

*Interagency
Development & Evaluation*

Chapter 6

Chapter 6: Interagency Development & Evaluation

Interagency Consultation in Rural Vermont: A Model for Serving Students with Serious Emotional Disturbances

Introduction

The prevalence of youth demonstrating serious behavior problems continues to grow at an alarming rate, creating a tremendous challenge for our schools and communities (Sixteenth Annual Report to Congress, 1994). Given the dramatic cuts in human services for children and adolescents, there is a growing need to identify alternative models for delivering effective and accountable services for youth and families with fewer resources.

The Community Collaboration Project represents an effort to maximize resources within one community in rural Vermont by creating an interagency consultation model designed to maintain students with SED in their local schools and communities. The principles of “Wraparound” were applied to create community based consultation practices and interventions that were inter-agency focused, family-centered, individualized, strength based, preventative, and reflective of multiple life domains (Burchard & Clarke, 1990). The model emphasized consultation instead of direct service in order to serve a greater number of children and families and create broader systems change.

Model Overview

The foundation for this project was an Interagency Support Team (IST) which provided consultation and training to community teams, focusing on both the individual student and broader systemic needs. Project funds were used to gain release time for four members of the community: (a) family consultant – a parent of a child who has experienced a serious emotional disturbance; (b) education consultant – an

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educator representing the three supervisory unions in the county; (c) mental health consultant – a clinician associated with the local community mental health center; and (d) social services consultant – a representative of the district’s social services department.

For twenty hours per week, these four individuals were released from their current responsibilities to serve as the region’s IST. The IST met regularly with the county’s directors of mental health, social services and education to review patterns of need and identify policies and practices that posed barriers to effective inclusion of identified children and youth. To foster systems change on multiple levels, the IST spent its first year designing and conducting a community needs assessment and action planning process. Based on the information from this process, numerous workshops (e.g., collaborative teaming, conflict resolution, developing interagency coordinated service plans, and family advocacy) were offered on a regular basis throughout the county. In addition, the project was involved in the reorganization of community governance to better serve children and families. Concurrently, the IST provided consultation to community-based teams on issues concerning individual students and broader systems level concerns. The primary focus of this summary will be the consultation provided to community teams.

Methods

Participants

This project was implemented in Addison County, Vermont, a rural region in central Vermont, with a population of approximately 33,000. Three school districts, composed of 5161 students (grades K-12), received services. At the start of the project, 67 children and adolescents in Addison County were in out-of-home placements.

Referrals for consultation around both individual students and broader systems issues were accepted. For individual student referrals, the major criteria for acceptance included: (a) the student must be identified as having an emotional and/or behavioral disorder (as defined by either the special education definition or ACT 264 legislation, 1988); (b) the student must be at high risk of removal from his or her home, school, or community; and (c) there must be a willingness on the part of those involved to work together as a team, with the objective of trying to maintain the student within the community. With respect to system referrals, the criteria included: (a) the system’s issues must impact on students with SED, and (b) there must be a willingness to work in a collaborative teaming fashion.

A total of 16 referrals were accepted involving 12 individual students and 4 broader systems issues. Individual referrals involved students in grades K-12. The families of these students reflected predominantly low socio-economic backgrounds (i.e., relatively low incomes, educational, and occupational status); over one-third were single parent homes, and one-third of the students were involved with social services. Of the systems’ referrals, two came from special education staff, one from an early education program, and one from the staff at the local community mental health center.

Project Interventions

Two project staff were assigned to each referral. For individual student referrals, the initial step included the formation of a planning team whose composition minimally included the student, the parents, educators, and service providers from relevant agencies. Weekly team meetings were encouraged to reinforce a preventative focus. Emphasis was placed on ensuring that parents were equal members of the teaming process. The second stage involved a comprehensive ecological assessment to gather background and current

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information reflecting all aspects of the student's life. The team focused on determining the student's strengths, as well as areas of need. Based on this information, a comprehensive plan was developed that built on these areas of strength, and addressed the needs of the student, the family, and the service providers. Resources were pooled from all of the involved agencies. Plans were monitored on an ongoing basis so that modifications could be made as necessary. The length of intervention varied according to the needs of the student and team.

System referrals also made use of a collaborative teaming model, with all key persons involved and meetings held on a regular basis. Similar to the process for individual referrals, an initial comprehensive assessment was completed to determine both the strengths and needs of the team members and the system aspects involved. Duration of intervention was dependent on need.

Evaluation Measures

Both quantitative and qualitative evaluation approaches were used to assess the efficacy of this model. With respect to the quantitative evaluation, all members of the team were given instruments to complete on a pre-post basis. The Consultation Satisfaction Questionnaire was used as a post assessment. All of the measures listed below were administered for individual student referrals. The Teaming Satisfaction and Consultation Satisfaction Questionnaires were given for systems referrals.

- *Demographic Survey*: assesses socio-economic indicators with respect to the student's family; completed by the parent(s).
- *Child Behavior Checklist* (CBCL; Achenbach, 1991), completed by the parent(s); *Teacher Report Form* (TRF; Achenbach, 1991), completed by the teacher(s); and *Youth Self Report* (YSR; Achenbach, 1991), completed by the youth if age

11 years or older: behavioral checklists used to obtain a global assessment of the student's emotional and social functioning.

- *Family Support Scale* (Dunst, Trivette, & Deal, 1988): a measure of perceived family support completed by the family.
- *Academic records*: attendance, suspensions, academic performance, and achievement scores.
- *Parent Satisfaction Survey and Youth Satisfaction Survey*: both designed specifically for this project to assess satisfaction with all services received; completed by parent(s) and youth respectively.
- *Teaming Questionnaire*: designed specifically for this project to assess satisfaction with the teaming process and interagency collaboration; completed by all team members.
- *Consultation Satisfaction Questionnaire*: designed specifically for this project to assess satisfaction with the services of project staff; completed by all team members.

The qualitative component of the evaluation consisted of semi-structured interviews with all team members for three select students to explore systems issues in a more in-depth fashion.

Results

Quantitative

According to the data from the CBCL, TRF, and YSR, significant pre- and post- differences ($p < .01$) were noted only with respect to teacher perceptions (see Table 1). In particular, significant decreases were reported on scales relating to externalizing problems (e.g., aggressive behavior and/or delinquency). No significant change scores were noted for the Internalizing scales on the TRF, nor for any of the broad-band scales of the CBCL or YSR. Data on academic performance is yet to be analyzed.

Based on the data from the Family Support Scale, there was a trend towards increased social support from both informal (i.e., extended family and/or friends) and professional resources. While this change score did not meet the traditional $p = .05$ cut-off, the p score of .10 is significant for this small sample size. Significant increases at $p < .05$ were also found with respect to almost all individual items on the Parent Satisfaction measure (see Table 2). Regarding teaming, parents felt more listened to, more involved in decision-making, more respected by other team members, experienced more equality as a team member, attended more meetings, and were satisfied with their child's progress. Increases in overall satisfaction and satisfaction with their family situation were noted at the $p < .10$ level. On the Youth Satisfaction Measure, the only significant item was an increase in perceived choice of services ($p < .05$). Overall, there was a high degree of satisfaction with project involvement from youth, parents, educators, and other service providers. On a 5 point Likert-type scale of Consultation Satisfaction, the mean group scores were as follows: (a) parents, 4.1; (b) youth, 5.0; (c) regular educators, 4.4; and (d) special educators, 4.3.

In terms of educational placement, at the time of referral, 10 students were served in their regular public school mainstream program, 1 was home-

schooled, and 1 was served in an alternative education program within the regular public school. At the end of the project, 10 students were served within the regular public school, one was in an alternative education program, and one student was placed in a residential school.

Qualitative

The qualitative interviews complemented the above results. Consistent pro-active team meetings were viewed as a critical component in the success of a student's planning effort. Parents emphasized the importance of being viewed as equal team members, with equal decision-making power. The most successful efforts gave considerable support to the direct care providers (i.e., families, teachers, individual assistants, mental health workers, and social workers). Interagency composition of the team, willingness to share resources, and flexibility in planning were also associated with a greater likelihood of student success. The nature of the student's behavioral disability did not appear to be predictive of outcome.

Table 1
Achenbach Teacher Report Form

Teacher Report Form	Pre (n=12)	Post (n=9)
Internalizing T- score	69	70
Externalizing T- score	68	66 *
Total T- score	73	70 *

* Significant at $p < .01$

Note:

T-score of 70 = 98th percentile (clinical range)

T-score of 67 = 95th percentile (borderline range)

Table 2
Parent Satisfaction Scale

Items (1-5 scale)	Pre (n = 12)	Post (n = 9)
Listened to	2.75	4.11 *
Decision-making	3.17	4.22 *
Respected	3.58	4.56 *
Equal	2.83	4.33 *
Meeting attendance	3.83	4.78 *
Overall satisfaction	2.58	3.78 **
Satisfied with child's progress	2.42	3.67 *
Satisfied with family situation	2.50	3.67 **

* Significant at $p \leq .05$;

** Significant at $p \leq .10$

Discussion

Based on these preliminary results, it appears that the interagency consultation model has the potential for being an effective use of resources for supporting children and adolescents with severe emotional disturbance within their local schools and communities. In this time of limited funding for education and human services, we can no longer afford to operate as independent agencies, each developing and implementing separate plans for youth and families. Through this model, agencies and families are encouraged to work together, building the capacity of direct line workers and maximizing the resources within a community.

