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Comprehensive services for students with serious emotional disturbance: An analysis of state legislation and policy

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COMPREHENSIVE SERVICES FOR STUDENTS WITH SERIOUS EMOTIONAL DISTURBANCE:

An analysis of state legislation and policy

A Dissertation
Presented to
The Faculty of the School of Education
The College of William and Mary in Virginia
In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

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by
Elizabeth B. Hill
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Dedication

This dissertation is dedicated to my father, without whom I never would have started this project, and to Susan, without whom I never would have finished.

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Acknowledgements

I wish to thank Dr. Virginia McLaughlin and the members of my committee for their support and guidance throughout the dissertation process.

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COMPREHENSIVE SERVICES FOR STUDENTS WITH SERIOUS EMOTIONAL DISTURBANCE:

An analysis of state legislation and policy

Abstract

The purpose of this study was to examine state legislation and policy related to comprehensive, integrated services for students with serious emotional disturbance. Legislation and policy documents from nine states, Virginia (the pilot study), Indiana, Maryland, New Jersey, North Dakota, Oklahoma, Utah, Vermont, and Wisconsin, were examined. These documents were compared to a set of components extracted from the literature as recommended practice for comprehensive services. The document analysis was confirmed through telephone interviews with state-level policymakers in each state's department of education, department of mental health, and/or department of children's services. Support documents were also examined to establish a history for each initiative and describe the model of service delivery created by each state's legislation.

Results indicated a core set of four components common to all 9 states studied: family focused services, full array of services, individualized services and an interagency collaborative structure. Two additional components were found to be present in the legislation

of many of the states studied. Community-based services was found in seven states and flexible funding was found in six states.
Three components were not found in the legislation of any of the nine states studied: co-location of services, unconditional care, and wraparound services. The degree of congruence between each state's legislation and the set of components ranged from 61% for New Jersey to 30% for Vermont.

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EDUCATIONAL ADMINISTRATION PROGRAM

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COMPREHENSIVE SERVICES FOR STUDENTS WITH SERIOUS EMOTIONAL DISTURBANCE:

An analysis of state legislation and policy

Chapter 1

The Problem

Introduction to the Problem

In July of 1993 the Commonwealth of Virginia began implementation of the newly passed Comprehensive Services Act for At Risk Youth and Families. The project that resulted in this legislation began in 1990 with these goals:

-preserve and strengthen families;

-provide services in the least restrictive environment while protecting the welfare of children and youth;

-identify and intervene as soon as possible;

-create services to meet the needs of individual youth and families;

-increase involvement of the family and child-serving agencies.

(Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services [DMHMRSAS], 1994)

Governor Douglas Wilder summarized the Commonwealth's concern in his 1991 testimony to the Congressional Select Committee on Children, Youth and Families:

> Troubled youth and their families have multiple needs. These youth often 'bounce' from agency to agency, from foster home to group home to institution, from funding stream to funding stream. A child is often removed from his or her home and the problem is 'fixed'. All too often, the child is then returned home without adequate support. Clearly the emotional costs to children and families are extremely high.

The Council on Community Services for Youth and Families further detailed the need for change in how troubled youth and families are served in the Commonwealth. While acknowledging the problems associated with the existing fragmented service delivery system, the Council focused on the tremendous cost burden. Expenditures for residential and nonresidential services have been increasing at an annual rate of 22% since 1989 (Council on Community Services for Youth & Families, 1991). These costs were projected to continue to rise at this same rate. The interagency Council on Community Services for Youth and Families was created by three Secretaries of the Governor's Cabinet in the spring of 1990, specifically the secretaries of Education, Public Safety, and Health and Human Resources. This Council was charged with improving services for youth with emotional and/or behavioral disorders (EBD) and controlling the costs for these services.

What is much less obvious from looking at the documents supporting this new legislation are the dismal outcomes associated with these rising costs. As early as 1969, it was reported that children and youth with EBD were unserved or served in excessively restrictive settings (Joint Commission on the Mental Health of Children, 1969). This report was followed by several others substantiating these results and indicating that existing services were "uncoordinated, inefficient and ultimately ineffective" (Koyanagi & Gaines, 1993, p.2; President's Commission on Mental Health, 1978; U.S. Congress, Office of Technology Assessment, 1986).

In her landmark study "Unclaimed Children" (1982), Jane Knitzer reported that, nationally, 2/3 of all 3 million children diagnosed at that time with serious emotional disorders were not receiving the services they needed. As costs for treating children and youth in residential placements rose, research to evaluate the efficacy of such placements expanded. Two major studies in 1991 found no evidence of improved outcomes for children with serious emotional disturbance, even in placements costing $80,000 per year per youth (Hoagwood, 1991; Hodges, Bickman, & Kurtz, 1991).

The thrust to improve services for children and youth with EBD did not, however, originate at the beginning of this decade, nor did it begin in the Commonwealth of Virginia. Beginning in the early sixty's, the literature from the fields of education, mental health and child welfare is replete with studies and position papers recommending changes in the ways families in trouble access and receive services (e.g., Ackerman, 1966; Bakan, 1971; Elmer, 1967; Epstein, et al., 1993; Gardner, 1990; James, 1975; Johnson, et al.,1982; Knitzer, 1982; Knitzer & Yelton, 1990). Several states including Alaska, Indiana, Kentucky, Maryland, Vermont, Oklahoma, North Dakota, California, Iowa, Utah, Wisconsin, New Jersey and Virginia have developed systems for comprehensive service delivery, and new programs continue to emerge. As Virginia embarks down a road well traveled, it seems wise to examine what other states have done, and the extent to which state policies have incorporated recommended practices in comprehensive service delivery.

Rationale for the Study

In 1986, the conceptual framework for comprehensive service delivery for youth with emotional and behavioral disorders was outlined in a monograph by Stroul and Friedman. Their model was designed "to be a guide, based on the best available empirical data and clinical experience to date. It is offered as a starting point...as a baseline from which changes can be made as additional research, experience and innovation dictate" (p.26). In this document, the authors have designed a system of care which they conceptualize in their System of Care model (see figure 1).

In what has become the classic model for a system of care, Stroul and Friedman have envisioned the family at the center or heart of the system with all services and service providers, linked to the family and to each other. The innovative nature of this model centered on the concept that no one agency or service delivery facility could provide a complete blanket of support for a family in need. Also innovative was the involvement of community based agencies not traditionally associated with mental health such as recreational services and independent living services. The idea that a family's access to public transportation services for trips to work or therapy, for example, might be critical to a child's performance in school, had not been well articulated before this model was published.

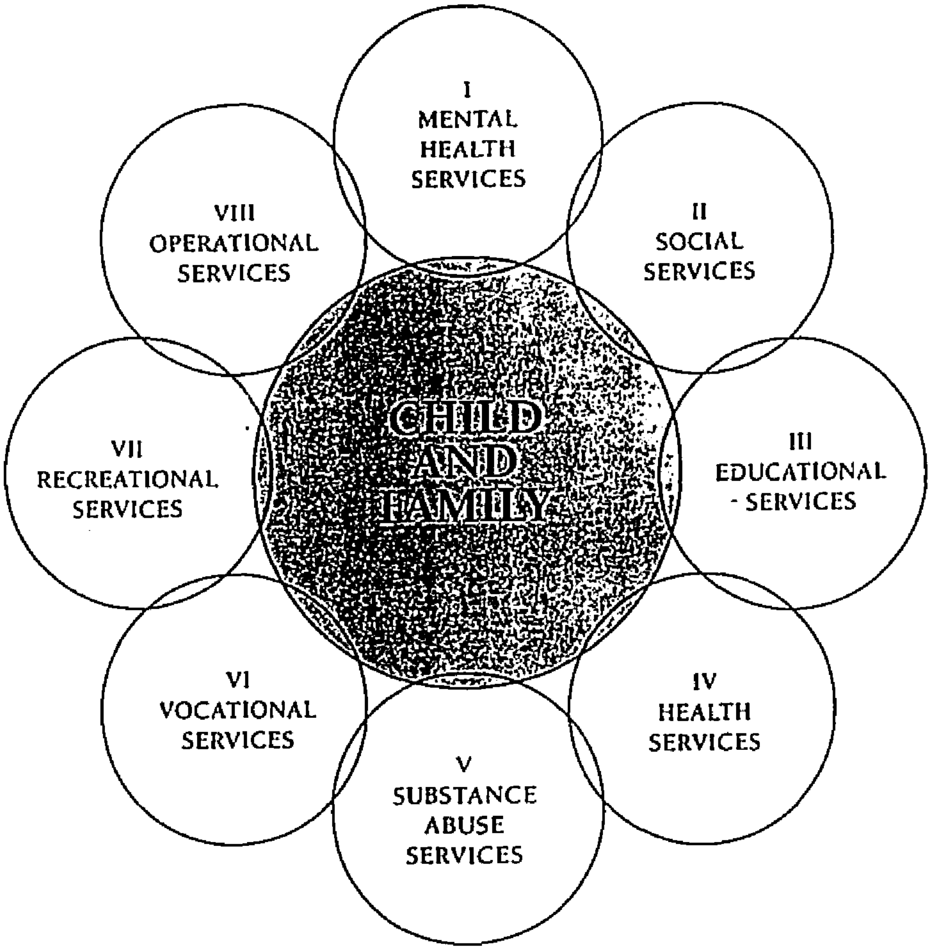

Figure 1. System of care framework. Reprinted with permission from A system of care for children and youth with severe emotional disturbances by B. Stroul and R. Friedman. July 1986, revised edition. CASSP Technical Assistance Center, Washington, DC.

Current research and empirical field work suggest that coordination of services is not enough. Many authors recommend systemic change leading to paradigm shifts in these fields of study and service. There has been a shift from casting blame and determining etiology to building on the existing strengths of youth and families (Kutash, Duchinowski, & Sondheimer, 1994). There has been a shift from education in isolation to education as part of a total service delivery system (Dryfoos, 1994). Finally, there has been a shift from coordination of services to integrated services via interagency collaboration (Melaville & Blank, 1991).

In the early 1980's. the National Institute of Mental Health (NIMH) received $1.5 million in seed money from congress. The money was used to form The Children and Adolescent Service System Program (CASSP). CASSP continues to fund, through the Technical Assistance Center of the Georgetown University Child Development Center in Washington DC, initiatives related to integration of services for EBD children and youth in all 50 states. These programs have built upon and expanded the conceptual framework outlined by Stroul and Friedman. The components of quality integrated services now include, for example, unconditional care (Burchard, Burchard, Sewell,

& Vandenberg, 1993; Epstein, et al.,1993), wrap-around services (Burchard, et al.,1993), and new structures for transdisciplinary interagency collaboratives (Melaville, Blank, & Asayesh, 1991).

Several of these programs will be examined in Chapter 2. At first glance, it will seem that these state initiatives are all headed in the same direction and adhering to similar principles. Careful inspection reveals that each program is slightly different. Each state has formulated its own individualized set of components to create what they feel is the best program to meet their needs. While it may be reasonable that no two states' programs look exactly alike, it is also reasonable to question why some components recommended in the literature are missing and examine the rationale for a state's particular design. In summary, the primary justification for this study rests on the need to begin a comprehensive, rather than fragmented, analysis of service delivery options for troubled children, youth and their families, beginning with state level legislation or policy.

Purpose of the Study

The purpose of this study was to select states with major, state-wide initiatives in comprehensive service delivery and examine their policies in depth. These policies and the related legislation were compared, component by component, with the constructs of recommended practices that emerged from the literature in comprehensive service delivery. The specific objectives of the study are: (a) to develop a comprehensive list of components described in current literature as necessary for quality service delivery, and (b) to select a number of states with legislation or policy addressing comprehensive service delivery for children and youth with EBD, (c) to describe the components of this legislation or policy, (d) to confirm these components with telephone interviews of persons in participating agencies, (e) to discuss the rationale for including specific components with these same agency personnel, (f) to identify the congruence between existing components and recommended practices, and (g) to determine the implications for future policy or practice that can be drawn from this analysis.

Research Questions

To address the objectives mentioned above the following questions were asked:

1. What are the components identified in current literature as being recommended for quality (improved) service delivery?

2. What are the specific programmatic components of the

legislation or policy from the states selected for study?

3. How would personnel at the participating agencies or organizations specify the nature of the components and discuss rationale for the included components?

4. What is the congruence between components in selected state legislation or policy and recommended practices?

5. What implications for future practices or change in current practice are suggested by this congruence?

Definition of Terms

Acute care: short-term services (less than 60 days in most cases) provided to a child and the family, designed to remediate a specific crisis. Also called 'crisis care'.

Advocacy: services for persons with disabilities that provide an objective third party to support or make decisions in the best interests of a person unable to provide such support or make such decisions on his or her own. Advocacy services can also be available for a family or for persons under the legal age of consent.

At-risk: exposure to any biological or environmental factor which may jeopardize developmental processes and/or outcomes (Mertens & McLaughlin, 1995, p. 75).

Case management: assignment of primary responsibility for helping specific families receive appropriate services to a professional located in one agency and cross-trained in community wide services (Melaville & Blank, 1991).

Child-centered: programs or policies designed to focus on a child's particular needs. Also called individualized services.

Collaboration: a style of working together (people or agencies) characterized by voluntary participation, egalitarian relationships, mutual goals, mutual problem-solving, shared resources, shared responsibility, and a commitment to the principals of confidentiality (Friend & Cook, 1992).

Co-location: the placement of satellite offices of several agencies at one, convenient spot in the community. For example, having a child protective services office and a mental health in-take office at a neighborhood school.

Competency enhancement: the process or type of treatment that improves an individual's skills and level of independence and interdependence. Usually contrasted with processes or treatments that belittle the individual or render the individual dependent on caregivers.

Comprehensive services: a wide array of preventions, treatment and support services, which are individualized, focused on the whole family, encompassing the principles of family empowerment, and evaluated on the basis of outcomes in the lives of the affected families (Melaville & Blank, 1991).

Cooperation: an informal agreement among people or agencies to help one another without altering any of their organizational structures. An example would be an agreement to refer clients from one agency to another (Kadel, 1992).

Coordination: a semi-formal agreement among people or agencies to work together to solve a mutual problem. The parties may share a goal and some resources, but the scope and duration of the project is mutually limited. An example would be a community task force to address juvenile violence (Kadel, 1992).

Cost containment: programs designed to maintain or decrease overall costs for services to the targeted population.

Culturally competent: services that are delivered and/or administered by persons of the same culture as the client or at the very least, by persons sensitive and respectful of that client's culture (Burchard, et al.,1993). Also referred to as 'culturally sensitive' or 'services that are culturally relevant'.

Day treatment: out-patient mental health services in which the child or youth spends an extended day at the treatment facility and goes home in the evening. Services traditionally include education or special education as well as individual therapy, group therapy and/or family therapy. This term can also refer to a school-based program where mental health services and educational services are delivered in a classroom setting.

Developmentally appropriate: programs or services that are responsive to age, milestones, and changing dynamics of the client or the client's family; not static.

Early intervention: services to young children, usually of pre-school age, who are determined to be at-risk for problems later in life, designed to remediate or lessen the effects of the at-risk factors. This term can also be used to describe services for older youth at the onset of at risk factors such as the death of caregivers or drastic changes in a family's economic status.

Emotionally and behaviorally disordered (EBD): a term used by mental health professionals to describe individuals with emotional and behavioral problems that interfere with the person's ability to function on a day to day basis. This term, when referring to children or youth, usually includes those who are found to have serious emotional disturbance, those who are socially maladjusted, those who are at risk of or who have been adjudicated, are considered to have a conduct disorder, and/or to be sociopathic or antisocial (Fredericks, 1993). Refer to the definition of serious emotional disturbance for a description of one major sub-set of this group.

Family-focused (pro-family) system of care: programs or systems of care that "place primary emphasis on the strengthening of individual and family functioning in ways that empower people to act on their own behalf... A common feature of most family support initiatives is the emphasis given to the importance of community support" (Dunst, Trivette, Starnes, Hamby, & Gorgon, 1993, p.3-4).

Flexible funding: state or local policies that enable agencies or individuals to use designated funds with minimal constraints imposed by the funding source. An example would be pooling funds from several agencies to create new community based programs.

Flexible programming: service delivery systems not bound by traditional parameters. Such programs are molded to meet the unique needs of the clients rather than asking clients to fit a particular program model.

Fragmented services: programs that deliver specific, disconnected pieces of help and support for a child or youth; such programs often have narrowly defined eligibility requirements and separate funding sources.

Full array of services: programs that offer or provide access to a broad variety of services or service delivery systems to meet the scope of needs evidenced by children and youth with serious emotional disturbance and their families.

Gatekeeping: policy or procedures that determine which individuals may access particular services, such as residential treatment programs, and the types of review processes that will be implemented.

Increased funding: policies and procedures designed to encourage regions and localities to find or utilize previously untapped resources for service delivery systems. Also refers to initiatives receiving new or additional funds for service delivery systems.

In-home services: any service provided to the youth or the family in the home. Usually refers to therapeutic interventions or treatment rather than respite services. Services can also include training in parenting skills, independent living skills, and behavior management skills.

Integrated services: "separate services which are connected by common intake, eligibility determinations, and individual family service planning so that each family's entire range of needs is addressed" (Melaville, Blank & Asayesh, 1993, p.12).

Interagency collaboration: "...organizational and interorganizational structures where resources, power, and authority are shared and where people are brought together to achieve common goals that could not be accomplished by a single individual or organization independently" (Kagan, 1991, p.3) and offers the opportunity for each agency to restructure their current expertise and resources to envelope that of the partner agencies.

Interdisciplinary team: a group of stakeholders formed to plan and/or implement services for clients in need. Such a team traditionally consists of the client, the client's family members, and a representative from all agencies involved, usually education, health/medical, mental health, court services, and social services. It may also refer to teams consisting of therapeutic service providers such as occupational, vocational, recreational, speech, or physical therapists. Also referred to, with some variation in meaning, as multi-disciplinary or trans-disciplinary.

Least restrictive environment: the treatment or service setting that most closely resembles the setting for the individual's non-disabled peers. Treatment settings become more restrictive as they move the individual physically away from family, friends and community. Settings also become more restrictive by denying the individual access to family, friends, and community.

Long-term care: services lasting from three months to several years designed to provide treatment for the youth with an array of problems that have persisted over time.

Outcome driven evaluation: the measurement of service delivery results through the collection of data concerning changes in client behavior, attitudes and/or situations, in contrast to measurement of numbers of clients served or amounts and types of services utilized.

Prevention services: services designed to provide assistance for an individual or family before at-risk factors become entrenched causing disabling or dysfunctional outcomes.

Residential services: educational and/or treatment services provided for children or youth in a 24 hour, live-in setting.

Respite care: care provided to a family that allows the primary caregivers time away from the home and/or the family member who needs extensive care.

School-linked services: programs designed to bring together a full array of services for children and youth with the school as the "hub" or service delivery place of origin. All parties participating in such a program are equal partners in a collaborative structure designed to improve outcomes for children. Also referred to as 'full service schools'.

Seriously emotional disturbance (SED): a disability category established by the special education legislation, the Individuals with Disabilities Education Act (IDEA,1990). Students having SED display characteristics that adversely affect their educational performance and include an inability to build or maintain satisfactory interpersonal relationships, inappropriate behaviors or feelings, a pervasive mood of unhappiness and/or a tendency to develop physical symptoms or fears associated with personal or school problems. The term excludes students who are socially maladjusted unless it is determined that they also have an emotional disturbance.

Single point of entry: a system of interagency collaboration or coordination that allows persons with special needs to access all available services for which they are eligible after in-take at any one agency. The family or individual does not have to re-register at each separate agency; all background and current information is shared by all participating agencies.

