

**Systems of Care  
Promising Practices in Children's Mental Health  
1998 Series**

**VOLUME III**

**THE ROLE OF EDUCATION IN A SYSTEM OF CARE:  
EFFECTIVELY SERVING CHILDREN WITH EMOTIONAL  
OR BEHAVIORAL DISORDERS**

**Center for Effective Collaboration and Practice  
American Institutes for Research**

**Authors:**

Darren W. Woodruff, Ph.D.

David Osher, Ph.D.

Catherine C. Hoffman, A.B.

Allison Gruner, B.A.

Mark A. King, B.A.

Stephanie T. Snow, B.A.

Jonathan C. McIntire, Ph.D.



Child, Adolescent, and Family Branch  
Division of Knowledge Development and Systems Change  
Center for Mental Health Services  
Substance Abuse and Mental Health Services Administration  
U.S. Department of Health and Human Services

**U.S. Department of Health and Human Services**

Donna Shalala

*Secretary*

**Substance Abuse and Mental Health Services Administration**

Nelba Chavez

*Administrator*

**Center for Mental Health Services**

Bernard S. Arons, *Director*

**Division of Knowledge Development and Systems Change**

Michael English, *Director*

**Child, Adolescent, and Family Branch**

Gary De Carolis, *Chief*

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# Foreword

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It is with great pleasure that we present the first collection of monographs from the *Promising Practices Initiative* of the Comprehensive Community Mental Health Services for Children and Their Families Program. The Comprehensive Community Mental Health Services for Children and Their Families Program is a multi-million dollar grant program that currently supports 41 comprehensive systems of care throughout America, helping to meet the needs of many of the 3.5 to 4 million children with a serious emotional disturbance living in this country. Each one of the seven monographs explores a successful practice in providing effective, coordinated care to children with a serious emotional disturbance and their families.

The 1998 Series marks a turning point in this five-year-old federal effort, which is administered by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. The first generation of five-year grants is about to come to an end, and with that “graduation” comes a responsibility to add to the national knowledge base on how best to support and service the mental health needs of children with serious emotional disturbance. Until the very recent past, these young people have been systematically denied the opportunity to share in the home, community and educational life that their peers often take for granted. Instead, these children have lived lives fraught with separation from family and community, being placed in residential treatment centers or in-patient psychiatric centers, hundreds and even thousands of miles away from their home. For many of these young people, a lack of understanding of their psychopathology, underdeveloped or non-existing community resources, and a sense of frustration of what to do have led to their eventual placement away from home.

The *Promising Practices Initiative* is one small step to ensure that all Americans can have the latest available information about how best to help serve and support these children at home and in their community. Children with serious emotional disturbance utilize many publicly funded systems, including child welfare, juvenile justice, special education, and mental health, and they and their families often face many obstacles to gaining the care they need due to the difficulties and gaps in navigating multiple service systems. Systems of care provide a promising solution for these children and their families by coordinating or integrating the services and supports they need across all of these public service systems.

The information contained within these monographs by and large has been garnered within the original 31 grants of the Comprehensive Community Mental Health Services for Children and Their Families Program. The research was conducted in a manner that mirrored the guiding principles of the systems of care involved so that it was family-driven, community-based, culturally relevant, and inclusive. Methods for information collection included: site visits and focus groups; accessing data gathered by the national program evaluation of all grantees; and numerous interviews of professionals and parents. Family members were included in the research and evaluation processes for all of the monographs. Two of the papers directly address family involvement, and all of the papers dedicate a section to the family's impact on the topic at hand. The research was drawn from the community-based systems of care and much of the research comes from systems of care with *culturally diverse populations*.

The 1998 *Promising Practices* series includes the following volumes:

Volume I - *New Roles for Families in Systems of Care* explores ways in which family members are becoming equal members with service providers and administrators, focusing specifically on two emerging roles: family members as “system of care facilitators” and “family as faculty.”

Volume II - *Promising Practices in Family-Provider Collaboration* examines the fundamental challenges and key aspects of success in building collaboration between families and service providers.

Volume III - *The Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders* explores sites that are overcoming obstacles to educating children with a serious emotional disturbance and establishing successful school-based systems of care.

Volume IV - *Promising Practices in Wraparound* identifies the essential elements of wraparound, provides a meta-analysis of the research previously done on the topic, and examines how three sites are turning wraparound into promising practices in their system of care.

Volume V - *Promising Practices: Training Strategies for Serving Children with Serious Emotional Disturbance and Their Families in a System of Care* examines theories of adult learning, core values, and four key areas (cultural competence, family-professional relationships, systems thinking, and inter-professional education and training), and looks at promising practices that are combining these concepts into a successful sustainable training program.

Volume VI - *Promising Practices: Building Collaboration in Systems of Care* explores the importance of collaboration in a system of care focusing on three specific issues: the foundations of collaboration, strategies for implementing the collaborative process, and the results of collaboration

Volume VII - In *A Compilation of Lessons Learned from the 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and Their Families Program*, the grantees themselves share their experiences in five main areas: family involvement/empowerment, cultural competency, systems of care, evaluation, and managed care.

**These seven documents are just the beginning of this process. As you read through each paper, you may be left with a sense that some topics you would like to read about are not to be found in this series. We would expect that to happen simply because so many issues need to be addressed. We fully expect this series of documents to become part of the culture of this critical program. If a specific topic isn't here today, look for it tomorrow. In fact, let us know your thoughts on what would be most helpful to you as you go about ensuring that all children have a chance to have their mental health needs met within their home and community.**

So, the 1998 *Promising Practices* series is now yours to read, share, discuss, debate, analyze, and utilize. Our hope is that the information contained throughout this Series stretches your thinking and results in your being better able to realize our collective dream that all children, no matter how difficult their disability, can be served in a quality manner within the context of their home and community. COMMUNITIES CAN!

Nelba Chavez, Ph.D.  
Administrator  
Substance Abuse and Mental Health  
Services Administration

Bernard Arons, M.D.  
Director  
Center for Mental Health Services

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# Executive Summary

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Improving outcomes for children with serious emotional disturbance depends not only on improving their school and learning opportunities, but also on promoting effective collaboration across other critical areas of support: families, social services, health, mental health, and juvenile justice. Although bringing about such collaboration poses a major challenge—due to different system priorities, agendas, structures, and ways of operating—the results of collaboration for children with serious emotional disturbance and their families include greater school retention and improved educational, emotional, and behavioral development. Our study examines the efforts, experiences, and outcomes for three urban sites that have struggled, with some success, to overcome the challenges to creating a comprehensive, school-based system of care.

## **CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE**

Children with serious emotional disturbance may be eligible for special education and related services under the Individuals with Disabilities Education Act (IDEA); however, although mental health researchers estimate that up to 19 percent of the student population exhibit symptoms of serious emotional disturbance, only one percent of students are identified and referred for the necessary support services. Indeed, national evaluation data from the Center for Mental Health Services (CMHS) reinforce the point that many children and youth with serious emotional disturbance are not receiving special education services.

**Students that are identified by schools as having serious emotional disturbance are usually male, over 13, and come from families with an annual income of less than \$12,000. Many come from single-parent homes, and African American children and youth are over-represented among this group. Because these students do not receive a full range of needed services, they typically realize poor school outcomes. Specifically, students with serious emotional disturbance fail more classes; miss more days of school; have lower grades; are retained at the same grade level; drop out more frequently; have a lower graduation rate; and have a higher dropout rate than other students with disabilities.**

## **Meeting the Needs of Children with Serious Emotional Disturbance**

The education system has struggled to accommodate the needs of children and youth with serious emotional disturbance and to effectively integrate them into mainstream classrooms. IDEA was passed, in part, to address the fact that more than a million children with behavioral disorders were excluded from public schooling on account of their behavior and the lack of services to meet their individual needs.

**IDEA, signed into law in 1975, established that all children with disabilities have a right to a free, appropriate public education. It offers funding and policy assistance to states in providing appropriate support services (e.g., counseling and transportation) to students with special needs. In 1984, Congress authorized the National Institute of Mental Health to start the Child and Adolescent Service System Program (CASSP) to help states develop comprehensive, community-based systems of care for emotionally disturbed children and youth.**

**However, neither IDEA nor CASSP has had a significant impact on the education of children with serious emotional disturbance, as observed by Congress during the 1990 reauthorization of IDEA. As a result, the U.S. Department of Education developed the *National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance*. The Agenda's targets include expanding positive learning opportunities; strengthening school and community capacity; addressing issues of diversity; collaborating with families; promoting appropriate assessment; providing ongoing skill development; and creating comprehensive and collaborative systems.**

## **The Role of Education in a System of Care**

Education plays a critical role in the development of children. Positive learning experiences help to prevent emotional and behavioral problems. Furthermore, schools provide a logical setting for both early identification of children at risk for serious emotional disturbance and for effective provision of services. Despite this acknowledged importance a 1992 study found schools to be only marginally involved in systems of care.

**Much more needs to be learned about how to involve schools in a system of care. In December 1997 and February 1998, focus groups comprised of staff from CMHS program grantees defined key questions regarding this issue. Those questions follow:**

- How do you build a real partnership with schools?
- How do you provide prevention services for children and youth who are as yet unidentified as having serious emotional disturbance?
- How do you get school personnel to buy into wraparound (system of care) strategies?
- How do you engage local education agencies in the system of care?
- How do you build opportunities for parents to work as partners with schools?
- How do you help school staff feel safe "outside of their usual box"?
- How do you have an impact on school services and programs?

- How do you integrate “plans” of various agencies and partners?

The issues posed by these questions are relevant in analyzing promising practices employed by select CMHS partnerships.

## **METHODOLOGY**

After a careful review of the literature on promising educational practices and on systems of care in education-based settings, three sites were chosen for participation in this monograph. There were several criteria for selection. First, they were chosen from a group of CMHS grantees that were at or near the end of their five-year funding cycle. This allowed us to examine the successes and challenges that the sites faced over time, and to also see how site administrators developed and evolved their programs and agency interactions to address specific issues. Second, they were nominated by individuals knowledgeable about education in all the sites. Third, program data suggested that they were realizing positive outcomes. Other criteria included: operation by the partnership in urban settings; use of local schools and the community as a foundation for services; and the integration of both families and service providers (i.e., education, juvenile justice, social services, health, and mental health) into their partnership. Two researchers visited each site and focus groups, interviews, and observations were conducted with a variety of stakeholders, including program administrators, clinicians, teachers, family members, and children. In addition to these visits, the researchers gathered information from other CMHS sites, including schools and state and county officials in Eugene, Oregon; Stark County, Ohio; and Vermont.

## **PROMISING PRACTICES THAT INVOLVE EDUCATION IN A SYSTEM OF CARE**

As noted earlier, collaboration among service providers helping children and youth with serious emotional disturbance is difficult. Yet, collaboration is possible and has shown itself to be effective in improving outcomes for children. To see what was possible, this study examined three urban, CMHS funded sites that have struggled with and started to overcome the challenges to collaboration. The sites are located in East Baltimore, South Philadelphia, and Rhode Island. The fact that these are urban sites was particularly crucial since the literature review found that the research focusing on promising school-based practices largely ignores urban contexts, where educators and service providers view the challenges as especially daunting. The monograph focuses on these settings in order to develop the knowledge base about interventions in urban contexts.

## **The Three Sites**

### **The South Philadelphia Family Partnership, Philadelphia, Pennsylvania**

The South Philadelphia Partnership, sponsored by the Children's Unit of the Philadelphia Office of Mental Health, is a collaborative effort involving the participation of more than a dozen groups, including citywide service agencies, family advocacy groups, and the school district of Philadelphia. The partnership provides an array of services and support to children with serious emotional disturbance and their families.

**A key feature of the partnership's approach to implementing an effective system of care is its emphasis on *school-based* behavioral health services that are comprehensive, preventative, family driven, integrated, and flexible. Working in support of the partnership are consultation and education (C&E) specialists, who are mental health professionals, and intensive case managers (ICMs), who are trained mental health clinicians. They work with schools, children with serious emotional disturbance, and their families to provide comprehensive support.**

### **East Baltimore Mental Health Partnership, Baltimore, Maryland**

The East Baltimore Partnership was developed in 1993 by a coalition of state, city, and local leaders, including representatives from city agencies; state departments; and other private and public entities (e.g., Johns Hopkins University, University of Maryland, Families Involved Together, and Alliance for the Mentally Ill). The Partnership's core service programs to assist children with serious emotional disturbance and their families include the Family Resources Coordination Unit, an outpatient unit, and the School-Based Program. Four principles guide the work of the Partnership: systems of care should be child and family centered; the needs of the child and family dictate the type and mix of services; systems of care should place decision-making responsibility in the hands of the local community; and services should help families empower themselves to achieve the highest level of participation in community life.

### **Project REACH, Rhode Island**

The Resources Effectively Allocated for Children Project (REACH) focuses on children and youth who meet the CMHS standards for severe emotional and behavioral problems and their families, regardless of their eligibility within state guidelines. A set of concrete principles defines how REACH serves those needs. First, the overarching goal of the project is to identify and provide a full continuum of services for children and youth with severe emotional and behavioral problems. Second, the provision of services must be highly flexible, child and family driven, and community based. Third, services should also consist of collaborations among both public and private agencies, and must be planned in a culturally competent manner to maximize access and delivery. REACH is a statewide program, operating in all of Rhode Island's

“catchment” areas, each with a Local Coordinating Council (LCC) responsible for implementing the system of care in the communities within that region.

## **CROSS-SITE FINDINGS REGARDING DEVELOPMENT OF SYSTEMS OF CARE**

The programs profiled here illustrate both the complexities and rewards of establishing school-based systems of care. Our visits to the partnerships revealed practices that were common to all the partnerships and evident in their success. The six practices that seem most integral to the success of the systems of care follows:

- *The use of clinicians or other student support providers in the schools to work with students, their families, and all members of the school community, including teachers and administrators.*
- *The use of school-based and school-focused wraparound services to support learning and transition.*
- *The use of school-based case management.* Case managers help determine needs; they help identify goals, resources and activities; they link children and families to other services; they monitor services to ensure that they are delivered appropriately; and they advocate for change when necessary.
- *The provision of schoolwide prevention and early intervention programs.* Prevention helps those students with or at risk of developing emotional and behavioral problems to learn the skills and behaviors that help in following school rules and enjoying positive academic and social outcomes. Early intervention allows schools to provide students with the support and training they need to be more successful in managing their behavior.
- *The creation of “centers” within the school to provide support to children and youth with emotional and behavioral needs and their families.* Students in the centers interact with caring staff members who can help students and their families connect with the entire system of care to help in meeting their needs.
- *The use of family liaisons or advocates to strengthen the role and empowerment of family members in their children's education and care.* All three sites studied have harnessed the power that involving family members as *equal partners* brings to their comprehensive programs.

## **CONCLUSION**

It is possible to improve outcomes for children with serious emotional disturbance. While many urban schools fail to attend to students' mental health needs, the South Philadelphia Partnership's efforts are helping to develop school-based practices that address the mental health needs of all students. Similarly,

while many have written off “poor, multi-problem families” as being unable to support their children, East Baltimore’s efforts have enabled mothers struggling with HIV and addiction to play a healthy and active role in collaborating with schools and clinicians to develop, implement, and monitor interventions for their children — while their children’s grades, and behavior improve. Finally, while 56 percent of students with serious emotional disturbance nationally drop out of school, only 5 percent do so in Narragansett, Rhode Island.

**Changing outcomes for children and youth with serious emotional disturbance and their families is not easy. It requires:**

- Strong capacity in homes, schools, and communities to care for and address the needs of children with serious emotional disturbance and their families;
- Robust and developmentally appropriate learning opportunities, and support for youth to use their skills at home, school, and in the community;
- Creative efforts to embrace as well as address diversity;
- Persistent collaboration with families;
- Child- and family-driven assessments, planning and monitoring of all interventions;
- Ongoing staff development and training that enables individuals to collaborate and to master new ways of doing things; and
- A comprehensive and seamless system of care that provides appropriate, culturally competent child- and family-centered services.

**The three sites examined here have started to do these things. In so doing they have produced results that have led to institutionalization at the school level, and to the scaling up of services at the city (Philadelphia) and state (Rhode Island) levels.**

# Chapter I

## Background: Children with Serious Emotional Disturbance, Schools, and Systems of Care

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### PROMISING PRACTICES THAT INVOLVE EDUCATION IN A SYSTEM OF CARE

Improving outcomes for children with serious emotional disturbance (SED) depends, in part, on improving their schooling and supporting their learning. Improving schooling and learning, in turn, depends upon linking students, their families, and the other adults who work with these children into systems of care — in other words, creating effective, accountable, child- and family-driven community collaborations that pool resources to address “the entire environment that affects kids.”

Doing this is not easy. Schools and the other agencies that make up systems of care have discrepant organizational structures, different organizational cultures, and sometimes conflicting imperatives. They work on different time schedules, speak a different language, and are often accountable to different constituencies. But collaboration is possible, and when it is realized, it improves outcomes for children with serious emotional disturbance — keeping them in or returning them to school, supporting their learning, and supporting their emotional and behavioral growth and development. The result, as in the case of Rane (above), is that successful collaborations transform our conceptualization of what is possible.

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*The big thing is for people to think about the entire environment that affects kids, pooling resources to provide kids with things they want to help them out in their lives.*

— Arlene Chorney, Principal,  
Rhode Island Training School  
(RITS)

*I used to not talk because I didn't trust people; now I believe that others care.*

— Rane, a youth at RITS serving 5 ½ years of a 20-year sentence for felony assault with death as a result

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This monograph will examine three urban sites that struggled with and have started to overcome the challenges to collaboration. It will:

- provide essential background information regarding the relationship between children with serious emotional disturbance and their families, schools, and systems of care;
- describe what the three sites have done to link schools and the system of care;
- highlight six promising practices that the sites have employed;
- analyze the cross-cutting principles that have led to the success of the three sites;



- examine the barriers to collaboration at these sites and provide suggestions regarding how these sites overcame these barriers.

The three sites chosen — East Baltimore, South Philadelphia, and Rhode Island — are all funded by the Center for Mental Health Services' (CMHS) Comprehensive Community Mental Health Services for Children and Their Families Program, in which they are considered to be urban sites. The sites were chosen for three reasons. First, each site has actively involved schools and learning in their development of community-based systems of care. Second, each of the sites faced and overcame barriers to including schools within systems of care. Third, the three sites were among the Center for Mental Health Services urban grantees. While these grantees faced barriers to linking schools with systems of care similar to those also found in small city, suburban, rural, and even frontier environments, they also faced what many educators believe are the particular challenges of improving educational outcomes within urban and, in one case, large and small city environments for children with serious emotional disturbance. Obviously, more information is needed about small city, suburban, rural, and frontier systems of care that involve schools; however, most of the educational literature that focuses on promising practices ignores urban sites altogether — the places which most educators and human service providers consider to be the most daunting. Of particular importance to our analysis are the challenges and successes that these urban sites have faced over time, and the resulting changes and improvements that they have implemented to effectively meet the needs of children and their families.

## **CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE IN SCHOOLS**

Children with serious emotional disturbance may be eligible for special education and related services under the Individuals with Disabilities Education Act (IDEA) if they are categorized as having an emotional disturbance, or if they are under nine years old and exhibit a delay in social or emotional development. Children with attention deficit/hyperactivity disorder may also be eligible for services under these two categories, as well as under categories for specific learning disabilities or other health impairment. Children with emotional disturbance (and attention deficit/hyperactivity disorder) may also be eligible for services under Section 504 of the Rehabilitation Act of 1973, as amended. As is true for students with other disabilities, students with emotional disturbance (and attention deficit/hyperactivity disorder) are not automatically eligible for services under these two Acts. They must meet the eligibility criteria of the Acts to receive services as determined by a decision by a multi-disciplinary team, which should include the child's parent or legal surrogate.

Mental health researchers estimate that there is a prevalence of serious emotional disturbance somewhere between 9 and 19 percent of the general population (Friedman, Kutash, & Duchnowski, 1996); however, schools typically only identify around 1 percent of their student population as having this disability



and qualifying for support services. In fact, national evaluation data for the CMHS grantees suggest that at the time of intake, 57 percent of the children and youth with emotional or behavioral challenges were not receiving special education services (MACRO, 1998).

There are strong political pressures within many school systems to control costs and not rush to adequately serve students with “behavior disorders.” Many educators and community members believe that there is such a large percentage of children with behavioral disorders in our schools today, that the provision of necessary services would overwhelm the education system and, ultimately, “break the education bank.” Many communities do not want to invest a lot of money in such “bad behaving” children, feeling they often do not deserve it, are a poor investment, and that other agencies should fund the supports these students and their families might need.

Another reason for the low identification rate is that many parents, teachers, and students prefer less stigmatizing labels to serious emotional disturbance, such as “learning disability.” Hence, some students with serious emotional disturbance may be served under other categories. In fact, the national evaluation data show that at the time of intake, about 16 percent of the children and youth receive some form of special education services under a different label.

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### ***Education and Mental Health System Definitions of Serious Emotional Disturbance***

The IDEA defines Emotional Disturbance as follows:

- (i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
  - (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.
  - (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
  - (C) Inappropriate types of behavior or feelings under normal circumstances.
  - (D) A general pervasive mood of unhappiness or depression.
  - (E) A tendency to develop physical symptoms or fears associated with personal or school problems.
- (ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

Children who meet these criteria, as determined by a multi-disciplinary team, may receive services under the category of Emotional Disturbance. In addition, children under nine who exhibit delays in social or emotional development may receive services under the developmental delay category.

The Center for Mental Health Services Definition defines serious emotional disturbance as: (a) the presence of a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> ed.) and which results in a functional impairment (difficulties) that substantially interferes with or limits the child's role or functioning in family, school, or community activities (Substance Abuse and Mental Health Services Administration, 1993).

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Many educators do not see public education as having the role of “fixing the serious emotional disturbance kids.” In fact, they consciously work to avoid it, fearing that if they do too much work in the area of mental health, other service agencies will back off. Conversely, many agencies that serve individuals

from birth to death believe that the IDEA places most of the fiscal responsibility for the comprehensive services on public schools. They justify not contributing agency funds on their desire to preserve their limited resources and "let education, which has the mandate," pay for it!

When services for children with serious emotional disturbance are made accessible, they are usually fragmented and provided in ways that are agency-driven and not responsive to the specific needs of children or their families (Schorr, 1988). This lack of coordination around service provision has contributed to what Schorr describes as nothing less than "rotten outcomes" (1988, p. 259). As a 1992 Packard Foundation Report suggests, fragmented services "divide the problems of children and families into rigid and distinct categories," and prevent agencies from "responding in a timely, coordinated and comprehensive fashion to the multiple and interconnected needs of children and families" (Packard Foundation, 1992, p. 8).

Students identified by schools as having serious emotional disturbance are usually male (65-76 percent), over 13 years of age when identified, and come from families with an annual income under \$12,000. Approximately 44 percent come from single parent homes (Friedman, Kutash, & Duchnowski, 1996). Furthermore, African American children and youth are over-represented among those identified as having serious emotional disturbance, a statistic that may be related to cultural misunderstandings and stereotypes. Finally, females have been under-identified in comparison to their male counterparts (Caseau, Luckasson, & Kroth, 1994).

