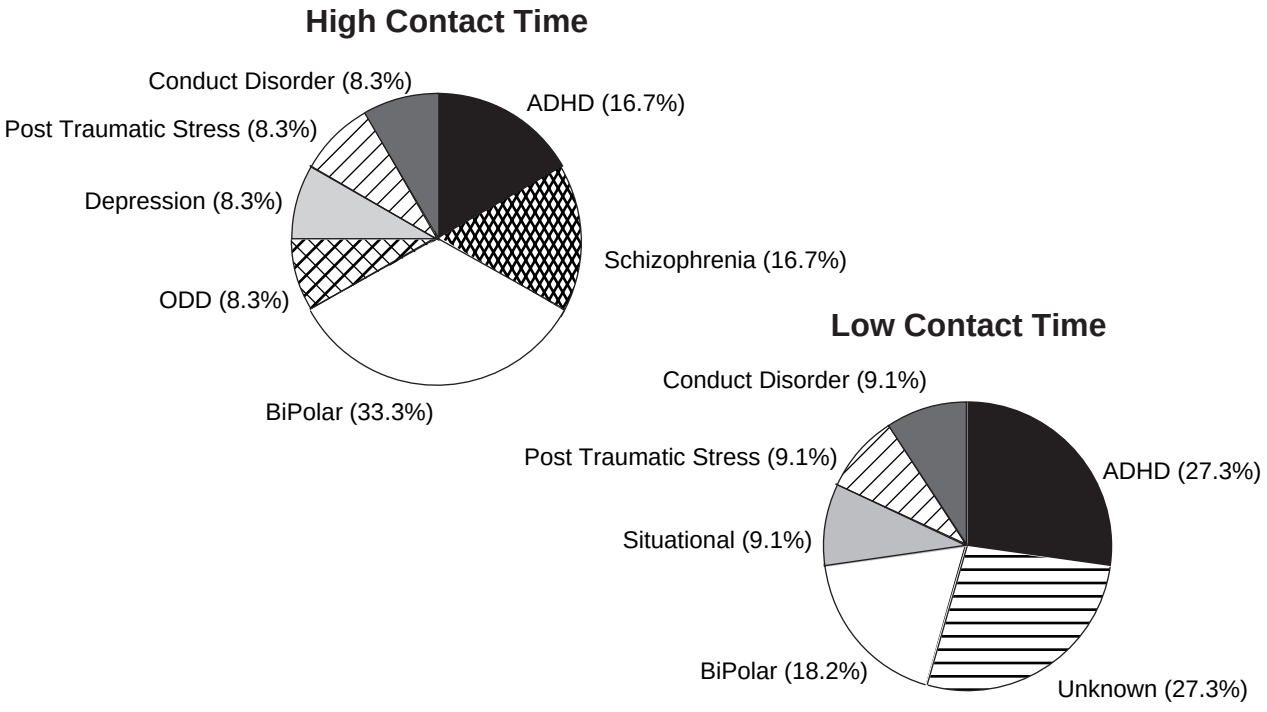
Examination of the clinical diagnoses of the HCT group indicated that the most contact time was spent with the parents / guardians of students with a diagnosis of Bipolar disorder. All of the students diagnosed with Schizophrenia, Depression and Oppositional Defiant were in the HCT group. Students with a diagnosis of Situational and Unknown were included in the LCT group, while no participants with these diagnoses were found in the HCT group. In the LCT group, the amount of time spent with families of students diagnosed with ADHD and Unknown was considerably more than time spent with parents of students with Bipolar disorders (see Figure 1).

The average of the HCT group for grades was 3.6 as compared to 3.0 of the LCT group (see Figure 2).

In the classroom, points are kept on a daily point sheet with six categories including on task, self control, completion of work, respect of property and two individualized target behaviors. The HCT group average on total daily points was somewhat higher than the LCT group. In a comparison of the 'self control' data, the average of 10.5 score of the HCT group was only slightly higher than 10.2 of the LCT group. Time spent 'on task' was also evaluated. Better response from the HCT group was found. The lowest rating for HCT was 4.58 while the lowest rating for the LCT was 3.12.