Socially maladjusted: a condition characterized by a perpetual struggle with authority and violation of societal norms, along with a low toleration for frustration, impulsivity and manipulation. A student could be considered socially maladjusted (rather than seriously emotionally disturbed) if his or her academic problems are due to truancy and/or substance abuse.

System of care: "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families" (Stroul & Friedman, 1986, p.3).

Therapeutic foster care: services provided by a family that is selected and trained to care for a child or youth with special needs.

Unconditional care: a level of service delivery in which the interdisciplinary team agrees to "never deny services because of the severity of the youth's problem behavior, to change services as the needs of the youth and family change, and to never reject the youth and family from services" (Burchard, Burchard, Sewell, & VanDenBerg, 1993, p. 4).

Wrap-around services: "an array of services that are developed by an interdisciplinary services team . . . which are community based, culturally relevant, unconditional, and . . . positively focused on three or more life-domain areas of the child and family (Burchard, et al., 1993, p. 3).

Limitations of the Study

Comprehensive, integrated services for youth with EBD as a strand of inquiry has become as fragmented as the service delivery system it criticizes. Some states have legislation in this area, others have policies. Some have pooled their funding streams, others have set up gatekeeping functions at the state level. Some have encouraged local initiatives, others have required waivers from existing state policy for localities to proceed. Most have tried to reduce costs, some have tried to improve outcomes for families. While this study did not answer all questions about how integrated service delivery affects outcomes for families, it is seen as a first step toward that end. This study did not shed light on how state legislation is implemented or specifically how it affects families. It is hoped that it has shed some light on the design of state legislation which purports to improve service delivery systems for families in need.

Another limitation of the study occurs in the area of external validity. Lincoln and Guba (1985) discuss the most traditional definition of generalization as being conclusions of enduring value "that are context free" (p.110). They suggest that Kaplan's (1964) definition of generalization, which includes the characteristics of being universal and unrestricted as to time and space, is nomic in nature, based on law or laws. They state that some researchers feel inquiry aimed at something other than the establishment of generalizations, is not worth the effort. After outlining the strengths and weaknesses of this position, these authors refer to Stake's (1978) suggestion that there are two types of generalizations. The first is nomic, rationalistic, and "propositional" (p.120). The other is more intuitive and empirical, "based on personal direct and vicarious experience" (p.120). This type of generalization is called naturalistic by Stake, and the type to expect from case study research by Lincoln and Guba.

This study offers descriptive, explanation generalization as it provides a view of state policy. It also provides some insight from the perspective of policy makers on the rationale behind these policies. This study did not result in rules or laws for such state policies that formulate "what is always and everywhere the case, provided only that the appropriate conditions are satisfied" (Kaplan, 1964, p.91).

It is also important to mention the limitation of the researcher's bias. While it is taken for granted that in case study or ethnography the researcher's personality and experiences will influence her research, it is not seen as a serious limitation by most qualitative researchers. Lincoln and Guba (1985) maintain that actual objectivity cannot be achieved. They feel that by utilizing certain techniques such as member checks, reflexive journals, triangulation of data collection, independent audits, and debriefings by peers, a researcher can control for this problem. Heshusius (1994) proposes that the insight and knowledge gained from not being as objective as possible results in a participatory paradigm of educational research. This approach, while not fully detailed as to methodology, suggests that the researcher will only fully understand the object of his inquiry if he can give up the idea of controlling and managing his distance. To this end, this study utilized member checks by having state officials review the data they submitted in their interviews, peer debriefings by a doctoral candidate in special education administration, and triangulation, gathering data from policy documents, interviews and actual legislation. In addition, the researcher has been personally involved in planning comprehensive service delivery for EBD children and youth, at the local level, since July 1993. It is hoped that this personal involvement and the specific techniques for gathering and analyzing data has provided a richness of generalization to balance any lack of absoluteness.

Overview of the Remaining Chapters

In summary, this study addresses the degree to which specific legislation or policy in nine selected states related to comprehensive services for EBD children and youth contains language designed to ensure quality service delivery. The following chapters provide an extensive review of the literature, the methods and procedures for collecting and analyzing data, the results of data collection and analysis, and conclusion and recommendations drawn from the data analysis.

Chapter 2

Review of the Literature

Introduction

Much has been written about improving services for children and youth with EBD and their families. Much of what's been written seems as fragmented as the services being described. In order to bring some cohesiveness to what is known about providing comprehensive, integrated services, each section of this review explores one part of the whole picture. The review begins with an overview of existing statistical information, demographic data and outcomes associated with traditional programs. This section is designed to demonstrate the need for change from several perspectives. Next, the history of this movement from both the mental health and educational perspectives is outlined to provide context for the study. An overview of research on comprehensive, integrated services precedes the section on recommended practices. These sections form the core of the review and provide the substance of what constitutes the recommended practice standards for the study's instruments (see Appendices A - C). This is followed by a review of what is known about interagency collaboration.

Outcomes for Children and Youth

Frequently, the most compelling and consistent rationale used by state and local government to move toward comprehensive services for EBD children and youth is escalating costs. Yet support is also gleaned from the disturbing statistical information, demographic data and outcomes associated with traditional programs. This section will review the most recently available data outlining the current status of children and youth with EBD and/or SED.

The number of students aged 6 though 21 identified as having serious emotional disturbance (SED) accounted for 8.3% of all children who received special education services in the 1992-93 school year (U.S. Department of Education, 1994b). This represents an increase of less than 1% from the 1976-77 school year (7.5% to 8.3%). The increase in the number of all categories of students with disabilities increased almost two full percentage points from 4.5% in 1976-77 to 6.4% in 1992-93 (U.S. Department of Education, 1994b). The Sixteenth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act (IDEA) reports that the overall increase is "almost entirely attributable" (p. 7) to increases in the number of students identified with specific learning disabilities. This report also states that "even the most conservative estimates ... suggest that between 7-8% of all school aged children and youth may have emotional or behavioral disorders severe enough to require treatment..." (p 112). This data seems to suggest that the number of students identified as having serious emotional disturbance should be higher. This possible reluctance of states to identify, and thus serve, students with SED is difficult to explain. Forness, Kavale, and Lopez (1993) suggest several explanations including lack of appropriately trained personnel, lack of appropriate and effective materials and support services, and the knowledge that, once identified, these frequently dangerous and disruptive students cannot routinely receive long term suspensions or be expelled without a special hearing. Others suggest that the current federal definition of SED, which excludes students that are socially maladjusted, is also responsible for the low incidence of students being found eligible for SED services (McLaughlin, Leone, Warren, and Schofield, 1994).

While IDEA requires that students with disabilities be served in the least restrictive settings possible, students having SED tend to be served in the most restrictive settings. Of those students who are identified as having SED:

> 18% ... are educated outside of their local schools, compared with 6% of all students with disabilities (U.S. Department of Education, OSEP, 1993). Of those in their local schools, fewer than 17% are educated in regular classrooms, in contrast to 33% of all students with disabilities. (U.S. Department of Education, 1994b, p.110)

Many states (by way of mental health, juvenile court services or social services) also place children and youth with EBD in the most restrictive placements possible - residential facilities out of their home state. For example, "in the late 1980's, West Virginia, with a population of 2.5 million, placed 160 youths out of state" (Epstein, et al., 1993, p.128). In such far away placements, the possibility of reuniting the family becomes very remote. Family therapy is not even attempted when the child or youth is only able to see family members two to four times per year. Once out of the home and out of the state, the child or youth with EBD is very likely to become out of mind as well (Epstein, 1993).

The Virginia Department of Education has looked closely at the demographics of students with disabilities exiting special education.

A study was directed by the 1992 General Assembly House Joint Resolution #4. The purpose of the study was to develop recommendations "for programs and activities to facilitate the transition of youth with disabilities from special education programs to the adult services system" (Virginia Department of Education, 1993, p.i). One of the most disturbing findings was that students with serious emotional disturbance are at the highest risk of dropping out of school or leaving the system without completing any program. The report indicated that in Virginia 24% of students with serious emotional disturbance officially drop out of school prior to graduation and another 22% are listed as "status unknown, presumed drop-out" (Virginia Department of Education, 1993, p.7).

The need for comprehensive service delivery systems is supported by other demographic data as well. Many studies have shown that males and African-American students are disproportionally identified as having SED (Algozzine, 1979; Cullinan, Epstein, & Kaufman, 1984; Kelly, Bullock & Dyles, 1977; Knitzner, Steinberg, & Fleisch, 1990; Marder & Cox, 1991). Studies also show that students having SED are more likely to come from homes with lower socioeconomic status (Bernard & Clarizio, 1981; Frazier & DeBlassie, 1984; Marder & Cox, 1991; Touliatos & Lindholm, 1980). These authors suggest that the factors contributing to this data include lack of adequate prenatal care, poor nutrition, and stresses related to poverty.

The Sixteenth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act (1994) summarizes data on the school performance of students having SED: "(These students) have lower grades than any other group of students with disabilities, fail more courses, are often retained in grade, and pass minimum competency tests at lower rates than other students with disabilities" (p.114). The report notes that students having SED have the highest dropout rate of any disability category. Only 17% go on to college or post secondary training programs compared to 53% in the general population. Forty-two percent of youth having SED earn a high school diploma compared to 76% of the general population and 50% of all youth with disabilities. These students also have difficulty holding a job and score very low on measures of independent living conducted three to five years after leaving high school. Most authors cited by this report feel that programs for students having SED overemphasize behavior management and neglect academic performance. In general, compared to other students with disabilities, students having SED are: (a) more likely to be placed in most restrictive settings, (b) more likely to have their family blamed for their difficulties, (c) more likely to have their family make financial sacrifices to find and get help for their family member with a disability, and (d) more likely to have their teachers and teacher assistants seek reassignment or look for other positions (U.S. Department of Education, 1994b).

Mental health outcomes, while more difficult to measure than educational outcomes, paint a similarly bleak picture. In 1969, the Joint Commission on the Mental Health of Children found that millions of children were receiving inadequate or even detrimental mental health services. Weithorn (1988) suggests that inpatient treatment services for children and youth with EBD are "typically less effective than are focused, community based interventions" (p. 828). Outcome studies of children in residential mental health facilities have produced ambiguous results at best (Pfeiffer & Strzelecki, 1990). Behar (1990) reported that "research validating the use of psychiatric hospitalization for children is virtually nonexistent" (p.128). She goes on to suggest that there is very little validation for other treatment approaches either. Rivera and Kutash (1994) review research on the effectiveness of several components of a continuum of services for children and youth with mental health needs. They conclude that many of the less restrictive components have shown positive outcomes for children and families. However, they find a very compelling need for further research, especially at the systems level. While these authors and others (Behar, 1990; Knapp, 1995) have remarked on the complexity of systems research in this area, they all agree on the need.

In summary, these children and youth have not fared well. They have been served in very restrictive, expensive settings but have not improved. Most do not graduate from high school or go on to lead independent, productive lives. They continue to cause problems for their families and their community. And even with such dismal outcomes, they continue to require a disproportionally high percent of available dollars for service delivery.

Historical Background

Mental health

The move toward comprehensive mental health services for EBD children and youth began with several federal initiatives in the early 1960s. Based on new developments in the field such as improved medications, changes in therapeutic approaches, and the realization that long term residential confinement made many patients worse (Nelson & Pearson, 1991), the Community Mental Health Centers (CMHC) Act of 1963 allotted federal funds for building community-based mental health facilities. However, the move and mandate to deinstitutionalize state facilities for long term care of mentally ill children and adults was not met with the needed expansion of community based services. These patients became isolated, often homeless, without access to treatment, medication or care.

The deinstitutionalization of persons with mental illness was soon followed by the Juvenile Justice and Delinquency Prevention Act of 1974, which called for the release of status offenders and the concomitant increase in community based services for young offenders. What actually happened was "a shift of children from the foster care and child welfare system into the mental health system...with no increase in community-based services" (Behar, 1990, p.129).

In 1982, the Children's Defense Fund published Jane Knitzer's landmark study, Unclaimed Children: The failure of public responsibility to children and adolescents in need of mental health services. At the time of her study, Knitzer reported that only seven states (Florida, Georgia, Maine, Massachusetts, New Jersey, New York and North Carolina) had taken any steps to create systems of care for children and youth having EBD. Only 18 states responding to her survey recognized the need to reduce fragmentation and improve the range of services available to these children. Nineteen states reported no efforts whatsoever in this regard and in fact did not play a role in shaping mental health services for children. This finding becomes even more significant when coupled with public attitudes and stereotypes of mentally ill people as "criminally insane, or with intractable, unmanageable and unpredictable diseases...who should be incarcerated for the protection of society" (Nelson & Pearson, p.2). Davis, Yelton, and Katz-Leavy (1995) attempted to update the work of Knitzer. They surveyed all 50 states and found, in general, "much to feel positive about" (p.17). They credit the work of Stroul and Friedman (1986) and the passage of the federal Comprehensive Child Mental Health Services Act (1990) for many of the improvements. There are now a total of 38 states with child and/or adolescent mental health administrative units or formal offices at the state level compared to 21 in 1982. They also found that 25 states had passed laws or had court orders enforcing the CASSP principles.

In 1989, the process to reauthorize the Education of the Handicapped Act (Public Law 94-142) prompted testimony from the National Mental Health and Special Education Coalition. Experts indicated that most communities lacked any range of services for children or adolescents, over relied on residential care, and lacked day treatment services that would enable a child to remain in his or her community (Forness et al., 1993; Nelson & Pearson, 1991). In 1990, Behar reported that 40-50% of children in psychiatric hospitals could be served with community based services such as family therapy, respite and day care, after school programs, and therapeutic recreation programs.

Education

The history of the education of students with emotional and behavioral disorders is difficult to separate from the disciplines of psychology and psychiatry. Efforts to educate such children began in the nineteenth century, first in institutions and finally in public school classes for "truants, troublemakers, and backward pupils" (Kaufman, 1994, p.92). Several educational programs with psychological frameworks began in the 1940s such as Bettelheim's Orthogenic School (1944, Chicago) or Redl's Pioneer House (1946, Detroit). As interventions in the field of mental health expanded in the 1950s and 1960s, so did programs for students with emotional disturbance. The field was influenced by psychoanalysis and behaviorism, as well as ecological and humanistic psychology. In 1961 William Cruickshank published A teaching method for brain-injured and hyperactive children and Nicholas Hobbs began Project Re-ED. Haring and Phillips (1962) gave teachers one of the first definitive guides in Educating emotionally disturbed students. These authors based their programs on the established practice of separating these students from the mainstream and providing structure and other therapeutic interventions. Although the Education of the Handicapped Act (1975) required that all students with disabilities be educated in the least restrictive environment, students with EBD and other severe disabilities continued to be educated in separate classrooms and facilities.

Recently, the move toward comprehensive, integrated services has become a national educational priority. The Sixteenth Annual

Report to Congress on the Implementation of IDEA (1994) reports that the federal Office of Special Education Programs (OSEP) has taken aim at improving outcomes for students having SED with seven specific targets:

Target 1 Expand positive learning opportunities and results
Target 2 Strengthen school and community capacity
Target 3 Value and address diversity
Target 4 Collaborate with families
Target 5 Promote appropriate assessment
Target 6 Provide ongoing skill development and training
Target 7 Create comprehensive and collaborative systems
(p.119-120).

The Office of Special Education Programs, Office of Special Education and Rehabilitative Services, U.S. Department of Education, has issued these targets as: A national agenda for achieving better results for children and youth with serious emotional disturbance (1994b).

Comprehensive Services

Results of research

The definition and design of a system of care for students with EBD began with the 1986 publication of Beth Stroul and Robert

Friedman's monograph. Convinced that the multiplicity of needs evidenced by these children and their families required a shift in the entire paradigm of service delivery models, they began the arduous task of convincing others. Their framework (see Figure 1) placed the child and family in the center of an array of services designed to interact with one another under the coordination of a case manager with oversight from an interagency team. Many states or localities have since implemented programs based on this framework. In February 1991, preliminary evaluation research from five such projects was reported at the Fourth Annual Research Conference sponsored by the Research and Training Center for Children's Mental Health at the University of South Florida. Summaries of these five reports follows.

Moore, Suter and Igneizi (1991) studied the program in Ohio. One of the original ten states to receive funding from the National Institute for Mental Health (NIMH) for a Child and Adolescent Service System Program (CASSP) in 1984, Ohio continues to evaluate and improve its services for children and youth having EBD. This study examined system and outcome variables using surveys from the cluster of state agencies collaborating to provide services, from the local agencies of the same departments and from 25 randomly selected Mental Health Board Executive Directors. They outlined the eight specific services that were rated as improved by those surveyed. These services were case management, early identification, independent living, home-based services, therapeutic foster care and teen parent training. They also pinpointed system barriers identified as impediments to further improvements. They found that the barriers with the greatest degree of change, from "very much a barrier" towards "not at all a barrier", after the CASSP initiative included: collaborative relationships, knowledge of services (among agencies), training and technical assistance, array of services, comprehensive assessment, family involvement, the child-center nature of the plan, and sharing client information.

Heffinger, Bickman, Lane, Keeton, and Hodges (1991) studied the Fort Bragg Child and Adolescent Demonstration Project in Fayetteville, North Carolina. The authors describe the effort involved in systems change and the innovative array of services offered under this project. These services, traditionally absent from most communities' options, included: day treatment, in-home counseling, family support, community-based residential treatment, centralized intake and assessment, and case management.

Pandiani and Maynard (1991) surveyed the perceptions of interagency team members in Vermont. The results supported the position that the existence of interagency teams improved coordination of services and quality of care for children, adolescents, and their families. The survey also brought weaknesses into focus. Respondents reported that family involvement and community education need to be increased.

Olson, Whitbeck and Robinson (1991) reviewed two research projects in Washington State. Washington focused its efforts at the community level. Local communities assisted in developing individualized approaches without changing the complex, formal child-serving systems. Their research efforts will continue to look at individual cases to determine the underlying causes of the family's multiple service needs and the process and structure of the community efforts to facilitate the family's access to the services.

Harrington, Schaefer, and Burchard (1991) reported case studies of four difficult-to-manage youths in Vermont who were reintegrated into their communities from residential treatment utilizing individualized care, coordination of services and behavioral adjustment. The authors summarized their results: "During the first year of Individualized Care only one of the four youths experienced a change in placement and none of the youths spent time in a long term residential treatment center" (p.140). The details of the cases demonstrated the success of the principles of individualized care including parental participation on the multi-agency team, community-based services, tailoring services to meet the changing needs of the families, case management, flexible funding, and unconditional care.

In addition, Beth Stroul (1993) completed a study to look at the data from 30 communities utilizing the systems of care approach. She found that in general, children in such systems were less likely to be served in restrictive settings and, if placed, to stay for shorter periods of time. These communities reported less out-of-home placements and less out-of-state placements. The children seem to improve in the areas of "symptom reduction, reduction of negative behaviors, and improved overall functioning" (p.18). There were trends toward improvements in school attendance and school performance. Interactions between children in these systems of care and the juvenile justice system were reduced. Families reported improved levels of satisfaction with services received. There were reported increases in funds spent on nonresidential services and an apparent overall decrease in costs related to services for the identified population (p.18-19).

More recently, several studies were completed to evaluate systems of care in localities across the country. Summaries of three of the most noteworthy follow.

Tighe and Brooks (1994) evaluated the New Directions Initiative in Vermont. Focusing on the problem of skyrocketing costs for residential placements for children and youth with EBD, they found that community based programs were significantly less expensive. Specifically, the average cost for out of state residential placements was $4893 per month, while the average for intensive, community based services was $4036 and was continuing to fall.