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### ***A Bleak Picture for Students with Serious Emotional Disturbance***

*Not surprisingly, students with serious emotional disturbance have a laundry list of negative outcomes.*

*Students with serious emotional disturbance:*

- *fail more classes;*
  - *miss more days of school;*
  - *have lower grades;*
  - *are retained at the same grade level more often than other students with disabilities;*
  - *drop out more frequently than any group of students;*
  - *have a 42 percent graduation rate; and*
  - *have a 55 percent drop-out rate (U.S. Department of Education, 1998).*
- 

The poor outcomes described in the sidebar, *A Bleak Picture for Students with Serious Emotional Disturbance*, reflect the fact that many students with emotional disturbance do not have available to them a full continuum of services within the school system and local community. Identification and placement rates vary by states and localities and are often driven by the availability of resources (Hallenbeck, Kauffman, & Lloyd, 1995; Kauffman & Smucker, 1995; U.S. Department of Education, 1998). Most students with emotional disturbance continue to receive

services in environments that separate them from their peers. Between 1984-85 and 1994-95 (the most recent national data available) approximately 55 percent of students with serious emotional disturbance were placed in special classes, day schools, and residential facilities. During 1995-96, 4.8 percent of students with emotional disturbance received services in residential settings, in hospitals, or at home, in contrast to 1.2 percent of all students with disabilities (U.S. Department of Education, 1998). Those students who are placed in mainstream classrooms rarely receive the supports that they need to succeed.

For example, according to the National Longitudinal Transition Study of Special Education Students, only 11 percent of students with emotional disturbance served in regular education environments had behavior management plans, and only 6 percent of the regular education teachers who served students with emotional disturbance received the support that teachers identify as being most important — a reduced teacher-student ratio (Marder, 1992; Wagner, 1995).

## **MEETING THE NEEDS OF CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE**

The IDEA was passed in 1975, in part, to address the fact that over a million children with disorders were excluded from public schooling because of their perceived disruptive behavior and because of the lack of services to address their individual needs. As an outcome of the IDEA, there has been an increasing focus on schools developing the capacity to meet the needs of children with disabilities. Since 1975, more and more children with emotional and behavioral disabilities have been included in mainstream education — a sharp contrast to the experiences of children who were excluded from schools in earlier generations. These children are, however, highly at risk of being pushed out and for poor functioning and low productivity both in and out of school settings. The provision

of proper services to these students is a complex and challenging process for all involved, and many children have fallen through the cracks, failing to receive the education or support services that they need. In addition, as schools strive to meet the needs of these children, many teachers and support staff are cast in unfamiliar roles and

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*I'd have to say that without a doubt this (school-based) program is the most supportive thing we have to provide for these children. When you look at the pattern of the children and their problems, at no time were we able to really get through to the homes and get the parents in and provide the children with what they needed. Now, it's easy. We call one of our people who are right down the hall. They meet with the children. They're able to get the parents in, get their support, and they have access to the different sources that we do not have, whether it's psychological, medical, whatever. It's unbelievably supportive and helpful to us.*

— Elementary School Principal, Philadelphia

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acquire new responsibilities with little preparation and support. Low teacher expectations for students with serious emotional disturbance reinforce their generally poor performance in schools, and such students have been pushed out of their local schools by transfer, suspension, and hostility (Walker, Reavis, Rhode, & Jensen, 1985; Rumberger & Larson, 1994; Osher & Osher, 1995). As this population of students grows in our schools, there is a clear necessity for greater mechanisms for school-based support for children, teachers, and family members.

The education system has struggled to accommodate the needs of children with serious emotional disturbance and to effectively integrate them into mainstream classrooms (McConaughy & Skiba, 1993). A study of 60 school districts across 18 states found that 58 percent of schools lack the capacity to provide any form of counseling to their students (Moore, Strang, Schwartz, & Braddock, 1988). In this under-

supported environment, children with serious emotional disturbance have been often viewed as the ones that make teaching and learning difficult — “terrorizing” classrooms, getting into trouble with the law, skipping school, and verbally and physically abusing others. Moreover, many of these children have families who struggle with multiple stressors, including poverty, single parenting, joblessness, racism, violence, drug abuse, alcoholism, and their own mental health issues (Harry, 1992). The social services community, including the schools, has often used the challenging nature of the symptoms and many of the issues that these families face to place blame onto parents and other family members for their children’s behavior, and have failed to serve the children adequately (DeChillo, Koren, & Mezera, 1996).

Caring for and providing services for children with serious emotional disturbance is particularly challenging because they need help from so many sources. In addition to the coordination challenges of working with several agencies at once, families of children with serious emotional disturbance encounter conflicting requirements, different atmospheres and expectations, and contradictory messages. While most children with serious emotional disturbance receive some services through the educational system, it is often separated from the mental health or social services they receive. Working with the social service industry has been compared to the rather challenging task of “dancing with an octopus” (Koppich & Kirst, 1993, p. 124). Koppich & Kirst identified three problems with conducting this “dance”: underservice, lack of prevention, and service fragmentation. The lack of adequate services, the crisis mentality, and the inconsistent services provided require a significant change in our approach to serving children with serious emotional disturbance.

## **Developing a System of Care and Making It Relevant to Education**

IDEA established that all children with disabilities have a right to a free public education. IDEA provides funding support and policy assistance to states to help them provide an education and appropriate related support services (e.g., counseling, transportation) to students with special needs. A call for further support for children with serious emotional disturbance came in 1982 when the Children’s Defense Fund published Jane Knitzer’s *Unclaimed Children*, which identified the inadequate and disjointed services that children with serious emotional disturbance and their families receive. After documenting that support agencies for children (e.g., schools, parent groups, mental health agencies, health care systems, social service agencies, and the juvenile justice system) were working separately on behalf of the same groups of children with limited success, Knitzer urged them to pool their resources and expertise to reach children in a more effective and efficient manner. The result of such a cross-agency collaboration on behalf of children and families would be a system of care. The system of care is defined as:

*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 youth with] . . . severe emotional disturbances and their families*  
(Stroul & Friedman, 1986, p. 3).

In 1984, Congress authorized the National Institute of Mental Health to launch the Child and Adolescent Service System Program (CASSP) to help states develop “comprehensive, community-based systems of care, and coalitions of policy makers, providers, parents, and advocates ... to promote the development of such systems of care” (Stroul & Friedman, 1986, p. iii). The CASSP principles for a system of care model provided a framework for integrating fragmented services and agencies into a more collaborative, cohesive system of care and support. CASSP operated under six program goals:

- 1) to improve the availability of continuous care for severely emotionally disturbed children and adolescents;
- 2) to develop leadership capacity that increases priority in allocations of resources for child and adolescent mental health systems;
- 3) to establish mechanisms to increase levels of collaboration and efficiency of service delivery among agencies;
- 4) to develop structures for family participation in the planning and development of service systems, treatment options, and individual service planning;
- 5) to ensure that all service systems provided by states and communities to children with serious emotional disturbance from culturally and/or ethnically diverse backgrounds are sensitive to those differences and designed to fit appropriately within the cultural norms of the child or family receiving services; and
- 6) to develop the capacity for and provide technical assistance on child and adolescent service systems development (NIMH, 1983, pp. 2-3).

A system of care involves the cooperation of everyone who has a role in serving a child with an emotional or behavioral disorder, including family members, educators, mental health workers, social services, health services, the juvenile justice system, and community and recreational agencies. This represents an important progression in philosophy because in the past, many families felt both excluded from the process and also blamed for their children's behavior. The various techniques for serving children with special needs, including wraparound planning, school-linked services, family support, individualized care, and multiple agency collaboration all emphasize the importance of bringing stakeholders together to work towards the common goal of serving the child.

Neither IDEA nor CASSP has had a great impact on the education of children with serious emotional disturbance. In fact, when it called for the reauthorization the IDEA in 1990 (and added a discretionary program on serious emotional disturbance), the House Committee on Education and Labor stated that “it is generally agreed that children with serious emotional disturbance remain the most underserved population of students with disabilities.” Both the House and Senate committees conceptualized this problem in broad terms:

- the stigma attached to the serious emotional disturbance label;
- the poor treatment of children, parents, and families;
- the differential treatment of African Americans, Latinos, and other children from minority ethnic groups;
- the need for coordination and collaboration among the multiple service agencies; and
- the need to improve prevention efforts and to reduce the use of out-of-community residential placements.

The Department of Education addressed this problem by undertaking an extensive and interdisciplinary strategic planning process that involved: (1) input from researchers, practitioners, and family members in education, mental health, child welfare, and juvenile justice; (2) an extensive literature review; and (3) the examination of effective programs and practices that included sites implementing systems of care. This four-year effort led to the development of the National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance (U.S. Department of Education, 1994). This national agenda has seven strategic targets and three cross-cutting themes, which flesh out how education, schools, and systems of care can be linked to improve outcomes for children and youth with serious emotional disturbance and their families. The seven targets are to:

- Expand Positive Learning Opportunities and Results;
- Strengthen School and Community Capacity;
- Value and Address Diversity;
- Collaborate with Families;
- Promote Appropriate Assessment;
- Provide Ongoing Skill Development and Support; and
- Create Comprehensive and Collaborative Systems.

Each target is described below.

### ***Expand positive learning opportunities and results.***

The poor outcomes achieved by students with serious emotional disturbance reflect school and community factors, as well as the nature of their emotional needs. Often student behavior escalates out of control and academic failure occurs before schools intervene. Intervention is often limited to external



control, with little attention given to internal development of self-control, self-management, self-advocacy, and conflict resolution skills.

Students with serious emotional disturbance must be engaged in culturally responsive, student-centered opportunities to learn, marked by high expectations and tailored to their individual needs. Curricula, instruction, and extra-curricular activities must build and support academic and social skills that enable students to sustain appropriate learning and behavior. School- and community-based learning must be better coordinated so that these students acquire and maintain the academic and social skills which will make them literate, productive, and responsible members of their communities.

### ***Strengthen school and community capacity.***

Students with behavioral problems and serious emotional disturbance are often removed from regular schools and general education settings. Their removal reflects many factors, including the current school environment and the need to provide complex and comprehensive services across many service delivery systems. Placements of children away from neighborhood schools and communities are often very costly to communities and disruptive to families. In addition, these placements may prevent many students from developing the academic and social competencies they need to function throughout their lives.

This National Agenda target calls for serving children and youth with serious emotional disturbance in the least restrictive and most appropriate environments. In particular, it means developing the capacity to successfully integrate these students into neighborhood schools and regular classrooms. To make integration and transitions work, students with serious emotional disturbance and the adults who work with them require support and resources. Educational systems and other providers must be prepared to facilitate integration and smooth the transition of students back into their own homes, schools, and communities.

### ***Value and address diversity.***

The rates of identification, placement, and achievement of children and youth with emotional and behavioral problems vary across racial, cultural, gender, and socioeconomic dimensions. An incomplete understanding of differences among children, families, and cultures can lead to the misidentification and inappropriate treatment of children. To avoid this problem, diversity must be addressed and valued. To value diversity is to acknowledge, understand, and appreciate the characteristics of different cultures and different groups of people. To address diversity is to develop the ability to work successfully with people of diverse backgrounds when designing and implementing services for children with serious emotional disturbance.

This target calls for approaches that improve the capacity of individuals and systems to respond skillfully, respectfully, and effectively to students, families, teachers, and other providers in a manner that recognizes, affirms, and values their worth and dignity.

### ***Collaborate with families.***

Family support services are frequently a key factor in successfully addressing the needs of children and youth with serious emotional disturbance. The degree of family support is especially related to the success of least or non-restrictive placements, as success may depend upon a family's ability to obtain the educational, mental health, and other services required to maintain a child in the home. Training that enables family members to advocate effectively for their children is also an important element in successful placement of students with serious emotional disturbance. To improve outcomes for children and youth, service providers must collaborate with families and support their active participation in planning and evaluation.

Collaborating with families and strengthening their access to required services is central to realizing the goal of implementing appropriate, integrated services across education, mental health, and other systems. Service providers should seek and facilitate active parental involvement when planning assessments and when determining what services to provide. The object of this strategic target is to reorient family-school and family-agency interactions to build a partnership in which service planning reflects the input of families' goals, knowledge, culture, and, in some cases, need for additional services.

### ***Promote appropriate assessment.***

Appropriate, ongoing, cost-effective, and practical assessment is essential to improving outcomes for children and youth with serious emotional disturbance. Screening, monitoring, and assessment can identify children at risk, support preventive interventions that may reduce the need for formal identification at a later time, augment planning, and monitor the implementation of comprehensive services. Culturally competent, linguistically appropriate, multi-disciplinary assessments that involve families can help teachers build on student strengths and address the changing developmental needs of students with serious emotional disturbance. Ongoing assessments that focus on the student's environment (including the school) can enable teachers and service providers to prevent emotional problems from intensifying, thus avoiding the need for more protracted and expensive interventions in the future.

The efficacy of service depends upon ongoing and continuous assessment that best captures a child's changing developmental needs. This target supports initiatives that provide for early identification and assessment tied to services rather than to labels. Identification and assessment frequently come too late and lead to the inappropriate placement, labeling, and treatment of students with emotional and behavioral problems.



### ***Provide ongoing skill development and support.***

Improving outcomes for students with serious emotional disturbance requires new skills, approaches, and collaborations among all who work with these children and youth. Teachers and professionals frequently report feeling isolated and unsupported by colleagues and families. In addition, the need for comprehensive services coupled with the complex nature of serious emotional disturbance may create a gap between what is learned in training programs and what teachers and other providers face at work. Educators as well as other service providers also require ongoing skill development and training that will enable them to work effectively with one another.

This strategic target provides for the ongoing support and professional development of teachers and other service providers in order to: (1) increase their capacity to teach and work effectively; (2) reduce their sense of isolation; and (3) enhance their commitment to meeting the needs of students with serious emotional disturbance. Professional development for teachers and other service providers should extend to families so that all those working with children with serious emotional disturbance can develop new skills, acquire knowledge of promising intervention techniques, and become aware of new innovations and practices.

### ***Create comprehensive and collaborative systems.***

Systemic change is needed to enhance regional and community capacity to the point where those involved can meet all of the needs of children and youth with serious emotional disturbance. Simultaneously, systems must be developed that can bring services into the child's environment, whether it be the home, school, or community. Furthermore, to achieve the desired outcomes for children and youth with serious emotional disturbance, public and private funding streams must be coordinated.

This strategic target supports initiatives to help generate comprehensive and seamless systems of appropriate, culturally competent, mutually reinforcing services. This target envisions systems that are more than linkages of agencies. It aims instead at developing new systems, built around the needs of students, families, and communities — systems that coordinate services, articulate responsibility, and provide system-wide and agency-level accountability.

Local systems should remain school- and community-based so that they can respond to local needs and reflect the cultures of the communities they serve. Systems should be outcome oriented, employ uniform definitions, provide individualized and family-centered services, and respond promptly, flexibly, and effectively during any crisis. Within a coordinated, collaborative system, services follow needs, and funds follow children and their families. Students and their families should be able to enter the entire system from

any point at which specific services are first offered. Finally, while the new systems should be community-based, policy must be coordinated at the state and national levels. Such coordination will eliminate bureaucratic road blocks, establish and reinforce commitment among agencies, and extend initiatives that coordinate previously non- or unaligned services and blend funding streams, both public and private.

## **THE ROLE OF EDUCATION IN A SYSTEM OF CARE**

Schools play a critical role in the development of all children on a daily basis. Positive learning and group experiences can serve as a foundation that helps promote healthy growth and development and prevents emotional and behavioral problems. Conversely, negative experiences, whether they be persistent academic failure, punitive discipline, isolation or rejection from mentally healthy peers, or public humiliation can lead to or exacerbate emotional disorders. Schools provide the logical setting for both early identification of children who are at risk of serious emotional disturbance and for the effective provision of services. Unfortunately, like other agencies that provide services for children with serious emotional disturbance, schools often approach their work with children and their families in isolation and within their own operating structure and culture (Fredericks, 1994). Like other agencies, this isolation reflects the imperatives of logistics and timing. Members of the system of care often do not have the capacity to make an immediate response. Educators who do attempt to collaborate and invite other agency personnel to meet, often tend to give up when agency personnel cannot respond quickly enough. Similarly, educators are often unable to attend off-site meetings due to the demands of their jobs, particularly when they are scheduled during school hours.

In addition, most school staff do not view their primary role as addressing the mental health of students, due in part to the fact that only 1 percent of the students who qualify for special education services qualify due to emotional problems. Furthermore, when schools identify students as having a behavioral or emotional disability, they frequently fail to provide the appropriate counseling services and behavioral supports, which are critical to the student's success. When students receive mental health or social services outside of the school, these services are frequently disconnected from the school's strategy because they are rarely included in planning the student's Individualized Education Program, the key accountability document for students with disabilities in schools (Knitzer, 1996). Finally, school officials who are mandated to serve all students are frequently wary of interagency collaboration because they fear additional responsibilities, accountability, and costs, and they frequently perceive other members of the system of care as calling for services without offering the resources to implement them.

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*Mental health services will never reach the majority of people who need it .... It seems to be that every racial, cultural, or ethnic group I've spoken to absolutely says, 'my people don't do mental health services' ... but behavioral health services in schools, everybody goes 'oh yeah, cool,' because it's a part of education.*  
— Mental Health Administrator,  
Philadelphia

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Despite these barriers, closer collaboration between schools, mental health, and social service agencies is necessary to improve learning and behavioral outcomes for children with serious emotional disturbance and to prevent many issues from reaching the crisis level. The work of service providers would benefit tremendously from access to information about school performance, family involvement, and other school related issues for the children they serve. Schools and school-related activities are where many young people spend the largest portion of their days; both the formal and informal curricular and extra-curricular activities provided by schools play a significant role in structuring their lives. For these reasons, links with education are “crucial to an effective system of care” (Stroul & Friedman, 1986, pp. 77-78).

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*Focus groups suggest that mental health must get into the schools — beg, borrow, or steal — but get in there. Additionally, mental health must help the teaching staff to lower stress, to build capacity for positive discipline, to design functional assessments that really analyze behavior. Mental health staff know how to do this, and they know how to design school and classroom based wraparound supports.*

— Jane Adams, Director

Keys for Networking, Kansas

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Too often, the cognitive strengths of students with serious emotional disturbance are overshadowed by their emotional and behavioral characteristics and needs. Some teachers and administrators are not trained and/or equipped to address the complex needs of these students. Consequently, they have developed a system of management and control that they view as necessary to protect the learning

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*Supports for behavioral health for kids belong in schools because that's where kids are, that's how we measure success for children, and the federal government mandates that we provide education in the least restrictive environment. I think children belong in really good schools with the supports that are required for that to happen. I think that when we take children out of their natural neighborhood environments, we only then have to talk about re-entry back into the environment of home. So, we can sort of give up that link and begin to provide the services that are required at home.*

— Family Support Group Director,  
Philadelphia

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environment for “every one else” in the school.

Where internal resources are not available (e.g., a school psychologist) schools must depend on external agencies in their system of care to bring in mental health professionals whose expertise can help schools address the complex needs of students with serious emotional disturbance. Placing the system of care in the school setting eliminates this dependency.

Just as schools benefit from integration into a system of care, so systems of care benefit from working with schools. Education is an entitlement that reaches all children, thereby providing schools with direct access to more children in need of services than any other community institutions (Osher & Hanley, 1996). In addition, teachers of

students with emotional and behavioral disorders are in a position to develop extensive knowledge of their students' strengths and weaknesses, and what works and what does not. As major participants in the

child's daily life and ongoing development, they also need more information and support in the performance of their work. Integrating teachers into a comprehensive system of care has the potential for improving the learning process for both students and their teachers.

Schools are often good places to base an integrated service system for children with emotional and behavioral problems for four main reasons:

- 1) Because children spend a large quantity of time in school, it is a logical location for service delivery and coordination (Eber, Nelson, & Miles, 1997).
- 2) The school systems generally possess well-trained personnel, access to supportive services, and mandated service delivery mechanisms (Eber, Nelson & Miles, 1997; Dwyer, Osher, & Warger, 1998).
- 3) Since there is less stigma attached to schools than to other social service agencies, there may be a greater possibility of attaining the participation of both child and family (Koppich & Kirst, 1993).
- 4) Location of services at school sites helps mitigate such barriers to service delivery, such as time and transportation (Osher & Hanley, 1996; Catron & Weiss, 1994).

There are over 87,000 public and 26,000 private schools in the nation, and over 15,000 school districts. These schools and districts are locally controlled entities that are hard to penetrate and change (Tyack & Cuban, 1997). Not surprisingly, the initial efforts by the Child and Adolescent Service System Program (CASSP), which focused on statewide planning and coordination, did not have a powerful impact on local schools. Despite the acknowledged important role of the educational system, a 1992 CASSP study of systems of care found schools to be only marginally involved in system of care efforts (Stroul, Lourie, Goldman, & Katz-Leavy, 1992).

The 1992 passage of the Comprehensive Community Mental Health Services for Children and Their Families Program provided an opportunity to address that gap, and site visits conducted at a number of locations suggest that this has been accomplished with variety and creativity in many places. Some grantees have involved superintendents (e.g., Stark County, Ohio), principals (e.g., Kansas) or teachers (e.g., Illinois) in the planning process in order to get them "on board." Others (including some of the initial grantees) have established trust with schools by being available in times of crisis and by reorganizing their staffs to address the needs of students and schools. Stark County, Ohio, for example, supports drop-out prevention efforts, while Lane County, Oregon, employs consultants to bring wraparound supports into the school. Still others, such as those involved in this study, have demonstrated the importance of systems of care by enhancing the role of families in educational endeavors and by addressing the schools' concern with schoolwide discipline.

In spite of these accomplishments, much more needs to be learned regarding how to involve schools and learning in a system of care. Focus groups of grantee staff members, convened at the December, 1997 Grantee Meeting and the February, 1998 Urban Hub Meeting, defined key questions that need to be addressed:

- How do you build a real partnership with schools?
- How do you create avenues to provide prevention-oriented services for unidentified children and youth?
- How do you get school personnel to buy into wraparound strategies?
- How do you engage local education agencies in the system of care?
- How do you strengthen the role of parents in education and build opportunities for parents to work as partners with schools?
- How do you help school staff feel safe “outside of their usual box”?
- How do you have an impact on school services and programs?
- How do you link IEPs and wraparound services?
- How do you integrate the “plans” of various agencies and partners?

The remainder of this monograph will attempt to address these issues by describing and analyzing promising practices and effective approaches that have been employed in a variety of schools by three Center for Mental Health Services grantees.



## Chapter II

# Program Descriptions

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### THE SOUTH PHILADELPHIA FAMILY PARTNERSHIP

#### Philadelphia, Pennsylvania

South Philadelphia is a collection of neighborhoods in the city of Philadelphia that can be characterized by the many challenges faced by its residents. Of the 18 areas in Philadelphia containing low-income concentrations, 7 are in South Philadelphia. South Philadelphia has large concentrations of poverty, and many of its residents lack easy access to medical or social service providers. The schools in South Philadelphia struggle with high dropout rates, and a high proportion of families are headed by single mothers. Other challenges, such as substance abuse, mental illness, homelessness, high teen pregnancy rates, and AIDS are also prevalent. The high incidence of emotional disturbance among children growing up in this environment was a primary motivation for the establishment of *The South Philadelphia Family Partnership*.