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The Access Vermont Initiative: An Investigation of Team Development in Two Vermont Catchment Areas Providing Services to Children with Severe Emotional Disturbances and Their Families

Introduction

This study was designed to document the processes and dynamics associated with the development and functioning of two multidisciplinary teams created in response to the Access Vermont Initiative.

Interagency and multidisciplinary teams are not new entities. During the past few years, researchers, health care professionals, educators, and business people as well as others, have voluntarily and/or been mandated to form working teams. The logic supporting the formation of teams is that, theoretically, a group of people pooling knowledge, experience, resources, and energies should be more productive, produce a more comprehensive product, and be more cost efficient. In short, a positive and synergistic effect is expected.

Much has been written regarding the hypothesized benefits and efficacy of the collaborative and multidisciplinary team and “system of care” approach to the treatment of children with severe emotional disturbances. However, there is a paucity of research related to the processes and dynamics associated with interagency team development and growth.

O’Looney (1995) distinguishes between the two terms “collaboration” and “service integration” that are often used interchangeably in literature. O’Looney defines collaboration as the processes or dynamic

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The researchers express sincere thanks to team members who generously contributed their wisdom related to the experience of team development. This study was truly a participatory undertaking, and it is hoped that it will act as a catalyst for ongoing support for and exploration of the Access Vermont teams.

associated with a system and which serve to promote integration; whereas service integration is defined as the system itself. Existing literature has tended to focus on the system rather than on the process. The processes related to collaboration include shared goals and leadership, the development of negotiation skills, consultation, conflict resolution skills, egalitarianism, interpersonal relations, and a respect for, value of, and empowerment of all team members. O'Looney (1995) further suggests that a successful collaboration will involve a relinquishing by individual members of a measure of autonomy and the development of a more global and less personalized agenda or perspective; a process that might prove threatening for some team members.

The current researchers suggested that a historical and almost biographical account of the developmental experience of the two Access Vermont teams would identify a pattern of growth, a dynamic unique to each team, as well as elements shared in a team experience. This study, therefore, focused on the process rather than on the system.

Background

In January, 1994, the State Interagency Team invited Local Interagency Teams to participate in an initiative designed to "promote family preservation." Local team coordinators were asked to convene a meeting of families and regional service providers to develop a plan for promoting family preservation including a supporting management structure (a Stakeholders' Team), and submit this resulting proposal in application for financial assistance (Access Vermont funding). From this initial planning meeting, regional or stakeholders' teams would evolve whose responsibility it became to oversee systems and financial planning, program and human resource development, and also to monitor and evaluate outcomes resulting from the implementation of the community plan. Twelve catchment areas throughout Vermont were awarded Access Vermont initiative funding.

Part of the expectation at the state level was that various service organizations involved in serving children with serious emotional disabilities and their families would collaborate in order to provide a more comprehensive and efficient mental health service delivery system. This increased efficiency would be facilitated by providing a multi-access point of entry to services. The initially contacted agency or service provider would offer to contact the appropriate agency or agencies for the family and thus provide a point of access to multiple services.

The plans submitted by both of the two community teams described in this study included the stated objectives of:

- A reduction in numbers of children placed in state custody;
- the promotion of family involvement in the development of plans for services; and
- the development of a referral process involving a multi-access point of entry.

Both of these catchment areas serve quite large geographical areas. Both regions experience relatively high rates of unemployment, child poverty, teen pregnancy, and child abuse compared with other Vermont regions. Working members on the Stakeholders' Team in both catchment areas included a member from Mental Health Services, Youth Services, Drug and Alcohol and Social Rehabilitation Services (SRS). Additional members on Team II included delegates from the Police, Education, the Department of Health, Domestic Violence and one active parent participant. Team I included only one additional member, a local hospital administrator. Two working team members served as representatives on both Team I and Team II. Interviews were also conducted with two former members of Team I, including a member of the local Police force and a parent representative. Both Stakeholders' Teams have

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been meeting for less than a year, but many members of these smaller teams were involved as members in the larger Governance or Access Planning Teams.

Method

The researchers investigated the experience and perceptions of Stakeholders' Team members using a qualitative methodology. The principle source of data involved the use of a semi-structured interview format. Team members were interviewed either in person (6 participants) or by telephone (10 participants) and were presented questions related to team involvement and experience as well as their perceptions related to degree of collaboration associated with the team. Secondary sources of data included field notes and investigator's observations resulting from attendance at Stakeholders' Team meetings, team meeting minutes, and planning applications. Participants' interviews were taped, transcribed, and coded by two independent raters, and resulting themes were recorded.

In this pilot study, three researchers conducted the interviews, collected field notes, and reviewed minutes and funding proposals (see Appendix for interview questions).

Results and Discussion

These two Access Vermont management teams were in the early stages of development. This study, then, may serve as a building block for future investigation into ongoing team growth and process. Members from both teams reported that team building is a process; three members from Team II described this process as evolutionary. When asked whether or not the team was fulfilling its purpose or goal, one member responded, "I think that question is premature at this point. The team and its goals are evolving and in a very positive way."

As the transcriptions were analyzed, five prominent themes emerged which spoke to the research question regarding the development of team unity and collaborative processes:

1. Issues of trust.
2. Professional and personal networking.
3. Unifying goals and a common vision.
4. Communication and negotiation skills.
5. Inclusive community representation.

1. Issues of Trust

Trust is a transactional construct involving a sense of the value of the contributions, experience, and knowledge of another or others who in turn reflect this confident reliance. Trust necessarily springs from a shared sense of security and faith and that one's beliefs and priorities will not be betrayed. Without the element of trust and the positive perception of interdependence among and between team members, the collaborative processes will be impeded. Previous research considering interdisciplinary collaborative efforts have identified issues of trust as being paramount to team development (Blechert, Christiansen, & Kari, 1987; Melaville, Blank, & Asayesh, 1993; O'Looney, 1995). Territorial or competitive attitudes were identified by both teams as early obstacles inhibiting feelings of trust.

A voice from Team II articulated this theme:

"I think there's enough trust in the group that people have been able to put things on the table and deal with them as they come up."

A second voice from the same team:

"Most of us that have been on this team had been on other teams together, so we've built up our relationship from there. I think we had already established a level of trust necessary for really the type of team that we have now. So, I think that it was really our own experience on other teams in the community that really helped us in our collaborative process. We're open to listening to each other's perspectives and willing to change our own."

Confidentiality is basic to the development of trusting relationships. A parent identified her feelings of lack of inclusion as a member of one team as directly related to the team's failure to invest trust:

"I was a bank manager – confidentiality is one of my better things. I'm on the school board. I have an autistic child. I work with special education. There's a lot of issues related to confidentiality that I've lived through. If you don't trust the parent, then there's no sense in having them on your committee."

Trust and confidence at the state and client levels were addressed. It appeared that the consolidation of trust at the team level made increasingly apparent the need for the development of trusting relationships at multiple organizational levels.

One voice addressed the need for state administrators to demonstrate faith in the competence of local teams:

"I think giving as much information as is known. So being really forthright... not having hidden agendas. If you know something's coming down the pike, just tell us something's coming down the pike. And we'll deal with it. And also respecting our ability to deal with issues."

Team members also expressed the need to extend this atmosphere of faith to the families they serve:

"I think most people really do feel that people [families] need choices so that people are able to pick who's best able to meet their needs. And I think we need to trust in people's ability to figure out what they need."

2. Professional and Personal Networking

O'Toole and Montjoy (1984) operationalize networking as "the actions of people working together on specific tasks that solidify collaboration and build a sense of interdependence that many who have studied collaboration identify as a key ingredient

in multi-action implementation" (page #). Many informants identified networking and task sharing as critical contributors to team unity.

"I think bringing people together to discuss common issues and concerns and offer opportunities to brainstorm and to work out problems [promotes team unity and benefits the target population]. And I think there's other things which obviously evolve from that – support to families, support to the community, to school personnel, and therefore it increases the understanding, the patience, and the support by having the appropriate people involved."

Provision of a forum in which to disclose and share personal and professional frustrations prompted a spirit of networking:

"Just getting things in place and talking to each other and working out the bumps. Everybody has kind of hung in together and there have been times when we all want to pull our hair out but people have continued to just sit down and talk to each other and put it on the table and say, 'This is what's making me crazy and can we do something about this.' And we've seemed to be continually doing that and able to do it and that's very satisfying."

A second individual described networking as pieces of a puzzle coming together to create a more efficient whole.

"I don't think any one of us provides what every family needs. Even if we had unlimited funds, I don't think any one agency, group, church, religion, or whatever group we come from can be all to all people. Who can offer what piece and share information with each other so we don't go off on tangents. If we were in our own little worlds, I think we'd duplicate more."

Collaboration includes a relinquishing of some portion of personal or professional status or position, a resolution of territorial issues, and an adoption of a team identity. Networking, an important component

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of team building processes, appears to promote creation of a team identity, as well.

“I think it’s going out into the community together. It’s developing that identification as being Access, and you tend to stop identifying yourself as SRS or Mental Health and you start identifying yourself as Access and that’s an important component in collaborating and team building and not only for the team itself, but within the community and among those agencies.”

3. Unifying Goals and a Common Vision

Research in team development and multi-agency collaboration has emphasized the importance of shared goals and a common vision (George, 1987; Mattessich & Monsey, 1993). The emergence of a shared mission or an ideal is an integral part of the process of team building. As Senge (1990) points out:

“Visions that are truly shared take time to emerge. They grow as a by-product of interactions of individual visions. Experience suggests that visions that are genuinely shared require ongoing conversation where individuals not only feel free to express their dreams, but learn how to listen to others’ dreams. Out of this listening, new insights into what is possible emerge.”