Yoe, Bruns, and Burchard (1994) studied the behavioral and service outcomes for this same program in Vermont. First, they found that the youth were in significantly less restrictive settings. They also found significant declines in problem behaviors as measured on the Quarterly Adjustment Indicator Checklist (QAIC), a three point scale completed by the child's case manager.

Hyde, Woodworth, Jordon, and Burchard (1994) studied the efficacy of the Family Preservation Initiative in Baltimore City, Maryland (FPI). They also found a reduction in overall costs. While out of state residential placements cost an average of $269 per day, the FPI program costs averaged $216 per day, returning 4.1 million dollars to the community over a two year period. Children and youth in restrictive placements (group home or more restrictive) were reduced from 80% to 12% over a two year period. And finally, on a five point rating scale, parents and youth indicated their satisfaction with a rating of 3.5 or better for all services and program components.

It would seem that the research and studies related to comprehensive integrated services for children and youth with EBD, while generally positive, suffer from one of the main symptoms found in traditional service delivery models: fragmentation. What seems to be missing is agreement, from program to program, on the components essential for integrated programs. The next section attempts to compile the literature addressing these essential components.

Recommended practices

Many authors have written about collaborative, comprehensive, integrated programs for students having EBD or other disabilities. Collectively, this work provides a picture of components recommended for the creation of exemplary programs. Credit is generally given to Stroul and Friedman (1986) for the development of the core values and guiding principles from which every comprehensive program has drawn. A brief synopsis of the values and principles follows.

Values: A system of care should be child-centered, family focused, community based, and culturally competent.

Principles: A system of care should ensure a full array of individualized services in the least restrictive, most normalized environment possible, with full family participation. Services should be integrated and coordinated through case management. The system should promote early identification and prevention interventions and ensure a smooth transition to the adult service system. Such a system of care would also protect the rights and provide advocacy for children with EBD and be committed to services that are provided without regard to race, religion, national origin, sex, and physical disability by professionals who are sensitive and responsive to cultural diversity.

It has already been noted from the review of other studies that most authors have used and/or expanded on this set of values and principles to create their set of essential components. Melaville and Blank (1991) proposed their essential elements for "high quality comprehensive service delivery" (p.9). In addition to a wide array of services, these authors suggest the system must include elements to ensure that families actually receive the services they need. These techniques include the co-location of staff at other agencies, "one-stop shopping centers" (p.9), where families can access a wide menu of services at one location (such as the neighborhood school), case management, and family empowerment. They conclude by suggesting that interagency partnerships are essential to "large scale comprehensive service delivery" (p.11).

Dunst, Trivette, Starnes, Hamby, and Gorgon (1993) recently conducted a national study of programs for persons with developmental disabilities. They developed a set of characteristics of family support that seems valid for any program designed to help families with children with disabilities. The characteristics include (a) competency enhancement, (b) a full range of flexible, responsive approaches and services, (c) building on strengths of the family and the family member with a disability, (d) families as full partners in the planning and implementation of interventions, (e) integration of the family into the mainstream of the community, and (f) building independence and interdependence.

Melaville , Blank, and Asayesh (1993) discuss the following characteristics of a successful system. The system must be: comprehensive - a full array of opportunities and services; preventative - resources applied " front end" rather than when a crisis occurs; family centered and family driven - building on family strengths and family participation; integrated - services connected by common intake, eligibility requirements and planning; developmental - plans that change as the family's needs change; flexible - rules waived, paradigms of treatment shifted; sensitive to diversity - respect for cultural, gender and racial differences; and outcomes oriented - programs evaluated in terms of changes to families instead of participation in a list of services of programs.

Reinherz, Giaconia, Frost, Cohen, Pakiz, and Silverman (1994) studied the comprehensive service needs of children and adolescents in Boston, Massachusetts. They found several components to be essential. First, a full array of service options must be available due to the substantial level of psychopathology and impairment found in these youth. They also found a significant role that families play in the pathology of these clients. These authors felt this factor reinforced the need to mandate family involvement in any service delivery program. The study also confirmed the need for early intervention and prevention services. They found that serious impairment can be reduced and clients served in less restrictive settings when interventions are done early.

Rutherford, Nelson, Wolford, and Forness (1994) have summarized the findings from the Shakertown Symposium. This symposium, sponsored by the National Coalition for Juvenile Justice Service in September 1993, pulled professionals from all major human services systems. This group developed recommendations to improve outcomes for children and youth involved in the juvenile justice system and included several related to comprehensive service delivery. First, all service delivery systems must collaborate to create early intervention and prevention programs. Systems of care should be created that are comprehensive, integrated, and child- and family-focused. They added that resources should be pooled and training shared across disciplines. They also recommended that funding be increased and outcomes-based research be initiated.

While this literature may seem fragmented, there are commonalities among the essential components of many integrated service delivery models. A set of common elements or components, presented by at least one author, emerges to describe recommended practices for a comprehensive system of care. These common elements would include (a) child-centered or individualized care, (b) family-focused service delivery, (c) cultural competency, (d) a full array of service options (e) services provided in the least restrictive environment, (f) case management, (g) integrated services, (g) early identification of children in need of services, (h) prevention services, (i) co-location of services, (j) community based services,
(k) an interagency structure, (l) competency enhancement goals for clients, (m) developmentally appropriate services, (n) flexible programming, (o) outcomes-driven evaluation, (p) unconditional care, (q) single point of entry, (r) gatekeeping, (t) flexible funding, (u) wraparound services, (v) cost containment or reduction, and (w) increased funding . Table 1 shows each of these components with the authors who have recommended their inclusion in an effective program.

Table 1, part 1
Recommended components for comprehensive service delivery

Authors	child centered	fam. focus	cultural comp	full array	LRE	case manage	integr. services	early ID	prevention	co-location	interagency
Stroul, 1986	●	●	●	●	●	●	●	●	●		
Greenley, 1991	●	●			●		●			●	
Melaville, 1991		●		●		●				●	●
Nelson, 1991		●		●		●			●		
Cohen, 1992	●	●	●	●	●		●				●
Hudson, 1992		●		●	●			●	●		●
Burchard, 1993	●	●	●	●	●						●
Duchnowski, 1993	●	●			●	●					●
Dunst, 1993	●	●		●							
Epstein, 1993	●	●	●	●	●	●	●				●
Fredericks, 1993	●	●		●		●	●				●
Melaville, 1993		●	●	●			●		●		
Phillips, 1993		●			●	●				●	●
Clark, 1994	●	●		●	●	●					●
Cumblad, 1994	●	●			●	●					
Dryfoos, 1994	●	●		●		●	●		●	●	●
McLaughlin, 1994	●	●		●	●		●				●
U. S. DOE, 1994a	●	●	●	●							●
Quinn, 1994	●	●		●		●		●		●	
Reinberg, 1994		●		●				●	●		
Rutherford, 1994	●	●		●			●	●	●		●
Schlock, 1994	●	●		●	●						
Young, 1994	●	●					●				

Table 1, part 2
Recommended components for comprehensive service delivery

Authors	compt. enhance	developmental	flex program	outcome eval.	uncondit. care	single entry	gatekeeping	flex funding	wraparound	cost reduc.	increase funds
Stroul, 1986											
Greenley, 1991						●	●				
Melaville, 1991											
Nelson, 1991								●			●
Cohen, 1992	●		●	●				●			●
Hudson, 1992											
Burchard, 1993					●		●	●	●	●	
Duchnowski, 1993	●			●			●	●			
Dunst, 1993	●										
Epstein, 1993				●	●		●		●	●	
Fredericks, 1993		●	●	●		●					
Melaville, 1993		●	●	●							
Phillips, 1993			●	●					●		
Clark, 1994		●	●	●			●				
Cumblad, 1994						●					●
Dryfoos, 1994	●			●							
McLaughlin, 1994		●	●	●		●					
U.S. DOE, 1994a	●	●		●							
Quinn, 1994			●								
Reinberg, 1994											
Rutherford, 1994				●							
Schlock, 1994											●
Young, 1994				●				●		●	

Interagency Collaboration

Recommended practices

The primary organizational structure recommended by the above authors and others to implement comprehensive service delivery systems is interagency collaboration. Shoop (1977) has suggested that the main motivation for successful collaboration efforts is to "better serve the various needs of the people by eliminating competition and duplication of services... in a more cost effective manner" (p. 30). He emphasized that individuals within the agencies must feel that by joining together they can accomplish goals that they could not have achieved individually. This is the critical component that differentiates projects that are motivated by local leaders (bottom up) from policies that are created, however expertly, by state or federal committees (top down).

According to Street and Friedman (1989), major interagency collaboration efforts can be traced to the 1979 Rand Corporation Report that brought attention to the fragmented and disorganized service delivery system for students with disabilities. They report that the system of services being delivered to the country's handicapped youth was inefficient, ineffective, random, disorganized, and poorly coordinated. The seventies also saw the passage of PL 94-142 which encouraged professionals of various backgrounds to work together to better serve children with disabilities. Due to the national recession of the mid-1970s, the public was also becoming less willing to have institutions remain unaccountable for poor outcomes of services provided. Johnson, McLaughlin, and Christensen (1982) suggest that interagency collaboration will improve services for children and youth with disabilities in addition to the financial benefits of melding community resources for the sake of economy. Bayer (1985) discussed the process variables for effective interagency relationships. He recommended that individuals involved in interagency collaboration establish specific structures for high levels of exchange of information; share values in the areas of productivity, community-centered rewards, and conflict resolution; and learn problem solving techniques. Hazel, Barber, Roberts, Behr, Helmstetter, and Guess (1988) also outlined factors that contribute to effective collaboration. These include development of a positive atmosphere for communication; strong respect for the expertise of others; development of close, face to face relationships with the leaders of each agency; commitment to solving problems together; and increased knowledge of each agency involved (p.43-44).

Melaville and Blank (1991) distinguish between cooperation to provide services when agencies refer clients to one another, and true collaboration. They suggest that in a collaborative partnership the individual agencies must establish common goals, pool resources, plan together and provide joint oversight for implementation and evaluation of new services and procedures. They also suggest that in a collaborative structure, all agencies share the responsibility for the outcomes of their joint efforts. They outline five variables that impact interagency partnerships: climate, processes, people, policies, and resources. They recommend that all five variables be specifically addressed when agencies form partnerships at the local or the state level. If all agencies co-plan prior to implementation, establish specific communication processes sensitive to the people and climate, train all staff in new ways of envisioning the problems, and establish policies and procedures for all aspects of the collaboration, including sharing resources, the partnership will be stable and powerful.

Most recently Kleinhammer-Tramill, Rosenkoetter, and Tramill (1994) recognized the importance of interagency collaboration for effective early intervention and transition services for students with disabilities. They suggested that these practices "help provide the conceptual foundation for a new model for integrated, uninterrupted services to persons with special needs at all ages" (p. 1). Among their recommendations for those responsible for implementation of such services were: the development of action plans to enhance horizontal service collaboration, written interagency agreements that span all age levels, improved training in the area of transdisciplinary teaming, and knowledge of multiple service agencies.

Cumblad, Epstein, Quinn, and Skrocki (1994) report on the interagency infrastructure of Project CANDU in DuPage County, Illinois. They attributed much of the success of this comprehensive program to the tri-level interagency system created to administer Project CANDU. Each level has specific duties, interagency stakeholders (including parents) and ties to the other two levels. The authors felt that the teams were strengthened by the Memorandum of Agreement which was created to form these teams. This agreement added permanency and legitimacy to the collaborative effort. It specifically addressed how collaboration would occur, procedural safeguards, rights, equal opportunity, the target population, principles of care, confidentiality, member responsibility, referral procedures, unified service plans, and program evaluation. The participants reported that this level of detail in the services agreement contributed directly to the success of the program.

Thus it becomes apparent that to be effective interagency collaboration must be more than representatives of various agencies sitting at the same table. Effective collaboration requires parity among players, a new formal structure for policies and procedures, shared goals and resources and shared responsibility for outcomes. Achieving this level of collaboration among agencies that are used to working autonomously requires a tremendous commitment and dedicated leadership.

Summary

It is clear that many localities in many states have recognized the problem of fragmented service delivery systems and tried to improve their programs. It is also apparent that many authors have used their experiences and research in the areas of comprehensive, collaborative, integrated services to create bench marks for measuring best practices. However, for states like Virginia which are struggling with this type of systems change, there is no solid blueprint for success. The process of building that blueprint could begin with this study if a pattern emerges to pinpoint the essential components of comprehensive service delivery for children and youth with serious emotional disturbance.

Chapter 3

Methodology

The review of the literature in the previous chapter suggests fragmentation, not only of services to children and youth, but of systematic and systemic review or evaluation of such programs on a national level or even across states. In 1984 Amitai Etzioni suggested that policy research would become even more essential as " . . . resources in both the public and private sector continue to be much in demand-that is scarce. Hence, the commanding need to use them wisely" (Majchrzak, 1984, p.8). Majchrzak (1984) defined policy research as "the process of conducting research on or analysis of, a fundamental social problem in order to provide policymakers with pragmatic, action-orientated recommendations for alleviating the problem" (p.12). The inconsistencies of programs attempting to create systems of care at the local level could be alleviated by state policy and/or legislation in this area. A need emerges to look at some major state level policies and compare their given components to components suggested as promising practice. As Knapp (1995) has pointed out, referring to studying comprehensive, collaborative services for children and families ". . . there is a need to do careful, probing research . . . to sort among the claims, characterize what pilot initiatives have indeed demonstrated, and discover what the sound and fury signifies" (p.5).

This study attempts to meet these needs through a descriptive version of case study research, with multiple cases. The case study is the "method of choice when the phenomenon under study is not readily distinguishable from its context" (Yin, 1993, p.3). This study also incorporates focused synthesis (Majchrzak, 1984). It looks at a variety of sources, incorporates discussions with experts and stakeholders, reviews documents and other published material, and reports on interviews (Majchrzak, 1984). It is an analysis of state level legislation and policy related to integrated, comprehensive services for students with EBD.

Many issues confront researchers looking at comprehensive, integrated services. Several authors (Kagan, 1991; Knapp, 1995; Wagner, et al., 1994) have indicated specific concerns: divergent perspectives; pinpointing cause and effect; the complexity of the variables; measuring the vast array of outcomes; the sensitive and confidential nature of the situations; and the impact of political variables. Knapp (1995) offered recommendations to address many of these issues. In addition to recommending that such research be "strongly conceptualized" (p.10), he pointed out that successful research would be "comparative" (p.11) and "descriptive" (p.12). He went on to suggest several promising designs including "multiple-case, thick descriptions of collaborative services arrangements . . ." (p.13). The conditions of this study, specifically the rich context, the variables that cannot be manipulated, and the small number of subjects, lead naturally to the use of a case study design. Yin (1994) suggested that case studies can be based on single or multiple cases in three types; a 2 x 3 matrix of choices. The three types are exploratory, descriptive or explanatory. This study is a descriptive, multiple case design. The purpose of the research is to compare data on a set of state legislation and policies against a descriptive theory, derived from experts in the field, that reveals the components constituting recommended practice.

Design

Research question

This study is an investigation of the degree of congruence between the components of state legislation or policy related to comprehensive services for students with EBD and the recommended components of such programs that emerge from research and related literature.

Method

This study is a descriptive policy analysis form of multiple case study research. First, a checklist was developed (see Appendix A) consisting of recommended practices for comprehensive services programs. While this checklist has not been validated, the list of components is derived from the literature (see Table 1). It is hoped that the checklist will stimulate further research to evaluate this list of components. Using the most current and extensive national look at comprehensive systems of care (Davis, Yelton & Katz-Leavy, 1995), nine states were selected which have legislation or policy that directs a systemic, state-wide program of comprehensive services for children and youth with behavioral and/or emotional problems. The actual legislation and support documents from these nine states were obtained from designated state-level policy makers. The support documents included position papers, legislative studies, implementation manuals, training materials, budget documents, and results of evaluations. The legislation and support documents were obtained from the informants prior to the interviews. The legislation and related documents were reviewed (see Appendix A for Data Sheet) to determine which components were present. Then, interviews (see Appendix B for Interview Questions) were conducted with those same designated state-level policy makers in at least two of the agencies involved in the initiative to confirm these components. At least one informant from the Department of Education and one from the Department of Mental Health or the Department of Children Services of each state were interviewed. Every effort was made to speak to the policymakers who are or were directly involved with the creation or the implementation of the legislation or policy. The contact persons listed in the Davis Study (Davis, Yelton, and Katz-leavy, 1995) were used to select informants. These contact people either agreed to be interviewed, or recommended someone else who would be appropriate. They also recommended someone from the Department of Education who would be knowledgeable about that state's system of care. The informants were asked to confirm the presence of the identified components and specify, if possible, the state's rationale for including or excluding components.

After the 15 to 20 minute telephone interview, the informants were sent a survey (see Appendix C) to follow-up and validate the information obtained from the interview.

Validity

Many authors have addressed the categories of validity for qualitative research (Guba and Lincoln, 1989; Lincoln and Guba, 1985; Mertens & McLaughlin, 1995; Stainback & Stainback, 1988). This section will establish the validity for this study based on the five categories from Guba and Lincoln.

The first category is credibility. As was mentioned in the section of chapter one concerning the limitations of the study, credibility is the category that parallels internal validity in positivist research. Credibility was enhanced in three ways. First, a peer (a doctoral candidate in special education administration) was selected to debrief the findings. All findings, conclusions, and analysis of the data were shared with the reviewer and input incorporated into the final report. Secondly, both formal and informal member checks were done with those interviewed. The informants from each state were asked to complete a survey regarding the general summaries of the data collected in their telephone interview (see Appendix E). Informal checks (e.g., does this summarize your answer accurately?) were made during each interview. And finally, triangulation was attempted by gathering data on all components from several sources: the actual legislation, the support documents, and the interviews.

The second category is transferability. At least two sets of authors, Mertens & McLaughlin (1995) and Guba and Lincoln (1985), have identified the concept of transferability in qualitative research as parallel to external validity in positivist research. They suggest that it is the researcher's responsibility to provide "thick description" (Mertens & McLaughlin, p.55) to enable the reader to generalize the qualitative findings to other situations. This study provides the level of detail needed to establish external validity by reporting feedback from a set of state level contact persons as well as from the supporting documents. The researcher has also established a theoretical base which, according to Yin (1993) is critical to external validity. The establishment of a set of components (see Chapter 2 and Appendix A) that constitute recommended practice and the comparison of these components to actual legislation creates a theoretical relationship from which generalizations can then be made.

The third category is dependability. Guba and Lincoln suggested dependability as the critical construct corresponding to reliability in qualitative work. Yin (1994) suggested that qualitative research must have formal protocols and an established data base to address reliability (dependability). This study has both formal protocols (see Appendices) and a data base. Data from the interviews will be coded and categorized to form a data base separate from the actual manuscript of the study which could be examined and reviewed by others.

The fourth category is confirmability. Guba and Lincoln (1989) suggested that confirmability is the construct in qualitative research equivalent to objectivity. They recommended a confirmability audit done by a researcher's peers. This can be done at the same time as the dependability peer audit. This study has undergone both (see section on Limitations of the Study, Chapter 2). A peer reviewer was selected to confirm conclusions drawn from the data as well as substantiate data drawn from the documents and interviews. A random selection process was used to determine which data and which documents to review. At least 33% of the data (three states plus the conclusions) underwent the peer review process.

Finally, Guba and Lincoln (1989) referred to authenticity as a fifth safeguard for qualitative research. In this study, authenticity was addressed by presenting as fair a view of each state's legislation as possible. This was achieved through the interviews. The researcher was able to discuss the legislation with both current policy makers as well as those who were involved in defining and shaping the reviewed legislation.

Procedures

Data collection

This section provides an overview of the data collection process. First, the procedure for selecting cases (states) is reviewed. Next, the procedure for collecting data from the legislation, the support documents and the interviews is discussed. Finally, the procedures for the pilot study are reviewed. Data analysis is discussed in the final section.