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*I think it's important for folks in mental health to work hand in glove with schools, because school is actually the work of children. How kids feel about themselves and whether they regard themselves as successes or failures is related to what happens every day in schools. In addition, huge numbers of kids and families who will never go into a community mental health center are happy to accept help in the context of education. So, I think they're our most critical partners.*

—Harriet Williams  
Office of Mental Health, Philadelphia

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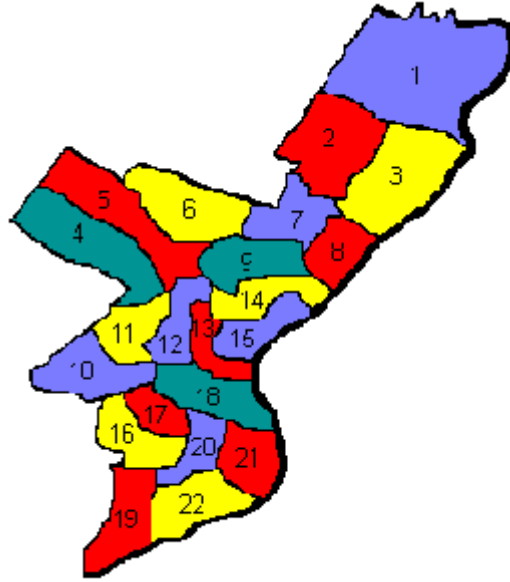
The *Partnership*, sponsored by the Children's Unit of the Philadelphia Office of Mental Health, is a collaborative effort involving the participation of over a dozen entities, including city-wide service agencies, family advocacy groups, and the School District of Philadelphia. Together, these stakeholders have formed a partnership to:

*Expand and enhance the capacity of the system of care to provide individualized, holistic, and family-centered services to children with serious emotional disturbance, through the direct provision of mental health services, and/or the reorganization of existing services, to better meet clear, definable unmet needs of South Philadelphia families, with a special emphasis on those families headed by a grandparent or caregiver. — Philadelphia Department of Public Health, 1998*



The *South Philadelphia Family Partnership* provides an array of services and support to children with serious emotional disturbance and their families. The central work of the *Partnership* is focused in three clusters of schools (in the city of Philadelphia, the 273 public schools have been organized into 22 clusters, which operate as mini-school districts within the larger system). The clusters collaborating with the *Partnership* are Audenreid, Furness, and South Philadelphia (see map).

- Cluster Offices
- |                        |                     |
|------------------------|---------------------|
| 1. Chain               | 12. Gratz           |
| 2. Northeast           | 13. Penn            |
| 3. Lincoln             | 14. Edison          |
| 4. Roxborough          | 15. Kensington      |
| 5. Germantown          | 16. West Phila.     |
| 6. M.L. King           | 17. University City |
| 7. Fels                | 18. Franklin        |
| 8. Frankford           | 19. Bartram         |
| 9. Olney               | 20. Audenreid       |
| 10. Overbrook          | 21. Furness         |
| 11. Strawberry Mansion | 22. South Phila.    |



Participating schools within the clusters were selected by the *Partnership* due to their high proportion of kinship families — families headed by a caregiver other than the parent. The *Partnership* places a specific emphasis on providing ongoing assistance to these families. All *Partnership* initiatives are overseen by a *Partnership* Advisory Board made up of agency representatives, caregivers, family members, and a state representative, whose role is to provide formal oversight of the *Partnership*'s efforts to transform and improve the effectiveness of the system of care.

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*I think [the schools] like having control of the services. It's like there's a big difference when you come in as an outside provider who says . . . this is how we do business, and if you want it, you have to follow our rules. I've made lots of accommodations in terms of making it accessible to people, using the right language, saying things that might not be politically correct in the broader sense, but work in that particular community . . . . You can't go into the schools and just do what you want to do, so you have to build some type of relationship with them. Each person that walks in, including myself, has to have an understanding of the nature of the school, how policy is set . . . accepting that among the various cultures we have to be competent in, one is learning how to be part of the school system and the school culture, not how to be partnered with, but be part of.*

— Ernest Bailey, Office of Mental Health Administrator

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A key feature of the *Partnership's* approach to implementing an effective system of care is its emphasis on school-based behavioral health services. Those services are designed to provide both mental health services and additional means of support, as appropriate, to students within their normal educational setting, in order to facilitate a system of care that is comprehensive, preventative, family-driven, integrated, and flexible.

In working closely with schools, participants in the *Partnership* recognize the importance of understanding and respecting the nature of schools and school collaboration as they integrate mental health services within the school environment. Through their experiences, they have learned that schools are more likely to respond favorably to new ideas and practices if they fit within the established procedures and culture of the school. The *Partnership* has learned to be flexible and adaptive and to work on a case-by-case basis with principals and other schools personnel.

## **Interventions that Focus on Children and Schools**

### **Consultation and Education**

The underlying philosophy of the *Partnership* is that bringing mental health services into the schools is ultimately beneficial to all children, their families, and those who serve children. To implement mental and behavioral health services on a schoolwide basis, each of the schools has been assigned a Consultation and Education Specialist, a mental health professional who works directly in the school setting. The Consultation and Education Specialist provides

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*I think supports for behavioral health belong in schools, because that's where kids are, and that's how we measure success for children.*

— Elizabeth, Family Resource Network

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#### ***The Role of a Consultation and Education Specialist***

*Not all of my children have [serious emotional disturbance] diagnoses ... when I first get them, some do have a diagnosis and I'm able to work with that and link them to intensive case management services. If they're not severe, I go into the family system and find out what they already have in place. If they have no supports, or very little support, then it's my job to as quickly as I can, link them to services that will affect change in their systems. It's also my responsibility to go back to the school, let them know what is going on in the family, so that they give me time to affect a positive change.*

— Priscilla, C & E Specialist

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support services for the entire school community. Their tasks include providing short-term counseling and social work services to children and families not qualifying for intensive case management under the *Partnership's* criteria, and linking children and families to additional sources of support. In addition, Consultation and Education Specialists provide consultation and training to teachers and other school staff on behavioral management issues for children, and on methods

for providing immediate crisis intervention and referral. Consultation and Education Specialists help school personnel with the student referral process, and often act as the “gatekeeper” for assigning a child for intensive case management services.

## **Intensive Case Management**

Also working in support of the *Partnership* are Intensive Case Managers, who are trained mental health clinicians who work directly with schools, children with serious emotional disturbance, and their families to provide comprehensive support. Through CATCH (Citizens Acting Together Can Help), a local mental health agency, the *Partnership* assigns 11 Intensive Case Managers to 9 elementary and middle schools across the 3 clusters. Nine of the Intensive Case Managers work directly with a school while the other two act as “floaters,” with the responsibility to provide direct case management for children who move from one school to another, so that both children and services do not get “lost” in transition. In addition, Intensive Case Managers inform and support parents throughout the referral and evaluation processes for children with emotional and behavioral problems. As a result of the *Partnership*’s implementation, capacity for Intensive Case Manager services in schools has expanded from 30 slots to over 150. Intensive Case Managers work actively with both children and family members, and they use their knowledge of local resources to access an array of support services for children. By bringing Intensive Case Managers directly into the schools, children benefit from a more intense level of mental health support and more children in need are reached. School administrators describe the Intensive Case Managers as the “missing link” between education and mental health (Appendix A includes a more detailed overview of CATCH services).

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### ***The Role of an Intensive Case Manager***

*I get my cases through referral, through our Consultation and Education person, which is based on what the family may need at the time. I follow through on implementing, monitoring, make assessments, developing a goal plan with the family and the the child . . . . Basically, as an Intensive Case Manager, you're always running. You're busy. In order to help a child with mental health issues in the school, you also have to look at the family component, because it starts there. It gets overwhelming at times, because our goal is to keep the child in the home and in the community, so, acutally, I'm an Intensive Case Manager/Social Worker sometimes. In the school, I try to be a mediator between the school and the parent, trying to get the parent to advocate for their child's education and mental health issues. Also, I try to be sure that the school understands the mental health issues [of the child] so the child is not denied an education.*

— Linda, Intensive Case Manager

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Bringing Consultation and Education Specialists and Intensive Case Managers directly into the school setting has had a positive impact on the quality of mental health services and outcomes for children with serious emotional disturbance in several ways. First, implementing mental health services on a schoolwide basis has helped to reduce the stigma that is commonly associated with going to mental health

clinics. Second, school-based mental health staff help to empower families and advocate for their rights. Third, by locating services within the school, the *Partnership* is able to more readily identify children with special needs and provide services at a much faster rate than the traditional referral procedures used at most schools. Finally, integrating mental health into the schools has led to noticeable improvements in social and academic outcomes for children receiving ongoing support.

## **Transitional Support**

Children often change schools — both when they graduate from one level of school and move to the next, and when they move from one neighborhood to another. This type of transition can be particularly disruptive for a child with serious emotional disturbance and other behavioral problems. It can be difficult to adjust to a new system of behavioral supports, new people, and new environments. The *Partnership* recognized the importance of supporting children through such transitions, and it has set up the intensive case management system to provide ongoing support.

## **Saturday Academy and Summer Camp**

Perhaps the most common transition that children experience difficulty with is the move between the school setting and the local community. This type of transition takes place both during and after the school year. To help develop a consistent therapeutic component to their behavioral support system and a supportive environment for children, the *Partnership* sponsors a Saturday Academy and a summer camp. The programming for both the Academy and the summer camp provides children with opportunities to learn and interact in a less structured environment than school, with one-on-one attention. By offering such an environment during the summer, and once per week during the school year, children have the chance to internalize appropriate behaviors that can carry over into improved behavior in the classroom. Families who send their children to the Saturday Academy and to the summer camp have reported positive outcomes for their children; family members report (and case managers agree) that their children are not getting into

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*We came up with Saturday Academy as a way of being able to have some kind of intervention during the school year and then follow up with summer camp for the five weeks and go back to Saturday Academy. There's more one-on-one attention. We try to address the issues that the children have when they're hurt, try and work through and develop their own ways of understanding appropriate and inappropriate behavior and we have staffing appropriate for that. Really, we try to provide some opportunity for them to get their frustrations out, do things that if done in school would not be appropriate ...*

*They need to see, when they have to sit in their seat, when it's time to listen, what those times look like and when it's time to play around, they need to see the difference. There's a lot of lap-sitting, hugging, kissing ... we make an effort to get down on the floor with children. Security guards walk them down the hall and get on the floor, get down to that level. With that kind of attention, anybody has to at some point feel really good about themselves ... I think that when you look at the summer camp and the Saturday Academy, you'll find that there's a lot of one-on-one and children just don't get that in school.*

— Tracy, Saturday Academy

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trouble as much, are not getting removed from the classroom, and are not spending most of their day in the time-out room. The improved conduct that these children have demonstrated has allowed them to remain in their local school.

Another benefit of the Saturday Academy is that it improves the referral process by identifying children who are in need of more school-based services. For example, Academy staff noticed a significant difference between children who were receiving school-based therapy and those who were not, based on their behavior outside the school environment (one staff member indicated that they never had any trouble with those kids who were receiving intensive services at their school). On the other hand, the children who had the most behavior difficulty were those who had not yet been identified for any Consultation and Education Specialist or Intensive Case Manager services in school.

In addition to the extra-curricular benefits for children, the school-based Intensive Case Manager system can also help in providing services to children where the traditional system might fail. One school principal described the example of Andy<sup>1</sup>, a second-grade boy who exhibited violent and disruptive behavior. School personnel first went through the traditional special education referral and evaluation procedures, but because of disagreement between parties, his case was consistently held up, causing enormous delays in authorizing the mental health services he needed. Finally, after one particularly violent incident in which Andy nearly held a teacher hostage, the Intensive Case Manager was able to move in, provide immediate psychiatric help and place him into residential placement. “If it wasn’t for the Intensive Case Manager at that point,” states the principal, “following through with the family and seeing that this really was a case that even the Department of Human Services needed to get involved in, we would have spun our wheels. You usually only have a counselor in the school — one person to deal with 500 kids — it’s impossible. This (the intervention) tremendously improved outcomes for both Andy and the school. It saved the child and helped the school, too.”

In addition to the services provided in the three South Philadelphia area clusters, the *Partnership* supports *behavioral health services coordination* in two clusters — Audenreid and Olney. The purpose of the behavior health care coordination initiative is to assure the fullest possible integration of the system of care into each individual school framework. This initiative is headed by a Behavioral Health Coordinator, who works in collaboration with each cluster leader and a coordinator from the School District’s Family Resource Network (FRN). Together, these individuals work to assess needs, identify goals, and to develop a plan for developing a seamless system of behavioral health care services. All of these agencies and services are integrated together for a seamless system of care.

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<sup>1</sup> The names of all children quoted have been changed.

## Interventions that Focus on Families

### School and Community Team Coordinator

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*I went to all of the meetings and conferences, anything that I could learn. Because I found out that my grandson had attention deficit disorder and I had no idea what that was. As a grandparent, it was the first time I had ever heard of it. It was very frightening for me, but by going to ROC — Raising Other's Children — and by talking with people, I found out that I wasn't the only one, and I found out what other people did and what worked for them and I went home and things did work for him. I did pretty well, so I was asked to come into the system and be an advocate for other children, to teach other grandparents and parents what I had learned. And that's how I became and advocate for the South Philadelphia Partnership.*

— Sylvia, Partnership Family Advocate

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Another important component of the Partnership staff is the School and Community Team Coordinator, a family member assigned to each school who assists children and families in accessing mental health and social services. The School and Community Team Coordinator plays a key role in the referral process. In particular, the School and Community Team Coordinator will participate in meetings of the Instructional Support Team, through which most schools operate their referral systems, or the Individualized Education Program team, where appropriate. The School and Community Team Coordinator is there to ensure that schools do not make crucial decisions about their students without the families' input. As a fellow parent who understands the system and the rights of families under the law, the School and

Community Team Coordinator is able to provide sensitive support to family members trying to access needed services, and is often able to build a strong relationship with families in need. As an additional service to the schools, the School and Community Team Coordinator conducts community education programs on mental health issues for school personnel, parents, and community members.

### Links to Families and Organizations

To provide further support for family members, the South Philadelphia Family Partnership also collaborates with several family advocacy groups, such as the school district's Family Resource Network, and independent organizations such as the Parents Involved Network and

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*I have found the program to be invaluable in our school, because there are so many families in crisis. And to go out to seek it on their own seems very, very difficult for them and when there's someone there to give them the guidance, it makes it much easier for the families. They just sometimes feel so frustrated, that they have no place to go and nobody to talk to and they keep on running against stone walls. Now, there's a person that coordinates this and puts it all together for them.*

— Elementary School Principal, Philadelphia

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Raising Other's Children, a kinship care support organization. The Partnership has four Family Advocates,



each of whom works directly with families served by the *Partnership*. Family advocates provide guidance and information to families, accompany families to interagency meetings, conduct home visits, help family members understand how the various systems work (e.g., school procedures or managed care), and generally act as a friend and advocate for each family. Their role in the process is very important to the families they serve, because they are the only people who are truly independent; family advocates do not work for the schools, the local government, the managed care company, or the provider.

The *Partnership* places a strong emphasis on the role that family support plays in improving results for children with emotional and behavioral problems. The philosophy of the *Partnership* is that families can and should be important advocates for their children — not only are their rights as advocates guaranteed under Federal law, but they are the ones who know their children best, and are thus in the best position to act as advocates. However, many family members often need guidance and support in order to feel and act fully empowered as advocates, as demonstrated in *Billy's Story*. The Intensive Case Managers, Consultation and Education Specialists, School and Community Team Coordinators, and family advocates provided by the *Partnership* have been able to provide that guidance.

Family members and support staff in Philadelphia noted that trust was the most important factor linking the system to families. One of the program coordinators for the Kinship Care program, a partnership agency, stated, “a lot of the families really depend on these intensive case managers. They’ve built that trust with them. They’re [working with families] in the home. They trust their judgment, [on issues] other than what’s going on with schools. So, that’s what’s really good with an Intensive Case Manager, being that liaison between the school and the home, being a broker of services that provide a lot of intensive case management.” Although the Intensive Case Managers are based in the schools, their support extends beyond the school and into the children’s home and

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### ***Billy's Story***

*Billy, six years old, was exhibiting behavior problems in his first-grade classroom. He was defiant and lacked self-control. He often did things like stand on banisters and hot radiators, without any evidence of understanding the seriousness of his actions. Billy's teacher referred him to the Instructional Support Team, where he was assigned to an Intensive Case Manager (ICM). Melanie, his ICM, received approval from Billy's parents to visit them at home, and worked with them to schedule an emergency psychiatric evaluation at the hospital. Billy stayed in the hospital for ten days, where the doctors had some initial trouble stabilizing him. As Melanie worked with the family, she learned that Billy had been exhibiting this type of behavior for some time, but that his parents hadn't known what type of supports he needed, nor where to get that kind of support. Billy's mother expressed frustration over not knowing what to do, and how she had decided that it was better to be quiet and not do anything. With Melanie's support, Billy's parents were able to bring Billy back to the school after his discharge from the hospital, and ensure that school personnel such as the counselor and teachers could provide the appropriate behavioral supports. Now, Billy's behavior has significantly improved. He is no longer aggressive towards adults or peers and has not done anything that would warrant a return to the hospital. Also, Billy's parents have an ongoing system of support in place to so that they can be sure their son is getting the services he needs.*

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community life, as well. They have a thorough understanding of all of the environments in which the child lives; therefore, their support is crucial to ensuring that the child has all the support he or she needs to be productive in school, at home, and in his or her surrounding community.

## **Outcomes for Children**

### **Improved Academic and Social Outcomes**

In addition to being highly responsive to the varied and immediate needs of children with serious emotional disturbance, the Intensive Case Manager system has led to significantly improved outcomes, such as those described in *Success for Tim*. For example, families and program administrators both noted a significant drop in the number of children referred to residential facilities and in those being expelled for behavioral problems. In addition, teachers reported several positive changes in students receiving Intensive Case Manager services, including:

- “Average or above” school performance increased by 5 percent after one year.
- Performance “at their individual ability” increased by 22 percent after one year.
- Children needing extra help decreased by 30 percent after one year.
- Children needing some type of behavioral intervention in the classroom decreased by 25 percent after one year.

Both parents and administrators also believe that participation in *Partnership* endeavors have reduced disciplinary removals and kept children and youth in school.

### **Providing a Model for the Future**

Absent a mental health diagnosis or intervention by the courts, very few behavioral health supports are available to children in need or to their families. The work of *Partnership* stakeholders and agencies in the three South Philadelphia clusters has led to the recognition that prevention and targeted early interventions are essential to diminishing the reliance on costly and intrusive interventions on children with serious emotional disturbance and their families.

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#### ***Success for Tim***

*Tim is an eight-year-old third grader who was constantly provoking and fighting with his peers, and being suspended on a regular basis. Tim's Intensive Case Manager, Judy, was able to come in and coordinate a range of services to help keep him in school, and prevent him from being suspended or possibly sent to a residential facility. Before Tim was assigned to Judy's caseload, he wasn't receiving any services at all. With Judy's support, Tim now receives outpatient services, where he sees a therapist and participates in an after-school program. He also receives wraparound services from the CATCH agency. Now, Tim is still in a regular education classroom, is academically performing better, and his behavior in the classroom has been stabilized.*

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As a part of the groundwork laid by the *Partnership* and an initiative through the Mayor's Cabinet for Children and Their Families, the Philadelphia Office of Mental Health has received funding for a districtwide model for behavioral health services. Across all of the school clusters, this model, starting with the 1998-99 school year, will implement planning, financing, and delivery of behavioral health services to children and youth in a school-based setting, with the investment of additional resources in prevention and early intervention programs.

The model for bringing school-based behavioral health services to scale is based on four fundamental cornerstones:

- **Cluster-based behavioral health system of care coordination**, designed to improve cross system collaboration and reduce fragmentation in service development and delivery, is essential to the provision of school-linked behavioral health services. In the proposed model, a system of care coordinator facilitates the local development of a comprehensive cluster plan and builds the requisite linkages within the community to assure a continuum of school-linked behavioral health services; that is, identifying existing services, assuring access through provider agencies and expanding capacity within the school and within the community when necessary supports or services are unavailable.
- **School behavioral health management**, designed to support local decision-making, ensure coordination of efforts within the school and among agencies, and facilitate selection of specific behavioral health care programs that meet the needs of the school community, requires the development of a school management team. This team will provide the mechanism for developing and monitoring school-linked behavioral health services. The team will include, for instance, the principal or principal designee, the school counselor, the school psychologist, a Consultation & Education (C&E) specialist, teachers, family members, and students. This team may also be responsible for crisis management and school safety.
- **Targeted, cross-systems skill-building** is implicit in every behavioral health initiative proposed. For example, multi-systems collaboration represents a major challenge on many levels and to both individuals and systems. Success requires a concerted effort to build skills from all participants (e.g., School District, Office of Mental Health, Department of Human Services, Juvenile Justice System, Recreation Department). Decision-making, consensus-building, problem-solving and communication are fundamental to effective collaboration, but these skills must be often be learned (or re-learned) for effective practice. Whole school behavioral management plans and programs require an understanding of, consensus about, and commitment to participate from all partners in the child-serving system; thus, from systems to communities to schools to classrooms, targeted skill-building must remain a priority.
- **Targeted skill-building opportunities offered to parents and caregivers** must parallel in expectation and content those which are provided to system staff. In fact, skill-building sessions in many instances should include the entire school community, including school staff, family members, and other interested members of the community. To facilitate full partnership with families and communities, respect and inclusion must be modeled throughout the process.



The promising outcomes reviewed here for the *South Philadelphia Family Partnership* reflect the presence of critical contextual supports for implementing school-based behavioral health services. Both participants and observers of *Partnership* activities have recognized that preventing school failure, behavioral conduct disorders, serious emotional disturbance, and juvenile crime is a complicated task requiring system-wide participation and commitment. An intense level of collaboration across stakeholders in South Philadelphia has led to interventions that are helping to meet the needs of children, schools, families, and communities. The true success of this *Partnership* is in the foundation that has been put into place for a continuing system of care.

## **EAST BALTIMORE MENTAL HEALTH PARTNERSHIP SCHOOL-BASED PROGRAM**

### **Baltimore, Maryland**

East Baltimore is an historic area located northeast of Baltimore, Maryland's downtown Inner Harbor — an area that has been gentrified in the last decade to become a major center of business and tourism — and west of Interstate Highway 95. East Baltimore is largely African American and, though populated by middle class families as well, is one of the poorest areas of the city. It has high rates of poverty, teen pregnancy, substance abuse, and the highest rate of juvenile violence of any district in the city. The residents of East Baltimore also have low levels of adult literacy. Nearly 15 percent of Baltimore's 154,915 students between the ages of 4 and 19 are considered to be at risk for school failure. Despite these challenges, however, East Baltimore benefits from having been named a Federal Empowerment Zone, with many citizen groups working together to make a difference in their community, including those involved with the *East Baltimore Mental Health Partnership*.