These wisdoms were echoed in the transcribed experiences of group members. One group member responded:

“I think that’s a place that we’re coming to. . . to begin to describe a vision. I think that we’re all moving in the same direction, but I can’t really say that – ‘Yes, absolutely we are and this is our vision.’ That’s the kind of developmental place that we are. I don’t feel like it’s something that’s lacking. I think that we’ve been busy doing other work and that we’re now at a point where we can step back and say – ‘Okay, where are we going?’ and ‘What’s our vision?’ I think that goes back to my desire for some time for planning and

thinking and dreaming about what we are going to do and how we are going to be most effective. Personally, I would like to try to involve kids and families and the community together in a way that incorporates kids more in what’s going on, so that they feel valued, and they feel wanted and feel they have a stake in the community and a stake in being here.”

Although common goals and a unifying vision have clearly been identified as essential in team development, they are also part of a growing process. Team members recognized that a sense of mission is not static, but rather it evolves with maturity. One informant defined the vision as:

“. . . a little bit fuzzy right now [but describes] a sense that there’s something bigger out there that we need to reach. . . to go beyond and to reach some of the outcomes that we’re talking about, because otherwise I think we’re just going to keep doing the same thing.”

4. Communication

The fourth theme, communication, has been identified in research as essential to team cohesion (Chafetz, West, & Ebbs, 1988; Mattessich & Monsey, 1993). Communication was defined as the channels through which information is disseminated. Effective communication is characterized by inclusive and respectful sharing of pertinent information.

Participants informed us that it is not only intrateam communication and information flow that impacts on team effectiveness, but equally, the channels carrying information between state and local levels. Team members called for communication clearly delineating and defining expectations and boundaries.

“If actions initiated at the state level are just going to be countermanded later on then it’s not going to be very worthwhile to put in a lot of effort at the local level. It’s a waste of time. So getting direction up front and honest clear

guidelines of what is going to happen is very worthwhile. 'What are the objectives? What is the point of having the team? What are the parameters of our authority?' Really define things and being really clear about what we are addressing."

Reiterating this concern related to state and local lines of communication, this participant used the example of a proposed announcement calling for redistricting as indicative of poor communication.

"For Governance Boards not to know about that, I think is unconscionable and it says that [it is assumed] that their maturity is not at a level where they can handle that information. We need to know [state expectations and projections] right from the start. What is it that the state will give to communities?. . . People began to be frustrated about what the state's vision of local control and community planning was. Are there limits to what you can do? Are there expectations from the state regarding goals and objectives? I think there are very definite expectations they want to see met, but they've not communicated that to us."

At the intrateam level, effective communication was also identified as a predictor of group cohesion. Participants revealed:

"I think that there are a couple of primary players. . . I think that those people need to let go a little bit and communicate better with our team in terms of [the information] that the state gives. A lot of times when we go to the meetings there are two or three people who really know what's been sent and really have a handle on what's going on. They're not really good at getting that information disseminated to the rest of the group. . . I don't know whether it's because they need to control the information or they just need to make things happen. Sometimes it's easier to say 'Oh I'll do it myself because that's a quicker way to make things happen.' But, it doesn't do the team building piece."

This observation was confirmed by other respondents:

"It seems that by default. . .that [one person] has access to a lot of information. It is that [person's] interpretation of information that we get and I do feel that that is not appropriate. I believe that as team members we should all have access to the same information."

"I think dissemination has been a problem. Since there isn't a coordinator for the team, a member of the team who already has another job is getting the information and then has to fit in time to mail out sometimes rather large volumes of paper. So, it doesn't always get out in as timely a manner as would be helpful."

5. Inclusive Community Representation

Part of the Access Vermont Initiative calls for representation reflective of the local catchment area population. Mattessich and Monsey (1993) recommend that "the collaborative group includes representatives from each segment of the community who will be affected by its activities". This theme was prominent, poignant, and recurrent.

"I think that teams have to like to work with parents. . . Specialists seem to think that they give the service so that they know more about things. Most parents feel inferior. . . some committees only want parents' signatures to show that they're trying to work with parents, but they don't really care what parents think. Professionals [need to] become human. . . to put themselves in the parents shoes and not just look at their books. Parents' voices are valuable. . . they have to listen to parents and make them feel a part of the team not make them feel they have to be there because that's how they get grants. So, they don't really want the parents' participation, but the state says, 'You really should have parents; you should listen to what parents want and stuff.' How's that for honesty?"

For their part, professionals are beginning to recognize that team environments can be uninviting

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and threatening to non-professionals. One agency member reflects:

“It’s been a real difficult test [inclusion of parents] and we still have a lot more to do to make this process more attractive to families. We have to create an environment where youth and family people feel safe coming to a meeting. I feel uncomfortable in a room full of bureaucrats, and I think we have to be sensitive to what that feels like to families.”

Although there appeared to be a general consensus regarding the need and desire for increased representation, it also appeared that the achievement of this goal will require significant and sensitive commitment from involved professionals. Recognition of the complexities associated with more inclusive representation have perhaps worked to delay realization of this goal. Team dynamics might be predicted to change as new members come on board, and it would be necessary for the language of the team to be accessible to all. One professional contended:

“There are not enough parents in the group. I think everyone agrees that there needs to be more people, but it will be interesting to see how the dynamic changes. In the long run, I think we can function without more community representation, but certainly we’d get a broader-based view when we add [people]. You know, you bring in different people from different areas and they have different perspectives.”

A parent reflected:

“It was like I was taking up too much of their time. Before you can make a comment about something, you have to know what they’re talking about. They did not want the bother of explaining to a parent that had been through just part of the system. . . I think the state level is very high on encouraging parents to participate. . . Instead of giving trainings to the parent all the time, give some to the professionals. What does it mean to have a parent in the group? What do you expect from a parent?”

We summarized the essence of these comments with the recognition that these teams are in the early stages of development and will inevitably evolve over time. In the words of one member:

“Two years from now it may not look like what it does now. That’s kind of the exciting part of the whole thing. So, we just keep moving.”

Conclusion

The purpose of this project was to explore the development of two Vermont Stakeholders’ Teams formed to respond to the Access Vermont Initiative. The researchers had hoped to draw from this developmental account an understanding of the dynamics associated with collaborative efforts. It was proposed that identification of variables influencing the team process might serve as a tool for the development of a learning model or source of reference for future teams. Awareness of the multiple variables influencing a collaborative team process and dynamic is critical to opening the process to potential mediation and consequent modification. This enhanced awareness may also allow a team to move beyond temporary obstacles inhibiting effective collaboration to a realization of its full and most productive potential.

Although five predominant themes were identified from the data, the individual themes themselves appear to call for continued investigation. Future research questions might include – “What are the precursors or antecedents leading to the establishment of trust in intrateam configurations?” and “How are intrateam trusting relationships maintained?” Future studies might also investigate the effect of crises such as economic change on team dynamic. The movement toward integration and inclusion of non-professional participants also calls for exploration. Both professional and parent representatives identified parent membership in these two teams as problematic, and future studies should address clear definitions of the

specific barriers to parental involvement. Researchers speculate the team members' difficulty in articulating these barriers may reflect the teams' early stage of development. Many participants, both professional and non-professional, identified increased parent participation and non-professional involvement on teams as critical to future team success. Members offered thoughts regarding ways to increase inclusion and resulting cohesion; these included provision of opportunities for parent networking and professional training highlighting the value of non-professional resources. A clear identification of obstacles to inclusive representation might aid the design of such training structures.

This study is limited in that only two Vermont teams were included in the analysis, and in that these teams are truly in the early stages of development; their current status may not reflect future developmental patterns. However, research designed to follow these and other teams longitudinally may prove revealing.

The value of this study lies with its contribution to the literature on team process. Future directions might lead to the development of a quantitative instrument designed to measure process and progress in interdisciplinary team evolution. Ongoing qualitative work will serve to inform future quantitative research with regard to issues relevant to productive team functioning.

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The Access Vermont Initiative: An Investigation of Team Development

Appendix 1

Stakeholders' Team Interview Questions

1. What do you see as your role as a working team member?
2. What are your personal reasons for involvement with this team?
3. What do you see as the purpose of this team? How is (or is not) the team fulfilling this purpose or goal?
4. What are the personal rewards or benefits of affiliation with the team? How does your target population (children with serious emotional disabilities and their families) benefit from the presence of this team in your community?
5. From your perspective, does your team provide for a fair distribution of responsibilities, roles, resources, and credit for accomplishments? Is its structure hierarchical or egalitarian? Are there defined leaders on the team or is leadership shared?
6. Do you feel that your team was given guidance or direction related to the formation of a working, collaborative team? If not, do you believe guidance would enhance team function? If so, what was the nature of the guidance or intervention? Did this guidance or intervention affect your team's collaborative effort?
7. Have there been obstacles or barriers realized in the process of building the team? From your perspective, what has been the most significant obstacle to team development? How have team members worked to address and surmount these obstacles?
8. Can you identify problems or conflicts that your team has encountered? When problems or conflicts have arisen, how has your team worked to resolve them? Does the team address the problem directly and openly or does it appear that it is the nature of the team to leave the problem or conflict unaddressed?
9. Have you experienced or recognized competitive or territorial attitudes among or between members of your team? If so, in your view, how have these attitudes affected team function? How do you personally deal with territoriality?
10. Do you feel that each team member is respected or valued and her/his voice heard at meetings?
11. Can you identify any issues, events, or situations that have contributed to team cohesion and cooperation among members?
12. In your view, how can collaboration be improved? What actions might be taken to enhance team unity and cooperative spirit among and between team members?
13. How can individuals or collaboratives at the state level facilitate interagency collaboration at the local level?
14. Do team members appear to have a common vision for improved services to severely emotionally disturbed children and adolescents and their families?
15. From your perspective, do you feel the team works effectively? Do you see yourself as part of a team?