The parent liaison survey shows a very high rating in all categories from both groups (see Figure 3). Although the differences in average ratings are too small to draw conclusions, it appears that 'resource information' was especially important to both

Figure 1
Student Diagnosis Overview



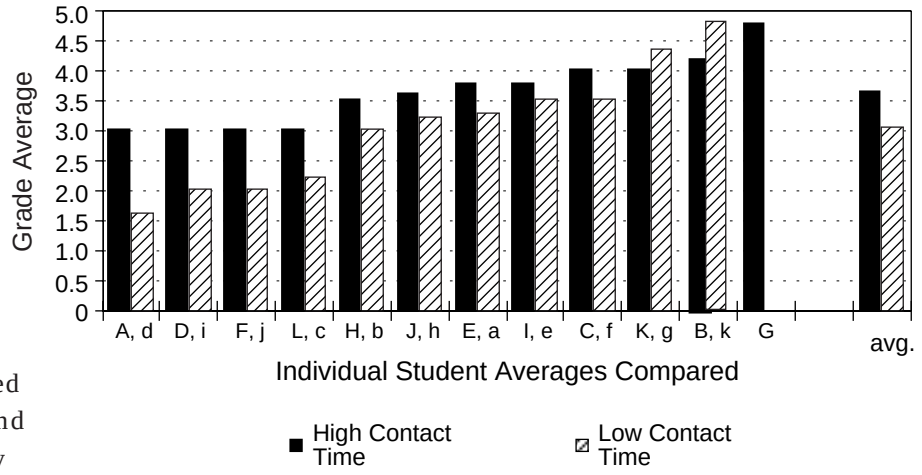
groups. The highest average rating occurred in the areas of 'resource information' and 'parenting classes' for the HCT group, while the LCT group rated 'individual support' as the highest. Although these findings are preliminary, they do suggest that the parents surveyed were satisfied with the identified parent liaison services.

Summary

To our knowledge, Project BRIDGE is the only day school in Kansas that has a parent liaison on staff. Analysis of the documentation and survey results suggest that parent liaison activities may have a positive impact on the overall program.

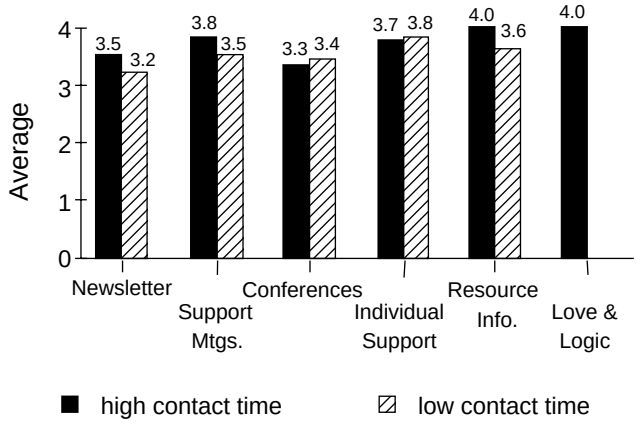
The study indicates the need for more research on the role and impact of parent liaisons in day school settings. Future research could study the impact on specific age groups, plus comparison of specific diagnoses, and assistance with agencies.

Figure 2
Grades *



* Highest grade average possible is 5.

Figure 3
Parent Liaison Survey Averages *



* Highest possible average is 4.

School-Based Mental Health Services: Service System Reform in South Carolina

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Introduction

Like most other states, South Carolina has great need for more mental health services for children, adolescents, and their families. Historically, such services have been both insufficient and ill-matched to the needs of children with serious emotional disturbance. The public service systems tend to be utilized more often when youth and families have reached the level of serious emotional disturbance, leading to perhaps unnecessarily frequent use of restrictive services and out-of-home placements.

The range of psychological, educational, family, and neighborhood problems of most such children suggest the need for intensive and comprehensive integration of services in everyday settings (e.g., Culberston, 1993). This need is intensified by the fact that both parent and child dropout from treatment is related to severity of problems (the more severe the problem, the more likely that attrition is to occur) (e.g., Kazdin, Mazurick, & Bass, 1993). If services are to "stick," they must be both easily available and easily accessible.