Selection of cases

Sample selection. Because state policy is the organizing force behind most local initiatives in mental health, education and social services, state legislation is the main unit of analysis. Nine states were selected for study using data collected by Davis, Yelton and Katz-Leavy (1995). In their study, which surveyed mental health services for children and adolescents in all 50 states, 25 states were found to have defined their system of care by law. They analyzed these legislative initiatives by identifying several characteristics. This researcher choose three of those characteristics that fell within the parameters of this study to select the states for this focused synthesis, case study. Of the eleven variables found to describe the legislation or policy by Davis and her colleagues, the three used to discriminate for this study were (a) creation of a state level interagency council/board/task force for planning/ coordinating a child and adolescent system of care, (b) creation of an interagency case review or treatment planning process at the state or local level, and (c) description of a coordinated system of care for children and adolescents that is separate from the adult system. Throughout this study, the authors use "system of care" as defined by Stroul and Friedman (1986), the definition used for this study as well. Together these characteristics would seem to describe legislation or policy that was aimed at creating integrated, interagency planning and treatment for children and youth with emotional and/or behavioral disabilities. The nine states that possess all three of these characteristics are (a) Indiana, (b) Maryland, (c) New Jersey, (d) North Dakota, (e) Oklahoma, (f) Utah, (g) Vermont, (h) Virginia, and (i) Wisconsin.

<u>Legislation/policy.</u> The legislation and support documents were

obtained from Maryann Davis, author of the national study mentioned above and from the informants from each selected state. Copies of the legislation and most support documents were obtained for review prior to the interviews.

Interviews. The goal of the interviews was to substantiate the information gleaned from the legislation and support documents as well as compile data on the history and models of service delivery for each state. One person from the state education agency and one person from the state agency for mental health services or children services was interviewed. This process began with a telephone contact to the mental health representatives listed in the study by Davis and her colleagues (1995). These representatives were given an overview of the study and asked if they could supply any documents and if they would agree to be interviewed. In five of the states this representative sent all needed documents, agreed to be interviewed and recommended someone from the department of education to be interviewed. In the other four states this representative sent documents and recommended someone else from the department of mental health that would be more appropriate for the interview. In all four of these cases, the recommended person agreed to be interviewed and was able to recommend someone from the department of education to be interviewed. The informants were selected because they were recommended and because they were instrumental in defining, shaping, evaluating and/or implementing the legislation. Prior to the interviews the informants were sent a packet of information that included a brief overview of the study, the definitions of all components, and the document reviews. Semistructured individual interviews were conducted by telephone using a standard interview questionnaire (see Appendix B). The questionnaires and procedures for the interviews were designed to ensure consistent data collection and still allow for respondent elaboration. After the interviews, interviewee were sent a follow up letter asking that they review the summary of the interview and the chart of present components for accuracy. A stamped self-addressed envelope was included with each survey. One or two responses from each state were received and corrections were made to each state's summary as needed.

Document review. The sources listed in the section on legislation and the contact people interviewed were the sources for obtaining the support documents. These documents consisted of legislative studies, budget initiatives, training materials, implementation manuals, pilot studies, evaluation reports, position papers and preliminary reports on the current practices in each state. Data from these documents were used to establish the history and description of each state's model as well as the rationale for various components in each state's legislation. The documents also established the relationship between the actual legislation and the need for change in that state.

Pilot Study

The data collection instruments and the interview formats were piloted using Virginia's Comprehensive Services Act. Virginia was chosen for the pilot because of accessibility of the actual legislation, the support documents and the contact people for the interviews. Using one of the selected states for the pilot follow's Yin's model of case replication (1993). The pilot results were used to modify the instruments and to finalize the emerging design for the entire study. As a result of the pilot study, one component was revised. Community-based services had been directly linked to co-location of services. It became apparent in preparation for the first interview that these two components needed to be listed separately. It was also discovered that several components lacked definitions in Chapter 1. Definitions were added for these components: a) cost containment, b) developmentally appropriate, c) flexible programming, d) increased funding, e) outcome driven evaluation and f) single point of entry. As no major changes were required, the pilot study served as the study which was replicated in the multiple case design.

Data Analysis

The goal of the data analysis was to present the evidence which addressed the original questions of the study. The data from this study were analyzed from several perspectives. The first step in the analysis was to provide a detailed description of the history and the service delivery model that emerged from each state's initiative. The second step in the analysis was to systematically describe the relationship between the state legislation and the components from the literature. This was done to show: (a) which states have incorporated which components into their legislation or policy, (b) which components emerge as being present most often in legislative initiatives, (c) which states have the most comprehensive array of components, (d) which components are consistently missing from legislative initiatives, and (e) which components appear in some legislative initiatives but not in the literature.

First, a history of each state's legislative initiative is presented. This history includes an overview of the process each state used to develop its initiative as well as an analysis of what its goals were for the program. Then, a model of each state's program was developed to provide a snap-shot of the essential elements. Finally, the particular components found in that state's legislation and support documents and confirmed by the interviewees are presented in chart form and discussed in length.

After each state is discussed, a matrix is presented to show the overall relationship of components to each legislative initiative. For each state and the cross-case analysis, a bullet (●) is used in the matrix to indicate the presence of a component. A component for each document was judged as present if its description closely corresponded to the definitions from Chapter 1. For the cross-case analysis the component was judged present if it was found in the legislative document and confirmed by all interviewees. These matrices provide a picture of which states have the most comprehensive array of components, which components appear most consistently in legislative initiatives, and which components are missing.

Summary

Many challenges face those attempting to research or evaluate comprehensive, integrated service delivery systems. The interaction of a host of complex variables combined with the political realities of multi-agency involvement are two such challenges. Participants and recipients of services in this process have come with multiple perspectives on the relationship of cause and effects of services. Michael Knapp (1995) has summarized this challenge:

> ". . . the integration of education and human services takes many forms and has different meanings. This makes for an independent variable-the programmatic factors presumed to bring about results for individuals or systems-of some complexity. In many manifestations of comprehensive, collaborative services, the notion of the independent variable itself ceases to be a *fixed treatment*, . . . and becomes instead a *menu of possibilities* accompanied by a series of supports that facilitate consumers' interactions with these possibilities". (p.7)

Dr. Knapp's perspective lends support to the rationale for this study as a first step in evaluating such programs. This researcher has translated the idea of a "menu of possibilities" into a checklist of recommended practices, by which various state level programs could be measured. To that end, this study is a descriptive, multiple-case analysis of current state legislation or policy related to comprehensive service delivery for children and youth with EBD. The legislation or policy and related documents were reviewed for data pertinent to specific components found in the literature. Contact persons for each state were interviewed to triangulate information from the documents. A comparative analysis revealed the congruence between state legislation and recommended practices.

Chapter 4

Results

The purpose of this study is to examine specific components of legislation and policy concerning comprehensive service delivery systems for children and adolescents in nine selected states. These components were compared to a set of recommended components that emerged from the review of the literature on integrated, interagency collaboration for comprehensive service delivery.

This chapter outlines the analysis of each state's initiative in comprehensive service delivery. A history of each program is presented followed by an overview of that state's service delivery model. Two or more documents were reviewed and two or more state level policy makers were interviewed to explore the relationship between a state's initiative and the set of recommended components. The analysis of the Commonwealth of Virginia was the pilot study and is presented first. Analyses of the other states follow in alphabetical order. The final section of this chapter is the analysis of all states compared to each other and to the set of recommended components.

Virginia

The Pilot Study

Description of the Initiative

History. In 1990 the Virginia Department of Planning and Budget (DPB) conducted a "Study of Children's Residential Services". This study concluded that costs for residential treatment in Virginia would continue to rise at an alarming pace without state level intervention. Specifically, the study found that services for children and youth with serious emotional or behavioral problems were overlapping services from four major agencies; the Department of Education, the Department of Mental Health, Mental Retardation and Substance Abuse, the Department of Social Services, and the Department of Youth and Family Services. These four agencies generated 14,000 cases serving only 4,993 actual children with expenditures for residential placements rising 22% annually. DPB recommended "expanding community-based nonresidential services, improving interagency collaboration and service delivery, and adapting the state's funding policies and management systems" (Council on Community Services for Youth and Families, 1992, p.i).

The Council on Community Services for Youth and Families, a cross-secretarial interagency council, was formed to recommend specific changes. In addition, five communities across the Commonwealth were awarded demonstration grants to improve services, control costs and expand community-based services using an interagency approach. Five regional meetings were held to solicit feedback from individuals and organizations. This interagency council issued a final report which outlined the proposed legislation, the Comprehensive Services Act for At Risk Youth and Families (CSA), and the Appropriations Act. The Council reported that the intent of the CSA legislation was "to create a collaborative system of services and funding that is child-centered, family focused and community-based (Council on Community Services for Youth and Families, 1992, p.ii). As outlined, the purposes of the legislation were to:

> -ensure that services and funding are consistent with the Commonwealth's policies of preserving families, and providing services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public;
>
> -identify and intervene early with young children and their families who are at risk of developing emotional or behavioral problems, or both, due to environmental, physical or

> psychological stress;
>
> -design and provide services that are responsive to the unique and diverse strengths and needs of troubled youths and families;
>
> -increase interagency collaboration and family involvement in service delivery and management;
>
> -encourage a public and private partnership in the delivery of services to troubled and at-risk youths and their families;
>
> -provide communities flexibility in the use of funds and to authorize communities to make decisions and be accountable for providing services in concert with these purposes. (Council on Community Services for Youth and Families, 1992, p.iii)

The model. The interagency structure at the state level is comprised of two parts; a State Executive Council and the State Management Team. The agency head from each of the five participating agencies, plus a parent, comprise the State Executive Council which establishes policy, distributes funds, oversees the work of the State Management Team, and advises the Governor and Cabinet Secretaries on proposed policies and procedures. The State Management Team members are appointed by the State Executive

Council and are comprised of representatives of the state agencies involved and representatives from the corresponding local agencies, a juvenile domestic relations district court judge, private providers and parents. This team recommends policy and procedure and offers training and technical assistance to state and local agencies regarding the CSA. The State Management Team also created ten separate work groups to assist with the implementation process. The membership of each work group has the same profile of representatives as the State Management Team.

There are also two interagency structures at the local level; the Community Policy and Management Team (CPMT) and the Family Assistance and Planning Team (FAPT). CPMT members are appointed by local government and must consist of agency heads or their designees from the juvenile court services unit, the health department, the department of social services, the community services board and the local school division. There must also be a parent representative and a private provider representative. The local government must also designate a fiscal agent to manage CSA funds. The CPMT must develop policy and procedures for implementing the CSA at the local level and link the local interagency structure to the State Management

Team. The local interagency structure also includes a Family Assistance and Planning Team (FAPT), or teams, with representatives from the same local agencies and a parent. Each FAPT may also have representatives from private providers and other agencies if they wish. The FAPT must review referrals and develop Individual Family Service Plans for each case.

Funding was achieved by pooling eight existing agency funding streams into a state pool. These monies are allocated to localities on a formula basis with a required local match. The CSA also established a State Trust Fund to provide start-up funds. Communities were able to apply for trust fund grants to establish early intervention and community-based services for children and families with emotional and/or behavioral problems.

Evidence of Recommended Components

To establish the relationship between the Virginia initiative and the set of recommended components, four documents were reviewed: a) Comprehensive Services Act for At Risk Youth and Families (1992), b) Comprehensive Services Act for At Risk Children and Youth implementation manual (Virginia State Management Team, 1992), c) Comprehensive Services Act for At Risk Youth and Families: A report to the governor and general assembly (Virginia Office of Comprehensive Services, 1992), and d) Comprehensive Services Act for At Risk Youth and Families: Implementation assessment (Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, 1995). Three informants were interviewed: a) The former director of child and adolescent mental health services from the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, b) a principal for the Special Education Office of Grants and Finance from the Virginia Department of Education, and c) a technical assistant from the Office of Comprehensive Services. The details of this relationship are summarized in Table 2.

Five of the 23 components were found in all documents and confirmed by all three interviewees: early identification, family focused, flexible funding, full array of services, and interagency collaborative structure. Six other components were found to exist in the legislation and were confirmed by all three interviewees: case management, community-based services flexible programming, gatekeeping, individualized services, and least restrictive environment. Four additional components were mentioned. Cost containment was found in two support documents and confirmed by all three interviewees. Increased funding was found in two support documents and confirmed by one interviewee. Integrated services was thought to be inferred in the initiative by one interviewee as was single point of entry.

Eight components were absent from all documents and confirmed absent by all three interviewees: co-location of services, competency enhancement, cultural competency, developmentally appropriate services, outcome driven evaluation, prevention services, unconditional care and wrap-around services. One interviewee said that the missing components were left out purposely to give the communities the flexibility to design their own systems. He said, "Virginia has a strong local tradition." Another interviewee indicated that the lack of more specific components allowed the localities to develop their own "recommended practices". He said that these missing components could be found in regular practice in most localities. The third interviewee confirmed that these components were left out of the legislation to allow more flexibility at the local level. She cited the example of prevention. She indicated that localities know that it is in their own best interest to have a strong prevention piece in place.

Additional components. Four of the documents reviewed and two of the interviewees indicated that Virginia incorporated an additional component; public-private partnerships.

Table 2
Recommended components for comprehensive service delivery
Commonwealth of Virginia

Components	Document One	Document Two	Document Three	Document Four	Interview One	Interview Two	Interview Three
Case management	●	●			●	●	●
Co-location							
Community-based	●	●	●		●	●	●
Competency enhancement							
Cost containment		●	●		●	●	●
Cultural competency							
Developmentally appropriate							
Early identification	●	●	●	●	●	●	●
Family focused	●	●	●	●	●	●	●
Flexible funding	●	●	●	●	●	●	●
Flexible programming	●	●	●		●	●	●
Full array of services	●	●	●	●	●	●	●
Gatekeeping	●	●	●		●	●	●
Increased funding				●		●	
Individualized services	●	●	●		●	●	●
Integrated services						●	
Interagency collaborative structure	●	●	●	●	●	●	●
Least restrictive environment	●		●	●	●	●	●
Outcome evaluation							
Prevention services							
Single point of entry							●
Unconditional care							
Wrap-around services							

Key: Table 2

Document One: Comprehensive Services Act for At Risk Youth and Families (1992)

Document Two: Comprehensive Services Act for At Risk Youth and Families: Implementation manual (1992)

Document Three: Comprehensive Services Act for At Risk Youth and Families: A report to the governor and general assembly (1992)

Document Four: Comprehensive Services Act: Implementation assessment (1995)

Interview One: Former Director of Child and Adolescent Mental Health Services, Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services

Interview Two: Assistant Director, Office of Special Education and Student Services, Virginia Department of Education

Interview Three: Technical Assistant, Office of Comprehensive Services

Indiana

Case Replication

Description of the Initiative

History. When Evan Bayh was elected Governor of Indiana in 1988 he committed his administration to the reform of human services. Specifically, he promised to focus on community-based decision making, blending funding streams, creating a coordinated service delivery system, and reducing inefficiency. In 1989, the Indiana General Assembly directed the Sunset Evaluation Committee to analyze programs for senior citizens, children, and persons with disabilities. This committee recommended that the state implement an integrated public assistance program. In July of 1991, the Legislature acted on the Sunset Evaluation Committee's recommendation and established the Family and Social Services Administration. This agency consolidated the three departments of Human Services, Mental Health and Public Welfare. Legislation was passed that same year to establish the Step Ahead Initiative with an office in the newly created Family and Social Services Administration.

In September of 1993, Governor Bayh convened the Indiana Policy Council for Children and Families. This council included the

Superintendent for Public Instruction, the Attorney General, the Director of the State Budget Agency, the Secretary of the Family and Social Services Administration, and the Commissioners of the Departments of Administration, Personnel, Correction, Health, Higher Education and Workforce Development. This Council approved the Proposal for a Consolidated State Plan for Services to Children and Families. In January of 1994, President Clinton gave enthusiastic support of this plan which became the Indiana Collaboration Project.

The model. The goal of the Indiana Collaboration Project is to provide a framework enabling all agencies that serve children and families to plan and act together. The purpose of these collaborative efforts is to:

-identify and recognize the various programs available at the local, state and federal levels;

-establish priorities on services to be provided and the children and families to be served;

-fully mobilize all available private and public community resources;

-inform and assist families to obtain services for which they are eligible; and

-collectively manage the delivery of services.

(The Office of the Governor, 1995, p.36)

Voluntary Step Ahead Councils in all 92 counties in Indiana work to achieve this purpose. Although the original Councils focused on early childhood development and child care issues, the current emphasis is on family-centered issues with a holistic approach to the challenges of children of all ages and their families.

The local Step Ahead Councils work in conjunction with multi-agency teams of state agency representatives to improve the quality of services for children, youth and families in the county. Policy and procedures are established by the state Working Group made up of representatives from all appropriate agencies. The Working Group's recommendations are coordinated with the Indiana Policy Council to create statewide policies that affect all or most agencies serving children and their families. Representatives from the Policy Council interact with the federal Regional Team to obtain waivers for flexibility in utilization of federal funds or to meet specific federal rules and regulations.

The local Step Ahead Councils prepare and submit annual plans for programs and services to children and families. The local Council must consist of public officials in the appropriate agencies; business, civic and religious leaders; neighborhood organization leaders; experts in relevant fields of study; and family advocates. The make up of the Council is required to reflect the ethnic diversity of the community. The council may also include individuals representing organizations providing private or public services to children and youth, such as job training, financial assistance, dental health, mental health, education, child care, and family support services.

The plan developed by the local Council must include a needs assessment for children and family services, goals, objectives, and an implementation plan. The plan provides for information sharing, a care coordination system, as well as collaboration on intake and eligibility processes. The plan must also have an evaluation component, multi-program service centers, joint or shared funding, and a system of coordination with local planning authorities and state and federal supervising agencies.

Evidence of Recommended Components

Two documents were reviewed to establish the relationship between Indiana's step Ahead Collaboration Project and the set of recommended components: a) Step Ahead Comprehensive Early

Childhood Program, Chapter 1.8 (1992) and b) Step ahead: Indiana collaboration project (Office of the Governor, 1995). Two informants were interviewed to confirm these relationship: a) a chief from the Bureau of Children's Services in Indiana's Division of Mental Health and b) an assistant director from the Division of Special Education in Indiana's Department of Education. The details of this relationship are summarized in Table 3.

Five components were found in both documents reviewed and confirmed by both interviewees: community-based services, family focused services, full array of services, interagency collaborative structure, and prevention services. Four additional components were found in the legislation and confirmed by both interviewees: cost containment, developmentally appropriate, flexible programming, and individualized services. Six components were found in the policy document and confirmed by both interviewees: early identification, flexible funding, increased funding, integrated services, single point of entry, and wrap-around services. Five components were confirmed missing from the documents but reported as part of practice by many state agencies consistent with their rules, regulations, and guidelines: case management, competency enhancement, cultural competency, gatekeeping, and least restrictive environment. The final three components: co-location, outcome evaluation, and unconditional care, were confirmed by the interviewees as being missing from the legislation and the policy document. Both said these components were important and had been mentioned as part of Indiana's vision for the future.