The goal of the *Partnership* is to provide a comprehensive and integrated system of care for children and adolescents with serious emotional disturbance living in East Baltimore. The *Partnership* was developed in 1993 by a coalition of state, city, and local leaders, including representatives from city agencies (e.g., city courts, police, health department, public schools, social services, and the Mayor's office), state departments (i.e., Juvenile Services and Mental Hygiene Administration), and other private and public entities (e.g., Johns Hopkins University, Johns Hopkins Hospital, University of Maryland, Families Involved Together, and the Alliance for the Mentally Ill). The *Partnership's* core service programs involve a coordinated system of services that serve the children and families that make up the community of East Baltimore: the Family Resources Coordination Unit, an outpatient center, and the School-Based Program, which will be described in detail.

The multi-level, multi-agency leadership teams that comprise the *Partnership* fit together to create a comprehensive system of leadership and responsibility, both with and across hierarchies. They are: the *East Baltimore Mental Health Partnership* Board, the Multi-Agency Coordination Committee, and the Integrated Service Planning Teams, each of which includes representatives from the public school system and is described in greater detail below.

At all levels and in all settings in which the *Partnership* functions, four basic principles guide the work of program administrators, staff, and volunteers:

- Systems of care should be child-centered and family-focused.
- The needs of the child and family dictate the type and mix of services.
- Systems of care should be community-based with services and decision making responsibility resting at the community level.
- Services should help families empower themselves to achieve the highest level of participation in community life.

## **The School-Based Program**

The *Partnership's* School-Based Program is based on the simple fact that schools are where the students are, making it a prime setting for provision of an array of services to the 19 Baltimore City Public Schools located in East Baltimore: 15 elementary schools, 2 middle schools, and 2 high schools. The School-Based Program directs its efforts toward serving 4 different groups through its programs and interventions: individual students, the school community, families of students, and the community as a whole. By design, however, the interventions specifically directed at one of these groups will positively affect all of the groups, because effectively addressing the needs of the children and families in the community means that all aspects of the school and community must be integrated into a common, unified system of care. According to Lisa, a school-based clinician, "every clinician sees the [whole] school as the client. Very rarely do you work with just a single population; we work with the whole school." Dr. Raymond Crowell, Director of the *Partnership*, states that the goal of the School-Based Program is "to help teachers and administrators look at kids through a mental health lens." The resulting approach is one that integrates the individuals that make up the school and larger community with the system in which they live, and meets their needs in the natural setting of the school building where students and families can feel comfortable.

## **Clinicians in the Schools**

The *Partnership's* School-Based Program maintains at least one clinician in each of its 19 schools. One school, the largest elementary school in the country with over 2,000 students, has two clinicians to serve the children and their families, one of whom is split between this campus and another school. The

clinician in each school primarily works with individual children who have been referred by their teachers or the principal. The most common reason for referral is because of physical aggression (24 percent), followed by a student's "social contact" problems (21 percent) or contact with the police (11 percent). Students may also be referred for attention deficit hyperactivity disorders, academic problems, non-compliant behaviors, or because they appear to be sad. In working with the children who are referred, clinicians try to discover the source of a student's emotional or behavioral problem in order to address not only his or her needs, but those of his or her family as well.

Clinicians find it advantageous to serve the children and their families in the school setting. As Donette, a middle school clinician explained, "the students are there everyday, so we can try to positively impact their relationship with the school setting and with teachers." Larry, a high school clinician, affirmed this, saying that students were more likely to seek out or agree to receive help through the program in the school than to "make the big cultural leap to go over to Johns Hopkins Hospital, where [they feel] it might be stigmatizing." Furthermore, because it is more comfortable for students who are experiencing problems to be seen in the schools, clinicians see students with a higher degree of need in the school than they do in out-patient clinics. In addition, school-based clinicians work closely with one another to ensure that a student who transfers or graduates into a new school continues to receive seamless care. *Getting John Back on Track* describes how clinicians work to align the needs of a child and his family with the services available to him through the system of care the *Partnership* has established.

Dr. Gayle Porter, Director of the School-Based Program, advocates having an understanding of the various models of care available so that each child's needs can be met in an individualized fashion. "You need to have people well grounded in the traditional models," she says, so that everyone understands what a diagnosis means or knows how to provide certain services, such as family therapy and community outreach. The "nontraditional" services integrated into the *Partnership's* program (i.e., linking the families, schools, and community with agencies that provide services through a common clinician or case manager; providing an after-school program; and organizing a summer camp) then contribute to the overall quality and capacity of the system of care. Dr. Porter is clear that as new problems or issues arise, the system needs to be responsive with training and a host of approaches in its repertoire to meet these changing needs. The vignette, *Helping Mary Through an Individualized Approach*, shows how a clinician used several different methods in helping Mary, a student who referred herself to the clinician at her school.

## **Clinical Support to Teachers**

Having school-based clinicians working in the schools provides schools with the opportunity to implement additional schoolwide prevention and early intervention programs, as they are needed. Lisa, a clinician from an elementary school in a neighborhood with a high level of drug use, told of an experience in which she was able to be responsive to particular needs in her building on two levels: both in the classroom and schoolwide. She

## ***Getting John Back on Track***

*John is nine years old, perceptive, intelligent and likeable. In the middle of the school year, both his teacher and principal referred John to the clinician in his school, Mr. Edwards, for violent and disruptive behaviors that included verbal and physical aggression toward his teachers, peers, and parents. Looking into his background with other service providers, Mr. Edwards learned that John had also recently been referred to the Kennedy-Krieger Institute — a mental health clinic affiliated with Johns Hopkins University and member of the East Baltimore Mental Health Partnership — for evaluation and individual counseling for his difficulties. His family would also be receiving instruction in parenting skills and how to support John's education. In addition, the clinic placed John on medication to help him control his behaviors.*

*Once John became placed on Mr. Edwards' caseload, he gathered every diagnosis, assessment, and physical exam John had in the last year to determine that his diagnosis was current. Mr. Edward's goal was to interface with the clinical treatment facility seeing John to avoid duplication of services and to work with both John's family and school to implement some supports in those settings to ensure total compliance with John's treatment plan. To do this, he met with John's psychiatrist both before and after he met with John, and helped to monitor John's behavior while on the medication.*

*John lived with his mother; his father played only a limited role in John's life. His mother placed full responsibility for remembering to take his medication on John, who took it for a while, but then slacked off. Very quickly, John's behavior deteriorated in his classroom, requiring his physical removal from school.*

*Mr. Edwards then worked with John and his mother to correct this problem, so that she helped John remember to take his medication consistently. Mr. Edwards continued to make behavioral observations and he enlisted both the teacher and John's parents to take notes on his behavior in school and at home. Once back on the medication, everyone saw quick, positive changes in John's behavior. He became productive in school, and reported that he felt proud of his progress and that he liked himself better, as well as his peers. During the summer John was seen on an out-patient basis to have his medication monitored.*

*It took a number of people and meetings to create a system to reinforce and assess John's behaviors. Together they were able to get John back to being productive, and he ended the school year well. Mr. Edwards believes that without these school-based services in place, John would have faced the Administrative Review and Dismissal (ARD) process (the first step towards determining whether or not a student should receive special education services), would have been removed from his local school to an alternative setting, or would have been suspended.*

described how parents would often be lined up at the crack houses across the street from the school, and “children would go to the window and say to other students, ‘isn’t that your mom out there?’ This caused a great deal of anxiety for the children and upheaval in the classrooms.” The clinician then got permission from the teachers in her school to provide full classroom instruction to students — all of whom were affected by the realities of their environment — on anger management and anxiety reduction.

## Schoolwide Prevention and Intervention

As part of the School-Based Program’s prevention efforts, a number of schools have incorporated schoolwide curricular programs into their plans to either prevent or early on intervene into violent and aggressive behaviors. Pro-social Skills Training, a pro-social skills initiative, has been implemented on a schoolwide basis in

8 of the *Partnership’s* 15 elementary schools. The purpose of Pro-social Skills Training is to reduce violent and aggressive behaviors in children and increase pro-social skills through the use of a prevention, intervention, and skills training curriculum. Pro-social Skills Training interventions focus primarily on teaching new skills to students and, secondarily, on strengthening existing skills in students who exhibit or are at risk of developing violent or aggressive behaviors. The Pro-social Skills Training curriculum teaches anger control and 50 pro-social skills, including empathy and appropriate ways to seek and receive help. The 10-week curriculum is taught to groups of 6 children, 3 times a week, by clinicians, trained teachers, or other school personnel. Teachers also receive training to identify and assist students who are at risk of or who exhibit early signs of aggressive behaviors, thus preventing these children from developing more chronic and intractable patterns of

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### *Helping Mary Through an Individualized Approach*

*Mary referred herself to the clinician in her school because she knew another child in her class was seeing the clinician, who had been in their classroom talking about conflict resolution. Mary was being teased about being overweight, dark-skinned, and having short hair. She said she didn’t want to fight, but the teasing made her mad. The clinician saw Mary individually to deal with how Mary felt about her mother, who worked two jobs and disliked Mary’s father. Mary favored her mother in appearance, but she felt she was the least favored child. Mary’s mother declined the invitation to work with her daughter and the clinician; however, she did become more sensitive to Mary’s feelings. The clinician worked with Mary on her self-esteem and feelings about her appearance, and they talked about her sadness.*

*In addition to these individual sessions, the clinician placed Mary in a group with other girls being teased about their appearances. Together they looked at books in which African American females are portrayed, talked about issues of appearance and examined media images of women, particularly African American women. They also worked on anger management. Gradually, the girls started thinking about different ways to define beauty. The girls’ group also discussed issues of academics and volunteering in class, and the clinician also went to Mary’s classroom teacher to discuss ways to talk about teasing, as well as more appropriate pro-social skills training strategies she could implement in her classroom. By approaching the situation in these three ways, Mary’s behavior changed, she had more energy to focus on her studies, and she improved academically.*

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delinquent and anti-social behaviors. When teachers rated the program after one year, their overall response was very positive. Teachers thought that the fourth-graders had especially made significant behavioral improvements. Parents, too, reported feeling very pleased with the improved behaviors they saw at home.

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*In the two years since PAR was introduced at two middle schools, disciplinary referrals have decreased by 40 percent at each school, and suspensions by between 36 and 48 percent.*

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The two middle schools in East Baltimore have implemented a prevention and intervention program called PAR, based upon schoolwide strategies to:

*Prevent* troubling behavior; *Act* on instances of rule

compliance and noncompliance consistently; and *Resolve* the issues that underlie or cause troubling behavior. Expectations, rules, and consequences that are responsive to each school's culture are clarified and a behavior management plan is formulated that all members of the school community can understand, including students, parents, teachers, school support staff, and administrators. This common plan, alone, is a form of prevention; it provides a predictable structure with clear, consistent, and simple expectations, and tools to meet those expectations have been linked to safer, more effective schools (Quinn, Osher, Hoffman, & Hanley, 1998).

Based upon the behavior management plan, both teachers and students receive training in the skills they need to know to meet a common set of expectations. Additional positive behavioral supports may be utilized to help students with troubling behaviors follow the rules. PAR includes two other components integral to the success of both the program and the students. First, PAR offers strategies for adapting academic instruction for the success of those students who need additional support. Greater academic success can often eliminate the need that students with behavior problems feel to act out; likewise, students experiencing greater success in controlling their behaviors often feel more motivated to achieve greater academic success. Second, strategies for involving parents are an important part of PAR. As described in the PAR literature, "a positive and well defined partnership between the school and the family provides benefits for all involved and can be a significant variable in reducing instances of school violence" (Rosenberg & Jackman, 1997).

## **After School and Summer Camp**

The *Partnership* also offers after-school programs in 17 of the schools and a summer camp for children with emotional and behavioral problems. The after-school programs were established with the support of each school, and members of the school community were involved in determining their school's specific needs, space and materials requirements, and desired programs. Many of the after-school programs offer students a place to do their homework with the support of program staff as well as opportunities to participate in extracurricular activities, such as art, music, or sports in a supervised setting. Clinicians are part of the teams that staff the after-school programs so that they may observe and address any problems that may arise with the students.



The *Partnership's* summer camp operates between 9:30 a.m. and 3:00 p.m. on weekdays for children and youth with serious emotional disturbance who might otherwise be excluded from field trips or extracurricular activities because of their behavior. In this setting, participants have opportunities to meet other children with similar behavior difficulties, and work together on more pro-social behaviors. The camp is run in collaboration with other organizations and the *Partnership* provides funds for children to attend summer camps outside the community that are designed especially for children with serious emotional disturbance. Both of these opportunities are open to all children being served through the *Partnership*.

## **Integrating Teachers, Administrators, and School-Related Personnel**

In addition to the direct services provided by the clinicians, the School-Based Program places an emphasis on developing a school-level capacity to implement a predictable environment for the children and teachers — one that is conducive to serving everyone in the school community. By taking a unified, schoolwide approach, the program eliminates the fragmentation of services that often characterizes school-based programs.

Program staff found that in-service training for all school staff, not just teachers, was an integral component in ensuring the success of the program. First, administrators and staff alike needed to understand mental health services and why the school was such an important place for their provision to students. Then, clinicians helped to run workshops to teach school staff about their role in the system of care and the difference between appropriate and inappropriate referrals. As each building's needs were assessed, in-service training was provided accordingly. Clinicians worked with teachers on interventions and strategies they could use before students' behaviors became serious enough to warrant referral to the clinician for services. This kind of training increased teachers' capacity to work effectively with students with emotional and behavioral problems, as well as the likelihood that students with difficult behaviors could remain not only in their home schools, but also in their home classrooms.

Clinicians also support the state-mandated Student Support or Student Assistance Teams within each building. The team includes parents, teachers, administrators, and support personnel in addition to the clinician, and, explained Sharronne, an elementary school clinician, "can help encourage a collaborative approach to serving students with emotional and behavioral problems, determine the needs for and plan in-service training to teach all staff new prereferral strategies for meetings students' needs in the classrooms, set policy for appropriate referral to the clinician, and raise awareness and support for the provision of mental health services in the schools."

Finally, clinicians are also available to be an information resource for both administrators and individual teachers or staff members. Principals may consult with the clinicians about integrating the school-based mental health program into the school community, working with individual students, or developing schoolwide efforts to promote more positive behaviors in all students. On one occasion, an elementary

school teacher referred a boy in her class to the school's clinician for being disruptive. After observing the teacher's class, the clinician found that while the student did have some individual needs, the whole classroom was chaotic. The clinician was able to help the teacher realize that she was giving the referred student ownership for all the problems in the classroom. She also worked with the teacher on using different class-wide discipline strategies and more positive, affirming language with the students who were receiving clinical services. Instead of seeing the clinician's presence as punitive, the teacher was able to view clinical work with students as a positive contribution to their individual skills, as well as to the classroom and school community.

## **Interventions that Focus on Families**

Dr. Porter notes that, "in minority and poorer communities, people are wary of mental health services, particularly medications. [Parents often take their children] off it or use it as a last resort." One school-based clinician, Alfred, agreed saying, "a continued fear and distrust of mental health" is a common issue for children and families. When Alfred sends forms home to get parental permission to see their children, they often get returned with notes stating that their children are not "crazy." Having the clinician present in the schools helps reduce the anxiety students and their families may have about mental health and supports compliance with prescribed medication. Larry, a clinician who also counsels youth at a clinic, notes that his clients, "would rather see me in the school than at the clinic, which many of them feel is stigmatizing." Indeed, Crystal, a parent of two daughters, candidly said that at first she felt uncomfortable with the words "mental health" in the program's title. "The name got to me at first," she said, and other parents in the focus groups agreed.

More than one parent also commented on the positive experiences they have had with the program and how much their children love to see the clinicians and therapists, both at school and at home. The school-based clinicians from *East Baltimore Mental Health Partnership* work with family members to overcome such initial hesitations and improve long-term academic and mental health outcomes for the entire family. Several family members noted that their children were brought into the *Partnership's* programs through a referral from the school. In fact, 31 percent of referrals to the *Partnership* come from the school — more than from any other source. Angela Vaughn, the *Partnership's* Parent Coordinator, explained that since teachers often do not have the time to create personal relationships with their students, having clinicians who are acquainted with the student and his or her needs means that, "there's someone in the school who understands." Viola, a mother of three boys ages 8, 10, and 12, described how her family was referred by the school clinician, who was "real supporting and helpful for my kids as well as me." In addition to getting her 10-year-old son into an anger management program, the clinician connected her with a class on parenting skills. "This program is really making progress," she said. "We all get along better, and have a good understanding."



Clinicians report that working with family members requires flexibility, as work schedules often require that evening meetings or home visits be set up between family members and clinicians. The parents we met with expressed appreciation for the efforts clinicians made to connect with them individually. When a clinician comes to a family's home, "everyone sits and talks together," described Gwen, a mother whose son began exhibiting serious behavior problems after learning she was HIV positive. "It's not just the child being helped. It gives you ideas on how to interact better with your children. It reaches out to everyone." Said Angela M., a mother of two children, one of whom has benefited from the *Partnership's* anger management program and summer camp, "I liked coming to parenting classes. . . . It's good to see that other parents have problems, too." Family members also suggested that working with the school-based staff allowed them to improve their relationships with the school. Many family members described their contact with the school prior to becoming involved with the *Partnership* as coming each day to retrieve their children after receiving a call from the principal's office. Working with the clinicians in the school building helps foster a more positive relationship with the school, teachers, and administrators. In addition, a family member's positive presence in the school shows the student that his or her family and the school are part of a team designed to help both the student and the family.

Family members enthusiastically described the increased success that they and their children experienced both at home, in the community, and at school as a result of working with the school-based clinicians. "There's been a big change," stated Angela M. with pride. "The teachers have noticed the change in [my son's] behavior. He can go on trips and participate in class parties now!" Another parent, Viola, marveled at how her son's attitude toward school has improved. "[He] got a certificate for most improved student, [and] he's already said he's going to do much better this year."

## **Involving Community Agencies in the Partnership**

The *East Baltimore Mental Health Partnership* has a multi-level, multi-agency system of leadership and action boards that include representatives from all community agencies. The *East Baltimore Mental Health Partnership* Board includes key city officials and representatives from the Mayor's office, family members, and community members. The Board provides oversight for the *Partnership's* activities and the organizational support at these upper administrative levels to ensure the commitment of the agencies to collaboration.

The *Partnership* also has organized Agency Liaisons who serve on the Multi-Agency Coordinating Committee. Liaisons are a core group of professionals from city and state agencies, each of whom is a mid-level manager from one of the four major service systems (i.e., education, juvenile justice, social services, and mental health). Liaisons have the opportunity to design and shape the system of care for children and families in concert with one another. Each liaison acts as an expert and information source on their respective system. For example, the school system's liaison would be an administrator from the school board who could describe the school system's role in serving children and youth with emotional and

behavioral problems, mental health programs available through the schools, and any concerns he or she had from the perspective of the educational system. Through the Multi-Agency Coordinating Committee, liaisons approve and coordinate referrals to the *Partnership* mental health services, facilitate communication and problem solving across agencies, and develop cross-training opportunities between agency staff. The Multi-Agency Coordinating Committee also develops protocols for collaborative and coordinated service delivery. This group meets bi-weekly to discuss systems issues, and once per month to discuss individual case presentations.

School-based clinicians have frequent contact with the Multi-Agency Coordinating Committee, as this group offers them the support they need to address difficult issues that may arise in their work with children and their families, particularly those that require collaboration among services and service providers. In the words of Ms. Holloway, the Deputy Director of the School-Based Program, "Multi-Agency Coordinating Committee meetings provide clinicians with places to find administrative-level solutions to stumbling blocks families face to receiving services. This group is high-level enough to be able to address these things so that students and families don't fall through the cracks." Dr. Porter states that having this group of people involved, "gives continuity of staff and people who can effect change."

When agencies refer children and families to the *East Baltimore Mental Health Partnership*, the *Partnership* views this as a petition from the agency to join a team of service providers called an *Integrated Service Planning Team*. In addition to the referring agency, Integrated Service Planning Teams include the referred family and *Partnership* staff members; however, the team is not limited to these members. Any other person that the family members feel is important to the child's well-being can be included on the Integrated Service Planning Team, including extended family members, parent advocates, school staff, staff from other agencies, or clergy. As the child's and family's needs are identified, the Integrated Service Planning Team determines how to best meet those needs, and through what agencies those services should be provided. These services are written into an Integrated Service Plan. The Integrated Service Planning Team shares responsibility among all agency representatives on the team for setting and implementing goals in the student's Integrated Service Plan, and for monitoring progress toward meeting them. For example, the *Partnership* representative on the Integrated Service Planning Team might be responsible for monitoring a student's behavior at school, while the representative from social services might be responsible for assisting the family with applying for public assistance benefits. Depending on what services are required by the Integrated Service Plan, agency representatives on the Integrated Service Planning Team may or may not be given a responsibility. If a student is also receiving special education services, the student's therapist ensures that the Integrated Service Plan is reflective of school-mandated services specified in the students' Individualized Education Program. As the Integrated Service Planning Team is responsible for meeting the particular needs of the individual child and family, the team works to avoid duplication of services and ensure a sense of responsibility and accountability. As circumstances change or problems appear, the Integrated Service Planning Team adjusts services or calls on community agencies affiliated with the *Partnership* for additional support.

## **Ensuring the Partnership's Future**

The *East Baltimore Mental Health Partnership* is in its last year of funding through its grant from the Center for Mental Health Services. To continue to meet the needs of those they serve without interruption, the *Partnership* has established itself as a Medicaid fee-for-service provider. This means that the program will continue on through revenues generated from the services they provide, which are usually covered under the Medicaid program. In addition, the *Partnership* plans to supplement its income with grant awards. While Dr. Porter's vision is to have a system in which the program does not have to worry about having its services reimbursed, it is a system that works and is able to meet the needs of the children and families in the community of East Baltimore.

## **PROJECT REACH: RESOURCES EFFECTIVELY ALLOCATED FOR CHILDREN RHODE ISLAND**

Continuing the Child and Adolescent Service System Program's work to support children and youth with serious emotional disturbance and their families in Rhode Island, the Resources Effectively Allocated for Children Project (*REACH*) was formed with the Center for Mental Health Services grant awarded to the state's Department for Children, Youth, and Families. *REACH* focuses on children and youth who meet the Center for Mental Health Services standards for severe emotional and behavioral problems and their families, regardless of their eligibility within Rhode Island's Department of Children, Youth, and Family guidelines. A set of concrete principles defines how Project *REACH* meets those needs:

- The overarching goal of the project is to identify and provide a full continuum of services needed by children and youth with severe emotional and behavioral problems and their families.
- Service provision must be highly flexible, child/family driven, and community based.
- Services should also consist of multi-agency collaborations at both the public and private levels, and be planned in a culturally competent manner to maximize access and delivery.

*REACH* is a statewide program operating in all eight of Rhode Island's mental health catchment areas. Each catchment area has a Local Coordinating Council responsible for implementing the system of care in the communities within that region. *REACH* uses Local Coordinating Councils and a structured case review process to creatively address the individualized needs of children and youth and their families, including the provision of school-based services as well as other services that support the child's ability to attend school and learn.