Because of their universality, their relatively non-stigmatizing character, and the significance of academic and social competence in children's development, schools can be ideal sites for delivery of a continuum of mental health services for children, adolescents, and their families. School-based programs are well suited to offer treatment and support at an early point to children and youth who are already exhibiting a significant

emotional disturbance and to assist schoolteachers and counselors in working with them. School programs also have many opportunities to assist children, adolescents, and their families at times of crisis and to prevent relatively minor problems from becoming serious, persistent disorders (Petersen, Compas, & Brooks, 1993). Schools also are useful sites for assistance to parents and siblings (e.g., Dryfoos, 1990), and school-based services attract troubled youth who often are not otherwise identified (Adelman, Barker & Nelson, 1993).

An ecological perspective is encouraged within this service system reform effort. Support for an ecological perspective can be found in the multi systemic work of Henggler (Henggler, & Borduin, 1990) and the risk and protective model of Hawkins and colleagues (Hawkins, & Catalano, 1992) as well as the theoretical and empirical work of several other programmatic researchers (e.g., Bronfenbrenner, 1979; Dunst, Trivette, & Deal, 1988; Garbarino, & Associates, 1992). An ecological approach (a) bridges preventive efforts and / or interventions across settings (e.g., classroom, school, home, community); (b) links interventions with youth and their families to changes in environment and systems; (c) alters processes in the system by involving multiple change agents (e.g., youth, teachers, parents, classmates, school-based team); and (d) conceptualizes individual and family functioning in terms of interactions between and among the broader social environments, rather than solely as an individual's performance.

Comprehensive school-based programs can take advantage of the full school community and respond to the needs of youth and their families through a wide array of services. Through partnership with existing mental health programs provided through the school (e.g., guidance, social work, and psychology), school-based programs can readily establish a base for developing a comprehensive school-based program.

Service delivery efforts in comprehensive programs focus on prevention, early intervention with youth at risk for social, emotional, behavioral, and / or academic difficulties, intervention with youth and / or families experiencing transitions and milestones, as well as traditional clinical intervention with youth and their families. Traditional mental health diagnostic and therapeutic services (e.g., individual and family therapy) must be available in all school-based programs, but school-based services must not be limited to those services. Home visits, classroom observations, teacher consultations, and community collaborations all may be a part of the efforts involved in rendering clinical services through school-based approaches. Mental health education or support groups (e.g., support for children in divorce, anger management skills) and preventive interventions (e.g., truancy prevention and violence prevention programs) are also typical elements of school-based programs.

The University of South Carolina School-Based Mental Health Project is designed to build the capacity of local community mental health centers and school districts. The project encourages access to traditional mental health services (e.g., individual and family therapy) through location within a school setting. More significantly, this project takes advantage of the school setting to maximize the preventive and educational effects of mental health services within schools.

The goals of the project are to: (a) develop a model for broad school-based services that can serve as a foundation for a statewide school-based system of care; (b) establish, implement and evaluate school-based services in pilot sites across the state; and (c) develop an implementation plan outlining the legal, fiscal and organizational structures, as well as the human resources necessary for the establishment of a statewide school-based system of mental health care.

One of the evaluation efforts concerns the potential shift away from only traditional diagnostic and treatment model of intervention towards a continuum

of services. Such a shift would suggest an ecological orientation is being applied. In this summary, preliminary findings focusing solely on graduate students and their service delivery daily logs will be addressed.

Method

Participants

Participants were the 33 graduate students providing mental health services as part of the School-Based Mental Health Project's 1996-1997 activities. Graduate students were recruited from psychology, social work, counselor education and rehabilitation counseling. The School-Based Mental Health Project currently serves 23 schools in South Carolina and works with 6 local mental health centers. Each student is supervised by a professional clinician from one of these centers.

Procedure

Graduate students logged their project activities. Logs were available for 31 of the 33 graduate students. Six months of records (July-December, 1996) were available for the current analysis. Because incomplete or missing data were not included in the analyses, totals across categories are not equal.

Results

Varieties of Services

Table 1 lists the types of services rendered.