Table 3
Recommended components for comprehensive service delivery
Indiana

Components	Document One	Document Two	Interview One	Interview Two
Case management				
Co-location				
Community-based	●	●	●	●
Competency enhancement				
Cost containment	●		●	●
Cultural competency				
Developmentally appropriate	●		●	●
Early identification		●	●	●
Family focused	●	●	●	●
Flexible funding		●	●	●
Flexible programming	●		●	●
Full array of services	●	●	●	●
Gatekeeping				
Increased funding		●	●	●
Individualized services	●		●	●
Integrated services		●	●	●
Interagency collaborative structure	●	●	●	●
Least restrictive environment				
Outcome evaluation				
Prevention services	●	●	●	●
Single point of entry		●	●	●
Unconditional care				
Wrap-around services		●	●	●

Key: Table 3

Document One: Step Ahead Comprehensive Early Childhood Program, Chapter 1.8 (1992)

Document Two: Step ahead: Indiana collaboration project (1995)

Interview One: Chief; Bureau of Children's Services, Division of Mental Health

Interview Two: Coordinator of Alternative/Residential Services; Division of Special Education, Department of Education

Maryland

Case Replication

Description of the Initiative

History. The seed of the initiative that became Article 49D and Senate Bill 588 in Maryland began in the late 1970s with a commission in the Department of Education that studied interagency collaboration for hard-to-serve students. The work of this commission was followed in the early 1980s with a study of children and adolescents in out-of-state placements. This report made recommendations on resources needed for the care and treatment of these children if they were served in their communities. In 1989 the governor established the Subcabinet for Children, Youth and Families charged with ensuring that services be delivered in an effective, efficient, and integrated manner. This Subcabinet conducted a study of the state's service delivery system and found many problems. The main areas of concern were that services were service and agency driven, fragmented, categorical, duplicative, inflexible, and based on a model of pathology (Senate Bill 588: Plan for implementation, 1993).

In 1990, as a result of this study, Article 49D of the Maryland Annotated Code established the Office for Children, Youth, and

Families (formerly the Office for Children and Youth) responsible for overseeing all general policies for children, youth and family services in the state. This code also required all local government bodies to implement interagency structures in all jurisdictions. These local entities became the Local Management Boards (LMBs) charged with effecting system change at the local level. This was followed, in 1992, by Senate Bill 588: the Return from Out-of-State Plan. This plan outlined the procedures for the development of the services needed to reduce out-of-state placements, flexible funding strategies, the format for a state-wide needs assessment, the structure for interagency agreements, a recommendation for outcome-based evaluations, increased involvement of the private sector, and the need for training of all stakeholders.

In 1995, the Subcabinet for Children, Youth and Families adopted the following vision and mission statements:

> Vision
>
> To build partnerships with communities which strengthen the capacity of families to adequately nurture and care for their children by providing quality education, safe environments, and the availability of good paying, family supporting jobs.

> Mission
>
> To build partnerships with communities to ensure effective, coordinated, outcome-based, family-oriented services which emphasize prevention and early intervention, and are culturally responsive to the needs, strengths, and priorities of families, in order to support the achievement and well-being of children (Governor's Office for Children, Youth, and Families, 1995, p.4).

The model. The Subcabinet for Children, Youth and Families consists of the Secretaries of the Department of Human Resources, the Department of Juvenile Services, the Department of Health and Mental Hygiene, and the Department of Budget and Fiscal Planning. Also included are the State Superintendent of Schools, and the Director of the Office for Individuals with Disabilities. This subcabinet is responsible for policy agreement among the agencies and guidelines for service delivery. It must ensure that training and technical assistance are available to local jurisdictions and that cross-jurisdictional evaluation efforts are tracked. The subcabinet must also " encourage the development and expansion of community-based services and establish the parameters for a non-categorical, family-focused service delivery model" (Subcabinet for Children, Youth, and Families, 1993, p.4). Two additional strands exist at the state level: the State Management Team and the Policy Team. The State Management Team, consisting of agency representatives, implements the policies of the subcabinet and provides technical assistance to both the Subcabinet and the Policy Team. The Policy Team consists of stakeholders from the state, local, and private sectors who develop and recommend policy to the Special Secretary.

Each local jurisdiction must establish Local Management Boards. The role of these boards is to create a comprehensive, interagency service delivery system for children and their families. They are also charged with developing goals, objectives and an evaluation plan for their service delivery system.

Evidence of Recommended Components

To establish the relationship between Maryland's initiative and the set of recommended components, two documents were reviewed: a) Office for Children, Youth and Families, Maryland 49D (1983 & Supp. 1995), b) Senate Bill 588: Plan for implementation (Subcabinet for Children, Youth and Families, 1993) and c) Background report: Policy team retreat (Governor's Office for Children, Youth and

Families, 1995). Two informants were interviewed to confirm this relationship: a) the director of administration and operations from the Maryland Office for Children, Youth and Families and b) the assistant state superintendent from the Division of Special Education in the Maryland Department of Education. The details of this relationship can be found in Table 4.

Nine components were found in all three documents and confirmed by both interviewees: community-based services, family-focused services, flexible funding, full array of services, gatekeeping, integrated services, interagency collaborative structure, outcome evaluation, and prevention services. Five components were found in two documents and confirmed by both interviewees: competency enhancement, early identification, increased funding, individualized services, and least restrictive environment. Four components were found in at least one document and confirmed by both interviewees: case management, flexible programming, single point of entry, and wrap-around services.

Two components were reported by one or both interviewees to be part of general practice in Maryland: co-location of services and unconditional care. An additional component, cultural competency, was found in two documents as a "culturally responsive" service delivery system. This is a close but not exact match to "culturally competent" as defined in this research. The "culturally responsive" language was confirmed by both interviewees.

Two components were not found in any of the three documents and were confirmed missing by both interviewees: cost containment and developmentally appropriate. Both interviewees reported that Maryland's program is one of cost redirection rather than cost reduction or cost containment, in which funds recovered from out-of-state residential placements are directed toward community-based initiatives. One interviewee noted that developmentally appropriate should not be a recommended component unless "age-appropriate" is also part of the definition.

Table 4
Recommended components for comprehensive service delivery
Maryland

Components	Document One	Document Two	Document Three	Interview One	Interview Two
Case management		●		●	●
Co-location					
Community-based	●	●	●	●	●
Competency enhancement		●	●	●	●
Cost containment					
Cultural competency					
Developmentally appropriate					
Early identification		●	●	●	●
Family focused	●	●	●	●	●
Flexible funding	●	●	●	●	●
Flexible programming			●	●	●
Full array of services	●	●	●	●	●
Gatekeeping	●	●	●	●	●
Increased funding	●	●		●	●
Individualized services	●	●		●	●
Integrated services	●	●	●	●	●
Interagency collaborative structure	●	●	●	●	●
Least restrictive environment	●	●		●	●
Outcome evaluation	●	●	●	●	●
Prevention services	●	●	●	●	●
Single point of entry			●	●	●
Unconditional care					
Wrap-around services			●	●	●

Key: Table 4

Document One:	Office for Children, Youth, and Families, 49D Maryland (1983 & Supp. 1995)
Document Two:	Senate Bill 588; Plan for implementation (1993)
Document Three:	Background report, Maryland policy team retreat (1995)
Interview One:	Director of Administration and Operations, Governor's Office, Maryland Office for Children, Youth, and Families
Interview Two:	Assistant State Superintendent, Division of Special Education, Maryland Department of Education

New Jersey

Case Replication

Description of the Initiative

History. The movement toward an integrated system of care in New Jersey began on several levels simultaneously. Part of this initiative was a response to a class action suit filed in the late 1970's in which the court required New Jersey to review their service delivery system for children with serious emotional disturbance. In a separate but similar project, the New Jersey Division of Youth and Family Services developed the family preservation project. This project began in the early 1980's with the primary goal of preventing out-of-home placements. The formalized Family Preservation Services (FPS) program was launched when a full time Project Director was hired in September of 1986. By June of 1988, FPS was operational in eight counties. In addition, several local projects such as the Monmouth County 65K Program, have designed wrap-around service delivery systems for children and youth with serious emotional or behavioral problems. This project began when a parent, with local support, challenged the state for flexible funding. She felt that the community could serve her child if given the funds being spent on residential services. The program was eventually designed as a pilot project and served six to eight children with nationally recognized success.

All these programs and projects had similar goals and objectives related to community-based services and interagency collaboration. In September of 1992 the New Jersey Senate tied these efforts together by passing the Bring Our Children Home Act. Stated clearly in the act is the intent to "preserve the sanctity of the family unit and to prevent out-of-home placement of emotionally disturbed children..." (Bring Our Children Home Act, 1992, § 2). This legislation mandated an individualized, family-focused system of care.

The model. The act authorizes the Commissioner of Human Services to develop an interdepartmental plan for the implementation of the mandated system of care. The legislation outlines the priorities for the first stage of this plan as: a) deinstitutionalization of any children ready to return to their communities and b) prevention services for those children at imminent risk for extended out-of-home placement. This plan requires a collaborative effort by the state departments of Education, Corrections, Health, Community Affairs, and Human Services: the Public Advocate: the Administrative Office of the Courts: and representatives from statewide family advocacy groups.

Under this act, each county may establish a Case Assessment Resource Team (CART) or a County Interagency Coordinating Council (CIACC). CARTs and CIACCs support cross-system planning for children with emotional disturbance, review the needs of this target population, and recommend service plans to best meet the needs of the child and the family. The policies and procedures developed by the CARTs and the CIACCs are reviewed by the state inter-department team. The state and local teams must develop policies and procedures that are consistent with a very specific set of components outlined in the legislation which include: services that are child and family driven, prevention of out-of-home placements, community-based services in the least restrictive setting possible, and individualized services to meet the child's and family's unique needs. The parents must be involved in the development of the service plan and plans must be comprehensive, addressing the child's need in all appropriate domains. Services must build on a child's strengths, and reflect a continuum of care options that are managed by a care coordinator.

Evidence of Recommended Components

To establish the relationship between the New Jersey initiative and the set of recommended components, three documents were reviewed: a) Bring Our Children Home Act (1992), b) Bring Our Children Home plan (New Jersey Department of Human Services, 1994) and c) The Monmouth County 65K program (Williams, C. & Gans, A., 1993). Two informants were interviewed to confirm this relationship: a) the assistant director of the Department of Human Services from the New Jersey Division of Mental Health and Hospitals and b) a program assurance manager from the Office of Education in the New Jersey Department of Human Services. The details of this relationship can be found in Table 5.

Five components were found in all three documents and confirmed by both interviewees: case management, community-based services, family focused services, full array of services, and increased funding. Nine other components were found in the legislation and confirmed by both interviews: cost containment, cultural competency, early identification, gatekeeping, individualized services, integrated services, interagency collaborative structure, least restrictive environment, and outcome evaluation. Four other components were found in only one support document: competency enhancement, flexible funding, flexible programming, and wrap-around services. Both interviewees reported that these four components were widely present in routine practice, but had not become policy for the State of New Jersey. Three of the missing components: co-location, single point of entry, and unconditional care, were mentioned by the interviewees as long range goals for New Jersey. The last two components, prevention services and developmentally appropriate services, were discussed by both interviewees as being embedded in all aspects of New Jersey's service delivery practices.

Table 5
Recommended components for comprehensive service delivery
New Jersey

Components	Document One	Document Two	Document Three	Interview One	Interview Two
Case management	●	●	●	●	●
Co-location					
Community-based	●	●	●	●	●
Competency enhancement		●			
Cost containment	●		●	●	●
Cultural competency	●	●		●	●
Developmentally appropriate					
Early identification	●			●	●
Family focused	●	●	●	●	●
Flexible funding		●	●		
Flexible programming			●		
Full array of services	●	●	●	●	●
Gatekeeping	●		●	●	●
Increased funding	●	●	●	●	●
Individualized services	●	●		●	●
Integrated services	●		●	●	●
Interagency collaborative structure	●		●	●	●
Least restrictive environment	●			●	●
Outcome evaluation	●	●		●	●
Prevention services					
Single point of entry					
Unconditional care					
Wrap-around services			●		

Key: Table 5

Document One: Bring Our Children Home Act (1992)

Document Two: Bring Our Children Home plan (1993)

Document Three: The Monmouth County 65K program (1993)

Interview One: Assistant Director, Department of Human Services, New Jersey Division of Mental Health and Hospitals

Interview Two: Manager, Program Assurance, New Jersey Department of Human Services, Office of Education

North Dakota

Case Replication

Description of the Initiative

History. In 1985, North Dakota House Concurrent Resolution No. 3052 requested that the governor direct the Commission on Children and Adolescents At Risk to make recommendations on needed legislation or policy. Eight specific objectives were presented to the Budget Committee on Human Services in September of 1986. To meet the needs of children and adolescents at risk the state of North Dakota must: a) improve the organizational structure to facilitate integration of services, b) improve the youth correction system, c) fill gaps that exist in the service delivery system, d) improve the quality of services, e) increase child advocacy efforts, f) support the role of the private service provider, g) increase the emphasis on prevention, and h) create policies that strengthen and support the family. In 1987, as a result of these recommendations, the Legislative Assembly passed House Bill 2039 establishing the state level Children's Services Coordinating Committee (CSCC). This committee became a permanent state committee in 1989. Regional coordinating committees were established in 1993 when the

Legislative Assembly passed Senate Bill 2016. Eight regional and four tribal CSCCs serve the counties or reservations in their area by coordinating children's services.

The model. The regional and tribal CSCCs consist of representatives from the child welfare system, mental health, education, health, substance abuse, social services, law enforcement, the courts, Head Start, churches, day care providers, the legislature, parents, and others as needed. Each CSCC appoints a coordinator to oversee each local planning process. Each region and tribe is required to develop a Five Year Community Plan to assess the needs and create coordinated and integrated programs to serve children and youth at risk in the area. Each plan must include components which: identify the children who need services, provide an overview of existing services and needed services, make recommendations for improving services, provide training in treatment and prevention, provide effective evaluation procedures, develop training for professionals in related disciplines, and create programs aimed at prevention of at risk activities.

The legislation, specifically SB 2016, also recommends specific programs and services for consideration by regional and tribal CSCCs.

These recommended programs include: family education, intensive in-home crisis intervention, respite care, parent aide programs, prime time day care, wraparound services, case management, drug free school programs, neighbor's program, family support, and juvenile diversion.

Evidence of Recommended Components

Two documents were reviewed to establish the relationship between North Dakota's initiative and the set of recommended components: a) Children's Services Coordinating Committee Act (1987) and b) Children's Services Coordinating Committee Appropriations Act (1993). Three informants were interviewed to confirm this relationship: a) the CASSP director from the North Dakota Division of Mental Health, b) the director of children and family services from the North Dakota Division of Mental Health and c) the assistant superintendent for adaptive services and special education from the North Dakota Department of Public Instruction. The details of this relationship are described in Table 6.

Five components were found in both pieces of legislation and confirmed by both interviewees: flexible funding, family focused services, full array of services, integrated services, and interagency collaborative structure. Six additional components were found in at least one piece of legislation and confirmed by both interviewees: case management, increased funding, individualized services, outcome driven evaluation, prevention services, and wrap-around services.

Eight components were not found in the legislation but were described as part of regular practice in North Dakota by one or both interviewees: co-location of services, community-based services, competency enhancement, cost containment, cultural competency, developmentally appropriate services, early identification, and least restrictive environment. Three components were not found in either piece of legislation and were confirmed missing by both interviewees: gatekeeping, single point of entry, and unconditional care.

Additional components. Both pieces of legislation mentioned the additional component of public-private partnerships which was confirmed by both interviewees.

Table 6
Recommended components for comprehensive service delivery
North Dakota

Components	Document One	Document Two	Interview One	Interview Two
Case management		●	●	●
Co-location				
Community-based				
Competency enhancement				
Cost containment				
Cultural competency				
Developmentally appropriate				
Early identification				
Family focused		●	●	●
Flexible funding	●	●	●	●
Flexible programming				
Full array of services	●	●	●	●
Gatekeeping				
Increased funding		●	●	●
Individualized services	●		●	●
Integrated services	●	●	●	●
Interagency collaborative structure	●	●	●	●
Least restrictive environment				
Outcome evaluation	●		●	●
Prevention services	●		●	●
Single point of entry				
Unconditional care				
Wrap-around services		●	●	●

Key: Table 6

Document One:	Children's Services Coordinating Committee Act (1987)
Document Two:	Children's Services Coordinating Committee Appropriations Act (1993)
Interview One:	CASSP Director, Division of Mental Health with (conference call) Don Schmit, Director, Children and Family Services
Interview Two:	Assistant Superintendent for Adaptive Services and Special Education, North Dakota Department of Public Instruction

Oklahoma

Case Replication

Description of the Initiative

History. In 1989 the second session of the 42nd Oklahoma Legislature directed the Oklahoma Commission on Children and Youth (OCCY) to create the Oklahoma Planning and Coordinating Council for Services to Children and Youth and to establish local and regional planning boards. This mandate was one of the results of a 1988 study of state services to children and families conducted by the Price Waterhouse Corporation. The Price Waterhouse Report recommended that Oklahoma develop programs and services for children and their families that crossed agency lines and reflected input from the community. In March of 1991 the Oklahoma Planning and Coordinating Council for Services to Children and Youth collaborated with local and regional leaders to develop and publish Children: Oklahoma's Gift to Tomorrow, a State Plan for Services to Children and Youth, 1992-1995. This document presented goals, and objectives to improve and coordinate services to children, youth, and families. In May of 1990 the legislature added Section 601.41: the Act for Coordination of Special Services to Children and Youth. This legislation extends the mandate for interagency collaboration to all children's services in Oklahoma, specifically to special needs children aged 3 to 21.

The model. The District and Regional Planning Boards were established by specific legislation which became codified as 10 OS 601.6a - 601.12, the Establishment of the Office of Planning and Coordination of Services to Children and Youth, and clearly established the ownership and responsibility for finding solutions to children's problems at the local level. The District Boards are the working body of community leaders while the Regional Boards serve as coordinating bodies. Each Regional Board has an elected representative on the Oklahoma Planning and Coordinating Council for Services to Children and Youth. In addition, the Oklahoma Interagency Coordinating Council for Special Services to Children and Youth was established under 10 OS Section 601.41 - 601.46 to create a system to serve children who have special needs or are in out-of-home placements. The Interagency Coordinating Council for Special Services to Children and Youth has ten state-level committees that make up the second tier of the structure at this level. This council has 11 regional advisory boards; each are co-chaired by a parent and school superintendent. The committees are: supporting families, mediation, transition, work plan, coordination of assessments, increasing providers, confidentiality, preschool, funding, and out-of-home placement. The principles that guide services for children and youth with special needs were developed by the Regional Advisory Boards, the state-level committees, and the Interagency Council. These principles suggest that programs be: family centered, outcomes based, community based, culturally sensitive, coordinated, efficient, flexible, and thoroughly evaluated.

Locally, the Council has focused on two themes, supporting families through Family Resource Centers and integrating services by linking service delivery to the schools. Family Resource Centers are parent-run non-profit organizations which provide information about services in a wide variety of forms and formats to any family in need. The State Plan discusses the philosophy behind these centers. " Families communicate best with other families and profit from understanding and assistance in dealing with service systems" (Oklahoma Interagency coordinating council for Special Services to Children and Youth, 1995, p.2). Integrated service systems are designed and developed locally to meet specific local needs. One community developed a day treatment program to prevent residential placements while another community developed a comprehensive transition program to provide on-the-job training. The interagency agreements at the state level and the flexible funding regulations allow for a broad diversity of programs.

Evidence of Recommended Components

To establish the relationship between the Oklahoma initiative and the set of recommended components, three documents were reviewed: a) Act for Coordination of Special Services to Children and Youth (1990), b) Establishment of the Office of Planning and Coordination for Services to Children and Youth (1990), and c) State plan for special education and special student service coordination and assistance: Final report (Oklahoma Interagency Coordinating Council for Special Services to Children and Youth, 1995). Two informants were interviewed to confirm this relationship: a) a senior planner from the Office of Planning and Coordination in the Oklahoma Commission on Children and Youth, and b) the associate director form the Oklahoma Department of Education. The details of this relationship can be found in Table 7.