Developing an Effective Statewide Network: Outcomes of Florida's System of Care for Students with Severe Emotional Disturbance

Introduction

Children in the education system with complex needs, at risk of costly institutionalization, present natural opportunities for cost-shared, collaborative planning, and service coordination. Many of these students may also be children served by the child welfare system, office of mental health services, and/or the juvenile justice system.

During the 1979-80 school year, Florida's public schools contracted for 72 residential placements of students with severe emotional disturbances; during the 1980-81 school year, 83 such placements were made prior to February of 1981. Total contract costs for these placements ranged from about \$1,000 to over \$248,000 per student. As a result of the increase in contracted services for residential placements by public school systems and the identified need for community based mental health services, the Bureau of Education for Exceptional Students, Division of Public Schools, Department of Education (DOE) was given the responsibility for conducting a study to determine the need for services for students with severe emotional disturbance (DOE, 1981). In February, 1981, a *Report of the Study to Determine the Need for Educational Centers for Emotionally Disturbed Students* was prepared for the Commissioner of Education. This study provided the information essential to the Florida Legislature to develop the Multiagency Network authorizing legislation.

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The study found that the majority of children who were in state-funded residential treatment were being served in programs outside the State of Florida, and that 75% of Florida's children's mental health funds were being spent on residential treatment. Very few exceptional student education programs existed for students with severe emotional disturbance. There was only minimal community-based multiagency service planning, coordination, or delivery. Consequently, children's mental health services were inadequate with virtually nothing to fill the void between outpatient care and hospitalization. It was also determined that the family involvement in children's mental health planning and programs was minimal or non-existent, and communication was limited across programs or agencies. There was limited cross program training, and any efforts in assessment were redundant and not focused. Finally, there was an absence of information and referral services, crisis intervention services, school-based mental health services, and multiagency case management for families.

Method

To address this multi-agency service issue, appointments by the Secretary of Health and Rehabilitative Services and the Commissioner of Education created a State Advisory Board composed of leaders in education, children's mental health, and children's advocacy. Working in an advisory capacity to the Bureau of Student Services and Exceptional Education, a plan to offer fiscal incentive for collaboration was developed and made available to select school districts within each region of the Department of Health and Rehabilitative Services (DHRS).

SEDNET projects were awarded to one school district within each DHRS region, and required signed cooperative agreements between DHRS and each school district. In many regions, projects were funded through the Individuals with Disabilities Education Act (IDEA) Part B, General Revenue, and local contributions. Each project was staffed by one full time project manager and various support staff. To date, over five hundred leaders in education, health and human service systems, mental health centers, parent coalitions, and juvenile justice entities voluntarily serve on regional SEDNET Advisory Boards.

Developing an Effective Statewide Network

Florida initially developed an urban and rural model in 1982-83. Pilot sites demonstrated the need for local flexibility and control for maximum success. Therefore, a statewide framework was developed requiring locally-determined, needs-based priorities consistent with guiding principles. Statewide network goals included the following: (a) multiagency planning for a complete array of services, (b) continuous improvement of service in the system of care, (c) evaluating the effectiveness of the system, and (d) disseminating information regarding the system of care.

In 1985, DOE contracted with the Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida, to administer the Quality Development Teams (QDT), in order to identify characteristics of successful projects and evaluate SED Network Project impact on the delivery and effectiveness of services to children with SED. Statewide project reviews were conducted and features of quality projects and effective networks with successful outcomes were examined at the planning, implementation, and evaluation levels. Multidisciplinary teams looked at what enabled networks to bring their children back to their communities from out of state and county placements, create new special education programs and day treatment programs, intervene in times of crises, provide multi-agency case planning and case management, and have meaningful parent involvement.

Standards and self assessment tools were developed for both the projects and networks, in addition to identification of competencies of effective project managers, board members, and other network participants. Five volumes of best practices were published as additional tools to assist communities in creative problem-solving, and program and professional development.

Florida's legislation authorizing the SED Network was amended in 1990 to include a requirement for annual reporting to the Legislature. Four annual reports have been produced to date, summarizing regional and statewide accomplishments and providing recommendations for further progress.

Results

Although enrollment in schools has grown by 32 percent over the past nine years, according to the March 2, 1995 memorandum to the Senate and House Appropriations Committee¹, only 28 students with severe emotional disturbance were in private residential programs under school district contracts during fiscal year 1994-95. This is a reduction of 61%. Similar progress is evident in DHRS placement data, with a significant increase in Florida's ability to serve children in therapeutic foster homes versus more costly residential treatment.

Florida's progress over the last ten years is also evidenced in outcomes of students with severe emotional disturbance. According to enrollment, placement, and exit data, there has been a 60% increase in the numbers of students with severe emotional disturbance graduating from high school. Also, there has been a 25% increase of students identified as eligible for educational programs for youth with emotional disabilities, albeit consistent with the increase in Florida's student population. There are 16% fewer students with SED being placed outside the public school system, and a total of 15% more students with emotional disabilities are being served in regular education classrooms. Finally, there has been a 100% decrease in the number of students who are placed outside the state for residential treatment with children's mental health funds and an estimated 3,000 students were diverted from residen-

¹ Prepared annually by the Bureau of Student Services and Exceptional Education, Florida Department of Education.

tial treatment during the past fiscal year through DHRS Family Service Planning Teams.

In 1995, families were more involved and active with multiagency planning at every level than ever before. Due mainly to strong, cohesive groups and organizations, parents had opportunities to be active partners in planning and service delivery. This has resulted in policy enhancements and changes that impact favorably on Florida's students with severe emotional disturbance. The SED Network has assisted in the growth and development of organizations, such as The Florida Alliance for the Mentally Ill - Child and Adolescent Network (FAMI-CAN); The Florida Federation of Families for Children's Mental Health (FFFCMH); and The United Families for Children's Mental Health (UFCMH).

Network projects now boast 100% family attendance and participation in Family Service Planning Team operations, where multidisciplinary case plans are developed, case managers are designated, and integrated service plans are agreed upon by the significant participants in each child's life. In addition, family members serve on the State Advisory Board and on 17 of the 18 regional, multiagency advisory boards.

Discussion

By providing staff support, the DOE creates opportunities for school districts to unite in a regional structure consistent with the DHRS, fiscal agents for children's mental health funds. This approach has resulted in a rich diversity of decentralized structures and approaches, reflecting local decision-making that builds on community leadership and resources. This structure also allows for the maximization of scarce resources, supplementing the capability of a single county school district.

According to the Florida Children's Mental Health Plan (annually required for federal block grant funds), \$228 million was spent on children's residential treatment services in 1995-96. The benefits of these funds is maximized with state, regional and locally integrated planning, implementation and evaluation. The total cost of the Statewide SED Network activities which assist with this function, as well as addressing the goal of an integrated system of care, is 2.2 million annually. During the 1995-96 legislature session, a 190% increase in General Revenue was allocated for SEDNET. As a result of an increased awareness for the needs of youth with emotional disabilities, advocacy, and research demonstrating the effectiveness of early intervention, Florida has (a) increased its budget for children's mental health by one million dollars in the last decade, (b) increased the number of children served by 78%, (c) reduced the expenditures per child by 73%, and (d) decreased the number of residential treatment from 29.3 days per recipient, in 1992, to 14 days, in 1994 or 52%.

The role of the state is to provide statewide coordination, identify and replicate effective practices, and provide technical assistance and evaluation. Multiagency networking contributes to student graduation, increased recognition of program and service eligibility, greater inclusion, improved access and effectiveness of the system of care, family involvement, and a broader array of community-based education and treatment alternatives.

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Utilization and Effectiveness of Florida's Multidisciplinary Family Service Planning Teams

Introduction

In Florida, Case Review Committees (CRCs) were developed in the early 1980's to be the gatekeepers of residential placement for children with emotional disabilities. There were, however, over 400 children statewide on CRC waiting lists, and no identified planning mechanism to maintain those children in the community awaiting placement or to divert children from CRCs. The Family Service Planning Teams (FSPT) were initiated in 1987 by the Office of Alcohol, Drug Abuse and Mental Health, Department of Health and Rehabilitative Services (DHRS) to accomplish this purpose.

FSPTs were implemented not as a result of new funding, but from a commitment of DHRS and the Department of Education (DOE) to create interagency planning forums to develop holistic service plans to enable children to live in the community and be successful in school. The Multiagency Network for Students with Severe Emotional Disturbance (SEDNET) was established by the Florida Legislature in 1981 in recognition of the significant cost and lack of progress of students served outside the state in psychiatric residential treatment. SEDNET project managers, already functioning as regional network coordinators throughout Florida and funded by DOE, became the facilitators of this new planning effort. FSPTs have become the focus of service planning for children at risk of out-of-home or school placement in need of multiagency involvement, bringing together parents and social service and education professionals.