Place of Service

Table 2 shows category frequencies for location of service delivery and time of service delivery. Services were delivered primarily at school, and were most likely to be delivered during school hours.

A mixed 2 x 6 ANOVA was run to assess any differences between graduate students' use of traditional (e.g., individual therapy, assessment) and non-traditional services (e.g., program consultation

Table 1
Types of Services Rendered

Service	Freq.	% of sessions
Consultation and Development	1007	33.5
Individual Therapy	819	27.3
Group Therapy	294	9.8
Assessment	227	7.6
Targeted Case Management	202	6.7
Presentations / Workshops / Inservices	141	4.7
Family Therapy	106	3.5
Crisis Management	88	2.9
Ancillary	80	2.7
Intakes	38	1.3

Table 2
Location and Time of Service Delivery

	Freq.	% of sessions
Location		
School	3718	74.1%
Mental Health Center	807	16.1%
Community, not school	372	7.4%
Home	122	2.4%
Total	5019	
Time		
During school	4198	80.6%
After school	719	14.4%
Before school	83	1.7%
Total	5206	

and development). Students were more likely to deliver non-traditional services [*M* number of sessions, non-traditional = 18.52; *M*, traditional = 5.53; *F* (1,25) = 43.27, *p* = .000]. However, there was a significant interaction between type of service (traditional / non-traditional) and the mental health center involved (*F*(5,25) = 3.44, *p* = .017). Tests of simple main effects suggested that the traditional vs. non-traditional difference was present at three of the six mental health centers [*F* (1,25)= 12.24, *p* = .002; *F* (1,25) = 45.44, *p* = .000; *F(* 1,25*)* = 11.54, *p* = .002].

A mixed ANOVA was also run to assess differences in the use of group and individual treatment. Significant effects were observed for group (*M* = 3.16) vs. individual treatment (*M* = 26.42) and mental health center [*F* (1,25) = 38.00, *p* = .000]. Again, a type of service x mental health center interaction [*F* (5,25) = 5.02, *p* = .003] occurred. The effect of treatment type appears to be limited to two of the six mental health centers. The average number of individual sessions per graduate student at these two centers combined was 49, as compared to 16.84 at the other four centers (*F* (5,25) = 36.97, *p* = .000; *F* (1,25) = 8.43, *p* = .008].

Recipients of Services

Table 3 lists the types of recipients of services.

Findings and Conclusions

These preliminary analyses help examine factors related to service system reform. A more systematic evaluation is underway to fully examine factors related to the process of shifting from a primarily traditional mental health system of care to a system of care that spans from prevention to early intervention to traditional client services. More detailed process measures will help identify the levels of program implementation across systems.

The present study details the service delivery efforts of graduate students in the project's school-based sites. These preliminary findings reveal that about 40% of the service delivery efforts of graduate students reflect non-traditional services such as program consultation and workshops. Review of their records suggests they are involved in program development activities such as violence prevention efforts; establishing ethnic-focused programming; consulting with teachers and other school personnel on issues such as ways to maximize the academic performance of youth with significant behavioral and emotional concerns; and helping to define the structure of an in-school suspension program. Graduate students reported serving large numbers of students that were not identified as clients (nearly 60% of persons receiving services). These findings are encouraging. They suggest that the graduate students in this project are viewing the delivery of services as much broader than traditional child mental health services.

Table 3
Persons Served by Type of Recipient

Type of recipient	# of recipients (duplicated count)	% of recipients
Non-Clients	10853	62.30%
Clients	2741	15.70%
Other School Staff	830	4.80%
Human Service and other agency staff	816	4.70%
Family members of non-clients	782	4.40%
Teachers	647	3.00%
Family members of clients	529	2.70%
School Guidance Staff	120	0.68%
School Administration Staff	106	0.60%
Total (duplicated count)	17424	

These data also show that when clinical services are offered, individual therapy is the primary mode of treatment provided. Over 25% of treatment sessions were individual therapy sessions. Also, anecdotal data and the daily log data suggest relatively low use of home-based and community-based settings. Although the present study does not address the reasons for the service delivery patterns (i.e., the clinical needs that dictate specific services provided), it is possible that graduate students are having difficulty implementing an ecological treatment perspective.