Three components were found in all three documents and confirmed by both interviewees: cost containment, full array of services, and interagency collaborative structure. Six additional components were found in one or both pieces of legislation and confirmed by both interviewees: competency enhancement, family focused services, flexible funding, increased funding, individualized services, and integrated services.

Two components were found in the State Plan and confirmed by both interviewees: community-based services and cultural competency. Three other components were mentioned. Case management, co-location of services, and gatekeeping were found in the State Plan and confirmed by one interviewee. Five components were mentioned by one or both interviewees as being embedded in standard practices in Oklahoma: developmentally appropriate services, early identification, flexible programming, least restrictive environment, and prevention services. Single point of entry was mentioned by one interviewee as being part of practice in some programs.

Three components were not found in any reviewed document and were confirmed as absent by both interviewees: outcome driven evaluation, unconditional care, and wrap-around services.

Table 7
Recommended components for comprehensive service delivery
Oklahoma

Components	Document One	Document Two	Document Three	Interview One	Interview Two
Case management			●	●	
Co-location			●	●	
Community-based			●	●	●
Competency enhancement	●		●	●	●
Cost containment	●	●	●	●	●
Cultural competency			●	●	●
Developmentally appropriate					
Early identification					
Family focused			●	●	●
Flexible funding	●		●	●	●
Flexible programming					
Full array of services	●	●	●	●	●
Gatekeeping			●	●	
Increased funding	●		●	●	●
Individualized services	●			●	●
Integrated services	●	●		●	●
Interagency collaborative structure	●	●	●	●	●
Least restrictive environment					
Outcome evaluation					
Prevention services					
Single point of entry					
Unconditional care					
Wrap-around services					

Key: Table 7

Document One: Act for Coordination of Special Services to Children and Youth (1990)

Document Two: Establishment of the Office of Planning and Coordination for Services to Children and Youth (1990)

Document Three: State plan for special education and special student service coordination and assistance: Final report (1995)

Interview One: Senior Planner, Office of Planning and Coordination, Commission on Children and Youth

Interview Two: Associate Director, Oklahoma State Department of Education

Utah

Case Replication

Description of the Initiative

History. In 1989, Utah passed House Bill 234: Early Intervention for Student Success. This precursor to coordinated services legislation allocated $100,000 each to the Departments of Health, Education, and Human Services. This initiative was followed by the formation of the state level Task Force for Children and Youth At Risk in 1991. The following year, 17 Local Interagency Councils (LICs) were formed and funded to expand the Early Intervention Program.

In 1993 Utah passed House Bill 39: Coordinated Services for Children and Youth At Risk Act with $3.2 million allocated to institutionalize and expand the Local Interagency Council's program. This legislation contained goals for all children from birth through 21 years of age which included: literacy; academic achievement commensurate with ability; and competent, productive and responsible participation in society. The service philosophy for the State of Utah states that programs must be: family centered, culturally competent, community based, and comprehensive.

Programs must also include early intervention and prevention components using collaborative strategies.

The model. House Bill 39 created a two part structure at the state level: the State Council for Children and Youth At Risk and the Steering Committee for Children and Youth. The Council must be composed of the state superintendent of public instruction, the executive director of the Department of Health, the executive director of the Department of Human Services and the state court administrator. The State Council is responsible for recommending policies and procedures to increase and enhance efficient and effective services to Utah's children and youth. The State Council is also mandated to develop and evaluate innovative service delivery and funding strategies. Other goals include promoting prevention and early intervention services, educating the public about the needs of the target population, increasing family involvement and public-private partnerships for planning and delivering services, and the dissemination of information regarding effective service delivery models. The Steering Committee membership is composed of directors of the relevant offices in the same departments that make up the State Council plus community, legislative, family, and local representatives.

The Act also requires the formation of Local Interagency Councils (LICs). Minimally, the LIC must consist of local representatives from: child welfare, mental health, education, juvenile justice, youth corrections, substance abuse, health, developmental disabilities, and parents. These Councils must develop service plans for each child or youth with activities coordinated by a case manager. The Act also allows the Councils to share information among all agencies involved with a particular case and mandates parental involvement in planning and service delivery.

Evidence of Recommended Components

Two documents were reviewed to establish the relationship between Utah's program and the set of recommended components for comprehensive service delivery: a) Agencies Coming Together for Children and Youth At Risk Act (1989, amended 1993) and b) Utah's interagency council manual (Utah Division of Mental Health, 1993). Two informants were interviewed to confirm this relationship: a) a children's specialist from the Utah Division of Mental Health and b) the director of services for at risk students from the Utah Office of Education. The details of this relationship can be found in Table 8.

Twelve components were found in both documents reviewed and confirmed by both interviewees: case management, community-based services, competency enhancement, early identification, family-focused services, flexible funding, flexible programming, full array of services, individualized services, interagency collaborative structure, outcome evaluation, and prevention services. Two components were found in the policy document and confirmed by one or both interviewees: gatekeeping and increased funding. Six components were cited by one or both interviewees as regularly occurring in practice: co-location of services, cost containment, cultural competency, developmentally appropriate services, integrated services, and wrap-around services. It should be noted that both documents contain language about the need for "cultural sensitivity." This component is a close but not an exact match to the concept, as defined, of cultural competency.

Both interviewees confirmed the absence of three components: least restrictive environment, single point of entry, and unconditional care. One interviewee reported that least restrictive environment was embedded in most practices related to children with disabilities. The LIC Manual refers to policies that closely resemble unconditional care.

The policy says "Once eligibility is determined for a child, the LIC will provide individualized services planning, service delivery and ongoing monitoring until the child is no longer needing collaborative multi-agency involvement" (Utah Division of Mental Health, 1993). This language supports the idea that eligible children will continue to get the services they need, but does not support the rest of the definition, that all children who need services are eligible.

Additional components. Both documents reviewed contained language concerning the additional component of establishing public-private partnerships.

Table 8
Recommended components for comprehensive service delivery
Utah

Components	Document One	Document Two	Interview One	Interview Two
Case management	●	●	●	●
Co-location				
Community-based	●	●	●	●
Competency enhancement	●	●	●	●
Cost containment				
Cultural competency				
Developmentally appropriate				
Early identification	●	●	●	●
Family focused	●	●	●	●
Flexible funding	●	●	●	●
Flexible programming	●	●	●	●
Full array of services	●	●	●	●
Gatekeeping		●	●	
Increased funding		●	●	●
Individualized services	●	●	●	●
Integrated services				
Interagency collaborative structure	●	●	●	●
Least restrictive environment				
Outcome evaluation	●	●	●	●
Prevention services	●	●	●	●
Single point of entry				
Unconditional care				
Wrap-around services				

Key: Table 8

Document One:	Agencies Coming Together for Children and Youth At Risk Act (1989, amended 1993)
Document Two:	Utah's interagency council manual (1993)
Interview One:	Children's Specialist, Utah Division of Mental Health
Interview Two:	Director, Services for At Risk Students, Utah Office of Education

Vermont

Case Replication

Description of the Initiative

History. Vermont began its efforts to integrate services for children and youth with severe emotional disturbance in 1985. Vermont received funding to develop an interagency structure of comprehensive service delivery from the National Institute of Mental Health's Child and Adolescent Service System Program (CASSP). The five year grant resulted in a System of Care Plan to provide community-based services to children and families by coordination of efforts from three departments, the Department of Mental Health and Mental Retardation, the Department of Social and Rehabilitative Services, and the Department of Education.

Collaborative interagency planning and the System of Care Plan was enacted into law in 1988 through the passage of Act 264. This act established interagency structures at the state and local levels and mandated the specific principles of service delivery for the state of Vermont. These principles included interagency collaboration, integration of service delivery, and strong parental involvement. Vermont has continued to refine its service delivery system through evaluation of local implementation projects funded by other federal and private grants including a Robert Wood Johnson Foundation Grant. Some of these local projects include: Project Wraparound, New Directions, Success by Six, Healthy Babies, the Family, Infant and Toddler Project, Success Beyond Six, New American Schools, Family Preservation/Access, and Reach-up. The vision statement from the System of Care Plan outlines the values reflected in their plan:

> -Vermonters are competent, caring, productive and responsible citizens committed to life-long learning who contribute value to their families and communities;
>
> -Families have primary responsibility for their children's physical, mental and social development;
>
> -Communities support families by joining with state and local government to create a unified system of education, health, and social services that is high quality and respects the diversity, uniqueness, strengths and potential of individuals, families, schools and communities; and
>
> -These services are school and community based, easily accessible, family centered, aimed at promoting self-sufficiency, oriented towards prevention and focused on the safety and

well-being of Vermont citizens, especially children (1994, p.62). The act also created a common definition for serious emotional disturbance that was kept very broad to encourage more agencies to support more children and youth needing services.

The model. Act 264 establishes a State Interagency Team consisting of representatives from the following agencies: the Department of Education, the Department of Social and Rehabilitation Services, the Department of Mental Health, divisions of mental health and mental retardation, the Office of Drug and Alcohol Programs as well as a parent of a child or adolescent with severe emotional disturbance.

This state team is directed to develop a system of care plan which identifies the needs of children and adolescents with severe emotional disturbance, describes services currently available, and recommends plans and priorities for the continuation or development of programs and resources. The state team must also oversee the work of the local interagency teams. They are required to help them resolve cases and make recommendations to the secretary of human services and the commissioners of education, mental health and mental retardation and social and rehabilitation services about any needed fiscal or programmatic changes.

In addition, the Act establishes an advisory board at the state level, appointed by the governor from recommendations of the State Interagency Team. This advisory board makes recommendations to the commissioners of the involved agencies concerning the system of care plan.

The Act also establishes local interagency teams with representatives from the local school districts, the local Office of Social and Rehabilitative Services, Community Mental Health and Mental Retardation Services and other local service providers of service, with the addition of the parents of the child or adolescent in need of services. The local team may also appoint other ad hoc members as needed. Any agency or parent may make a referral to the local team when agreement can't be reached on the provision of services. If the local team cannot resolve the issue, the case is referred to the state team.

Locally, a two step treatment process is the backbone of the coordination efforts. First, a case manager is identified by the agency initially involved with the child. This case manager and this agency are responsible for the development of a Coordinated Services Plan implemented by the child's individual treatment team. If the treatment team has any problems creating a package of services to meet the needs of the child and the child's family, the case manager may bring the case to the local interagency team and, if necessary, the state team as outlined above.

Evidence of Recommended Components

Two document reviews were conducted to establish the relationship between the Vermont program and the set of recommended components: a) An act relating to the creation of an advisory board and state and local interagency teams to assist in the provision of care for children and adolescents with severe emotional disturbance (1990) and b) Vermont system of care plan (Vermont Advisory Board for children and Youth with Special Mental Health Needs, n.d.). Two informants were interviewed to confirm this relationship: a) the interagency teams administrator from the Vermont Department of Mental Health and Mental Retardation and b) the interagency coordinator form the Vermont Department of Education. The details of this relationship are found in Table 9.

Seven components were found to be present in the legislation and the policy document and confirmed by both interviewees: case management, community-based services, competency enhancement, family focused services, full array of services, individualized services, and interagency collaborative structure. Seven additional components were present in the policy document and confirmed by both interviewees: co-location of services, early identification, flexible programming, increased funding, least restrictive environment, prevention services, and unconditional care. Three other components received some mention. Cost containment was found in the policy document and confirmed by one interviewee. Cultural competency was reported as present in the support document by one interviewee. Gatekeeping was found in the support document and confirmed by one interviewee. Three components were discussed as existing in practice by one or both interviewees: developmentally appropriate services, flexible funding, and wrap around services. Finally, three components were found to be part of Vermont's vision for the future by one or both interviewees: integrated services, outcome evaluation, and single point of entry.

Table 9
Recommended components for comprehensive service delivery
Vermont

Components	Document One	Document Two	Interview One	Interview Two
Case management	●	●	●	●
Co-location		●	●	●
Community-based	●	●	●	●
Competency enhancement	●	●	●	●
Cost containment		●	●	
Cultural competency			●	
Developmentally appropriate				
Early identification		●	●	●
Family focused		●	●	●
Flexible funding				
Flexible programming		●	●	●
Full array of services	●	●	●	●
Gatekeeping		●	●	
Increased funding		●	●	●
Individualized services	●	●	●	●
Integrated services				
Interagency collaborative structure	●	●	●	●
Least restrictive environment		●	●	●
Outcome evaluation				
Prevention services		●	●	●
Single point of entry				
Unconditional care		●	●	●
Wrap-around services				

Key: Table 9

Document One:	An act relating to the creation of an advisory board and state and local interagency teams to assist in the provision of care for children and adolescents with serious emotional disturbance (1990).
Document Two:	<u>Vermont system of care plan</u> (n.d.)
Interview One:	Interagency Teams Administrator, Department of Mental Health and Mental Retardation
Interview Two:	Interagency Coordinator, Department of Education

Wisconsin

Case Replication

Description of the Initiative

History. In 1989 Wisconsin passed Senate Bill 31, (SS 46.56) The Integrated Service Programs for Children with Severe Disabilities Act. Leaders in human services in Wisconsin had begun much earlier to realize the need for improved treatment services for children with severe emotional disturbance and their families. Their efforts began in 1984 when Wisconsin became a recipient of a grant issued by the National Institute for Mental Health's Child and Adolescent Service System Program (CASSP). One goal of this initiative in Wisconsin was to recognize the role of families in the treatment of children and adolescents and build on their strengths. Other goals included the establishment of an interagency structure, use of case management to coordinate service delivery, and the creation of community-based services that could prevent institutional placements of children and adolescents with serious emotional disturbance.

The model. Senate Bill 31 enabled a county board of supervisors to appoint a coordinating committee and designate an administering agency for any related programs. The coordinating committee must include representatives from the county department of child welfare and protection services, the county department of mental health, the county department of developmental disability services, the family support program, the juvenile courts, the largest school district in the county and any cooperative educational service agency, other school districts willing to participate, and at least two parents of children with severe disabilities. This committee may also include: representatives from the department of vocational rehabilitation, representatives from any vocational education school district in the county, physicians specializing in the care of children, representatives from health maintenance organizations in the county, representatives from law enforcement agencies in the county, representatives from the county health department, and representatives from other appropriate agencies.

This local coordination committee must develop any necessary interagency agreements, ensure that new programs do not duplicate existing services, assist agencies to acquire the necessary funds for needed services, and review the appropriateness of service plans developed by specific treatment teams within the designated service coordination agency. The specific parameters of these interagency agreements are designated in the bill as well. The committee may also apply for state and federal grants, and establish target groups of children and families to receive services. The service coordination agency must identify a specific service coordinator for each child and the child's family. The service coordinator is responsible for the facilitation of the integrated service plan. This plan must include: present level of functioning, short-term and long-term goals and objectives, services needed and organizations responsible for providing such services. Each plan must also include specific criteria for measuring the effectiveness and appropriateness of the plan. Details of how the service plan will be funded must also be included. Senate Bill 31 requires the full participation of the family and close associates of the family in the development and implementation of the integrated services plan. The services provided in such plans must be community-based and in the least restrictive environment possible. Service plans must be reviewed every six months or more often if needed.

Senate Bill 31 establishes a statewide advisory committee to support the local efforts. This committee must be comprised of representatives from the county departments of health and social services, the department of public instruction, other educational agencies, experienced professionals, families with children with severe disabilities, advocates for such children and their families, the department of vocational rehabilitation, the vocational, technical and adult education system, health care providers, the courts, child welfare officials, and other appropriate officials. This state level interagency committee must monitor local programs and the coordination of services among agencies involved. This committee must submit a report regularly (every two years or more often) to the governor and both houses of the legislature. This report must evaluate existing programs established under this Act and make recommendations for any actions needed to improve services for children with severe disabilities and their families.

The Act also requires the department of health and human services to provide support to localities in the areas of service plan development, and mediation of conflict among service providers or between service recipients and organizations. The department must also conduct an evaluation of all programs funded under Senate Bill 31. This evaluation must include: number of days in out-of-home placements, whether programs met their goals, a comparison of problem behaviors before and after treatment, school attendance data, and school performance data, rates of delinquency, and parent satisfaction.

Evidence of Recommended Components

Two document reviews were conducted to establish the relationship of between Wisconsin's initiative and the set of recommended components: a) Integrated Service Programs for Children with Severe Disabilities (1989) and b) Project FIND: Families in new directions (Mezera, M. & Corp, C., 1993). Two informants were interviewed to confirm this relationship: a) a section chief from the child and adolescent section of the Bureau of Mental Health in the Wisconsin Department of Health and Social Services and b) the consultant for students with autism, TBI, OI, and OHI, from the Wisconsin Department of Public Instruction. The details of the this relationship can be found in Table 10.

Nine components were found in both documents and confirmed by both interviewees: case management, family focused services, flexible funding, full array of services, gatekeeping, increased funding, individualized services, integrated services, and interagency collaborative structure. Four additional components were found in the legislation and confirmed by both interviewees: community-based services, least restrictive environment, outcome driven evaluation and single point of entry. Two components were found in the support document and confirmed as common practice by both interviewees: competency enhancement and cost containment. Six components were identified by one or both interviewees as being regular practice in Wisconsin's service delivery system: cultural competency, developmentally appropriate services, prevention services, unconditional care, and wrap-around services. The final two components were not found in the documents and were confirmed absent from Wisconsin's current integrated services system as it pertains to House Bill 31 by both interviewees: co-location of services and early identification.

Table 10
Recommended components for comprehensive service delivery
Wisconsin

Components	Document One	Document Two	Interview One	Interview Two
Case management	●	●	●	●
Co-location				
Community-based	●		●	●
Competency enhancement		●	●	●
Cost containment		●	●	●
Cultural competency				
Developmentally appropriate				
Early identification				
Family focused	●	●	●	●
Flexible funding	●	●	●	●
Flexible programming		●	●	
Full array of services	●	●	●	●
Gatekeeping	●	●	●	●
Increased funding	●	●	●	●
Individualized services	●	●	●	●
Integrated services	●	●	●	●
Interagency collaborative structure	●	●	●	●
Least restrictive environment	●		●	●
Outcome evaluation	●		●	●
Prevention services				
Single point of entry	●		●	●
Unconditional care				
Wrap-around services				

Key: Table 10

Document One:	Integrated Service Programs for Children with Severe Disabilities (1989)
Document Two:	<u>Project FIND: Families in new directions</u> (1993)
Interview One:	Section Chief, Child and Adolescent Section, Bureau of Mental Health, Wisconsin Department of Health and Social Services
Interview Two:	Consultant for Autistic, TBI, OHI and OI students, Wisconsin Department of Public Instruction

Cross-case Analysis

Description of the Initiatives

History. The actual legislation reviewed in this study was passed in the late 1980s or early 1990s in all nine states. The dates of passage range from 1988 for Vermont's initiative to 1993 for Utah and Maryland. The driving forces behind these initiatives fell into four categories: increasing costs, increased number of children and adolescents in residential placements, a desire to reduce the duplication of services, and a need to improve the quality of services. Increasing costs was a motivator for Virginia. The desire to decrease residential placements was a factor for Virginia, New Jersey, Maryland, and Oklahoma. Three states expressed a desire to reduce the duplication of services: Virginia, Indiana, and Maryland. Six states also expressed the need to improve the quality of services for children and adolescents: Utah, Vermont, Wisconsin, North Dakota, New Jersey, and Maryland.

Seven states used a top-down approach to reform, with a strong legislative framework as the beginning of the initiative: Virginia, Indiana, Oklahoma, Vermont, Maryland, Utah, and North Dakota. The movement to change the service delivery structure in New Jersey and

Wisconsin began with local initiatives that spread to other areas and was eventually mandated in all localities through state level policy or legislation. Two states were supported in their efforts by grants from the National Institute of Mental Health's Child and Adolescent Service System Program (CASSP): Vermont and Wisconsin.