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Since implementation of FSPTs, many of the children previously in out-of-state residential treatment have been able to return to Florida. Referrals to CRCs have decreased. Concurrent educational program development and multiagency cooperative systems of support have promoted educational reviews of clients of DHRS resulting in a 260% increase in student eligibility and in services provided through educational programs for students with severe emotional disturbance. Multiagency case management services have simultaneously increased, as have parent/professional partnerships, access to Medicaid, and private contributions to local systems of care.

In response to continuing needs for improving implementation, identifying training needs, and supplying additional data on this pre-residential intervention, a multidisciplinary planning team review was conducted.

Method

The multidisciplinary planning team review was conducted in three parts. Part One focused on the utilization of services by the FSPTs. SEDNET Project Managers were asked, "What services purchased by the FSPT(s) make the most difference in improving the lives of the children and families served?"

Part Two provided a status report of the children whose collaborative treatment plans were described in one of four *Best Practices in Creative Service Delivery* manuals (1989-1992). A total of forty-seven cases were selected. Project Managers were asked, "What was the major contributing factor of successful service planning?" and "What was the most valuable contribution of the system to this child?"

Part Three focused on a single county's FSPT efforts to assess the overall satisfaction of the consumers they served. This FSPT also conducted a

needs survey to identify those services most frequently requested by parents/guardians. Twenty interviews with parents/guardians were conducted.

Results

Part One

Responses were received from 14 of 18 regional SEDNET projects, representing 50 of Florida's 67 counties (75%). Ranked in the order of making the most difference, purchased services included:

1. Recreational/leisure activities aimed at improving self-esteem & social skill development.
2. In-home services/in-home parent education and counseling/therapy.
3. Respite care
4. Behavior Specialist/Certified Behavior Analyst in school and home
5. Mentor/Therapeutic friends
6. Case Management

Part Two

Looking at Family Service Plan development process and outcome, SEDNET was able to provide the child's status and residential placement history for sixteen of the forty-seven children. (Children in the *Best Practices* manual were identified by numbers or initials only. Identifications relied on project manager's or case manager's memory of the child from brief, anecdotal case presentations.) Of these 16, 10 of the youth staffed at FSPT (63%) did not go on to the CRC, although three were placed in residential facilities. Four youths did go on to CRC; three were placed in residential facilities, and one remained at home with support services. Two of the sixteen youths reviewed had already been discharged from residential placement and went to CRC for review only.

In response to the question, "What was the major contributing factor of successful service

Florida's Multidisciplinary Family Service Planning Teams

planning?," findings of the reviews suggest that when the youth did not go on to CRC, there was a consistent individual involved in planning and implementation of service plans. Involvement was primarily with a family member, usually the mother. Other individuals included biological father, case manager, and teacher in an SED classroom. Consistent family involvement was also the common factor with the one child who went to CRC but was not subsequently placed out-of-home.

With the three youths who were placed in residential treatment through the CRC, family involvement was described as less consistent: (a) one child had family involvement in the early years but less involvement after placement; (b) one child with the mother involved, but her own addictions problematic to consistent treatment; and (c) the third child with parents who were divorced but involved and concerned. In the two cases where the youths were reviewed at the CRC, following discharge from residential placement, one family was involved in team planning from the beginning with regular communication with the case manager, while the other family became more involved and participatory as they began to see improvement. The three youths who did not go to CRC but were placed in residential treatment were youths in foster care with no direct family involvement.

When asked "What was the most valuable contribution of the system to this child?," the three most frequent responses were: (a) looking at the family as a unit, (b) keeping the child in the home with in-home services, and (c) multiagency planning meetings.

Part Three

The FSPT in Hernando County endeavored to assess the overall satisfaction of the consumers whom they served. These consumers were determined by the committee to be both the children of

concern and their parents/guardians. However, only the parents/guardians were surveyed.

The FSPT Satisfaction Survey consisted of 29 statements based on a 5 point Likert-type scale to determine their satisfaction and attitudes toward the FSPT process and actual services provided.

- 74% felt included in the planning of services at the FSPT, wanted to come to the meeting, and be part of the process.
- 58-73% felt they were treated with respect and given the opportunity to speak.
- 64-85% felt that their beliefs, values, and points of view were used to plan services.
- 74-95% felt that FSPT provided good services for children/families.
- 74-95% felt that the goals of the Family Service Plan were explained adequately.
- 36% felt blamed for their child's problems.
- 43% strongly agreed, and 26% somewhat agreed that their children could be helped in the home.
- 63% did not feel intimidated by the process.
- 69% felt that the FSPT committee used the family's day-to-day life to plan for services.

Recommendations based on survey outcomes include: (a) hiring a Parent Liaison to help parents feel less intimidated with the FSPT process and be more of an integral member of the case plan; (b) developing strategies to overcome the transportation barrier and provide more in-home services whenever possible; (c) developing surveys for the children of concern so that their satisfaction can also be measured; and (d) including the children of concern in the FSPT process whenever possible.

The needs survey to determine what services were most frequently requested by parents/guardians consisted of twelve individual categories of services and was measured on a 0 - 2 scale.

- 70% felt the following services were very needed: Case management, recreational activities, one-to-one adult/child relationship (e.g., Big Brother/Big Sister).
- 50-65% felt the following services were very needed (ranked in order of importance): (1) Financial assistance; (2) counseling, family, individual and group; (3) social skills training; (4) evaluations; (5) vocational training/job coach; and (6) home-based services.
- 60% felt out-of-the-community residential services were not needed.
- 45% felt parent education was very needed.
- 45% felt parent education was somewhat needed.

Recommendations based on the results of the Needs Survey included: (a) developing a therapeutic mentorship program; (b) provision of financial support for a child psychiatrist so that medication management, therapy, case management, and non-clinical services can be obtained for Medicaid clients; (c) continued parent education in the community; (d) increased respite in the community for special needs and at-risk children; and (e) continued funding for specialized training/personnel for summer recreation programs.

Discussion

Multiagency case planning has allowed concerned individuals to request that significant partners in a child's life collaborate in the development and implementation of the best possible plan utilizing existing community resources, or with limited availability, new resources. The family-centered, customized approach to service, resource development and coordination on behalf of children who need services from multiple systems has been key to the success of regionally-initiated FSPTs. Multiagency case planning has also provided continuous needs assessment data to program planners for improving the local system of care.

With resources at a premium, identifying and providing the services which make the most difference in efforts to assist youth with special needs is more important now than ever before.

The key services identified in this study reflect the concerns of this special population. For example, many students lack initiative, self-discipline, and continuous guidance/supervision, resulting in the need for external support systems to boost self-esteem, as well as to increase their ability to seek out constructive activities for personal growth. Similarly, the ability to provide essential respite care at the time of need has long been reported as a major contributor to parental ability to maintain children with intense needs within their homes. Traditional outpatient services often neglect the ability and potential of the caretaker in shaping behaviors and providing extended support. Counseling services made available to children and parents in their home setting may allow a more complete view of family and environmental dynamics, and contribute to more accessible and effective interventions. Additionally, the study shows that parents, teachers, and caretakers of children often lack the benefit of professionally trained experts in systemic approaches to behavior management. The services of specialists in behavior management, however, not only provide direct assistance with student and child-behaviors, but provide a source of instruction and technical assistance to teachers/caretakers. Also, the value of a significant other has been consistently documented in mental health and delinquency-related research; the use of mentors or therapeutic friends, in volunteer, paid, or Medicaid funded non-clinical in home service utilization is perceived as having made a difference in positive outcomes. Finally, designating a service coordinator as needed is a key to success in assisting and monitoring the implementation of many multiagency plans.

Florida's Multidisciplinary Family Service Planning Teams

New funds earmarked for student success and support are available through delinquency prevention opportunities, family preservation, family support, and other initiatives with similar missions. Managers of these funds and prospective providers are encouraged to maintain and/or develop responsive programs, new and creative services, and maximize opportunities for flexibility necessary for truly individualized services.

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The Prime Time Project: Developing an Intensive Community-Based Intervention for Youth in the Juvenile Justice System

Introduction

The Prime Time Project is a comprehensive intervention model for youths who are at the extreme end of the juvenile justice continuum due to their history of repeat offending, relatively severe offenses, a high degree of isolation or abandonment from their natural community, and the co-occurrence of mental health disorder. Prime Time was initiated in the fall of 1995 in King County, Washington. Faced with rising juvenile crime and violence, increasing public concern, and a corresponding rise in demands placed on the county juvenile justice system, county officials have voiced a high level of interest in alternative, or enhanced, services to address juvenile crime. The county council awarded a two-year grant, recognizing that effective interventions exist and that linkages and collaboration between agencies and service providers play a role in successful intervention. The goals negotiated with the county were simple: (a) reduce recidivism, (b) reduce severity of violent and other offending behavior, (c) increase school attendance and performance, and (d) increase residential stability. The county council also mandated that we target those youth in the “deep end” of the juvenile offender population. This translated to the following entrance criteria for youth in the program: (a) currently in detention; (b) age 12 to 17; (c) at least two admissions to detention; (d) adjudicated for a relatively serious offense (e.g., assault, burglary, vehicular homicide, etc.); and (e) presence of a diagnosable mental health disorder.

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Theoretical Background

Social-ecological models explain delinquent behavior as multiply determined by interactions between genetic, psychiatric or psychological variables, and key elements of the environment such as family, school, peers, and other systems. Accepting this approach, we found more specific guidance in Patterson's (1982) explication of a "coercive cycle" in aggressive children's antisocial interactions. Patterson described an interaction pattern in which a youth's antisocial behavior is followed by the parent's negative reactions. This, in turn, escalates the youth's antisocial, aggressive behavior, triggering a cycle that is both cause and effect.