## **Key Components**

A Local Coordinating Council is a network of families, service providers, advocates, and community resources. School representatives participate in each of the eight Local Coordinating Councils. Each Local Coordinating Council works in a collaborative fashion to develop a coordinated system of care that will support children and youth with serious emotional disturbance and their families. They meet monthly and are responsible for assessing the service needs of families and communities in their catchment areas. Local Coordinating Councils identify barriers impeding effective systems delivery, and then advocate for change. In addition, Local Coordinating Councils try to involve families and local community

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### *The Story of George*

*George is a 17 year-old Latino boy who was incarcerated at the Rhode Island Training School (RITS) for felony assault. He served five months of his sentence and was released on probation. He had a history of physical aggression and gang involvement and multiple contacts with police prior to his incarceration. He was also diagnosed with two clinical disorders and a drug problem. He moved in with his maternal grandmother following the death of his mother two years ago.*

*A RITS social worker referred George to Project REACH. The service plan that was developed for him used blended funding to provide a variety of services. George received placement in an adolescent day treatment classroom funded by the school and run by the local community health center. The Department of Children, Youth, and Families provided money for intensive home/community based clinical services with multiple contacts per week, including individual/family/collateral contacts. He had access to an individual psychiatric rehabilitation worker funded by Project REACH whose services focused on improving social activities, job searching, and dealing with "down time." Project REACH also sent George to summer basketball camp at a local college and provided him with a basketball hoop for home recreation.*

*The school chose to transition George back to his regular high school in February. The clinical team at the mental health center did not support this decision; therefore, they negotiated a partial day school schedule and increased Project REACH funded psychiatric rehabilitation time to compensate. They also assisted him in finding a job through the Summer Youth Employment Program.*

*George was originally diagnosed with conduct disorder, attention deficit/hyperactivity disorder, and substance abuse problems. He is now emotionally stable, and has experienced improvements with his moods. He hasn't had any problems with the law, and has decreased his gang involvement. He is working on his substance abuse problem, and has achieved some measure of success. George expects to finish high school next year.*

organizations and agencies in the system of care. Local Coordinating Councils are responsible for providing services for children in local schools, as well as in the community or in out-of-home placements through both

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*You may think that we talk ourselves silly about [Project REACH], and about children's mental health and accessing systems, and coordination, but one of the things we've learned is that school superintendents aren't necessarily privy to that information. They aren't necessarily actively involved enough to understand what that [the systems of care approach] can do for them as administrators, and how they can help to facilitate some of their own programs.*

— Pamela Watson, Director of Outpatient Services at the South Shore Community Center

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a multi-agency planning process and the empowerment of communities to care for their children and families. Local Coordinating Councils develop plans for individual children and families through case review teams that bring together children and families and their chosen advocates, service providers, and other community resources to create a meaningful plan of services. Each Local Coordinating Council employs a Family Service Coordinator who works directly with families to help them prepare for case review meetings as well as to navigate the mental health, education, social, and health services systems.

Family Service Coordinators must be “parents of special needs children” with “experience in special education and children’s mental health . . . gained by parenting and advocating for their child or adolescents.” Currently there are 17 Family Service Coordinators in Rhode Island. Each Local Coordinating Council also has funding available for highly flexible, individualized services for each child, as well as therapeutic recreation services and short, planned respite for parents. *REACH* also provides resources for intensive children’s services; therapeutic foster care; day treatment programs; training and technical assistance to parents, school systems, and other interested providers; family support (through parent organizations); and infant mental health services.

## Education Initiatives

*REACH* initiates a variety of services that involve schools and learning in the system of care. They include:

- day treatment programs in South County, Providence, Pawtucket/Central Falls, and Kent County, which help reintegrate some students with serious emotional disturbance into their school while enabling others to remain in those schools and at home;
- flexible individualized services to children which address personal barriers to learning;

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### *Rhode Island School Data*

	<u>Enrollment</u>	<u>Graduation Rate</u>
Westerly (1995)	3,249	84.6%
Narragansett (1995)	1,926	96.5%
South Kingstown (1995)	3,810	90.0%
Rhode Island Training School (1998, residential)	220	N/A

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## ***Integrating Education into a System of Care: Stages of Development***

- I. ***Denial and lack of awareness*** — when schools are unaware of the needs of students with serious emotional disturbance and the resources that can be made available to address these needs.
- II. ***Awareness*** — when schools are aware of the promise of a system of care.
- III. ***Willingness to participate*** — when schools are willing to participate in a system of care, referring children to REACH or participating on Local Coordinating Councils or case review teams.
- IV. ***Child-by-child partnership or coordination*** — when links to Local Coordinating Councils lead schools and Local Coordinating Councils to work together in a child-by-child manner.
- V. ***Programmatic collaboration*** — when schools and Local Coordinating Councils work to build on individual successes to develop and coordinate some of their activities.
- VI. ***Routinized participation*** — when success in specific collaborations lead schools and Local Coordinating Councils to work together in a regular manner that is fully integrated into the daily routine of school staff.
- VII. ***Transformation*** — when routinized collaboration changes day to day practices, how individuals conceptualize the principles of the system of care, and the overall culture of schools and other child serving organizations.

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- training for school staff to help them improve their capacity to teach and work with students with serious emotional disturbance; and
  - support for families, which enables them to play an active role in their child's education.

REACH's education initiatives reflect the convergence of developments in two historically distinct sets of areas — education and juvenile justice on the one hand, and mental health and child welfare on the other. Each of these developments was somewhat independent. For example, education reform at a state level has been influenced by state implementation of Goals 2000 and the Safe and Drug-Free Program, and education at a local level has been influenced by such factors as parent advocacy and taxpayer concern with special education costs. Similarly, the Federal Child Adolescent Service System Program has influenced mental health and child welfare reform, while local initiatives have been influenced by the development of Local Coordinating



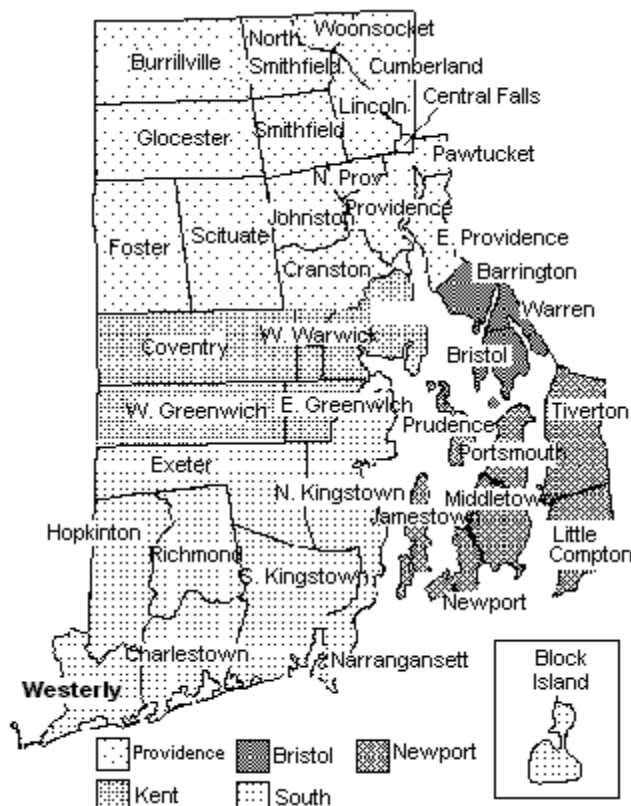
Councils. Development in each of these areas set the stage for initial collaboration, and successes in the initial collaborations set the stage for further collaboration between schools and Local Coordinating Councils. Families, practitioners, and administrators whom we interviewed described the transformation of relationships. John Brinz's (a Day Treatment Program Manager in South County) description was typical:

*[Initially, many schools addressed students with severe behavior as] 'out-of-sight, out-of-mind.' Often an individual's behavior was swept under the rug or ... someplace else, because there were no resources, or there wasn't an investment in that individual. When success was realized at an out-of-district placement, there weren't sufficient supports to make that transition back into school successful. As a consequence, the same problems would resurface. However, once schools become convinced that collaboration is possible and can work, their enthusiasm and energy strengthen the entire system by providing an important setting for service delivery. In addition, these schools become examples for other school systems, demonstrating how Child and Adolescent Service System Program principles can be actualized.*

Schoolbased and learning-focused services funded by *REACH* can be found across the state in a variety of educational settings, using innovative, diverse models of service delivery. However, all schools and communities are not at the same stage of development. Schools (and systems of care) can be conceptualized (as they were by *REACH* Project Director, Sue Bowler) as being at seven developmental stages that reflect the history of communities and schools, as well as the relationships between key individuals (e.g., superintendents and mental health directors). These seven stages are described below:

Four sites receiving Project *REACH*'s support and which are at the routinized stage or transformational stage (depending on one's perspective) exemplify Rhode Island's efforts to fully integrate education into a system of care. These sites show how distinct developments in education and the system of care set the stage for collaboration, and how success with the initial collaborative, can set the stage for more collaboration. The sites are: the Westerly Public School System; the Narragansett and South Kingstown Public School Systems, which we will present together; the Rhode Island Training School.

## Westerly Public Schools: A Districtwide System of Care for All Students



**Overview.** Westerly, Rhode Island, is a small city school district of about 3,600 students located in a manufacturing and tourist community of 21,000 people on the state's Southern coast. In the late 1980s, the district was the subject of parental complaints over their treatment of students with disabilities. In addition, many of the district's students with serious emotional disturbance were placed in expensive out-of-district placements, which frequently separated them their families and non-disabled peers. During the 1990s, the district addressed these problems through changes in its philosophy, school capacity, and teacher practice. Westerly, in 1998, exemplifies a school system at a transformational level of development: it has a strong culture that is committed to a school-and community-wide system of care; it is a self-conscious learning community that is committed to continuous improvement; it has structures in place to support the school and community-wide system of care — including routine collaborations with the system of care, and it has political and community support to sustain the change process.

Embracing the philosophy of including all students, Westerly evaluated what its needs were, re-deployed the resources that it was expending on out-of-district placements into building a school-wide capacity to serve all students, and then implemented intensive, ongoing staff development and collaborative



team teaching to provide educators with the skills needed to educate as many students as possible within their neighborhood schools. Westerly restructured schools as well as district and building policies and programming to reflect their clear expectations and commitment to the needs of each individual student, incorporating preventive districtwide programs; providing intervention when needed; and working with case review teams, which provided targeted interventions for students with more serious needs. As the President of the School Committee said, "What is the alternative? This is our community! These are our kids!" Her comment reflected the philosophical shift that occurred in the last eight years, not only in the schools, but also throughout the entire community.

**Interventions.** Westerly employs a variety of practices to create a school and system-wide foundation that works for all students, providing early intervention for students who are at risk of serious emotional disturbance, and more intensive services and supports to address the needs of students with serious emotional disturbance. With the help of *REACH* funds, Westerly created a continual system of care for its students from early elementary school through high school that reflects Westerly's Guiding Beliefs, which state, "it takes a whole village to raise a child," and "our responsibility is to provide opportunities for all students to learn and be successful" as well as its goal (one of seven) "to establish a process for connecting the community with social services agencies to meet the needs of students in a society undergoing demographic shifts."

Westerly administrators speak of a "zero failure policy," of refusing to "give up on any student," and of providing students with "meaningful supports" that are "child-focused." Westerly achieves these results through a coordinated program of service delivery, incorporating five components: research-based instructional strategies; intensive staff training, team teaching, and teacher support; planning centers to provide behavioral and emotional supports for all students; case management; and effective use of student support services and alternative settings for early and more intensive interventions.

**Research-based instructional strategies.** Students with serious emotional disturbance often receive inferior instruction that employs educational practices not validated by research. Westerly's schools have employed effective approaches to improve student learning, which address the unique needs and strengths of each student (i.e., social, emotional, behavioral, and academic) while addressing the demands of the general education curriculum. Some of the teaching practices utilized include:

- class-wide, cross-grade, and even cross-peer tutoring;
- cooperative learning among groups of four students which taps student strengths' and provides an opportunity to teach social skills, such as team building, leadership development, sharing, turn taking, and other age-appropriate peer interactions;

- fast-paced instruction paired with supports for student comprehension, such as visually organizing ideas of the chalk board through graphic organizers; providing tutorial support during study sessions; collaborative teaching; and curricular modification in order to enhance learning opportunities for its students.

**Intensive staff training, team teaching, and teacher support.** As East Baltimore found, addressing the needs of students with serious emotional disturbance requires a staff that is prepared to respond to the behavioral, emotional, and academic needs of all students. Westerly addressed this need by providing and supporting a comprehensive approach to staff development that included providing in-service training and factual information regarding the nature of students with serious emotional disturbance. Many training activities included teachers, school staff, administrators, family members, and school board members. Training ranged from core value issues (e.g., inclusion and collaboration) to issues that were particular to children with serious emotional disturbance (e.g., information on specific disorders, reality therapy, behavioral intervention and prevention), and general instruction (e.g., cooperative learning and peer tutoring). Westerly's investment in staff development includes stipends for sessions attended, five days per year for in-service training, a two-day off-site conference for staff, and a staff development coordinator (at a .6 full time equivalent level).

Westerly also enhanced the capacities of its teaching staff by encouraging and supporting (through release time and extra training) team teaching that paired a special educator with expertise in addressing diverse learning and behavioral needs with general educators with expertise in subject content. Westerly now has over 80 sets of team teachers, which has improved the ability of teachers to support and educate students with serious emotional disturbance and other severe disabilities. As the number of these teams grew (from 2 to 56 in 4 years) the number of self-contained classrooms decreased (from 13 to 2).

Westerly also supports its teaching staff by providing teachers with ongoing information, access to support personnel (e.g., the members of the student services team), time for planning and training, support for risk-taking and problem solving, consultation with specialists, and, perhaps most importantly, a feeling that they are part of a community that can serve all students.

**Planning centers.** Westerly provides planning centers at several of its elementary schools, as well as at its middle school and high school. These centers provide an "alternative space" to assist students in learning to take responsibility for their own behavior, including their academic achievement. The centers have many resources in one room. Support, time-out, crisis intervention, individualized academic support, a social network, and links to necessary social services are all provided there. Ultimately, the centers provide students with three essential things:

- *Time* — to address problems;
- *A safe place* — to fall apart, address problems, regroup, or develop strategies; and

- *Support* — through crises and in developing and implementing strategies to address problems.

The planning center at Westerly's middle school exemplifies the planning center model. The center is staffed by a full-time behavior specialist and by a special education aid. It serves all grades, seven periods a day; during the course of the week the Center serves between 35 and 40 students. The center's goals are to improve behavior and cooperation in school, attitudes towards school, attendance, completion of work assignments, study habits, and grades as well as to provide support for long-term student projects and in the relationship between students and teachers.

The center's building-wide support programs are open to all students, and half of the students who use the centers do not receive special education services. While time in the

center may be written into students' Individualized Education Programs and behavior intervention plans, any student may select to go to a planning center for a period of the day to work on academic work in its structured setting or to "cool off" and work through a problem if he or she is angry. The vignette, *Addressing the Needs of Students at Risk: Planning Center for All Students in Westerly, Rhode Island*, explains how students use the planning centers.

**Case management.** While Westerly's planning centers have phones so that they can provide links to necessary services, they are not staffed to provide case management. Recognizing the need for integrating services within the school setting for students with intense needs, *REACH* and Westerly High School developed the Westerly Integrated Social Services Program (WISSP). Located in the school building, and directed by a school psychologist, WISSP coordinates school services and community resources in a place accessible to students and their families to meet any social or emotional needs they might have. Its vision is "to promote all students' success in school and enhance the quality of life for all families in the community"

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### ***Addressing the Needs of Students at Risk: Planning Centers for All Students in Westerly, Rhode Island***

*The elementary and middle schools in the Westerly Public School District maintain planning centers within each building where all students can choose to get emotional support or "cool off," resolve conflicts, get assistance with school work, have a quiet space to work on homework, or work on problem-solving skills with an adult or on the computer. While all students can choose to come to the planning center throughout the school day, some students have written in their Individualized Education Plan a class period or more time during the school day to spend in the planning center. An adult trained in behavior management staffs the planning centers. Planning center teachers can also help students and families access mental health or other community services when a need is identified.*

*The planning centers facilitate the early identification of, and intervention into, problems students are having; staff can then work with students to teach them coping and problem-solving skills to manage their difficulties. These centers also serve to prevent the escalation of inappropriate behaviors by addressing academic, emotional, or behavioral problems before they become crises. "The planning center," observed Joe, a seventh grade student, "gives space to resolve conflicts." Combined with other programs, the planning centers have resulted in improved grades, achievement, and attendance and fewer disciplinary referrals, creating a positive, trusting learning environment that promotes high academic and behavioral expectations.*

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(WISSP Pamphlet, 1997). For students at risk of school failure or of dropping out of school, taking advantage of WISSP services keeps them in the school building, while still receiving support services. The vignette, *Involving the Community to Improve Services for Children's Special Needs*, illustrates how WISSP coordinates the services students and their families need, while enabling them to progress academically, as well.

### **Effective use of student support services and alternative settings for early and more intensive interventions.**

Westerly draws upon and coordinates the services of student support personnel to provide services that are provided in Baltimore by the clinicians and in Philadelphia by the Intensive Case Managers and the Consultation and Education Specialists.

Westerly's elementary schools employ a *consultation model* where school psychologists and special educators consult with elementary school staff — conducting observations in classrooms, developing behavioral intervention plans for students, working with families, and creating links with outside agencies.

Westerly's middle school and high school employ a Support Services Team that includes a school psychologist, school social worker, behavior specialist, and a school administrator (e.g., the assistant director of special education), some of whom also work with the planning center and with

WISSP. The team members are available to consult with students, families, and staff. For example, in the case of students who are not identified as eligible for special education services, the team works with the parent and child to develop a behavioral support plan, which might include alternative disciplinary responses, an altered

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### ***Involving the Community to Improve Services for Children's Special Needs***

*The Westerly Integrated Social Services Program (WISSP) worked with the school and other community organizations to help Marcy, a high school senior. Marcy's teachers noticed that she had been late to school or skipping classes. When asked about her tardiness and missed classes, Marcy revealed that her father was terminally ill. His disease was degenerative and he was beginning to lose his mental faculties. Marcy came to school each day fearful that her father might take the wrong medication, take his medication incorrectly, or not heed his strict dietary restrictions. Working with the high school and with WISSP, Marcy was able to work out a partial day schedule so she could stay home with her father part of the day and then attend school for the rest of the day. They also helped Marcy arrange to take two courses at the community college she would need to meet graduation requirements.*

*When Marcy's mother was laid off and their car broke down, things went from bad to worse. WISSP mobilized to get the word out about this family's great financial need to the clergy of two local parishes. Together, they were able to collect close to \$900 for Marcy and her family. This allowed them to pay for car repairs, tuition for Marcy's college courses, medical expenses, and food. Today, Marcy attends a bereavement support group at the WISSP Center to help her cope with her father's imminent death. This was just one example of what the integration of services can do to help students in need, no matter how great or small that need is.*

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school day or schedule, and positive reinforcers for appropriate behavior. When a student is eligible for special education services, the team participates in developing and implementing the Individualized Education Program, which will include the behavioral support plan. The teams review referrals once a week, and conduct individual program reviews on a scheduled basis.

Westerly also provides the *STAR Program*, an elementary classroom staffed by a special education teacher and two behavioral assistants to provide a safe and nurturing program for eight elementary school students “who present severe social/emotional/behavioral issues” and who have a history of acting out at home, in school, and in the community. *STAR*'s key components are consistently structured, behaviorally based interventions to alleviate barriers to learning, backed by therapeutic support and intensive parent involvement.

In order to keep students with very severe behavioral needs in the community and to facilitate the reintegration of others back into the community, Westerly has implemented, in collaboration with Elmcrest Hospital, the *LINKS Program*. *LINKS* provides a highly structured, therapeutic educational setting designed to meet the academic, social, emotional and/or behavioral needs of up to 10 students. *LINKS* is designed as a short-term placement, although some students may participate on a more long-term basis. *LINKS* enables students to participate in all of Westerly's required curricular areas as well as in a clinical group program. The *LINKS* team is headed by a special education teacher who is responsible for instruction, a parent liaison, and program managers. The team also includes a hospital clinician with a minimum of a master's degree and several years experience working with school-age children and a bachelor's degree-level mental health worker/tutor who acts as a teaching assistant and provides behavioral support.

While Westerly has much internal capacity, it builds on its relationship with external components of the system of care to improve outcomes for those students who require more intensive services. When Westerly students require out-of-district placements, Westerly staff works with the setting, family, and student to prepare the student's transition to that setting, and again works to support the student's return to Westerly.

Westerly demonstrates what can happen when schools develop a capacity to serve all students. Their efforts have paid off in a suspension rate nearly six times lower than the state figure (.038 compared to .232). Similarly, Westerly's suspension figures are also lower in comparison to two demographically similar towns in Rhode Island. Implementing this integrative and comprehensive approach to educating its students has also led to improved grades, achievement, and attendance of special education students, and to decreased disciplinary referrals. For example, 60 percent of Westerly 8th-graders receiving special education services scored in the middle or high range on the Metropolitan Math Test, in contrast to 27



percent of Rhode Island's special education students; and 47 percent scored in the middle or high range on the Rhode Island writing assessment, in comparison with 28 percent of Rhode Island's special education students.

## **The Narragansett and South Kingstown School Systems**

**Overview.** Narragansett, like Westerly, is located on the Atlantic shore in South County and has a comparable demography. While it has a smaller population than Westerly (15,071), it is more geographically spread out. In addition, while Westerly's five elementary schools feed one middle school, all of Narragansett's students attend one 800-student elementary school (pre-kindergarten through 4th grade), a 750-student middle school (grades 5 to 8), and a 550-student high school. (Many students attend parochial high schools.)

Narragansett has a strong commitment to hiring high quality staff. In addition, many of its key administrators have strong backgrounds serving students with serious emotional disturbance. The Superintendent, who has been in the school system for almost 12 years (seven years as a curriculum coordinator and four years as a Superintendent), has a broad background in working with students with serious emotional disturbance and is trained in Reality Therapy. The Elementary School Principal has a counseling background, was the district's special education director, and prior to that, served as the director of a private school for children with serious emotional disturbance (as did the assistant principal).

The director of special education, who was Westerly's assistant director of special education, is also an expert on serious emotional disturbance and a long-term participant on the Child and Adolescent Service System Program teams. She described her entry into Narragansett in the Fall of 1996 as walking "into a culture and environment that was already prepared" to build a districtwide system of care.

South Kingstown is larger than Narragansett and Westerly, and is located on the Rhode Island coast between the two towns. It has a population of 24,631 people and is more economically and culturally diverse than the other two towns. South Kingstown also encompasses the University of Rhode Island. It has an early learning center, five elementary schools, one junior high school, and one high school.

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### *Outcomes*

*While over 55 percent of youths with serious emotional disturbance drop out of school nationally, only 5 percent of Narragansett youths with serious emotional disturbance drop out of school — a rate that is no higher than the district dropout rate for all students with disabilities, and all students.*

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Historically, South Kingstown has had a strong reputation for its public school programs. During the past three years, South Kingstown has experienced a variety of important administrative changes. The Superintendent retired two years ago and was replaced by a former Assistant Superintendent. There have been three special education directors, and a number of new building principals.