Several factors may affect the ease and swiftness of a shift to an ecological orientation. There factors include (a) skill and experience of graduate students in delivering multi systems clinical services; (b) quality of clinical supervision, especially in support of an ecological perspective; and (c) need to contribute the fiscal base of the school-based program through maximizing billing for clinical services.

The USC project developed several resources to address these factors. Ongoing technical support for program development is provided to address issues of training and skills building for graduate students and school-based clinicians. Techniques used include pre-service and in-service technical assistance workshops, ongoing on-site technical assistance for school-based teams, and an interdisciplinary issue and intervention-focused seminar for graduate students.

To address financing school-based mental health services, the project faculty worked with the state Medicaid agency and the Department of Mental Health to facilitate a better funding arrangement for school-based services. A bundled service code allowing a broad range of services to be delivered on a single day with a daily bill rate is now available to school-based clinicians. This bundling of services reduces paperwork for multiple services to the same client and encourages clinicians to offer of a wide array of services. Efforts to define the cost-effectiveness of school-based services at project sites are underway.

Current data suggest that system reform that supports service delivery in school-based settings can occur. Further examination of process measures will help greatly in addressing this shift from a traditional service delivery model in schools to a more prevention oriented model that utilizes an ecological perspective.

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Sheltered Homeless Children: Eligibility and Unmet Need for Special Education Evaluations

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Introduction

School-aged children living in emergency homeless family shelters are at risk for not receiving the education needed to break their cycle of poverty (National Law Center on Homelessness and Poverty, 1990), due to disproportionately high levels of poor academic skills, erratic school attendance (Cavazos, 1990; Ely, 1987) and school failure (Bassuk & Rosenberg, 1990; Parker et al., 1991; Wood, Valdez, Hayashi, & Shen, 1990). Their academic achievement may be further hampered by developmental delays and behavioral disorders (McGee & Share, 1988; Mannuzza, Klein, Bessler, Malloy, & LaPadula, 1993), problems which are common among homeless children and often remain untreated (Parker et al., 1991; Wood, Valdez, Hayashi, & Shen, 1990; Zima, Wells, & Freeman, 1994; Bassuk & Rubin, 1987; Fox, Barrnett, Davies, & Bird, 1990; Masten, Miliotis, Graham-Bermann, Ramirez, & Neeman, 1993).

Schooling, however, may ameliorate some of the negative consequences of homelessness, and special education programs with more individualized teaching approaches may be particularly beneficial (Heflin & Rudy, 1991; Wiley & Ballard, 1993). The structured environment of a school program fosters the child's concept of personal place (Rivlin, 1990), and may be a main source of stability for a homeless child. Further, under federal law, homeless children are guaranteed a free and appropriate public education, even if having significant disabilities (U.S. Department of Education, 1995).

Yet children living in homeless shelters face numerous barriers to educational services, such as residency requirements for school registration and poor transfer of records (Cavazos, 1990; Ely, 1987). Determination of eligibility for special education, the first step to accessing programs, may be especially problematic for homeless children due to their transiency and lengthy Individualized Education Program (IEP) timelines for evaluation and placement (Heflin & Rudy, 1991). In an earlier study in Los Angeles County, only 19% of children living in homeless shelters had been in special classes compared to almost one-third of poor children with housing (Wood, et al., 1990).

The purpose of this study is to: 1) describe the proportion of sheltered homeless children with a probable behavior problem, learning disability, or mental retardation; 2) examine the level of unmet need for a special education evaluation; and 3) explore how child need for a special education evaluation may relate to use of services in other sectors, such as specialty mental health and general health.

Method

Sampling strategy

Twenty-two emergency homeless family shelters were identified in Los Angeles County, and eligibility was confirmed by a brief telephone survey. An emergency shelter was defined as any program that allowed homeless families to sleep overnight, but for short-term stays only. Homeless shelters were selected in random order and surveyed twice between February and May 1991. Families were eligible if they had at least one child age 6-12 years and had stayed at least one night at the facility. The parent who felt they knew the child best was interviewed. If there were more than two eligible children in a family, two were randomly selected. The survey was translated and back-translated into Spanish.