With Patterson's model in mind, we noticed a striking pattern of coercive exchanges across a wide range of systems in which juvenile offenders interact. For many of these youths, reciprocal coercive exchanges characterize interactions with family members, teachers and other school officials, and members of the community. Once referred to the juvenile justice system, the youth's interactions with police, courts, detention staff, and probation and parole officials are often coercive in nature. Building on the reciprocal effects and negative reinforcement described in Patterson's model, it followed that an intervention which broke the "coercive cycle" might be effective in enhancing pro-social behavior and reducing offending.

We were also impressed by the success of the Multisystemic Therapy Model of Henggeler and Borduin (1990) and set out to fashion our intervention after their model. Specifically, we sought to design a family-based therapeutic intervention that would integrate affective, cognitive, and social interventions, be community-based, incorporate case advocacy, and involve youths and families in treatment planning and implementation.

Boundary Spanning and Collaboration

In light of the multiple systems in which juvenile offending youth are involved, and guided by Child and Adolescent Service System Program (CASSP; Stroul & Friedman, 1986) principles, we framed program development in terms of the Jericho Principle (Melton, 1989). The Jericho Principle is a metaphor, suggesting that walls should come tumbling down between disciplines, or sectors, of the child and family service system.

Prime Time Project: Intervention for the Youth in the Juvenile Justice System

Collaboration with Families

Although many families, for both obvious and subtle reasons, are unable to provide consistent support for their children, we place a strong emphasis on collaboration with parents and families when possible. Families are contacted while youths are in detention. Meetings, for assessment, treatment planning and counseling, begin at that point. Families are involved in developing a structured transition back to the community, and in fine-tuning services to meet their specific strengths and needs.

Collaboration with the Juvenile Justice System

The Prime Time Project is based out of the King County Department of Youth Services (DYS) and a nearby community health clinic. Therapist/case managers of the Prime Time Project make contact with youth and families while the youth are detained and then follow them into the community upon release. Through our physical placement within juvenile detention, we have watched and perceived some walls to have buckled, although not totally collapsed, between the juvenile justice and mental health system.

Judges

Close collaboration with judges has afforded us a high degree of involvement in judicial disposition planning. Juvenile court judges refer youths to our program and invite our recommendations as to disposition planning. Eager for an expanded set of options for these troubled youth, judges have enthusiastically welcomed our efforts to demolish the metaphoric wall between the justice and mental health system.

Probation Counselors

Similarly, program staff have developed close collaborative relationships with probation and parole officers. The leveling of this wall has facilitated the design of a seamless approach to behavior management across systems and permitted more consistent monitoring of youth's participation and compliance in treatment, school, or vocational activities. Probation officers have welcomed the involvement of mental health professionals, leading to the construction of detailed probation orders tied to established principles of behavior management.

Collaboration with Police

Working closely with probation counselors, we have found that responding to youths' non-compliance with a warrant and brief detention may serve as an effective container, in both the literal and therapeutic sense. Recently, we have been able to forge a collaborative alliance with local police officials.

Collaboration with Schools

While education represents an important avenue of change for youth in the juvenile justice system, school has often been the setting for repeated failure, both socially and in the classroom. Among participants in the Prime Time Project, few are enrolled in school upon release from detention, and almost all have a history of multiple suspensions or expulsions. Collaboration with teachers and administrators is vital to facilitating youths' re-entry into the education system.

The Prime Time “Day Time” Program: A Transitional Community

In light of the degree to which many youths are extruded from their communities and lack many of the competencies necessary to social, academic, and vocational success, it should be useful to put in place a set of structures to facilitate youths' transition towards broader community involvement. To this end, the Prime Time Project incorporates a series of structured group activities. These activities do not take the place of intensive family-based (when possible), eco-systemic intervention. Instead, they serve as a transitional community for some youths and as an adjunct for others.

Prime Time activities seek to provide additional structure and external control for youths who both have too much time on their hands and too little capacity for impulse-control. Involvement in these activities offers a respite from the youth's involvement in coercive interactions, allowing them to practice alternative, pro-social styles. Some youths benefit from a graduated return from detention (where many report feeling quite safe as a function of the structure inherent in the setting), to the community, where risks are greater and external controls limited. The structured daily activities may serve as the venue for the “in vivo” transfer of vocational, academic, and social skills in a setting located in the community, while featuring opportunities for structured, pro-social interaction. Finally, by designing activities that proceed through a series of stages, youth are given the opportunity to follow a graduated pathway of success experiences leading to increasing community involvement.

This aspect of the intervention takes the form of structured half-day and evening activities located in a local community center under the umbrella of the community health clinic in which

the program is based. Vocational training forms the centerpiece; youths spend two or more days each week involved in hands-on job skills training. Youths begin with a set of job readiness and basic skill building activities, moving through a series of stages to employment in the community. Youths also participate one or two days per week in training modules targeting areas such as social skills, affect management, interpersonal problem solving, and drug and alcohol abuse.

One evening per week, youths and a parent (or involved adult) attend a group meeting. Participants and program staff share a meal together before breaking up into separate parent and youth groups. After youths and adults break into groups, youths engage in a series of activities designed to afford an opportunity to practice pro-social interactions while working on tasks centered around identity development. In an adjoining room, parents receive training in communication and behavior management.

Research

Currently, a pilot study with 25 youths is being conducted. This study is designed to (a) give information about the population being served, (b) explore the effectiveness of the enrollment and data collection procedures that have been implemented, and (c) give a preliminary indication of the effectiveness of the intervention in reaching desired outcomes. This pilot study will also guide the preparation of a proposal for a larger, outcome-based evaluation.

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California's System of Care Model for Reducing Juvenile Crime: Riverside County's Successful Interagency Program

Introduction

Riverside County's interagency program combines mental health, educational, and probation services in an effort to reduce juvenile recidivism. The program provides interagency services at three therapeutic high schools (12th Street, Perris, and Indio Community Schools) and one juvenile facility (Van Horn Youth Center) with the goal of keeping minors at home, and thereby reducing recidivism by keeping them out of restrictive facilities (e.g., group homes, juvenile hall, California Youth Authority).

Riverside County's interagency services began in FY 1989-90 under Assembly Bill 377 (AB 377) as part of the California System of Care (SOC) model first developed in Ventura County in FY 1984-85. After six years of AB 377 implementation (FY 1989-90 through FY 1994-95), Riverside County has served a total of 1,507 juvenile wards at the interagency community schools and juvenile facility. The sites currently are serving about 300 juvenile wards in FY 1995-96.

As a requirement of AB 377, the Riverside County Mental Health Department annually evaluates the effectiveness of interagency services in reducing recidivism among juvenile court wards. Previous evaluation found that the number of felony and misdemeanor offenses significantly decreased for wards one year after AB 377 services compared to their criminal activity the year before such services (within program outcomes). The number of felony offenses also declined compared with comparison group samples (between group samples).

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Riverside County's interagency program for juvenile offenders is representative of the System of Care model being implemented in 19 other California counties. The goal of the state's Department of Mental Health is to establish System of Care programs in all 56 California counties and thereby replicate statewide the positive recidivism findings that have been reported in Riverside County.

After six years of interagency cooperation between the County Office of Education, the County Department of Probation, and the County Department of Mental Health, Riverside County reports two key outcomes with implications for reducing juvenile crime in California's counties:

- The total number of felony and misdemeanor offenses significantly decreases for juveniles one year after attending an interagency school/facility compared to their criminal activity the year before being assigned to program (*within program outcomes*).
- Juveniles are rearrested less often for felony and misdemeanor offenses one year after attending an interagency school/facility compared with youths who attend non-therapeutic, non-interagency sites (*between program outcomes*).

Method

A pre-treatment and post-treatment design was used to evaluate the effectiveness of interagency programs in reducing juvenile recidivism. Juvenile recidivism was measured one year before receiving AB 377 services and one year after receiving such services. Four studies (FY 1990-91, FY 1991-92, FY 1992-93, and FY 1993-94) were conducted that employed the one year pre-treatment and one year post-treatment design. A fifth study was conducted (FY 1994-95) that employed a two-year pre-treatment and two-year post-treatment design. Comparison groups were used for the

1990-91, 1992-93, and 1993-94 studies to establish a non-treatment recidivism baseline.

The Riverside County Office of Education, the County Department of Probation, and the County Department of Mental Health provided collaborative educational, probational, and therapeutic services to wards at the interagency high schools and juvenile facility. Wards at the comparison sites received joint educational and probational services, but did not receive mental health services.

Sites

Samples were selected from four interagency sites (Van Horn Youth Center, 12th Street Community School, Perris Community School, and Indio Community School). Samples were also selected from two pre-AB 377 sites (Van Horn and Perris) and from a non-AB 377 community school (Jurupa) to serve as comparison groups. Juvenile wards who were discharged from the four AB 377 sites and who had at least two weeks of interagency services were randomly selected for inclusion in the studies. For the comparison group samples, juvenile wards who were discharged from Jurupa or a pre-AB 377 program and had attended that school for at least two weeks were randomly selected for the studies. Altogether, 239 wards receiving AB 377 services were randomly selected for the five recidivism studies; 71 wards were selected from the comparison groups.