Both Narragansett and South Kingstown exemplify school systems at the routinized stage of development (Stage VI), where success in a specific collaboration led schools and *REACH* to work together in a regular manner that is fully integrated into the daily routine of school and *REACH* staff. Sandra Keenan, (the former Westerly administrator who is now Narragansett's Special Education Director), sees her district as now being where Westerly was three years into its change process.

## **Interventions**

Narragansett and South Kingstown employ four common strategies to improve outcomes for students with serious emotional disturbance: staff training and consultation; individualized mental health supports and services; a school-based day treatment center; and an external day treatment program. In addition, Narragansett employs two other strategies: a planning center in the elementary school, and a student support team, both of which are similar to Westerly's arrangements (described above).

**Staff training and consultation.** *REACH* has provided resources for staff training and consultation to address the needs of students with serious emotional disturbance. In addition, Narragansett provides intensive training to its staff in William Glasser's Control Theory and Reality Therapy. In order to ensure that all staff work from a similar intervention perspective, the school system devotes one day in which all new hires are trained in Reality Therapy.

**Individualized mental health supports and services.** Both districts utilize wraparound planning and individualized supports. These supports include: in-home behavioral supports to help students get ready for school, after-school support, therapeutic recreation, support for opportunities to engage students and enhance their sense of self-worth (e.g., music lessons), and links to more intensive comprehensive supports.

**School-based day treatment.** *Project WRAP* is an innovative approach to day treatment that is offered in two South County Schools: Narragansett's Pier School and South Kingstown Junior High School. In Narragansett, *Project WRAP* is referred to as the Support Service Center, and in South Kingstown as the WRAP Room. *Project WRAP* provides all of the supports of a planning center, but also case management. The WRAP case manager (who works at both sites) provides a link between school services (such as the Individualized Education Program) and Local Coordinating Council services. In some cases her role may include initiating an Local Coordinating Council case review. In other cases she may follow up on the Integrated Service Plan and ensure that it is working at the school and is linked to school



supports. Still, in other cases, she may bring the Individualized Education Program and Local Coordinating Council case review team together to create one plan, such as in Narragansett, where the school provided for intense services to get the student to school, and the Local Coordinating Council paid for an after-school program that included therapeutic recreation. The vignette, *John's Story*, provides an example of how this works in Narragansett.

The two other WRAP staff often help regular class teachers adapt to the needs of students with emotional or behavioral problems, and they provide direct services to students. They identify behavioral targets for them, provide daily adjustment counseling, assist the teacher on occasion, and provide support to address social and emotional issues students experience. This often requires staff instruction, support and encouragement to maintain appropriate behavior and prevent behavioral incidents. In some cases, this service may take the form of short-term co-teaching, consulting, monitoring progress, and modeling appropriate teacher-student interactions for the student. In the interest of engaging students and providing informal social skills training, WRAP staff organize field trips and special projects. The WRAP Room at South Kingstown sponsors a consulting psychologist to run an anger management group for one hour once a week, and a consulting counselor to run a bereavement group once a week. Other needs, such as personal care assistance and transition services, are addressed by WRAP resources as well. WRAP Room staff are responsive to student needs, and as new needs arise, staff adjust and creatively problem solve to address them.

Like the planning centers, *Project WRAP* also provides a place where students can voluntarily seek out services. Some students use it as a homeroom for organizing their materials, discussing concerns that are potential triggers for problem behaviors, and reviewing their schedules and behavioral contracts. Students also receive homework support through a variety of interventions, including recording assignments in daily schedules, parent-teacher sign off, posted feedback, and reinforcement strategies. Students sometimes use WRAP's behavioral services for anger management, self-imposed time-outs, problem solving assistance, or a place to

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### ***John's Story***

*Because of his behavior problems at school, home, and in the community, John, a seventh grade student, was placed in a day treatment program an hour distant from his home. During a 60-day period in this setting, he only attended school 17 percent of the time. Narragansett's case manager worked with the mother and youth and convened a meeting that included the youth, mother, special education director, and director of a Local Coordinating Council vendor (an alternative program at South Shore Mental Health Center that provided therapeutic recreation). Participants at this meeting developed a single plan that included school district and Local Coordinating Council services — placement at the South Shore Mental Health Center day treatment program that was close to three miles from Narragansett, intense support to help the youth get ready for school and intense support after school. The youth's attendance improved to 98 percent during the past year, and he is being returned to Narragansett, where he will receive support from Narragansett's WRAP room.*

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vent frustrations. The WRAP Room and Support Service Center are even used to enjoy social interactions, store belongings, or have a snack. *Project WRAP* provides services in the least restrictive manner, in some instances allowing students to decide for themselves when they need help, while ensuring supports are in place to provide required services.

A total of 30 students were served by *Project WRAP* in 1996-97, with 15 students participating in each school. Of the 15 students at South Kingstown Junior High School, 8 had Individualized Education Programs, and 6 had an Integrated Service Plans. All 15 Narragansett students had Individualized Education Programs, and 10 students were either in the process of receiving an Integrated Service Plan or had one. All 30 students receiving *Project WRAP* services were promoted to the next grade, and 9 of those students were not expected to require WRAP Room services during the next school year.

These successes have led both school districts to absorb WRAP within their own school budgets. In addition, WRAP's success provided a viable model that families and other child advocates built on to extend WRAP to South Kingstown's high school. It demonstrated, said Local Coordinating Council Co-chair Pamela Watson, that schools "cannot operate education in isolation." The model, according to John Brinz, enabled the school department to learn "that they don't have to handle it all."

The development of the high school program was precipitated by two facts that: (a) youth who returned from out-of-district placements were not succeeding in the high school and were being returned to expensive placements; and (b) many students who had received WRAP services did succeed in the high school, and were being removed from the school at a personal cost to themselves and their families. Understanding the link between system of care support and school success, the Local Coordinating Council set up a meeting where parents asked knowledgeable questions of the Superintendent, who looked at outcome data from South Kingstown and Narragansett, listened to the parents, reevaluated his own views, and decided to adopt the model for the high school. Since then this Superintendent, along with the case manager, a school community member, and Local Coordinating Council chair, has presented the WRAP model to his colleagues at a Summer Leadership Institute.

External day treatment. Some students require, at least for a short term, more intensive services than are provided in the two school systems. Both Narragansett and South Kingstown employ the Day Treatment Program at South Shore Mental Health Center to help some students with intense needs to remain near their homes. In addition, some schools may, on occasion, need support in "integrating a successful out-of-school placement with" full and long-term reintegration into the local school. The South Shore Mental Health Center day treatment program provides these services a short distance from the two districts.

The South Shore Mental Health Center Day Treatment Program is located in South Kingstown and supports 25 full-time students and four part-time students from many districts in South County. Program services include screening and evaluation, case management, classroom consultation, education, individual and group counseling, family counseling and treatment, crisis intervention, vocational supports and planning, physical education, and therapeutic recreation. Like LINKS, the staff for each class includes a certified teacher, a master's level clinician, and a behavioral support specialist. Additional program staff include a program manager, program supervisor, and physical education teacher. Because the school staff have good working relations with the South Shore Mental Health Center staff, they are able to use the day treatment program creatively, for example, as an interim alternative placement for a student who has brought a weapon to school or for short-term end-of-the-year and summer support for a high school student at risk of not completing the year and perhaps dropping out.

### **The Rhode Island Training School (RITS)**

**Overview.** Nationally, over 55 percent of students with serious emotional disturbance drop out of public school, and 73 percent of these young people are arrested within three to five years of leaving school. Rhode Island data flesh out the implications of these figures. A 1995 study of one out of three records of Rhode Island Training School residents (randomly selected) found that of the 61 youth in the sample, 55 had dropped out of school or were excessively absent in the year prior to incarceration and that only 4 had passing grades, while 2 had mixed passing and failing grades. In addition, a 1996 survey of residents found that 54 of 159 residents had Individualized Education Programs that reflected behavioral disorders. Further, at that time, RITS clinical staff believed that many youth without Individualized Education Programs had mental health needs within the clinical range including depression, post traumatic stress disorder, and attention deficit/hyperactivity disorders. These observations are consistent with our site visit findings: professional staff estimated that between 60 and 100 percent of the residents had “moderate to severe mental health needs.”

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*Some people believe that our mission is to protect the community, and some people act as if that is the only mission we have at the training school. We approach it as basically one and the same. By running a good program that focuses on the needs of the resident we are, in effect, protecting the community.*

— Warren Hurlbut, Superintendent  
Rhode Island Training School

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It is important to address the learning and behavioral needs of these young people, and wherever possible to develop mechanisms for enabling them to complete their education so that they can develop appropriate skills and earn necessary credentials. In addition, Rhode Island requires as a condition of their sentences that all incarcerated youth attend school full-time, year round. This mandate, however, does not ensure that youth who have experienced long-term failure will be engaged in their schooling, or that communities that are often fearful of the youngsters, doubtful of their academic abilities, lack after-care

supports, and happy to off-lay expenses onto the juvenile justice system, will support their reintegration into the community and its schools once they return. *REACH* addresses these problems by working with the staff of the RITS to support education-related and mental health services to those youth with serious emotional disturbance and to support their transition back to their community (including to schools and jobs).

The RITS is a secure facility that provides co-located programs for detained youth as well as those adjudicated on a finding of delinquency. It is the only juvenile detention facility and juvenile correctional facility within the state. Seventy percent of its inmates are children of color and 90 percent of its inmates come from three of the most impoverished areas of the state: Providence, Pawtucket/Central Falls, and Woonsocket. While about 275 residents live at the facility, 1,500 youth pass through the RITS per year. The average adjudicated resident spends 6.8 months in the RITS, in addition to time spent awaiting trial, which can range from a weekend to 2 years.

While often viewed as a custodial entity, the RITS is also a Rhode Island School District. The RITS provides the first consistent school experience that many of the youth have had in years. By state law residents must participate in and receive education programming in one of three areas: secondary education, General Educational Development (GED) diploma, or Postsecondary Services. The average age of the residents is 17 years old. Their average reading level is seventh grade; their average math level fifth grade. The RITS education program must address this history of underachievement, as well as the fact that students' sentences do not correspond to academic years.

**Setting the stage for collaboration.** The RITS is at a transformational stage of development. It has strong leadership that views the setting as a component of a system of care, a critical mass of staff who share that vision, fully integrated relationships with *REACH* staff, an institutionalized commitment to self-evaluation and continuous improvement, and external recognition of and support for what (in the words of state education official Ken Fish) is "the process of education reform within the training school." The process of getting to the point where (according to Ty Izo, Chairman of the Rhode Island Senate Standing Committee on Health, Mental Health and Welfare) "the school is working as an educational institution," involved changes at the RITS, changes in the orientation of the Local Coordinating Councils, and the impact of statewide reform in education and human services.

Unlike 10 years ago, the RITS leadership now views the primary role of the institution as being *education*. A decade ago, the Department of Children, Youth, and Families was the subject of a class action suit (*In Re: Anna A.*) that focused on the lack of services for RITS residents and served as a platform for reform at the institution. At that time most staff and administration at the RITS viewed their mission as simply custodial or distinguished between the custodial and rehabilitative functions of the RITS. This is no longer the case. "The training school," Superintendent Warren Hurlbut states, "is one facility. We try to be good about remembering our mission: rehabilitate the kids." The RITS staff have (in the

superintendent's words) "reconceptualized rehabilitation." As a group, they now view the RITS as part of a system that should include prevention and early intervention on the one end, and transition supports on the other.

In 1996, the RITS received a state GOALS 2000 Planning Grant that supported an 18-month strategic planning process. This process reinforced a vision of RITS built around the education and rehabilitation of youth, and called for reaching out to families, education professionals, and community supports.

*REACH* also began to reexamine the relationship between systems of care and the juvenile justice system. In July, 1996, *REACH* sponsored a day-long forum to enhance collaboration between juvenile justice and mental health. Attendees included representatives from the Local Coordinating Councils; juvenile justice staff from education, administration, and social work; incarcerated youth and their families; and family organizations. Participants agreed on three steps:

- developing and sharing information about needs and strengths;
- increasing parental involvement in planning for youth; and
- opening access for transitioning youth to Local Coordinating Councils.

The collecting and sharing of information evidenced the overrepresentation of children of color at the RITS and underrepresentation of children of color in Local Coordinating Council-funded activities — a finding that energized the Local Coordinating Councils, and led *REACH* staff such as Project Director Sue Bowler to state, "residential places like this must not be ignored. This program is necessary, but must be supportive of the Child and Adolescent Service System Program values, and has to be a part of what's going on in the whole system of care."

Other developments also reinforced the changes at the RITS and within *REACH*. The state's Comprehensive Education Strategy, which was a policy agreement by the Board of Regents, Governor, and General Assembly, included among its six goals the integration of services, as described below. As a result of the RITS and *REACH* planning processes, in October, 1996 the Governor appointed a Special Task Force chaired by the Director of the Department of Children, Youth, and Families and the Chief Judge of the Family Court to recommend legislation and administrative reforms to strengthen juvenile justice and provide more options for youth. This plan was adopted by the state in the Governor's 1997 Juvenile Justice Task Force Report, *Stopping the Violence*, which called for identifying transitioning youth to the community and strengthening family involvement.

## **Interventions**

The RITS employs six interventions that provide positive learning opportunities for youth with serious emotional disturbance: an appropriate learning environment; special education; support for family participation; enhanced learning opportunities; mental health supports; and planning and support for successful transitions.

**An appropriate learning environment.** Within 24 hours, all youth at the RITS (including those in detention) receive an immediate educational assessment to provide the teachers with direction. After five days, staff requests (by fax) records, and if they do not receive them quickly, staff make follow-up phone calls.

The average incarcerated youth has experienced about two years of inconsistent schooling before entering the RITS. The RITS addresses their needs by providing individualized instruction, keeping class sizes to a maximum of twelve students, and providing one-on-one tutoring when necessary.

The RITS has become a Title I School, and uses Title I funds to support bilingual instruction, as well as extensive staff development in English as a Second Language, creative instructional strategies, conflict resolution, meeting the needs of high risk students, encouraging parental involvement, and collaboration between educational and other staff.

RITS staff has also taken active steps to break down the division between the school and the residential environment. Mentors, who offer tutoring in art and music activities, barbering, computer maintenance, parenting training, driver education, and culinary arts instruction, are provided outside of school hours. In addition, education and residential staff work together on Action Teams to address issues such as discipline, family and community friendliness, performance standards for staff and students, and the incorporation of technology into resident life.

**Special education.** Over 50 percent of the youth placed in the RITS have been identified as having an educational disability before entering the RITS, and another 10 percent are diagnosed as being eligible for special education services once at the RITS. For this process to work, parents and youth must be actively involved in the development of the Individualized Education Plans and Individual Treatment Plans. *REACH* Family Service Coordinators and RITS Transition Coordinators play key roles in making this happen, meeting with students and families before the meetings and (as shown below) supporting family participation. Students have two Individualized Education Program meetings and at least two Individual Treatment Plan meetings, when they enter and 45 to 90 days before they leave the facility.



The special education approach extends beyond the 60 percent of residents who have Individualized Education Programs. “We have, by our nature as a facility, small classes, teachers who are here working with these kids because they want to be here working with these kids, [and] we individualize or do small modules of instruction geared towards individual needs. So whether a kid is special ed. or not, he’s getting the approach of all special education kids, meaning individualized work with a lot of support,” observed Principal Arlene Chorney.

**Support for family participation.** Eighty percent of the youths with Individualized Education Programs have active parent participation written into them. This high level of participation is central to the development of strengths-based Individualized Education Programs and Individual Treatment Plans, and reflects both that steps are taken to actively involve and accommodate the needs of parents (including the use of teleconferences) and that *REACH* supported family service coordinators actively work with the parents.

Whether it is a case review meeting at a public school or at the RITS, Family Service Coordinators, Local Coordinating Councils, and *REACH* staff continue to solicit parent involvement. They believe that family member insights during the development of a service plan help to create a family-centered plan, especially when the family member is made to feel comfortable with the system.

Family members, educators, or any community or state agency can refer a child to the Family Service Coordinator, who is, in addition to being a parent or family member of a child with serious emotional disturbance, a member of the community, and is experienced in managing social service and mental health systems. The Family Service Coordinator assists the family and relevant case managers with gaining access to the services determined to be necessary for the child and family in a meeting with Local Coordinating Council case review team by performing a variety of tasks including:

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*The Child and Adolescent Service System Program opens doors for parents to learn to communicate and how to navigate systems. It helps to facilitate that process . . . as a parent, you don't even know where to begin. You have a child that has been institutionalized for a long period of time, and you have many concerns about their ability to transition back into community life, back into home life, and back into school life. It's very overwhelming. You don't really even know where to begin. The Child and Adolescent Service System Program has helped immensely to sort it all out, where to start . . . whom to talk to. My son . . . actually came to a case review . . . even though he was still at the RITS. They do let the kids come out for the meetings. It was very overwhelming for him. It's a lot of strangers sitting around a table who all think they know what's best for your life, but it gave him an opportunity to have his little bit of control, and to be able to voice his feelings.*

— Cathy Ciano, Parent Support Network

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- meeting with the families, preferably in their homes, prior to the initial case review to offer support and an opportunity to communicate effectively about the philosophy and process of the care review service planning;
- scheduling case review meetings;
- coordinating and scheduling appropriate participants to attend the case review meetings;
- supporting and advocating for family needs;
- documenting the confidentiality of client related information; and
- following up with case review team members on their assigned tasks.

**Enhanced learning opportunities.** RITS and *REACH* staff work hard to re-engage students in learning, help students expand their sense of self, and see themselves as learners — even those who are at the RITS for a short period of time. The RITS staff have often succeeded in their efforts to harness youths' energy, expand their skills and horizons, and give them a sense of self worth, which in turn influences staff interaction with the youth and the youths' motivation to participate in the academic program. They have done so by providing group and workshops in:

- non-violence
- job skills and preparation
- poetry, fine arts, and music

The Poetry Group at the RITS exemplifies what can happen when youth are engaged creatively. Guided by a teacher and poet beloved by both students and staff, the Poetry Group provides a creative outlet for residents that has become more than just a hobby — participants have developed identities as poets. Various members of the poetry group explained what poetry does for them in the sidebar

*Why I Write.* Demian, the instructor who leads the group, allows the students to write on their “own terms.” He provides a minimal structure, allowing the students to design their own curriculum. Accustomed to being told what to do, students were initially at a loss when asked choose their own topics. Eventually, however, they became very responsive to having control over a part of their lives and began to impose a structure themselves.

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### ***Why I Write***

*I try to show people what I believe or what I think, and have them understand me.*

— Chamel, 19 years old

*I started writing poetry to let my feelings out instead of acting on them.*

— Rane, 19 years old

*I [write] love poems ... that's the only thing I [want] right now; somewhere peaceful, no crime, nothing.*

— Miguel, 18 years old

*... Most of the time when we're hurt or something happens, a bad experience or something, expressing our poetry helps us to redevelop ourselves and get in the right mind-state ... To me it's like an act of recovery, how I get back on track.*

— Roger, 18 years old

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Poetry Group members are currently submitting their poetry to a magazine for publication. One member of the Poetry Group already has begun to take college-level courses through the RITS education program. Another wants to be a nurse's assistant in a hospital. This kind of guided but not dictated activity can motivate children in ways that more directed activities cannot. In addition, the collective readings and presentations by the youth provide an opportunity to employ organizational skills and social skills that they have learned in other areas.

**Mental health supports.** The re-engagement and transformation of youth requires mental health supports — for both students and staff. The RITS employs clinical social workers and a school psychologist to provide mental health support to students on a regular basis — one that is not disconnected from their learning experiences. In addition, as a regular part of the institution, the mental health staff are able to support the teaching and residential staff to (in the words of a school psychologist) “enhance the capability to care.”

Breaking down the division between the academic and residential staff and re-engaging youth also support the healing process. Youth who participate in the non-violence program speak of how it has improved their social skills and problem solving abilities. One youth (Chamel), who spoke of “learning new ways to manage his anger,” states that, “the program makes you question yourself and your actions to reevaluate them.” Another (Christell) said, “training really helps you to think differently about things,” and still another (Rane) spoke of “learning to express anger through talking” and learning “to believe that others care.” Similarly, many members of the Poetry Group employ their poetry to prevent themselves from acting out negative thoughts, to live out their dreams, or even to heal themselves. According to Demian, the therapeutic aspect of the poetry “is a process of generating something, structuring it, but then in the middle of that falling into a place where you're not thinking at all, you're feeling . . . and it's in that mode that they understand the healing process.”

Collaboration with *REACH* enhances the capacity of the RITS to address mental health issues in four ways. First, the Family Service Coordinators (who make the links with community agencies) have freed up the time of the clinical social workers so that they can be available to provide mental health support to youth on a timely and day-to-day basis. Second, *REACH* staff supports students and staff in their growth. For example, Demian views his work as similar to that of the *REACH* director and tells how she has helped him. “She works individually with the kids on self-esteem. That is the same thing that I hope poetry will do. We both want to help the kids to begin to be initiators . . . . If we will ‘rehabilitate’ [them] it has to be an individual process . . . . [The youth] are comfortable in being told how to think. Sue has made sure to pull us back when we become too directing.” Finally, *REACH* staff support individuation and links to

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### ***Results***

*The transformation of the RITS is starting to produce impressive outcomes. For example, in 1997, RITS students advanced an average of 10 months in reading scores over a six-month period. This progress has continued. In June, 1998, RITS graduated 71 students with either a GED or high school diploma.*

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the community that counter the institutionalization of residents and of staff that occurs in even the best of residential institutions (Goffman, 1959). For example, Tracy, a family service coordinator, was described by Demian as doing “one-on-one stuff and asking the kids what kinds of things they would like to be doing . . . [helping them develop] a plan of action, and taking responsibility for that plan.” I think that [REACH] helps . . . to counter the bureaucratic tendencies of this place.”

## **Planning Support for Successful Transitions**

National studies of recidivism suggest that “after care” and reintegration into the communities is critical to successful post-incarceration outcomes. This may particularly be the case for the RITS, where students return to learning, but where (to quote special education director Bob Dumas), “the student has too many bad memories, and people on the outside misjudge the kid given the kid’s history.” In addition, the schools who saw the students drop out, “do not want the kids back.” These challenges are particularly great for youth who have a serious history of violence. Staff and stakeholders agree that unless the RITS is part of a fully functioning system of care, their residents are likely to return.

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*We had a forward-thinking program on the inside, but we didn't pay enough attention to transitions. There are kids with behavior problems who will need just as much support on the outside.*

— Principal Arlene Chorney

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Transitioning from life at the RITS back into the community is a very difficult task for the residents as well. Principal Chorney described the process as it was explained to her:

*One student likened the loss of freedom coming in here to dying, 'It just happens. One day we're free. One day we're here. There is no preparation for that . . . and the same thing going out; one day we're here. One day we're free. This has become our life. These people have become our family. This is our world, and now we're losing that. As much as we lost our families coming in, now we're losing our families again.' They viewed that time when they first get out — the loss and the grieving process — as to why they sometimes come back.*

While it may be impossible to prepare them for entering the juvenile justice system, it is quite possible to prepare them for leaving. In conjunction with REACH, RITS addresses these issues by planning for transition, and by providing youth with transition supports including wraparound planning, and individually-based supports.