The models. All nine states studied had state and local interagency structures. The state level structures of all states studied had responsibilities for development of policies and procedures to guide the localities. Four of the states, Virginia, Utah, Oklahoma and Vermont, had two-tiered systems. In these states, one tier was set up to review and recommend policy and the other to make recommendations to the first level and provide technical assistance to localities. One state, Maryland, had a third tier consisting of a Policy Team. This group functioned as a stakeholder team to provide oversight for the entire system.

The major difference among the local structures was whether or not any local team actually reviewed cases and wrote treatment plans. In five states, Vermont, Indiana, Oklahoma, North Dakota, and Maryland, the local interagency team was responsible for the development of local policies and procedures. Four states, Virginia, New Jersey, Utah and Wisconsin, also had a local interagency team structure that was directly involved with individual cases. These teams, along with the families needing services, developed individual service plans and oversaw their implementation.

Evidence of Recommended Components

Table 11 shows which components were present in which states. For purposes of state-to-state comparison, a component was considered "present" in a state's initiative if it was found in the actual piece of legislation reviewed and confirmed by all interviewees. Four components were determined to be present in all nine states reviewed: family-focused services, full array of services, individualized services and, by definition from the selection of cases, interagency collaborative structure. The next most frequently found components were community based services, found in seven states and flexible funding, found in six states.

Three components were found in five of the states studied: case management, integrated services, and outcome evaluation. Four components were found in four states: gatekeeping, increased

Table 11
Recommended components for comprehensive service delivery
All states

Components	Virginia	Indiana	Maryland	New Jersey	North Dakota	Oklahoma	Utah	Vermont	Wisconsin
Case management	●			●			●	●	●
Co-location									
Community-based	●	●	●	●			●	●	●
Competency enhancement						●	●	●	
Cost containment		●		●		●			
Cultural competency				●					
Developmentally appropriate		●							
Early identification	●			●			●		
Family focused	●	●	●	●	●	●	●	●	●
Flexible funding	●		●		●	●	●		●
Flexible programming	●	●					●		
Full array of services	●	●	●	●	●	●	●	●	●
Gatekeeping	●		●	●					●
Increased funding			●	●		●			●
Individualized services	●	●	●	●	●	●	●	●	●
Integrated services			●	●	●	●			●
Interagency collaborative structure	●	●	●	●	●	●	●	●	●
Least restrictive environment	●		●	●					●
Outcome evaluation			●	●	●		●		●
Prevention services		●	●		●		●		
Single point of entry									●
Unconditional care									
Wrap-around services									

funding, least restrictive environment, and prevention services. Four components were found in three of the states studied: competency enhancement, cost containment, early identification, and flexible programming. Three components were found in one of the states studied: cultural competency, developmentally appropriate, and single point of entry. While often mentioned as part of practice in many states, three components were not found in any of the state legislative documents: co-location of services, unconditional care, and wrap-around services.

An analysis was done to determine the percent of states that included each component. Table 12 shows the list of recommended components and the number and percent of states that included that particular component. Three components were present in none of the nine states studied. Three components were present in 11% of the nine states studied. Four components were found in 34% of the nine states. Four components were found in 44% of the nine states studied. Three components were found in 56% of the nine states and one component was found in 67% while one other was found in 78%. Four components were found in 100% of the nine states studied.

Table 12
Percent of states utilizing each component

Components	Ratio of states	Percent of states
Case management	5/9	56%
Co-location	0/9	0%
Community based	7/9	78%
Competency enhancement	3/9	34%
Cost containment	3/9	34%
Cultural competence	1/9	11%
Developmentally appropriate	1/9	11%
Early identification	3/9	34%
Family focused	9/9	100%
Flexible funding	6/9	67%
Flexible programming	3/9	34%
Full array of services	9/9	100%
Gatekeeping	4/9	44%
Increased funding	4/9	44%
Individualized services	9/9	100%
Integrated services	5/9	56%
Interagency structure	9/9	100%
Least restrictive environment	4/9	44%
Outcome evaluation	5/9	56%
Prevention	4/9	44%
Single point of entry	1/9	11%
Unconditional care	0/9	0%
Wraparound services	0/9	0%

From the opposite perspective, the number of components from the set of recommended components found in each state was analyzed. This data is reported in Table 13. New Jersey had the highest percent with 61% of the 23 components found and confirmed by interviewees. Wisconsin had the next highest percent of the 23 components, 57%. Two states had 52% of the 23 components, Maryland and Utah. Virginia was next with 48% of the 23 followed by Indiana and Oklahoma with 39%. North Dakota had 35% of the 23 components followed by Vermont with 30%. The average number of the 23 components found in state level legislation in the nine states studied was 46%.

Additional Components. Four states, Virginia, North Dakota, Maryland and Utah, described an additional component as essential to the operation of their initiative: a structured public-private partnership between government service providers and private service providers.

Table 13

Percent of components present by state

State	Ratio	Percent
Virginia	11/23	48%
Indiana	9/23	39%
Maryland	12/23	52%
New Jersey	14/23	61%
North Dakota	8/23	35%
Oklahoma	9/23	39%
Utah	12/23	52%
Vermont	7/23	30%
Wisconsin	13/23	57%

Chapter 5

Discussion

Introduction

This study compared a set of recommended components for comprehensive service delivery that emerged from the literature to components found in legislation or policy documents from nine states. Twenty-three components were extracted from an extensive review of research and other work which looked at effective practices for systems change in this field. This set of components was used as a template to examine the characteristics of comprehensive service delivery systems developed in the nine selected states. As Knapp (1995) pointed out, it is difficult to study comprehensive service delivery systems. These systems are so complex that traditional cause and effect evaluations are less than satisfactory. This study was seen as a first step toward the creation of an ideal yet realistic model of effective service delivery for students with severe emotional disturbance.

This chapter will include a discussion of the findings and an overview of possible conclusions that can be drawn from the results. It will also include recommendations for related legislation or policy at the state level and an overview of the limitations of the study. Finally, it will include implications for further research.

Discussion of Findings

Two fairly distinct patterns of data emerged from the analyses of the components. The first pattern is the group of most commonly found components. A core set of four components - individualized services, family focused services, a full array of services, and interagency collaborative structure - was found in each state level policy or legislation studied. This set creates a model in which an interagency collaborative structure is designed to provide a full array of family-focused, individualized services. It could be said that without these core components, the legislation or policy would describe traditional service delivery. Assuming a state is interested in redesigning some aspect of its current system, it follows that these four components are the minimum set necessary to create a comprehensive service delivery system.

If the next two most frequently found components - community-based services and flexible funding - are added to this set, a picture emerges of a significantly changed service delivery system. Community-based services was found in seven states and flexible funding was found in six. Together, these six components form a system of comprehensive service delivery that provides a full array of family focused, individualized, community-based services through a flexibly funded, interagency collaborative structure.

If components are added according to the frequency they were found in this set of states, the model becomes increasingly idealized. For example, the three components found in five states were integrated services, outcome driven evaluation, and case management. Integrated service delivery requires professionals trained in segregated disciplines to cross firmly established boundaries. Acceptance of this component may require changes in professional training programs as well as service delivery systems. Outcome driven evaluations require complicated and often sophisticated data collection and analysis which might be prohibitive for some states. Case management can mean retraining for many levels of service providers. It is encouraging that five states studied are making efforts in this area.

Thus, it seems reasonable to designate the set of six most frequently found components as the core set. This set consists of community based services, family focused services, flexible funding, a full array of service delivery options, individualized services, and an interagency collaborative structure. This set depicts a service delivery system that would be a significant reform effort for any states dissatisfied with their traditional systems. As can be seen by Table 11, the states in this study that have at least this core set of six components are Virginia, Maryland, Utah, and Wisconsin.

As the strength of this group of components is examined, it is important to look at two sets of data. First, four states of the nine studied felt compelled to include each of these six components in their legislation. While this may not seen quantitatively significant, it does seem meaningful. Policymakers from several departments in each of these states, after studying this topic over time, reached consensus on the importance of these components for their reform efforts. This validates the importance of these components.

Even stronger is the data related to the individual components themselves. The fact that all nine states endorsed the first four components of this set says much about the compelling appeal of these descriptors. It means that policymakers from nine states with very heterogeneous profiles felt that reform must include agencies working closely together with parents as partners to create individualized service plans from a full array of service options. These commitments collapsed longstanding barriers among agencies and service providers. The strength of the final two components is also evidenced by their individual inclusion in state level legislation. The need to provide services in the community was endorsed by seven states and flexible funding was endorsed by six. When compared to the data about the restrictiveness of placements for children and youth with EBD and what is intuitively known about funding regulations, the endorsement of these two components by so many policymakers could be seen as radical systems change.

The second pattern of components that emerged from this study was the set of missing components. Three components were not found in any piece of legislation studied - co-location of services, unconditional care, and wrap-around services. These components share a significant characteristic. Co-location of services, unconditional care, and wrap-around services, if mandated by legislation, would be very costly for any locality to implement and fairly cost-prohibitive for an entire state. While cost containment or reduction was not found as a component in all legislation or policy documents, it was inferred by the interviewees as a factor for the missing components. No one interviewed felt that these components were unworthy or inappropriate characteristics for a service delivery system; rather, interviewees reported that these components were so idealistic as to be currently out of reach. For example, co-location of services would require massive movement of offices and treatment facilities to new locations which would have to be prepared to receive them. Such an undertaking would most likely need to happen on a small scale at first, gradually expanding from community to community if these programs proved successful.

It should also be noted that an additional component emerged from this study. Four states invited or mandated representatives from the private sector to participate on their interagency teams at the state and local levels. Interviewees reported that the rationale for this component centered on the need to lessen competition between the private and public service providers. The interviewees indicated they hoped and predicted private providers would be motivated to develop less restrictive, community-based systems if they were part of the team. As there was very little mention of such partnerships in the literature, this component will require further investigation.

Two patterns also emerged from the description of the models found in the legislation and the support documents. First, in each state's model the agencies that must collaborate were very clearly delineated. In most cases, the actual individual from each agency that must sit on the interagency team was specified. It seems significant that each state was careful to construct the specific makeup of these interagency teams. Although the agencies have different names in the various states, the agencies that were always mandated to be part of the interagency teams were education, mental health, social services, and juvenile justice or court services. After these core members were established there was wide variance on the additional members of the teams. Many states included parents on policy level teams, and four states included a representative of private service providers on one or more of their interagency teams. It was interesting to note that the policy or legislation for the states studied described or mandated very few specific procedures for the local interagency teams beyond membership and sometimes case review. For example, local agencies were not required to pool resources or engage in joint oversight of their implementation and evaluation efforts (Melaville and Blank, 1991).

Another pattern that emerged was the two distinct local interagency structures. In five states - Indiana, Oklahoma, Vermont, North Dakota, and Maryland - the local interagency teams set policy and procedures for service delivery in all programs for children and adolescents and their families. In the other four states, Virginia, New Jersey, Utah, and Wisconsin, there were two layers of local teams, one to set policy and procedures and one to review and oversee cases. The five states that have only local policy and procedures teams do not share any other components besides the ones that all states share. The four states that have the additional team to review cases and write treatment plans also share the components of case management and community-based services. While it will require further research to determine if one system is more effective than the other, it does seem that state level policy makers made specific decisions about how much structure they would dictate to localities. There is not, on the other hand, any clear pattern in these four states that would suggest lack of local flexibility. In fact, the commonality of case management and community-based components suggests that the added local structure might foster local flexibility.

Conclusions

The matrix that has emerged (see Table 11) by comparing the set of recommended components to components existing in a set of nine selected states provides a conceptual framework for systems change in service delivery for children and youth with serious emotional disturbance. There was not overwhelming congruence between the set of recommended components and those found in state legislation (an average of 46%), but a core set did emerge. This core set seems to outline a basic model for policy related to comprehensive service delivery. As described above, this model would have both state and local interagency structures with membership on the teams specified in detail. The local interagency structure would have access to a full array of services for children, youth, and their families. The services would be individualized to meet the specific needs of the children found eligible. Both the planning process and the service delivery system would require the full participation and involvement of the child's family. The services would be located in the community in which the family resides. The community would have the flexibility to use existing funds in creative ways or seek additional funds from untapped resources to pay for these services.

The question remains as to why so few recommended components appear in the legislation of these nine states. Only four components were common to all these state initiatives. It appears that some components, such as the core set that emerged from this study, may be more appropriate for state level policy or legislation and others are more appropriate for local application of that policy.

Limitations of the study

There are several factors that must be considered when drawing conclusions from the data collected in this study. First, many states did not define all the terms used to describe their initiative. This required the researcher to use some interpretation to extract components from the documents. The confirming interviews did assist with this extraction but misinterpretation cannot be ruled out entirely.

The second limitation is the number of states studied. Nine states provided some depth and breadth for the study. Studying fewer states might have allowed a more in-depth look at each state. A study of more states might have provided stronger evidence concerning the essential core of components.

The overview of each state's model must also be viewed with some caution. The information describing the history and models was taken directly from documents. The evidence of recommended components includes information from the interviewees. Specifically, the components that were described by the interviewees as occurring in practice were not substantiated. It was beyond the scope of this study to validate reported practices for each state.

Another limitation was the difficulty of keeping policy and practice separate. Only the actual legislation were clearly policy documents. In other support documents, it was less clear whether a component being described was policy or recommended practice for localities. Many interviewees were clear that local flexibility was a goal for their initiative. This flexibility meant that some lines between policy and practice were less distinct.

Caution must be used in looking at the tables reporting percents of components present for a state. Percents imply that each component is of equal value or equivalent. These components are all very different and represent a broad band of possible practices. Some are philosophical, such as family focused services, and others are very practical, such as increased funding. The percents are reported to show a snapshot of a state's relationship to the set of components. It should not be seen as an evaluation of the quality of any state's initiative.

Finally, the telephone interviews created some limitations for the study. These interviews lasted from 15 to 30 minutes. This was enough time to get confirmation of the components but not enough time to discuss the components in depth. Using the telephone eliminated information that could be extracted from body language and facial expressions. Longer, face-to-face interviews would have strengthened the study.

Recommendations for State Policy

As stated in the methodology section, the main purpose of policy research is to "provide policy makers with pragmatic, action-oriented recommendations..." (Majchrzak, 1984, p.12). The results of this research suggest five such recommendations.

The first is the creation of a set of definitions. It will never be possible to measure results accurately, compare programs, or study integrated service delivery systems comprehensively without an agreed upon set of defined terms. While some states defined some of the related terms, no state defined all terms and no two states agreed on all definitions. It is always difficult to be precise when discussing human services. Most practices and procedures are open to some interpretation. A clear set of defined terms, accepted across state boundaries, would add strength to our policies and our practices as well as future research efforts. While not a perfect model of federal education policy, the Individuals with Disabilities Education Act with its set of definitions related to special education, has provided some consistency across states. As comprehensive service delivery systems become more widespread, it may be necessary to define terms at the nationals level.

The second recommendation concerns the level of specificity in state level legislation. Many interviewees reported that specific components were left out of their legislation to give localities increased flexibility. Only further research will determine if this lack of specificity is an asset or a liability. Flexibility could allow a locality to do less rather than to do more or to do things differently. A community could decide to be less effective, utilize less collaboration in developing plans and policies, evaluate their efforts superficially, maintain barriers between disciplines, maintain a high frequency of restrictive placements, or fail to serve the most needful children.

A third recommendation is that the core set of recommended components become a starting place for policy makers as they consider systems change. This common core of components - individualized services, family focused services, a full array of services, interagency collaborative structures, flexible funding and community-based services - seems to be a reasonable starting point for any state beginning the process of comprehensive service delivery. Policy makers could then examine the other components in terms of their appropriateness in their state.

The fourth recommendation is for state policymakers to explore what other states are doing at two levels. First, states should examine what components other states have incorporated into their policies along with the processes used to select or reject specific components. Second, states should examine the results or outcomes from various initiatives in pursuit of the most effective policies. This is especially true of the idea of public-private partnerships which has received little attention in the literature but was included in the legislation of four of the states in this study.

Finally, the three components that were incorporated by five of the states studied, should be carefully scrutinized for inclusion at the state level - case management, integrated services, and outcome driven evaluation. While more difficult to manage at the state policy level, at least one of these components, outcome driven evaluation, seems intuitively important. Poor outcomes for these targeted youth and their families was mentioned by every state policy maker interviewed as a catalyst for change. It is imperative that systems change in this area be tied to careful, systematic evaluation of outcomes.

Recommendations for Further Research

The purpose of this research was to provide some knowledge about comprehensive services for students with serious emotional disturbance. Knowledge in this area must be seen as a continuum starting with national and state policy and procedures through implementation and practice to case by case outcomes. While much has been written about comprehensive service delivery, little is known. Research is needed at every point on this continuum.

Research is needed on the feasibility and potential impact of national norms or standards in this field. This parallels the questions about national standards in education currently being debated. This study suggests that a broad-based national policy which included a set of defined terms and mandated parameters is worthy of consideration.

Further study is needed to revise the list of recommended components. As practices are evaluated and other research is conducted, additional components might become apparent. Other components may be shown to hinder rather than enhance effective service delivery. Research is needed on the efficacy of each individual component and specific components used in pairs or clusters. Research is also needed to distinguish between components that are more effective as part of state policy and those that are more appropriate as part of local application of policy.

Research is needed on several specific aspects of practice in this area. Little is known about the efficacy of interagency teams, the quality of the plans they develop, or the extent to which families are actively involved in these plans.

A full evaluation of the two local models that emerged from this study seems warranted. It would be very valuable to know if having local interagency teams review cases is more effective than local teams that focus only on policy. The primary question seems to be whether an interagency team is more effective that the traditional multi-disciplinary or inter-disciplinary team.

A longitudinal review of cases before and after comprehensive service delivery implementation is needed. Very little is known about short term or long term changes in these families. Do families stay together? Do maladaptive and disruptive behaviors decrease in frequency? Do families acquire the skills needed to provide their own support system? Do children receiving such services stay in school and receive better grades? Do they gain the skills needed to live independently and interdependently? Do they obey the law and make contributions to their community?

Also needed is a detailed cost-effectiveness evaluation of comprehensive service delivery systems. Such research would be complicated by the inconsistent spending patterns from state to state. As can be seen from Table 11, some states have increased funding for their initiatives; other states have tried to reduce spending. Some states have tried to do both by reducing spending in one area (local tax dollars) and increasing it in others (grant funds, medicaid waivers). Some interviewees indicated that their states were redirecting money saved by less restrictive placements to community-based services. Whatever the status of funding for these programs, a method to determine cost-effectiveness is needed. There are programs of various sizes and characteristics in every state (Davis, Yelton, & Katz-

Leavy, 1995). Without a strong indication of the financial impact of these programs, states and localities will fail to match effort to outcomes.

Summary

Children and youth with emotional and behavioral disorders face many challenges and have traditionally poor outcomes. New hope for these youth and their families has been suggested by the literature on comprehensive, integrated service delivery models. Research in this area has been as fragmented as traditional service delivery models. It is a complex, sensitive topic which needs rich, descriptive analysis at many levels.

In this study, a set of recommended components for comprehensive service delivery, derived from the literature, was compared to legislative initiatives in nine states. A set of four components emerged as common to legislation in all nine states - individualized services, family focused services, a full array of service options, and an interagency collaborative structure. Two additional components were found with enough frequency to be included in the common core of components. Community-based services was found in seven states and flexible funding was found in six. This core set of six components described the characteristics of systems. The missing or less frequently documented components were reported as being part of local practice by many policymakers. Further research is needed to validate the implementation of these components and to determine their efficacy for comprehensive service delivery.