Arrest and disposition records were examined for juvenile wards in the four interagency samples and the comparison group samples. These records were collected from official court and probation department documents. The number of sustained offenses by wards (i.e., felonies, misdemeanors, and probation violations) before entry into an AB 377 interagency program was compared with the number of sustained offenses after their exit from the pro-

California's System of Care Model for Reducing Juvenile Crime

gram. The same information was collected for the pre-AB 377 and non-AB 377 comparison groups.

Analysis

Both inferential and descriptive statistical were used to analyze recidivism outcomes. Paired t-tests and t-tests for independent samples were used to measure recidivism before and after interagency intervention. The data is currently also being reanalyzed using a 2 x 2 (Condition x Time) repeated measures analysis of variance (ANOVA). In addition, the effect sizes (also known as *program or clinical effectiveness*) corresponding to the inferential statistics were also reported. Two types of significance testing were thus reported: statistical significance and clinical significance (*effect size*).

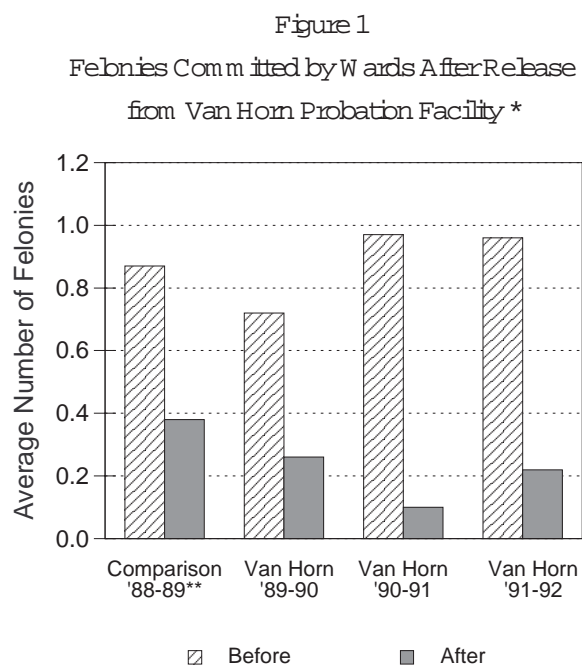
An effect size is a statistical measure of program effectiveness that compares the degree of a program's effectiveness against a baseline or comparison group. A program can have a result that is simultaneously statistically non-significant *and* clinically significant. One may infer statistical significance from a clinically significant outcome; that is, a clinically significant outcome denotes a statistically significant outcome (Cohen, 1988; Thompson, 1993).

Results

Overall, findings suggest that AB 377 has been effective in reducing the number of felony offenses committed by wards. The number of felony offenses committed by wards at Van Horn and the three community schools significantly declined one year after AB 377 services compared to felony offenses committed one year before such services ($t = 5.40, df = 121, p < .001$). The number of felony offenses also declined compared to the comparison group samples. When compared to a pre-treatment comparison sample, the number of felony offenses committed by wards significantly declined at Van Horn one year after AB 377 services compared to

felony offenses committed one year before such services ($t = 2.03, df = 59, p < .05$; see Figure 1). The decline of felonies from pre-treatment to post-treatment approached significance for wards at the three community schools ($t = 1.72, df = 203, p < .09$) when compared with the non-AB 377 samples (see Figure 2).

The differences in felony offenses between the AB 377 sites and the comparison samples were all clinically significant. Based upon effect size analyses, 44% of the wards from the community schools were likely to commit a felony after AB 377 services compared with 56% of minors from the comparison groups; 37% of the wards from Van Horn were likely to commit a felony after services compared with 63% of wards from the comparison group. Employing a measure of effectiveness (Rosenthal, 1984; Rosenthal & Rubin, 1982), the AB 377 interagency program was



* Criminal activity one year before confinement at and one year after release from Van Horn.

** Van Horn wards one year prior to implementation of AB377.

12% more effective in reducing felonies at the community schools than were the comparison programs; it was also 26% more effective at reducing felonies at Van Horn than the comparison group.

The effect size difference for the community school wards relative to the comparison group was .25 standard deviations, felony recidivism was thus reduced by a quarter standard deviation. The effect size difference for the Van Horn wards relative to the comparison group was .53 standard deviations, felony recidivism was thus reduced by more than half a standard deviation. Employing Cohen's (1988) measure of effect size rubric, the community school and Van Horn effect sizes represent small and medium effect sizes, respectively.

The therapeutic interagency programs were therefore (clinically) effective in reducing felony recidivism. The (clinical) effectiveness of the AB

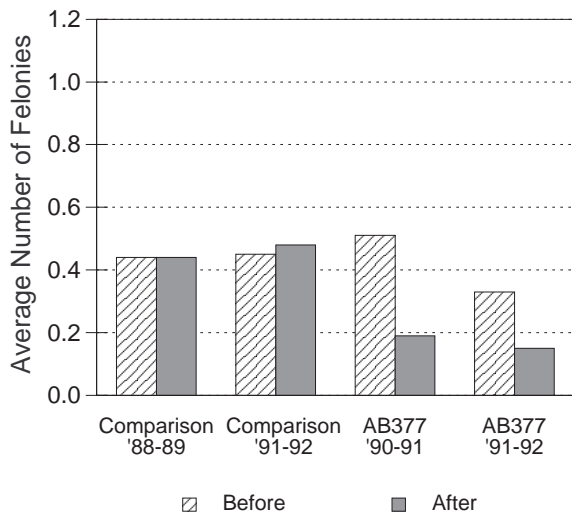
377 community schools and Van Horn in reducing recidivism compares favorably with the success rates (effect sizes) reported in 200 recidivism studies reviewed by Lipsey & Wilson (1992) that show that between 43% to 45% of juvenile wards were likely to reoffend after intervention services compared to 54% to 57% of minors in programs without intervention services.

The fifth study that employed a two-year post-treatment design showed a decline over time in juvenile recidivism (see Figure 3) based on descriptive statistics (inferential statistics have not yet been conducted). This study also showed that juveniles who previously reoffended were likely to reoffend within the first three to six months after receiving interagency System of Care services (see Figure 4). Wards who did not reoffend one year after services were likely not to reoffend during the second year after services.

Discussion

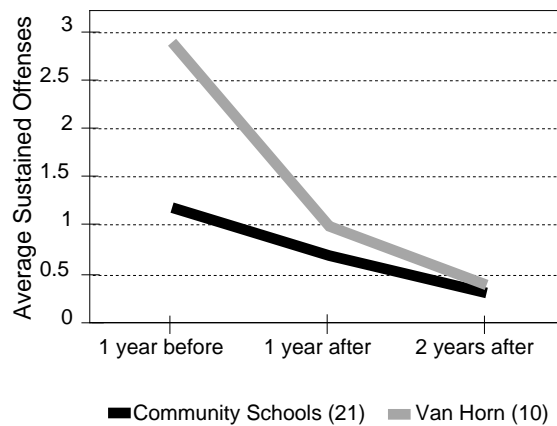
California's System of Care as implemented in Riverside County is helping deter juveniles from committing additional crimes. Riverside County's

Figure 2
Felonies Committed by Wards After Release
from Therapeutic Community Schools *



* Criminal activity one year before assignment to and one year after release from AB377 program.

Figure 3
Sustained Felonies and Misdemeanors



California's System of Care Model for Reducing Juvenile Crime

interagency program for juvenile offenders is similar to a model that is also in place in 19 other California counties. San Mateo, Santa Cruz, and Ventura counties have also reported that juvenile wards commit fewer felonies and misdemeanor crimes one year after their AB 377 System of Care services compared to their criminal activity the year before such services.

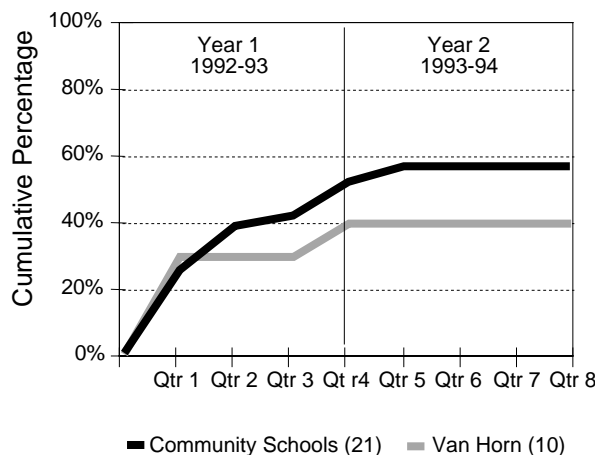
The goal of California's Department of Mental Health is to establish system of care programs in all 56 counties and thereby replicate positive recidivism findings statewide. The positive recidivism outcomes in Riverside County show that the interagency System of Care approach offers other counties in California an effective model for reducing juvenile criminal activity. John Ryan, Riverside County Director of Mental Health and past President of the California Mental Health Director's Association, stresses that "We have shown through research the effectiveness of our collaborative work with juvenile offenders. We have also shown that an interagency approach is

more effective when working with juvenile offenders than either mental health or probation trying to work alone."

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Figure 4
Percent of Youth in AB 377 Program
in 1991-92 with One or More
Felony or Misdemeanor



The Relationship of School-Based Services to Mental Health Networks

Introduction

Reforms including integration of children's mental health services have emerged in a variety of regions, communities, and institutions. Consequently, psychologists and other mental health professionals are increasingly interested in working with schools to provide better, integrated services (Carlson, Tharinger, Bricklin, DeMers, & Paavola, 1996; Paavola et al., 1996). To support these collaborations, it is important that child services professionals understand how schools relate to a network of care for children's mental health services.