Collaboration with REACH has enhanced the capacity of the RITS to support the transition process. While RITS has a transition coordinator, she has limited time to devote to the number of youths who are replaced into the variety of settings that they came from. In addition, while there are 300 to 400 agencies that can provide supports to those 90 percent of the RITS residents who return to Providence, Pawtucket/Central Falls, and Woonsocket, the transition coordinator lacks the information, contacts, and

the time to leverage these resources. Bob Dumals (the Assistant Principal and Special Education Coordinator) thinks that “there’s a wealth of assistance, and a wealth of information out in the communities, but accessing it is difficult. Knowing what is available is difficult.” *REACH* provides key links to this information and sustained links to supports.

The Local Coordinating Councils are the connections to those agencies. Wraparound planning and individualized supports are the key to effective transitions. The Local Coordinating Councils of the three cities now fund “wraparound services” to help parents and teachers keep youth in school or in-job training.

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*When a family sits down and you bring everyone together it has been a challenge to get the school to come too...that is still a developmental process, but people are now trying to work together to find the answers: kids, parents, etc. It takes time to really listen to the parents and hear them. Often the education piece is so important. And is problematic because often kids are returned and aren't welcomed.*

— Lisa Conlan, Parent Support Network

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The Family Service Coordinator is the vehicle and link for making this happen in a manner that actively involves youth and families, and to connecting with schools. “Tracy is the link between RITS and schools. She brings everyone into it.” It’s that link that she facilitates that works,” observed Susan Stevenson, Providence Local Coordinating Council chair.

The mechanism for guiding the transition is another Individual Treatment Plan meeting which focuses on transition and takes place 45 to 90 days before the youth is scheduled to return to the community (for special education students, this may serve as an

Individualized Education Program meeting as well). One resident, Miguel, who now “want[s] to finish school,” described the process in the following manner: “[Tracy and I] discussed everything that would take place during the meeting, before the meeting. [At the meeting] I told them what I want to do, and they told me how they think I can do it. I just said all right. I felt comfortable with what people said.”

## **Towards Transformation**

The collaboration between RITS and *REACH* has started to transform how RITS and *REACH* staff view themselves, their role, and each other. RITS continues to focus on education and rehabilitation while *REACH* staff understands the role of extending systems of care into restrictive settings. Demian (the RITS Poetry teacher) suggested the power of this transformation when he observed an unexpected effect of the poetry writing process occurring in a subtle, but telling way. “One of my kids . . . used to write to a girl . . . and he used to sign each letter with his gang insignia . . . . Now he ends them with his poetry. . . . Instead of having to be a member of a team, he’s starting to discover his individual talents . . . and he’s falling back on that as opposed to some other identity.” Principal Chorney provided a complimentary thought: “I’ve just seen the way kids have changed who have been part of this . . . they’re not afraid to tell people about poetry being a

part of them. When I think about where they might have been before . . . I think that it wouldn't have been something they would be proud of." The students' pride provides internal motivation driving them and the adults who work with them.

Residential staff have also been affected by this process. For example, they have developed a voluntary mentoring program in which they are provided with counseling training and the necessary equipment, such as pagers, so that they can mentor residents who have left the RITS. Roosevelt Benton, the Deputy Superintendent, describes the process, "During the course of a youngster's incarceration, relationships are developed with program staff. . . . Basically they act as a parent. We help them continue with that. They begin here as mentors as well as security personnel working with them on personal issues. [They then] continue it into the community. Most [facility staff] are very much involved with [residents'] education and how they progress, where they're going to live when they get out, and what they're going to do."

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### ***Family Service Coordinators Describe Their Work***

- *We have to get everyone's input, but it comes back to me to get the kid through transition. I get paper work to the school district, and take the kid if necessary.*  
— Tracy Jones,  
Providence Local Coordinating Council
  - *I come to meet the youth so they when they are in the Child and Adolescent Service System Program meeting they are comfortable. I do a home visit and try to find out the parents' needs and make myself available to them.*  
— Bany Rivera,  
Northern Rhode Island Community  
Mental Health Center
  - *I do case management. I follow it through.*  
— Betty Farizer, Pawtucket Community  
Counseling Center.
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## **The Impact of REACH on Improving the Capacity of Schools**

REACH's work with schools is starting to produce results. REACH staff have held meetings with all school district representatives to explain how the system of care works and school people have become more knowledgeable about systems of care. Fewer schools deny that they have any needs or know nothing about the system of care (Stage II), and more schools are willing to innovate and to work with Local Coordinating Councils (Stage III). Success in one locality is spreading to other localities as administrators (or teachers) listen to their peers at meetings, and as family members and other citizens ask for services. For example, there are now planning centers in six school districts and school-based day treatment programs in five districts.

The next stage is to participate in decision making after referral, such as employing individualized supports to reintegrate a youth returning from the RITS. Some schools have started to integrate the Local Coordinating Council case referral process and the Individualized Education Program process — a

development that took time because the Local Education Agencies saw the Individualized Education Program as legally binding for them, and not for *REACH*. Eventually, as *REACH* produced resources, more districts (such as Westerly) began to collaborate with *REACH* regarding individual children (Stage IV).

Finally, schools and Local Coordinating Councils begin to do programmatic work together (Stage V), such as developing *Project WRAP*. At this point the focus is on small steps. A series of small collaborations builds a shared history of collaboration. The relationships formed in this manner break down the walls that separate the cultures of school personnel, mental health personnel, and juvenile justice personnel, to name a few. Smaller collaborations initiate a process leading to partnerships that involve shared programs and funding, such as the first developments at the RITS (Stage VI) which can lead to increased collaboration, and the institutionalization of change (such as schools funding *REACH*-initiated programs), and to a transformation of behavior (Stage VII).

## **Institutionalization**

This transformation is now also occurring at a state level. The Rhode Island General Assembly passed into law a bill that enabled Rhode Island to translate the values of a system of care (and of Target Seven of the National Agenda) into law. Legislative leaders and advocates agree that passage of the bill was due to the model that *REACH* provided. The legislation authorizes the re-allocation of state funding that had been used for the residential treatment of children in the pilot counties by the state government to implement a system of care in two of the state's six counties (South County, and Central Falls/Pawtucket). Using these pilot sites, the state can assess the effectiveness of the law. The results of this funding will potentially inform the decision to enact the law on a statewide basis.

The legislation specifically states that its resources can be expended for "the education and/or care and treatment needs of a particular child and family," under the following conditions: (1) when the child and/or family has education and/or care and treatment needs which have been identified and which cannot be met through the existing community social service, education or mental health services systems in isolation; and (2) when the family and participating agencies agree that merged funding will be accessed to provide whatever services the community planning team recommends for the child and/or family. The legislation also states that "the principles and purposes of organizing the locally administered merged funding for coordinated community social service, education and mental health services for children in need of education, care, and treatment and their families" are to:

- place authority for making program and funding decisions at the community level;
- consolidate categorical funding and institute community responsibility for the provision of a full continuum of services;



- provide flexibility in the use of funds to purchase services based on the strengths and needs of children in need of education, care, and treatment and their families;
- reduce disparity in accessing services and fiscal incentives for serving children in particular placements and services not necessarily directly responsive to their identified individual needs;
- ensure that the funding “follows the child” and that any savings realized be applied to the continuing development of an appropriate continuum of community-based children’s services;
- ensure that funding is based upon achievement of specific agreed upon performance outcomes for children and families receiving those services; and
- create an equitable, stable and consistent allocation of funding responsibility between state and local governmental agencies sharing responsibility for children and families.



## **Chapter III**

# **Cross-Site Findings: Practices and Lessons for Developing a System of Care**

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The programs outlined here illustrate both the complexities and rewards of establishing school-based and learning-focused systems of care. Our visits to the partnerships, which included program observations, focus groups, and individual interviews, identified practices that were common across the partnerships, and evident in the success of their programming. The six practices that seem most integral to the success of these systems of care are:

### *The use of clinicians or other student support providers in the schools.*

Both *East Baltimore Mental Health Partnership* and the *South Philadelphia Family Partnership* have integrated clinicians directly into their schools to work with students, their families, and all members of the school community, including teachers and administrators. Westerly, and Narragansett, Rhode Island, as well as the Rhode Island Training School, have implemented similar systems in their schools through the behavioral specialists, school psychologists, and social workers who staff the planning centers, and through the Westerly Integrated Social Services Program (WISSP).

### *The use of school-based and school-focused “wraparound” services to support learning and transition.*

Wraparound services are strengths-based, child- and family-driven services and supports that are community-based and address needs at home, school, and in the community (Clarke & Clarke, 1996; Lourie, Katz-Leavy, & Stroul, 1996; Eber, Nelson, & Miles, 1997). They are developed collaboratively with the child, family, and others who provide the child or family with support, and are incorporated into a plan. Project *REACH*, for example, employs wraparound planning to support students' coming to school, their care after school, and their successful transitions from more restrictive placements. After experiencing some conflict over the integration of wraparound services in schools, South Philadelphia brought providers and school staff together to develop criteria for successful school based wraparound services. *East Baltimore Mental Health Partnership* employs Integrated Service Planning Teams to plan each referred student's Individualized Service Plan, with the input of family members, the school-based clinician, and agency representatives.

### ***The use of school-based case management.***

Case managers perform five important functions: they help determine needs; they help identify goals and the resources and activities needed to achieve them; link children and families to other services; monitor services to ensure that they are delivered appropriately and achieve results, and advocate for change when necessary (Early & Poertner, 1993). They can work with students who have severe needs and require intensive services, and they can work with students who have more moderate needs. When they work in a strengths-based manner, case managers support child- and family-driven inter-agency planning process (Donner, Huff, Gentry, McKinney, Duncan, Thompson, & Silver, 1993). All three partnerships place case managers directly in the school buildings. In East Baltimore, clinicians act as case managers, ensuring that students and their families are linked to the services they need outside the school building that are provided by the *Partnership*. By participating on the schoolwide Comprehensive Process Supports team, the Intensive Case Managers in South Philadelphia have been able to coordinate a range of services to help children successfully remain in school and at home. Intensive Case Managers work with both parents and school staff to establish behavioral management and longterm academic goals for each child receiving services. As a result, many children who may have been otherwise suspended or placed in a residential facility are remaining in the classroom, showing academic progress, and making strides in their social skills development. *Project WRAP* in Rhode Island has placed case managers in the schools who link school-based services included in students' Individualized Education Programs with Local Coordinating Council supports specified in Integrated Service Plans. Westerly's WISSP Center is directed by a school psychologist who, with her staff, coordinates both school- and community-based services for students in need of support and their families.

### ***The provision of schoolwide prevention and early intervention programs.***

All three sites have demonstrated the importance of taking a three-stage approach to addressing students emotional and behavioral needs: prevention, early intervention, and targeted intervention. Schoolwide prevention programs help those students with or at risk of developing emotional and behavioral problems, as well as those students who are not at risk, learn the skills and behaviors that help them follow school rules and enjoy positive academic and social outcomes (e.g., the *Prevent, Act, Resolve* approach in East Baltimore's middle schools). Early intervention programs or curricula allow schools to provide needed support and training to students whose behaviors require additional attention. This early intervention helps them to be more successful in managing their behaviors (e.g., the planning rooms in Westerly and Narragansett, Rhode Island, the Pro-social Skills Training curriculum in East Baltimore's elementary schools, or Philadelphia's Consultation and Education Specialists). Finally, students requiring intensive, more targeted intervention receive individualized services through the clinicians or support staff in the schools who help them learn the skills they need to be successful in the least restrictive environment possible (e.g., the Rhode Island Training School's individualized curricula and transition programs, Philadelphia's

Intensive Case Managers, or Westerly's WISSP Center). These targeted interventions also address the transition needs these students have in successfully going from more structured settings to less restrictive ones.

***The creation of "centers" within the school to provide support to children and youth with emotional and behavioral needs and their families.***

The schools and programs profiled here provide students with a place to go when they or their teachers feel they need emotional, behavioral, and academic support. Students who take advantage of these settings interact with caring staff members who can help students and their families connect with the entire system of care to meet all the needs they might have. Westerly and Narragansett, Rhode Island's planning centers, Westerly's WISSP center, and South Kingstown and Narragansett's WRAP rooms ensure that students of all ages have a comfortable place to go to in their school buildings where they can receive support. Similarly, most schools in East Baltimore have a clinic, which students may visit to work with the school-based clinicians and receive the emotional and behavioral supports they need.

***The use of family liaisons or advocates to strengthen the role and empowerment of family members in their children's education and care.***

All three sites have harnessed the power that involving family members as equal partners brings to their comprehensive programs. Both the *South Philadelphia Family Partnership* and the *East Baltimore Mental Health Partnership* employ parent advocates who attend meetings with family members and assist them in understanding and navigating the system and services available to them. In addition, East Baltimore's parent advocate conducts courses for family members and works with the clinicians to help families meet the academic, behavioral, and emotional needs of their children. Rhode Island's Project *REACH* also involves parents in a number of capacities and in a variety of settings. Family Service Coordinators, who are themselves family members, work with and on behalf of family members to access needed supports and services. Similarly, the RITS has Family Service Coordinators that work with the students and their family members to prepare them and the student's home school for his or her transition back into the home setting or to set goals and make plans for his or her future education or career.

These practices worked in the specific contexts described. Other settings will be somewhat different. To apply these practices to other contexts, however, requires understanding the underlying principles that informed their implementation in each setting. The following discussion examines the guiding principles and design features of effective systems of care, and approaches to implementing the practices and interventions that make up an effective school-based system of care.

## **UNDERLYING PRINCIPLES OF EFFECTIVE SCHOOL-BASED AND LEARNING-FOCUSED SYSTEMS OF CARE**

There are two principles that are so important to both the design and implementation of effective systems of care that they must inform every aspect of the program being developed and the members participating in its development. First, at the heart of effective systems of care is an unwavering focus on providing child- and family-driven services. Second, these services must be provided in a culturally competent manner that takes into consideration the background and characteristics of the children and families being served.

### **Child- and Family-Driven Services**

At the core of systems of care are children and their families. Traditionally, services to these clients have been fragmented, difficult to access, and allowed a lot of room for those in need to “fall through the cracks.” At the heart of the system of care philosophy is the goal of creating a seamless, coordinated continuum of services that meet all the needs of children and their families. Schools are a natural environment in which to provide and coordinate services because they are, by their nature, child-oriented. Students are expected to be there everyday, and often teachers and administrators are in a good position to be able to spot potential needs students may have in terms of their academic, social, or emotional well-being. The ease of entering the system of care through the schools means that students and their families are more likely to receive the services they need. This point of entry also provides a critical opportunity to build the trust of children and their families. Hence, the coordinated services that the system provides must maximize this opportunity by ensuring that the needs of children and their families are at the root of their philosophies and their actions. Doing this requires that children, youth, and families be afforded the respect and provided with the support that will enable them to actively participate in the design implementation and evaluation of services and service plans.

### **Cultural Competency: Meeting the Needs of Diverse Stakeholders**

Improving results for children and youth with serious emotional disturbance requires approaches that improve the capacity of individuals and systems to respond skillfully, respectfully, and effectively to youth, families, educators, and other providers in ways that recognize, affirm, and value their worth and dignity. It is projected that nearly 40 percent of the consumers in the service delivery system will be people of color by the year 2000; thus, it is necessary to develop culturally competent services that address the needs of all children and youth with serious emotional disturbance (Isaacs & Benjamin, 1991; Focal Point, 1994). Targeted groups for the goal of culturally competent systems of care include African Americans, Asian



Americans, Latinos, and Native Americans. These groups are targeted because they have historically had limited access to economic or political opportunities and have been largely unable or not allowed to influence the structures that plan and administer children's mental health service systems.

A culturally competent system of care is made up of culturally competent institutions, agencies, and professionals. Five essential elements contribute to a system's, institution's, or agency's ability to become more culturally competent. The culturally competent system values diversity, has the capacity for cultural self-assessment, is conscious of the dynamics inherent when cultures interact, has institutionalized cultural knowledge, and has developed adaptations to diversity. Further, each of these five elements must function at every level of the system. Practices must be based on accurate perceptions of behavior, policies must be impartial, and attitudes should be unbiased.

In addition to these elements of practice, effectively bringing service agencies into a system of care requires an understanding of the fact that many family members have often had painful experiences with school and social services agencies, either in their own experiences as students or as individuals seeking services for their children (Schrag & Divorky, 1975). Contributing to this issue are the frequent ethnic and cultural differences among consumers and service providers. Children of color have comprised a disproportionately large percentage of children and youth diagnosed with serious emotional disturbance. White students are less likely to be identified as having serious emotional disturbance than are black students. Black students, when identified, are also less likely to receive school- and community-based support and are more likely to spend time in restrictive settings away from their home community. White students with serious emotional disturbance are more likely to receive school-based counseling, more likely to receive higher grades, and are more likely to graduate (46 percent to 28 percent) than are their black counterparts (Valdes, Williamson, & Wagner, 1991). In spite of these disparate outcomes, service providers have rarely considered the social and cultural aspects of working with children with serious emotional disturbance and their families. While the need for greater cultural competence in providing services is recognized, there has been little knowledge and few strategies generated on how to accomplish this.

Dr. Gayle Porter of the *East Baltimore Partnership* emphasizes that "you need to have ongoing training in cultural competency that is not just based on race and ethnicity, but on race, ethnicity, gender issues, and class issues. Simply because the provider is an African American clinician [serving African American clients], does not necessarily mean that [his or her] level of sensitivity to gender issues or class issues is sufficient." Poverty, color and class are major issues that require various intervention points all along the system of care, as well as within each system. A key component of this at the school level, according to Porter, is to "get groups of kids to look at themselves differently." Reinforcing collaborations to get teachers and administrators to buy in to the importance of cultural competency and strategies they can use to build this capacity are integral to making students and their families feel accepted and understood.

Improving results for children and youth with emotional and behavioral problems requires approaches that improve the capacity of individuals and systems to respond skillfully, respectfully, and effectively to youth, families, educators, and other providers in ways that recognize, affirm, and value their worth and dignity. It is necessary to develop culturally competent services that address the needs of all children and youth with serious emotional disturbance (Isaacs & Benjamin, 1991; *Focal Point*, 1994). A culturally competent approach to providing services should attend to the power of language and communication; view families and community as critical parts of the child's support system; and demonstrate a willingness and ability to draw on family and community-based values, traditions, customs, and resources. Furthermore, the implementation of culturally competent approaches requires an understanding of the extent to which school-family and professional-family encounters are often bi-cultural encounters (Cross, Bazron, Dennis, & Isaacs, 1989; Harry, 1992).

The goal of cultural competence as applied to systems of care is to ensure that services for children and their families take place in ways that meet the needs of culturally and racially diverse groups. Cultural competence is achieved through consistent behaviors, language, attitudes, and policies that serve to enable professionals to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates — at all levels — the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs (Cross, et al., 1989).

## **DESIGN FEATURES OF EFFECTIVE SCHOOL-BASED SYSTEMS OF CARE**

Analysis of data gathered during the site visits suggest that a variety of key components are fundamental to creating effective school-based and learning-focused systems of care. The most commonly found components of the effective partnerships are that they:

- build support and maintain flexibility;
- build on opportunities strategically;
- have a system of coordinated leadership;
- provide continuity of school-based staff;
- involve and empower families;
- provide prevention and intervention programs;
- offer non-traditional learning environments; and
- ensure institutionalization.

These components are discussed below using examples from each site.

## **Build Support and Maintain Flexibility**

By integrating education and schools into the system of care, the services provided by the partnerships can be family-driven, preventive in approach, and flexible to the needs of the child, family, and school. Bringing about significant change in school practices is, however, often a slow and challenging task due to what many call “the culture of schools (Sarason, 1990).” Schools are often strongly tied to structures and procedures that make it difficult to quickly adopt changes, even when they are positive. Each school has its own policies, traditions, and procedures which, when disrupted, can unknowingly subvert the intended goals for new programs. Teachers also have learned to “duck” change as innovations come and go. To avoid such disruptions and to fit into the existing school structure, the programs engaged in a multi-year effort to integrate a system of care that was flexible and responsive to the school culture, its students, and its staff.

Both the East Baltimore and South Philadelphia Partnerships, for example, encountered difficulties in their first year in integrating themselves into the schools. *Partnership* staff found they had to “start over” by building more support prior to going into the schools, negotiating with administrators and teachers about how to best integrate the program into the physical building and its culture, and by changing their workstyle to adapt to the needs of the school and its community. As a result of taking the time required to build support and acceptance from everyone working in the school, integration of the *Partnership* into the schools was more successful; children with emotional and behavioral needs are now identified more quickly; and they are referred to the appropriate social services, when needed.

Similarly, the *South Philadelphia Family Partnership* had to develop a format for bringing all participants in their school-based system of care together in a way that is both sensitive to its environment and enables full collaboration and knowledge by all stakeholders of the wraparound service process. It developed Guidelines for Provision of In-School Wraparound Services (see Appendix A). In response to the concerns of school staff that wraparound services were not being integrated into the school setting, the Guidelines call for an interagency meeting to be convened prior to the delivery of any in-school mental health services. At this meeting the parent or family member, child, teacher, wraparound service provider, case manager, and school representative are all represented. Collaboration across all parties is emphasized and specific interventions, outcomes and goals for the child are reviewed. Finally, a model for developing positive social skills for the child is identified. These early steps towards inclusion enabled the *Partnership* to gain the trust of the school, as well as that of the families they serve.

Project *REACH* had the challenge of figuring out how to work with systems that were at different stages of readiness to collaborate with Project *REACH*. Each district was at a different stage in their development and needed different things from Project *REACH* in order to strengthen the programs and

services already being provided. Recall Sue Bowler's (Project *REACH* director) description of the process of developing support for Project *REACH* in one district. As school staff members became more comfortable with and knowledgeable about Project *REACH*'s services, they increased their participation and collaboration with their Local Coordinating Council significantly, which helped to eliminate barriers and foster trust between participating agencies. In all settings, this process requires the understanding that change is necessarily slow paced because it requires that everyone involved is ready and able to support it. Both schools and collaborating agencies can increase their chances for successful integration by demonstrating flexibility to each other's needs.

## **Build on Opportunities Strategically**

Related to the issues of building support and maintaining flexibility is the practice of building on existing opportunities to establish an effective system of care. Working with the structures already in place results in a system of care that is more culturally synchronized and also eases the process of "buy-in" by the members of the affected community. All three of the *Partnerships* examined the ways in which the schools and community operated prior to integrating their programs. While each functions very differently, the *Partnerships* were able to successfully connect existing structures and procedures into their structure and mode of operation.

The *East Baltimore Mental Health Partnership*, for example, considered both the needs of the school system and the state mandate that each school have a Student Support Team in place to serve children and youth with special needs. The School-Based Program is designed to be responsive to the needs of both the community and the schools, and the clinicians are trained to be active as well, supporting members of each school's student support team. The clinicians are able to coordinate with what both students and schools need and what administrators, teachers, and school-related personnel need to know in order to meet these needs.

The *South Philadelphia Family Partnership* took into consideration that a new Superintendent of Schools, David Hornbeck, came on board in the mid-1990s and reorganized the city into 22 clusters, organized by region and neighborhood. This reorganization recognized that the communities of Philadelphia have a localistic identity and think of themselves as distinct entities within the city. The *Partnership*, too, integrates three clusters within South Philadelphia and works with others as students transition to schools in other parts of the city.