REFERENCES

Ackerman, N. W. (1966). Treating the troubled family. New York: Basic Books.

Act for Coordination of Special Services to Children and Youth, 10 Oklahoma. Stat. Ann. §§ 601.41-601.46 (1990).

Agencies Coming Together for Children and Youth at Risk Act, 146 Utah. Stat. Ann. §§ 63-75-1-7 (1989, amended 1993).

An act relating to the creation of an Advisory Board and state and local interagency teams to assist in the provision of care for children and adolescents with severe emotional disturbance, 3 Vermont. Stat. Ann. §§ 31-35 (1990).

Algozzine, B. (1979). An analysis of the disturbingness and acceptability of behaviors as a function of a diagnostic label. Minneapolis, MN: University of Minnesota. (ERIC Document Reproduction Service No. ED 185 748)

Bakan, P. (1971). Slaughter of the innocents. San Francisco: Jossey-Bass

Bayer, D. (1985). Variables in effective interagency relationships. Harlan KY: Cumberland River Comprehensive Care Center. (ERIC Document Reproduction Service No. ED 267 339)

Behar, L. (1990). Financing mental health services for children and adolescents. Bulletin of the Menninger Clinic, 54(1), 127-139.

Bernard, R., & Clazio, H. (1981). Socioeconomic bias in special education placement decision. Psychology in the Schools, 18, 178-183.

Brandenburg, N., Friedman, R., & Silver, S. (1990). The epidemiology of childhood psychiatric disorders: Recent prevalence findings and methodological issues. Journal of the American Academy of Child and Adolescent Psychiatry, 29, 76-83.

Bring Our Children Home Act, 4C New Jersey. Stat. Ann. Article VI. §§ 1-8 (1992).

Burchard, J., Burchard, S., Sewell, R., & VanDerBerg, J. (1993). One kid at a time: Evaluative case studies and descriptions of the Alaska Youth Initiative Demonstration Project. Washington DC: Georgetown University Child Development Center. (Eric Document Reproduction Service No. ED 364 043)

Children's Services Coordinating Committee Act, 185 North Dakota. Stat. Ann. §§ 54-56-01-01 (1987).

Children's Services Coordinating Committee Appropriations Act, 185 North Dakota. Stat. Ann. 54-56-05-13 (1993).

Comprehensive Services Act for At Risk Youth and Families, 46 Virginia. Stat. Ann. §§2.1-745-759 (1992).

Council on Community Services for Youth and Families. (1991). Improving care for troubled and "at-risk" youth and their families: Restructuring service delivery and funding. Richmond, VA: A report to the Governor and General Assembly.

Cullinan, D., Epstein, M., & Kauffman, J. (1984). Behavior disorders of children and adolescents. Englewood Cliffs, NJ: Prentice-Hall.

Davis, M., Yelton, S., & Katz-Leavy, J. (1995). State child and adolescent mental health: Administration, policies and laws. Tampa, FL: Florida Mental Health Institute, University of South Florida, The Research and Training Center for Children's Mental Health.

Dryfoos, J. (1994). Full service schools: A revolution in health and social services for children, youth and families. San Francisco: Jossey-Bass.

Dunst, C., Trivette, Starnes, A., Hamby, D., & Gordon, N. (1993). Building and supporting family support initiatives: A national study of programs for persons with developmental disabilities. Baltimore: Brookes.

Elmer, E. (1967). Children in Jeopardy. Pittsburgh, PA: University of Pittsburgh Press.

Epstein, M., Nelson, C., Polsgrove, L., Coutinho, M., Cumblad, C., & Quinn, K. (1993). A comprehensive community based approach to serving students with emotional and behavioral disorders. Journal of Emotional and Behavioral Disorders, 1(2), 127-133.

Epstein, M., & Quinn, K. (1996). A case study approach to analyzing the relationship between children and services in a system of care. Journal of Emotional and Behavioral Disorders, 4(1), 21-29.

Establishment of the Office of Planning and Coordination for Services to children and Youth, 10 Oklahoma. Stat. Ann. §§ 601.6a-601.12 (1990).

Forness, S., Kavale, K., & Lopez, M. (1993). Conduct disorders in school: Special education eligibility and comorbidity. Journal of Emotional and Behavioral Disorders, 1(2), 101-108.

Frazier, D., & DeBlassie, R. (1984). Diagnosing behavior disordered early adolescents as a function of cultural differences. Adolescence, 19, 381-390.

Fredericks, H. (1993). The education of troubled youth. Unpublished manuscript.

Friend, M., & Cook, L. (1992). Interactions: Collaboration skills for school professionals. New York: Longman.

Gardner, S. (1990). Failure by fragmentation. Equity and Choice, winter, 4-12.

Governor's office for Children, Youth and Families. (1995). Background report: Policy team retreat. Baltimore, MD: Author.

Guba, E., & Lincoln, Y. (1989). Fourth generation evaluation. Newbury Park, CA: Sage Publications.

Hazel, R., Barber, P., Roberts, S., Behr, S., Helmstetter, E., & Guess, D. (1988). A community approach to an integrated service system for children with special needs. Baltimore MD: Brookes Publishing.

Harrington, N., Schaefer, M., & Burchard, J. (1991). A case study of the use of individualized care to reintegrate a youth with serious emotional disturbance into the community. In A. Algarin, and R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp.127-140). Fourth annual research conference proceedings. Tampa, Florida: Research and Training Center for Children's Mental Health: Florida Mental Health Institute, University of South Florida.

Heffinger, C., Bickman, L., Lane, T., Keeton, W.,Hodges, V., & Behar, L. (1991). The Fort Bragg child and adolescent demonstration: Implementing and evaluating a continuum or care. In A. Algarin, and R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp. 83-96). Fourth annual research conference proceedings. Tampa, Florida: Research and Training Center for Children's Mental Health: Florida Mental Health Institute, University of South Florida.

Heshusius, L. (1994). Freeing ourselves from objectivity: Managing subjectivity or turning toward a participatory mode of consciousness? Educational Researcher, 23(3), 15-22.

Hoagwood, K. (1991). Evaluation of the outcomes of youth with emotional disturbance in residential placements for educational purposes. In A. Algarin, and R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp.141-148). Fourth annual research conference proceedings. Tampa, Florida: Research and Training Center for Children's Mental Health; Florida Mental Health Institute, University of South Florida.

Hodges, K., Bickman, L., & Kurlz, S. (1991). Multidimensional measure of level of functioning for children and adolescents. New

York: Harper and Row.

Hyde, K., Woodworth, K., Jordon, K., & Burchard, J. (1994). Wrapping services in an urban setting: Outcomes of service reform in Baltimore. In C. Liberton, K. Kutash, & R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp. 255-260). Seventh annual research conference proceedings, Tampa, Florida: Research and Training Center for Children's Mental Health; Florida Mental Health Institute, University of South Florida.

Integrated Services Programs for Children with Severe Disabilities, 1101 Wisconsin. Stat. Ann. §§ 46.56-46.69 (1989).

James, H. (1975). The little victims: How America treats its children. New York: David McKay,

Johnson, W., McLaughlin, J., & Christensen, M. (1982). Interagency collaboration: Driving and restraining forces. Exceptional Children, 48(5), 395-399.

Joint Commission on the Mental Health of Children. (1969). Crisis in child mental health. New York: Harper and Row.

Kadel, S. (1992). Interagency collaboration: Improving the delivery of services to children and families. Atlanta: Southeastern Regional Vision for Education.

Kagan, S. (1991). United we stand: Collaboration for child care and early intervention services. New York: Teachers College Press.

Kaplan, A. (1964). The conduct of inquiry. San Francisco: Chandler.

Kaufman, J. (1994) Characteristics of children's behavior disorders, fourth edition. Columbus, OH: Merrill.

Kelly, T., Bullock, L., & Dykes, M. (1977). Behavioral disorders: Teachers perceptions. Exceptional Children, 43, 440-444.

Kleinhammer-Tramill, P., Rosenkoetter, S., & Tramill, J. (1994). Early intervention and secondary/transition services: Harbingers of change in education. Focus on Exceptional Children, 27, 2. 1-14.

Knapp, M. (1995). How shall we study comprehensive services for children and families? Educational Researcher, 24(4), 5-16.

Knitzer, J. (1982). Unclaimed children. Washington DC: Children's Defense Fund.

Knitzer, J., Steinberg, Z., & Fleisch, B. (1990). At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems. New York: Bank Street College of Education.

Knitzer, J. & Yelton, S. (1990). Collaborations between child welfare and mental health. Public Welfare, spring, 24-33.

Koyanagi, C., & Gaines, S. (1993). All systems failure: An examination of the results of neglecting the needs of children with serious emotional disturbance. Alexandria, VA: The National Mental Health Association and the Federation of Families for Children's Mental Health.

Kutash, L., Duchinowski, A., & Sondheimer, D. (1994). Expanding the research base for children's mental health services. Journal of Emotional and Behavioral Disorders, 2(4), 199-197.

Lincoln, Y. & Guba, E. (1985). Naturalistic inquiry. Newbury Park, CA: Sage Publications.

Majchrzak, A. (1984). Methods for policy research. Newbury Park, CA: Sage Publications.

Marder, C., & Cox, R. (1991). More than a label: Characteristics of youth with disabilities. In M. Wagner, L. Newman, R. D'Amico, E. Jay, P. Butler-Nalin, C. Marder, & R. Cox, (Eds.), Youth with disabilities: How are they doing? The first comprehensive report from the National Longitudinal Transition Study of special education students. Menlo Park, CA: SRI International.

McLaughlin, M., Leone, P., Warren, S., & Schofield, P. (1994).

Doing things differently: Issues and options for creating comprehensive school linked services for children and youth with emotional or behavioral disorders. College Park, Maryland: The Center for Policy Options in Special Education; Institute for the Study of Exceptional Children and Youth, University of Maryland at College Park.

Melaville, A., Blank, M., & Asayesh, G. (1993). Together we can: A guide for crafting a pro-family system of education and human services. Washington DC: U.S. Government Printing Office.

Melaville, A., & Blank, M. (1991). What it takes: Structuring interagency partnerships to connect children and families with comprehensive services. Washington DC: Education and Human Services Consortium.

Mertens, D., & McLaughlin, J. (1995). Research methods in special education. Thousand Oaks, CA: Sage Publications.

Mezera, M., & Corp, C. (1993). Two models of Robert Wood Johnson Mental Health Services Program for Youth projects using parents as advocates in Pennsylvania and Wisconsin: Rationale, strategies and outcomes. In C. Liberton, K. Kutash, & R. Friedman, (Eds.) A system of care of children's mental health: Expanding the research base (pp.53-58). Sixth annual research conference proceedings. Tampa, FL: Research and Training Center for Children's Mental Health; Florida Mental Health Institute, University of Southern Florida.

Moore, D.,Suter, E., & Igneizi, S. (1991) Post-CASSP evaluation in Ohio. In A. Algarin, and R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp. 113-125). Fourth annual research conference proceedings. Tampa, Florida: Research and Training Center for Children's Mental Health; Florida Mental Health Institute, University of South Florida.

Nelson, C., & Pearson, C. (1991) Integrating services for children and youth with emotional and behavioral disorders. Reston VA: The Council for Exceptional Children.

New Jersey Department of Human Services. (1994). Bring our children home act plan. Trenton, NJ: Author.

Office for Children, Youth and Families, 49D Maryland. Stat. Ann. §§ 1-38 (1983 and Supp. 1995).

Office of the Governor. (1995). Step ahead: Indiana collaboration project. Indianapolis, IN: Author.

Oklahoma Interagency Coordinating Council for Special Services to Children and Youth. (1995). State plan for special education and special student services coordination and assistance: Final report of the 3 year plan. Oklahoma City, OK: Oklahoma Commission on Children and Youth.

Oklahoma Planning and Coordinating Council for Services to Children and Youth. (1991). Children: Oklahoma's Gift to Tomorrow, A State Plan for Services to Children and Youth, 1992-1995. Oklahoma City, OK: Author.

Olson, D. Whitbeck, J., & Robinson, R. (1991). The Washington experience: Research on community efforts to provide individualized tailored care. In A. Algarin, and R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp. 113-125). Fourth annual research conference proceedings. Tampa, Florida: Research and Training Center for Children's Mental Health; Florida Mental Health Institute, University of South Florida.

Pandiani, J., & Maynard, A. (1991). Vermont local interagency team evaluation: Team members perceptions of system's process and outcomes. In A. Algarin, and R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp. 113-125). Fourth annual research conference proceedings. Tampa, Florida:

Research and Training Center for Children's Mental Health; Florida Mental Health Institute, University of South Florida.

Pfeiffer, S. & Strzelecki, S. (1990). Inpatient treatment of children and adolescents: A review of outcomes studies. Journal of the American Academy of Child and Adolescent Psychiatry, 29, 947-853.

President's Commission on Mental Health, (1978). Report of the sub-task panel on infants, children, and adolescents. Washington DC: U.S. Government Printing Office.

Rivera, V., & Kutash, K. (1994). Components of a system of care: What does the research say? Tampa, FL: University of South Florida; Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Shoop, R. (1976, revised). Developing interagency cooperation. Midland Michigan: Pendell Publishing.

Stainback, S., & Stainback, W. (1988). Understanding and conducting qualitative research. Dubuque, IA: Kendall/Hunt Publishing.

Stake, R. (1978). The case study method in social inquiry, Educational Researcher, 7, 5-6.

Step Ahead Comprehensive Early Childhood Program, 1.8

Indiana. Stat. Ann. §§ 20-1-1.8-1-23 (1992).

Street, S., & Friedman, R. (1984). Interagency collaboration for children with emotional disorders. Tampa FL: Florida Mental Health Institute, University of South Florida.

Stroul, B. (1993). Systems of care for children and adolescents with severe emotional disturbances: What are the results? Washington DC: Georgetown University Child Development Center; CASSP Technical Assistance Center.

Stroul, B., & Friedman, R. (1986, revised 1994). A system of care for children and youth with severe emotional disturbances. Washington DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Subcabinet for Children, Youth and Families. (1993). Senate Bill 588: Plan for implementation. Baltimore, MD: Author.

Tighe, T., & Brooks, T. (1994). Evaluating Individualized services in Vermont: Intensity and patterns of services, costs and financing. In C. Liberton, K. Kutash, & R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp. 47-52). Seventh annual research conference proceedings, Tampa, Florida: Research and Training Center for Children's Mental Health;

Florida Mental Health Institute, University of South Florida.

Touliatos, J., & Lindholm, B. (1980). Relationship of children's grade in school, sex, and social class to teachers' ratings on the behavior problem checklist. Journal of Abnormal Psychology, 3, 115-126.

U.S. Department of Education. (1994a). National agenda for achieving better results for children and youth with serious emotional disturbance. Washington DC: U.S. Government Printing Office.

U.S. Department of Education. (1994b). Sixteenth annual report to congress on the implementation of The Individuals with Disabilities Act. Washington DC: U.S. Government Printing Office.

U.S. Congress, Office of Technology Assessment. (1986). Children's mental health: Problems and services-A background paper. Washington DC: U.S. Government Printing Office.

Utah Division of Menta Health. (1993). Utah's interagency council manual. Salt Lake City, UT: Author.

Vermont Advisory Board for Children and Youth with Special Mental Health Needs. (n.d.). Vermont System of Care Plan. Waterbury, VT: Agency of Human Services, Department of Mental Health and Retardation.

Virginia Department of Education. (1993). *Demographics of students exiting special education.* 1992 House Joint Resolution #4 of the Virginia General Assembly. Richmond VA: Author.

Virginia Department of Mental Health, Mental Retardation and Substance Abuse. (1994). *Comprehensive services for at-risk youth and families.* Richmond VA: Author.

Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services. (1995). *Comprehensive Services Act: Implementation assessment-fiscal year 1994.* Richmond, VA: Research and Evaluation Center.

Virginia Department of Planning and Budget. (1990). *Study of children's residential services.* Richmond, VA: Author.

Virginia Office of Comprehensive Services. (1992). *Comprehensive Services Act for At Risk Youth and Families: A report to the governor and general assembly.* Richmond VA: Author.

Virginia State Management Team. (1992). *Comprehensive Services Act for At Risk Youth and Families: Implementation manual.* Richmond VA: Author.

Weithorn, L. (1988). Mental hospitalizations of troublesome youth: An analysis of skyrocketing admission rates. *Stanford Law*

Review, 40, 773-838.

Williams, C., & Gans, A. (1993). Qualitative Evaluation of Community-based Prevention Services: The Monmouth County 65K program. In C. Liberton, K. Kutash, & R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp. 197-205). Sixth annual research conference proceedings, Tampa, FL: Research and Training Center for Children's Mental Health; Florida Mental Health Institute, University of South Florida.

Yin, R. (1993). Applications of case study research. Newbury Park, CA: Sage Publications.

Yin, R. (1994). Case study research: Designs and methods. Newbury Park, CA: Sage Publications.

Yoe, J., Bruns, E. & Burchard, J. (1994). Evaluating individualized services in Vermont: Behavioral and service outcomes. In C. Liberton, K. Kutash, & R. Friedman, (Eds.) A system of care for children's mental health: Expanding the research base (pp. 9-12). Seventh annual research conference proceedings, Tampa, Florida: Research and Training Center for Children's Mental Health; Florida Mental Health Institute, University of South Florida.

Appendix A

Recommended Components for Comprehensive Services

Checklist

State: Title of Legislation/policy:

Case management ___

Community/neighborhood based ___

Co-location) ___

Competency enhancement ___

Cost containment/reduction ___

Cultural competency ---

Developmentally appropriate ___

Early identification ___

Family focused ___

Flexible funding ___

Flexible programming ___

Full array of service options ___

Gatekeeping ___

Increased funding ___

Individualized services (child-centered) ___

Integrated services ___

Interagency collaborative structure ___

Least restrictive environment ___

Outcomes driven evaluation ___

Prevention services ___

Single point of entry ___

Unconditional care ___

Wrap-around services ___

Appendix B

Comprehensive Services for EBD children and Youth

Interview Questions for Agency Informants

Date:

Name:

Title:

Agency:

Address:

Phone/fax:

Referred by:

Relationship of the informant to the legislation or policy:

1. What is the title, if any, of the comprehensive service initiative in your state?

2. Are there any other critical pieces of related legislation?

3. How did this initiative get started in your state?

Follow-up:

4. (If not addressed above)-What are the major goals of this initiative?

Follow-up:

5. Could you explain the rationale for including the following

components in your state's policy or legislation?

Follow-up:

6. Are there reasons that your state policy or legislation does not address the following components?

Follow-up:

7. Are there any supporting documents you could share related to this legislation or policy?

8. Is there anything else you want to tell me about this initiative?

Notes/Impressions:

Note: Lists of components and their definitions were sent to interviewees ahead of time.

Appendix C

Agency Informants on Comprehensive Services Legislation or Policy

Interview Feedback Survey

Date

Dear ________________,

On ___________, 1995 we spoke on the phone regarding your state's legislative initiative toward comprehensive services for children and youth with emotional or behavioral problems. I have attached a summary of our conversation for your review.

Please examine this document carefully and answer the questions below:

1. Does this summary accurately represent our conversation?
2. If no, please indicate corrections you feel would be needed; feel free to write on the document or indicate changes here:
3. After having time to think and review this summary, would you like to change any of your answers? Please write on the document or add comments here:

Thank you so much for taking the time to speak with me and review this document. Please put your responses, comments, corrections or changes in the attached envelope and return it to me as soon as possible. If you have any questions or would like to speak to me directly, please feel free to call. I can be reached at (804) 427-4425.

Sincerely,

Elizabeth B. Hill, EdS.

Vita

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