This summary examines the role of schools in integrated service delivery using data from a project in South Carolina that provides services to children with severe emotional disturbance (SED). South Carolina presents an interesting case of state child service systems reform; beginning in 1989, it was one of the first states to develop Medicaid services utilizing local education agencies as medical providers. The Medicaid office and the Department of Education identified potentially reimbursable services, including psychological services. In July, 1995, the Medicaid agency was renamed the Department of Health and Human Services, and supported services for eligible children with a disability through an Individual Education Plan (IEP; Cantrell, 1996). These services were provided in the school building, using a strategy sometimes known as "push-in" integrated therapy. This contrasts with a strategy of "pull-out" clinical services, in which children needing services are removed from the classroom and school.

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The involvement of schools in a network of care for children with SED is important for several reasons. Schools are potentially effective health delivery systems for children because they are stable, universal, and cost-effective (Carlson et al., 1996). To some extent, public schools have served to integrate children's social services since their inception (Fagin, 1992). Schools may work with families to ensure that their services are appropriate to both the family and the school's administration. In exceptional or special student education, an IEP that integrates services and service providers is essential to child health and family involvement in education (Duchnowski, Kutash, & Knitzer, 1995). Along with inpatient or residential services and mental health counseling, schools are a major axis of care and expense over time for children with emotional or behavioral problems (Epstein & Quinn, 1996).

Additionally, children with serious emotional or behavioral disorders often receive care from multiple service providers. Responsibility for care and health outcomes is shared, and the degree to which this shared responsibility is coordinated can be improved through system interventions (England & Cole, 1995; Friedman, 1996). Under these conditions, system coordination appears to be critical (Johnsen, Morrissey, & Calloway, in press). The degree of change in integration and coordination of child services may be measured using network analysis (Morrissey, 1992). In evaluations of service integration programs in upstate New York and western North Carolina, social network analysis demonstrated that service enhancements such as co-locating services and expanded case management, created greater systems integration (Morrissey, Johnsen, & Calloway, 1994).

In the context of a national mandate to establish systems of care for children (Stroul & Friedman, 1986), comprehensive care and full-

service school models have become prominent (Dryfoos, 1994; Roberts, 1994). In terms of actual service use, research suggests that schools already provide a large proportion of mental health services for children and adolescents. In western North Carolina, the Great Smoky Mountain Study (GSMS) focused on representative 9-13 year olds attending public schools. In the GSMS, only 40% of children with SED received services. Of children with SED who received services, only half received them in the mental health sector (Burns et al., 1995). Mental health services in the education sector were reported for 71.5% of children with SED (vs. 41.5% who reported receiving services from community mental health providers). Earlier studies support the importance of school-based mental health services, identifying teachers as the professional group that most often serves children with mental health problems (Cohen et al., 1991; Offer, Howard, Schonert, & Ostrov, 1991).

Method

How are schools involved in networks of care for children with SED? This study examined organizations participating in a mental health services demonstration sponsored by the federal Center for Mental Health Services (CMHS) and administered by a Community Mental Health Center in an urban area of South Carolina. A rural comparison region served three nearby counties. A systems-level assessments was designed to measure differences in development and coordination among service organizations in the demonstration site ($n = 61$) and its comparison community ($n = 39$). In the urban demonstration site, organizations serving children with SED were coordinated through a system of care model and featured multi-systemic therapy, an ecological treatment model (Henggeler & Bourdin, 1990; Henggeler et al., 1994). Baseline data were collected

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between December, 1994 and May, 1995. The sample of organizations in this study was unique because the sample was carefully designed to include a range of schools in the region. The project was funded for 5 years, and services began in March, 1994.

This study used an inter-organizational network survey based on Van de Ven and Ferry's "Organizational Assessment Instrument" which has been tested for validity and reliability (Morrissey, Johnsen, & Calloway, 1994; Van de Ven & Ferry, 1980). Researchers gathered responses from over 90% of 117 services identified in the two counties. Selected services were those which performed a CASSP function (Stroul & Friedman, 1986), were identified as a key agency, and/or were used by children with SED. The survey instrument included detailed indicators of client referral patterns and information exchange relationships among child serving agencies in the region.

The inter-organizational network of referral and communication among services for children with SED was summarized by indicators of social network structure, including connectedness, density, and centralization (Wasserman & Faust, 1994). Network analysis techniques provided the number and density of referral and communication ties to and from particular service providers. Analysis at the system level was complemented by analysis of schools in the network, including a comparison of those urban schools with and without in-school therapeutic intervention.

Results

The network of service providers was moderately integrated in both the urban and rural regions, and more centralized in the rural region. The client referral patterns among 61 organizations in the urban service delivery network were more dense (18% vs. 13%) and less centralized (.26 vs. .43) than the 39-organization rural network (see Table 1). Density is a measure of the proportion of possible ties which are present, expressed as a proportion of non-zero cells in a n -by- n organizational matrix. Similarly, the information exchange patterns were more dense in the urban region (.23 vs. .18) and less centralized than those found in the rural area. This could have been due to a smaller student and client population in the rural network, requiring fewer relationships between services and allowing greater centralization of services. These findings also may have been related to greater integration in the urban region as a result of the early effects of the CMHS project.

Table 1
Two Children's Mental Health Service Networks

System Indicators	Urban Region	Rural Region
Network Providers (n)	61	39
Schools (n)	9	7
Client Referral Network		
Density	0.18	0.13
Centralization	0.26	0.43
Information Exchange Network		
Density	0.23	0.18
Centralization	0.24	0.38

Table 2 reports a Z-test for the difference between two proportions to compare the density of system ties and the connectivity of school ties for rural and urban systems. The urban density measures for referrals and information exchanges were significantly higher than rural measures ($p < .01$). The “connectedness” of schools (the proportion of possible ties to or from schools to other system respondents) refers to the network density of relations involving particular schools but excluding the school district office.

Although the service system as a whole was more dense, urban region schools show a significantly lower degree of connectedness in terms of the proportion of services to which they send clients ($Z = 2.4$). In general, there were no significant differences in connectedness; schools exchanged clients and information with relatively few other services (one in ten, or less). The low connectedness measures were partially due to the fact that the school district office, which was central and highly connected with other services, was excluded from the analysis of school ties.

In order to examine the potential benefit of the demonstration, Table 3 compares urban schools with and without school-based counselors (SBCs). Proportionately, the urban system schools with SBCs sent clients to more than twice as many service providers as the schools without SBCs ($Z = 2.66$). Likewise, the schools with SBCs sent communications, proportionately, to almost twice as many other providers. This suggests that schools with SBCs may actively initiate relations with other services to a

greater extent than those without SBCs. Most of the schools in the sample were elementary level, suggesting that urban region SBCs were most active in advocating for services for younger children with SED.

Discussion

Schools are important service providers for children with SED, but they are not always highly integrated within a larger system of child mental health services. This summary described schools in two districts that were somewhat isolated from other providers in the local service system. School-based mental health counselors, however, played an important role in bringing schools into the system of care, primarily through increased client referrals. The presence of school-based mental health counselors was associated with more than twice as many client referrals and almost twice as many information exchanges from schools. Although the survey was conducted at an early point in a demonstration project, it suggests that

Table 2
Rural vs. Urban Comparisons for System and Schools

	Rural Service System	Urban Service System	Rural v. Urban Z-test
Network Indicators			
All service providers (<i>n</i>)	39	61	
Schools (<i>n</i>)	7	9	
System density: client referrals	0.13	0.18	4.40**
System density: information exchanges	0.18	0.23	3.90**
Connectedness: proportion of possible ties to/from schools:			
Send clients to service providers	0.12	0.07	2.40*
Receive clients from service providers	0.04	0.03	0.73
Send information to service providers	0.11	0.10	0.44
Receive information from service providers	0.08	0.10	0.10

* $p < .10$

** $p < .01$

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school-based mental health counselors may increase the integration of schools with the larger system of care, building bridges of referral and information to better serve the needs of children.

Since the results reflect less than a year of intervention in one state, and since the comparisons were across services rather than over time, the full impact of school-based counselors cannot be fully assessed using these data. In addition, these results are limited to a single demonstration in a particular area and context. Future research should examine the role of schools in different regional contexts, and ensure that schools are included as respondents in surveys regarding the provision of mental health services for children. Families and counselors should be partners in both health and education, meeting needs of children in their most familiar environments. Bringing services into schools, in addition to referring children out to services, may improve both health and education, in addition to supporting the CASSP goal of providing services in the least restrictive environment.

As interventions are implemented, social network analysis can be used to measure the impact of the integration process and to evaluate the degree to which new service models help schools cooperate within a system of care. In addition, there is some evidence that school level (e.g., elementary vs. high school) is related to the degree of service integration, so developmental issues should be considered. Relationships between schools and other SED service providers may be identified and promoted when they serve the interests of children.

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Table 3
Urban School Comparisons:
Presence of School - Based Counselors (SBCs)

	A Urban Schools: SBCs	B Urban Schools: no SBCs	A vs. B Z-score
Schools (n)	5	4	
Connectedness: proportion of possible ties to/from schools:			
Send clients to service providers	0.10	0.04	2.66**
Receive clients from service providers	0.03	0.02	0.73
Send information to service providers	0.12	0.07	1.94*
Receive information from service providers	0.04	0.07	-1.52

SBC = School- based mental health counselors providing therapeutic intervention

* $p < .10$

** $p < .01$

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