Data Collection

Parent interviews and child testing were conducted simultaneously at the shelter. Informed consent was obtained from the parent and child following UCLA Human Subjects Protection Committee approved procedures. Parent interviews were performed by trained lay interviewers with a graduate level education. Child testing in English was conducted by a board certified child psychiatrist (BZ), and child interviews in Spanish were performed by two trained bilingual graduate research assistants with additional training in child measures and on-site supervision. Bilingual children were tested in both languages, and their best receptive vocabulary and reading scores were taken. Measures and criteria for need for a special education evaluation and service use are described in Table 1.

Results

Eighty-two percent (18/22) of the homeless shelters participated, ranging from missions to publicly funded facilities. Interviews were completed on 118/121 (98%) families and 169 (100%) children. Forty-five percent of the children (N= 79) had been homeless for more than 2 months, and 47% (N=83) had lived in 3 or more different places in the past year (see Table 2). Latino children were more likely to be homeless longer than children from other ethnic groups (χ^2 (df=1) 8.14; p=.004) and White children were more likely to experience greater residential instability than children from minority backgrounds (χ^2 (df=1)=11.48; p=.001). The majority of children (N=157; 89%) were enrolled in school, but 39% (N=69) had missed more than one week of school in the past 3 months, and 40% (N=70) had changed schools 2-5 times in the past 12 months. Latino children were more likely to stay in the same school or change schools only once in the past year than non-Latino children (χ^2 (df=1)=6.48; p=.011).

Overall, more than one quarter of the children merited a special education evaluation for a behavior problem (*N*=48; 28%), 20% (*N*=36) for a learning disability, and 8% (*N*=14) for mental retardation, yet few received special education services (see Table 3). Less than one-third of children (*N*=15; 31%) with a probable behavior problem, 17% (*N*=6) with signs of a learning disability, 36% (*N*=5) in the borderline or lower range for mental retardation, and 23% (*N*=18) with signs of a behavior and / or learning problem, had ever received a special education evaluation or placement. Children who screened positive for a behavior problem, mental retardation, or any disability, were more likely to receive special education services than children who tested negative for their respective disability (BD: χ^2 (*df*=1)=10.95; *p*=.001; MR: χ^2 (*df*=1)=6.99; *p*=.008; Any: χ^2 (*df*=1)=6.99; *p*=.008).

Likewise, one-third of children (*N*=16) with a probable behavior problem, 14% (*N*=5) with a probable learning disability, 29% (*N*=4) with probable mental retardation, and 22% (*N*=18) with signs of any disability, had received any counseling or mental health treatment in past 12 months.

Table 1
Measures and Criteria for Need for a Special Education Evaluation and Service Use

Domain	Informant	Measure	Criteria
Behavior Problem	Parent	Child Behavior Checklist (CBCL: Achenbach & Edelbrock, 1983)	
Receptive Vocabulary	Child	Peabody Picture Vocabulary Test[a] (PPVT: Dunn, 1981)	
Reading	Child	Woodcock-Johnson Language Proficiency Battery[a] (WJ: Woodcock, 1984)	
Need for a Special Education Evaluation			
Behavior problem			CBCL total T > 60
Learning disability			If PPVT >75, PPVT-WJ 15 (1SD)
Mental retardation			PPVT and WJ < 75
Service Use	Parent		
Special education / lifetime			Received an evaluation for special education or enrolled in a special class
Specialty mental health / 12m		National Health Interview Survey, Child Supplement (NHIS: National Center for Health Statistics, 1988)	Treatment or counseling or use of medication for either a developmental delay, learning disability, or an emotional or behavior problem
General health / 6m		NHIS	Received services at a clinic, health center, hospital, or doctor's office for routine care or care of a sickness or injury

Note: [a]standard score normed by age

Children with a probable behavior problem were more likely to have received mental health services than children without a problem (χ^2 (*df*=1)=10.37; *p*=.001). Only 2% (*N*=3) of the children had taken medication for an emotional or behavior problem, developmental delay, or learning disability in the past 12 months. In contrast, among children testing positive for any disability, almost two-thirds (*N*=117; 66%) had received routine health care and 47% (*N*=81 / 173) had received care for sickness or injury in the past 6 months. With the exception that non-White children were more likely to receive routine general health care (χ^2 (*df*=1)=4.11; *p*=.043), use of special education, mental health, and general health services did not vary by child age, sex, ethnicity, homeless history, or school attendance or changes.

Discussion

Almost one-half (45%) of school age sheltered homeless children in our study merited a special education evaluation, yet less than one quarter (23%) of those with any disability had ever received special educational testing or had been in special classes. Use of mental health services was at similarly low levels. In contrast, the main point of contact for homeless children with signs of a behavior problem, learning disability, or mental retardation was the general health care sector. Our findings underscore the need for greater clinical suspicion among primary care providers for behavior problems and developmental delays when evaluating a homeless child, and familiarity with eligibility criteria and mechanisms to access special education programs.

The main limitations of this study are the use of screening measures and lack of a comparison group. The level of need and unmet need for a special education evaluation may be overestimated by including children who scored in the borderline range and relying on parent report for a history of special education testing and programs. The estimates for

Table 2
Percentage of Sheltered Homeless Child Characteristics, by Ethnicity

	African-American (*n* = 83)	Latino (*n* = 69)	White (*n* = 25)	Total (*N* = 177)	χ^2 [a]
Child					
Gender					4.66
Female	55	54	30	50	
Male	45	46	70	50	
Age (yrs)					1.72
6-9	33	44	38	39	
10-12	67	56	62	61	
Homelessness					
Amount of time / lifetime					8.14**
2 mos.	63	44	65	55	
> 2 mos.	37	56	35	45	
Residential instability / 12 mos.					11.92**
> 3 places	55	59	23	53	
3 places	45	41	77	47	
School					4.72
Enrollment					
Yes	89	92	78	89	
No	11	8	22	11	
Days missed / 3mos.					2.17
1 wk	60	67	48	61	
> 1 wk	40	33	52	39	
Changed schools / 12mos.					7.18*
0-1 schools	51	72	61	60	
2-5 schools	49	28	39	40	

Note. Data weighted for number of eligible children per family.
[a]Overall χ^2 for all three ethnic groups (*df* = 2). *$p < .05$, **$p < .005$

unmet need for a special education evaluation, however, may also be conservative because the cut-points were lower than those used clinically to determine eligibility for special education (Mattison, Morales, & Bauer, 1992; Forness, 1985; Kavale & Forness, 1995). The sample also had a selection bias towards homeless children in school, a requirement for shelter stay, and may not be representative of the needs of the larger homeless child population who live doubled-up with relatives or in cars, theaters, or campgrounds (U.S. General Accounting Office, 1989). Further, the absence of a comparison group of poor, housed children– a common methodological problem in studies on use of school or mental health services among children (Forness & Hoagwood, 1993)–prohibits any conclusions about the impact of homelessness.

This study's findings nonetheless suggest that homeless children have a high level of unmet need for a special education evaluation, educational services they are entitled to under federal law. Procedures for determining eligibility and placement into special education programs should be adapted to accommodate the extreme transiency of homeless children, and interventions for school age homeless children should be coordinated with special education professionals, general health care providers, and housing services.

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Table 3
Percentage Use of Services Among Sheltered Homeless Children Who Warrant a Special Education Evaluation, By Disability

	Behavior Disorder (*n* = 48)	Learning Disability (*n* = 36)	Mental Retardation (*n* = 14)	Any Disability (*N* = 80)
Special Education/lifetime				
Evaluation or placement				
Yes (*n* = 27)	31**	17	36*	23**
No (*n* = 150)	69	83	64	77
Mental Health/12months				
Counsel / Treatment				
Yes (*n* = 30)	33**	14	29	22
No (*n* = 147)	67	86	71	78
General Health/6months				
Routine care				
Yes (*n* = 117)	70	68	79	68
No (*n* = 59)	30	32	21	32
Sick / injury care				
Yes (*n* = 81)	58	52	50	54
No (*n* = 92)	42	48	50	46

Note. Data are weighted by number of eligible children per family. Subjects are age 6-12 years.
*$p < .05$, **$p < .005$

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