Finally, Project *REACH* in Rhode Island learned that its opportunities would come when people and programs around the state were ready for their involvement, and that the Project's overall goals would be met by fitting into what already existed in programs and communities throughout Rhode Island. Westerly Public Schools, for example, had already developed a strong system of student support services, namely the

planning centers and the WISSP Center, to meet the needs of all of their students and their families. While not reliant on Project *REACH* for their operation, Project *REACH* was able to contribute funding to these initiatives to strengthen their resources. At the other extreme is *Project WRAP*, which established a new concept and structure within the school system with Project *REACH* funds. Finally, the development of a relationship with the RITS built upon the state mandate that all RITS youth attend school and the institution's desire to address the transition of the youth from the institution. While these are very different programs, Project *REACH* helped to meet their needs by helping them to be more effective in working with children and youth with serious emotional disturbance and their families.

## **Have a System of Coordinated Leadership**

The role of a multi-agency advisory team is to provide a method of formal oversight for the system of care that represents and incorporates all families and partner agencies, including education, into the decision-making and planning process. Such a team helps to monitor the development of cross-agency collaborations and to improve the overall effectiveness of the partnerships. The advisory team helps to maintain open communication and efficiency in decision making across many different groups and stakeholders. In addition, it provides a supportive and powerful backup to the front line clinicians, family members and agency representatives who make up the system of care.

In South Philadelphia, the *Partnership* is overseen by a Partnership Advisory Board that is made up of agency representatives (including education), caregivers, family members, and a state representative. The East Baltimore *Partnership's* Board, a coalition of leaders from the city, state and public service agencies, serves to maintain the partnership aspect of their system of care. Project *REACH* in Rhode Island uses a Local Coordinating Council that represents family members, service providers, child and family advocates, educators, and community agencies. The members of these groups work together, as well as with other committees within their programs, to coordinate the network of services and information that forms each system of care for children and their families.

## **Provide Continuity of School-Based Staff**

The relationships established through the efforts of a stable core of mental health staff have shown long-term benefits for children, families, and schools, particularly in schools with a high rate of teacher and administrator turn-over. Continuity in school-based staff results in greater stability and consistency in the services that children and family receive. If there is a high turnover rate, due to "burn-out" or a lack of support, all members of the system of care, including the students and their families, experience frustration. Efforts to increase continuity are discussed in the next section.

## **Involve and Empower Families**

Family members need to be treated as knowledgeable, necessary, and equal partners in creating effective systems of care for children and youth with emotional and behavioral problems. Recent amendments to the Individuals with Disabilities Education Act (P.L. 105-17) hinge on making family members greater participants in the identification and assessment of their children's disabilities and in the process of developing the Individualized Education Program. Similarly, the National Agenda and the Center for Mental Health Services grantee program envisions the creation of family-driven systems. These family-driven approaches represent significant departures from previous approaches to serving children with serious emotional disturbance. All three of the sites find that a high level of family involvement in the development and implementation of systems of care help make these programs more effective.

Across the sites, the partnerships involve the full participation of parents and family at all levels of decision making. As a full participant on planning teams, family members can help develop goals for their child and monitor his or her progress. East Baltimore, for example, places parents or other family members on its Integrated Service Planning Team, where they work with service agency representatives on behalf of their child. As circumstances change, a family member can offer input into the appropriate next course of action. An additional advantage of the school-based setting is that as children transition from one school to another, the system of care can track their movement and continue to provide support. This seamless network of service avoids the incidence of children and families "falling through the cracks" in the system.

The *South Philadelphia Family Partnership* similarly found that the ability to bring parents to the table enhanced their credibility with the school system. Their family advocates work directly with families to provide them with guidance and information, accompany them to inter-agency meetings, and enable them to take on the role of self-advocate as they feel more involved and comfortable with the system. The *East Baltimore Mental Health Partnership* has likewise benefited from having a Parent Coordinator on staff to be a parent advocate in meetings and to teach classes for parents on parenting skills and supporting their children's education. In addition, clinicians also recognize family members of the student's they serve as crucial participants in the task of improving outcomes for their children.

Rhode Island's Project *REACH* also incorporates family members into a number of its programs. Rhode Island's Family Service Coordinators are family members who can assist families and case managers in gaining access to the services determined to be necessary for a child and his or her family. The Rhode Island Training School (RITS) also utilizes to work with students and their families to prepare for transition back into the youth's home, school, and community. RITS staff have noticed that involving parents has led to increased parental "buy-in." With the support of *REACH* resources, families have become powerful aids for social workers at the RITS; they become advocates for their child, pushing for systemic change in serving their children and contacting the various agencies themselves.



South Kingstown's superintendent stated that it took the impassioned advocacy of parents on a panel discussion he observed to make him realize the importance of including parents in the system of serving children and youth. He realized that even though he was accountable to the school committee and town council, there are others who know his system well, such as parent advocates and agency professionals. He learned that he had to acquaint himself with their systems and begin to work with them on coordinating their collective efforts to serve all children and youth to truly make systemic changes in his district.

## **Provide Prevention and Intervention Programs**

Effective programs combine three approaches in the provision of mental health services in schools for children with or at-risk for serious emotional disturbance: schoolwide prevention efforts for all students; early intervention for students who are found to be at risk of behavioral problems; and targeted individualized interventions for students with severe behavioral problems. To provide services on all three of these levels, all of the sites profiled have placed their mental health staff directly into the school setting. The schoolwide prevention efforts in the Philadelphia *Partnership*, for example, are the Consultation and Education Specialists, who provide support services to the entire school community. This assures that even students who are not identified as requiring more intensive services still get the support they need, and that teachers get the additional training they desire to work more effectively with all their students. The 11 Intensive Case Managers working in South Philadelphia then work with students requiring more intensive levels of early intervention or targeted services and their families. The goal of their targeted approach is to coordinate and provide individualized "wraparound services" to the students they serve, so as to ensure the provision of required services from all agencies and to decrease the chance that any child will fall through the cracks. These clinicians have been praised by school administrators for providing to their schools a critical "missing link" in the establishment of effective services for all students, particularly those with emotional or behavioral problems. By working closely with children and their families in the school setting, the Consultation and Education Specialists and Intensive Case Managers have been able to provide ongoing support and are immediately aware of any changes in status for the children they serve.

The *East Baltimore Mental Health Partnership* also provides continuous support to children through their clinicians who work in the school setting to provide immediate crisis intervention for children and families and to link them to additional support services, if needed. To address the schoolwide needs of children and youth and other members of the school community, the *Partnership* has developed programming such as the Pro-social Skills Training curriculum and the *Prevent, Act, Resolve* approach to reorganizing the school's philosophies and practices toward developing and supporting positive student behavior. These programs work to improve student behavior on a *schoolwide* basis. School-based clinicians also support teachers, administrators, and school-related personnel through the provision of in-service training in positive behavioral supports and other strategies they can use with students to avoid the

need for referral for more targeted, individualized services. When students do require a greater level of intervention, clinicians work in a one-on-one context with children, and ensure that all of their needs, as well as those of their family, are being met through the coordinated agency structure of the *Partnership*.

Finally, in Rhode Island, schoolwide support is offered to all students in Westerly and Narragansett, Rhode Island, through their planning centers at elementary and middle schools and through the Project *REACH*-supported Westerly Integrated Social Services Program (WISSP) at the high school level. These two programs offer students both academic and behavioral support, as well as well-established links to social services that they or their families might require. These programs are flexible enough to provide students requiring early intervention for emotional or behavioral problems with the programming and services they need to keep them in the regular school setting. Similarly, Westerly and Narragansett employ staff development and student service teams to build a schoolwide capacity and serve all students, while Narragansett and South Kingstown use WRAP Rooms to provide early intervention and more intensive support. The Rhode Island Training School (RITS) provides targeted interventions for all students in its juvenile detention facility. Specifically, the program provides ongoing individualized treatment and support for the youth in an educational setting. In addition, specific and individualized planning takes place to prepare the students, families, and home schools for transition out of the RITS back into the community, and to support them once this transition has taken place. Across the sites, the emphasis on school-based care enables children to receive services that promote their healthy development in the least restrictive environment possible for each student.

## **Offer Non-Traditional Learning Environments**

Extracurricular opportunities for children, such as summer camps and after-school programs, provide an extra layer of support for improved academic and social outcomes for children with serious emotional disturbance who might not otherwise be allowed to participate. The After-School, Saturday Academy and Summer Camp programs provided for children in East Baltimore and South Philadelphia's systems of care are both therapeutic and fun. These kinds of recreational activities offer opportunities for learning and exposure to other children with similar difficulties in less formal environments, and they reinforce the behavioral techniques utilized in the classrooms and in school-based clinics. The pro-social behaviors taught, reinforced, and internalized by the children through these programs often result in improved behaviors both at school and at home.

The whole notion of the Rhode Island Training School (RITS) is somewhat of a non-traditional approach. The RITS, like many juvenile detention centers, used to think of itself as mainly custodial, even though the provision of education services in these settings was mandated by law. Today, however, the RITS takes its educational responsibilities seriously, providing year-round individualized and group instruction to all of its students based on their educational attainment and specific needs. The RITS Poetry

Group is a creative mechanism for child-centered learning. In addition to what they learn about language and writing construction, the process that the youth go through in creating and sharing their poems represents “a healing process” that is critical to addressing their emotional and behavioral issues in a supportive context.

## **Ensure Institutionalization**

Developing financial resources can enhance the capacity of the system of care in many ways and can ensure the future growth of the project even after the original funding ends. Being able to access funds that each agency or system by itself would not be able to contribute has immeasurable benefits. In South Philadelphia, program administrators found that the additional resources provided by Center for Mental Health Services funding had a tremendous impact on less tangible aspects of the system of care. The grant support increased the credibility of the program in the eyes of the School Board, which otherwise might not have been as receptive to implementing school-based services:

*What this grant has given us is tremendously more resources. And I also believe there's been a credibility issue that when we began, certainly the school boards in South Philadelphia, at least, and it was just a microcosm of the city, we weren't trusted, because we had said lots of good words, but didn't bring anything to the table. The thing the grant did was bring something real to the table, which has both helped with our credibility with education and has in fact, in the long-run, increased the mental health service budget for children, which is the advantage of sustainability because, for instance, the intensive case managers won't go away with the grant. So the system is permanently enriched. — Program Administrator*

In addition, the grant funding has allowed the *Partnership* to extend services into other parts of the city, where schools were aware of the progress that South Philadelphia is experiencing.

Each site has developed strategies for ensuring the continued institutionalization beyond the duration of their Center for Mental Health Services grant funding period. The *South Philadelphia Family Partnership* is arranging for continued funding through school district resources. In addition, it has been awarded a grant from Community Behavioral Health, a local behavioral managed healthcare plan for medical assistance recipients.

*East Baltimore Mental Health Partnership* plans to continue offering its services to children and their families by operating on the Medicaid fee-for-service system. This means that the *Partnership* will be reimbursed by the Medicaid program for the services they provide in all the settings in which they operate for the families who qualify for Medicaid assistance. (Most families in East Baltimore do qualify, and the *Partnership* staff readily assists families with the paperwork to apply for benefits if they have not already

done so.) While managed care poses many challenges to how the program operates, including a large amount of paperwork to be completed, the *Partnership* cites the benefits and opportunities to operating this way, as well. The *Partnership* will also supplement its funding through grants from other sources.

Rhode Island provides the most auspicious example of ensuring the future of Project *REACH* statewide. The state legislature has passed a law to scale up the project's principles and practices over the next few years, guaranteeing state support and funding for Rhode Island's system of care effort. The result is a mandated redeployment of resources to support a community-based system of care services, specifically naming schools as key players in this effort.

## **APPROACHES TO IMPLEMENTING AN EFFECTIVE SCHOOL-BASED SYSTEM OF CARE**

Schools are where the kids are. This simple fact makes the school a uniquely effective setting for the provision of services to children and their families. Having the services of school-based clinicians provides a context for prevention and intervention programming on a schoolwide level. Once the school staff is confident that the collaboration being implemented is real and can provide support for their work with children, their enthusiasm, energy, and participation will strengthen the entire system of care. With these features in place, the following approaches to implementing an effective school-based system of care can be taken:

- approaching collaboration developmentally;
- providing ongoing support for school-based staff; and
- reducing the stigma of mental health services.

School-based systems of care that follow these three guidelines can establish a partnership that has a much stronger impact on children with or at risk of developing serious emotional disturbance.

### **Getting Started: Collaboration is Developmental**

Stakeholders in the *South Philadelphia Family Partnership* recognized early on the importance of understanding and respecting the nature of schools as they worked to integrate mental health services within the school environment. From their experiences since the initial school implementation, they have learned that schools were more likely to respond favorably if program activities were set within the established procedures of each particular school. They learned to be flexible and adaptive and to work on a case-by-case basis with principals and other personnel. This approach was useful across the partnership sites.

“The biggest challenge,” states Ms. Holloway, Deputy Director of the School-Based Program in East Baltimore, “is getting started.” The solution, adds Dr. Gayle Porter, director of the School-Based Program, is to “form partnerships, both internally and system-wide, before you move in [to a school].” This approach increases “buy-in” and accountability at every level, improving the chances of a program’s success. Prior to establishing themselves in the 19 schools that now participate, *Partnership* staff and clinicians met with each principal at the school building and discussed the importance and benefits of having mental health services provided in the school. This administrative philosophical support was crucial, because it is principals who then make decisions about allocating precious building resources toward such things as in-service training, additional programming for students, building space in which to operate, and supplies. A principal who shows both philosophical and active support for a new program conveys a sense of the importance of child-centered practices and models support for the program for the rest of the school staff. This demonstrated commitment creates a sense of collaboration that is critical for the success of the school-based work.

## **Support for School-Based Staff**

Working with children with serious emotional disturbance is an intense and challenging process. In addition, nearly every urban program faces issues of high personnel turnover. Across the partnerships, training and support for the clinicians in school-based programs has been critical to their happiness and effectiveness. Guidance and training should be provided in working with large systems and bureaucracies. Often, the clinician may be the only person on a school-based Student Support Team or other committee who has been exposed to the concepts of working with various systems and facilitating group processes.

In addition to training, structures should be in place to provide each clinician with individual support. In Philadelphia, the Director of Case Management helps to provide coordination and support for their Consultation & Education Specialists and the Intensive Case Managers. The East Baltimore *Partnership* developed the Multi-Agency Coordination Committee (MACC) to provide clinicians from the School-Based Program with a place to find administrative-level solutions to stumbling blocks they may face to obtaining services for children and their families. Clinicians in the School-Based Program also benefit from multi-disciplinary supervisory teams that are headed by a senior supervisor, psychologist, or psychiatrist. There are four such teams, each made up of approximately five clinicians and a supervisor. These supervisory team meetings enable clinicians to seek advice from one another and from the supervisor, discuss students’ needs who may be transitioning from one school to another, or discuss other issues pertinent to the system of care. As described by Lisa, a clinician who has worked with the *Partnership* for four years, “there are so many systems that clinicians in the schools work with (e.g., the school system and different agencies’ systems), each with its own structure, that working with each simultaneously can get difficult.” The multi-disciplinary supervisory team can offer the clinicians needed guidance for navigating these systems, and can also offer clinicians assistance or solutions to clinical issues that may arise. “If [the clinicians] have to carry all of this alone, they’ll burn out and leave,” states Dr. Porter.

In Rhode Island, many of the sites reported that the entire teaching staff receives extensive support that enables them to effectively respond to the behavioral, emotional, and academic needs of all of their students. Training activities on children with serious emotional disturbance and related issues such as collaboration and behavioral management are provided through inservice training, a two-day conference, and a staff development coordinator.

## **Reducing the Stigma of Mental Health Services**

Traditionally, when children and their families are referred to outside mental health facilities, many are embarrassed or deny the existence of problems; they may end up avoiding the issue or under-utilizing the services provided through traditional methods of service delivery. By placing services for children with serious emotional disturbance and their families into the “normal” environment of the school, however, the stigma commonly associated with receiving mental health services is largely reduced. One of the clinicians in East Baltimore, Larry, endorsed the idea of a school-based program by stating that students were more likely to seek help through their program than by making the “big cultural leap to go over to Johns Hopkins Hospital, where it might be stigmatizing.” By partnering with schools, where children spend the majority of their time, and by offering such services within the context of behavioral health and support, the system of care is able to reach a greater proportion of children and families in need. As a result, access to appropriate mental health services increases, especially among traditionally under-served groups, such as those from lower income families or from ethnic and racial minorities.

Administrators at both the *South Philadelphia Family Partnership* and in Westerly, Rhode Island, found that they were able to reach a greater number of children by bringing the services into the school. In the regular school setting, both children and family members come to see the mental health staff in the school as a regular and acceptable part of their environment. Additionally, family members obtain an additional entry point to access related services they may need, which helps them perceive schools as a place of support, not a place that assigns them blame for their children's problems. Finally, principals and teachers are able to build relationships with parents through their involvement in the school, making them an effective source of support for managing students with behavioral difficulties. The presence of these programs in schools has eliminated a major barrier for parents who would otherwise shy away from taking their children into a setting away from the school, and is providing them with the support they need to work with their children more successfully at home.



# Chapter IV

## Overcoming Barriers to Establishing Comprehensive, Collaborative Systems of Care

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To comprehensively address the needs of children with severe emotional illness it is imperative that multiple public and private agencies work together. No one group has the resources or expertise needed to address alone the comprehensive needs of children with serious emotional disturbance and their families. The process of developing a local system of care for these children and their families is anything but easy. Different professional cultures, belief systems, organizational structures, fiscal foundations, legislative mandates, and levels of cultural competency can all hinder the levels at which interagency teaming on behalf of a child and their family can occur.

The three partnerships struggled with barriers to their collaboration with schools and developed strategies to overcome the barriers that were grounded in an understanding of: (1) how schools are structured; (2) where decisions are made; (3) what mandates must be met; (4) how the money flows; and (5) what schools are accountable for. We identify these differences below and provide examples of how these three partnerships have addressed them.

### **HOW ARE SCHOOLS STRUCTURED?**

#### **Schools Are Designed for Groups of Children, Not Individual Children**

The planning of school systems from both a programmatic and fiscal basis is premised on meeting the needs of different subgroups of children within the surrounding community. The most common way of “grouping” students is around their age and/or educational development level (i.e., grade). This planning approach is different from mental health, child welfare, and even juvenile justice settings that focus on addressing the individual needs of children and youth.

An internal conflict within the education system among teachers and administrators is structurally created by how schools are organized. Special education personnel (e.g., teachers, administrators and related service providers) are required by law to evaluate an individual child and, based on the results of the evaluation, develop an Individualized Education Program that can meet the educational needs of the particular child. Special educators advocating for scarce resources are often viewed as greedy and unreasonable when they ask for the resources needed to meet the needs of a single student with emotional disturbance. *Project WRAP* in Narragansett has creatively addressed this issue by working with the school district to cover the cost of after-school care.

## **Schools Are Self-contained Units Within a Larger Organization**

Each elementary, middle, or secondary school is considered a functional component of the comprehensive school system as a whole. While schools must abide by state and school district policy, the individual schools are also viewed as self-contained units within the larger school district. The concept of "school-based" management is increasingly used but, by and large, schools must adhere to the general organization of the school district. As a result, the flexibility and authority of local school building teams can be compromised, especially from a budget planning standpoint.

The relative autonomy of schools means that district level integration into systems of care may not be sufficient. Principals and key staff are often gatekeepers for what gets implemented in their individual school buildings. In both Baltimore and Philadelphia, for example, the *Partnerships* met early on with each principal to gain his or her support, ensuring their help in integrating the system of care in each building.

## **WHERE ARE DECISIONS MADE?**

### **The State Educational Agency Establishes Standards Based on State and Federal Law**

The standards established within state and federal general education statutes are largely structured around how the overall group should perform. They tend to be global in focus. It is primarily the special education and civil rights legislation alone that focus on the needs of individual students.

State legislation can be important and influence the organization of systems of care within schools. Maryland's mandate that each school create a Student Support Team influences the role of school-based clinicians on these teams, and Rhode Island's mandate that all RITS youth attend school helped set the stage for collaboration with *REACH*.

### **Local School Boards Set Policy Based on Community Standards**

Local school board members, most of whom are elected, represent the larger community. Whatever issues the local community sets as its priorities ultimately have powerful control over what the local school board policies will be and what the charge is to the superintendent they hire to run the schools. Some school districts place a high priority on meeting the needs of children with special needs including children with severe emotional disturbance. However, unless this is a priority of the local community at large, it often does not happen. The reasons given are usually because of the high cost of special education and a general lack of understanding regarding the benefits to the community of investing in these students. Westerly, Rhode Island, has demonstrated what can be done to ensure local school board commitment. Westerly staff collected cost and outcome data and provided that data to both school board members and

to the greater community to which the school board is accountable. In East Baltimore, mid-level administrators from the school board actually serve on the *Partnership's* Board and on the Multi-Agency Coordinating Committee, making them part of the decision-making process for the system of care.

## **Principals Determine How Policy Is Implemented Inside Their Building**

The quality of services provided to students with severe emotional disturbance and behavioral disorders is directly related to the attitude, beliefs, and desires of the building principal. Without his or her belief in the importance of investing resources in this population of students, it by and large does not happen as fully as it needs to unless they are forced by parents or their superintendent to do it. All three projects worked with principals to gain their active support of the system of care initiatives.

## **Teachers Plan Lessons Based on an Approved Curriculum and on Their Training**

Teachers plan their lessons to provide a series of learning experiences that will develop the knowledge and skills the state and local standards indicate are priorities. Teachers are trained to teach to the group and that is their focus. All good teachers individualize as much as possible, but their primary charge is to get their "group" of students to acquire the knowledge and the skills established for students in their grade by the end of the year. Schools and school systems can, however, enhance the capacity of teachers and curricular to respond to the needs of students with serious emotional disturbance. The RITS, Westerly, and Narragansett, Rhode Island did so through staff development regarding effective teaching practices, team teaching, and support from the planning centers. The Consultation and Education Specialists in Philadelphia developed in-service training sessions to help teachers work effectively with individual students. Likewise, the *East Baltimore Mental Health Partnership* worked with teachers as a group and individually to work on strategies for addressing the needs of their students with emotional and behavioral problems.

## **WHAT MANDATES MUST BE MET?**

### **Communities Are Required to Operate Schools and Children Must Attend**

As recently as 20 years ago school officials were allowed to remove students they felt were unable or unwilling to be educated. Any seriously emotionally disturbed student who did not function in school successfully was largely removed. The Individuals with Disabilities Education Act changed this; however, recent concerns with discipline may undo this mandate. Hence, the importance of Baltimore's use of

schoolwide behavioral management, Philadelphia's districtwide attempt to improve the capacity of all schools to work with and serve all students, and Rhode Island's statewide efforts to serve these students effectively in a variety of settings, is evident.

## **Accommodations and Special Education Must Be Provided for Students with Disabilities**

The Individuals with Disabilities Education Act requires educators to identify the special "educational" needs of students with serious emotional disturbance, to provide them with a free and appropriate public education, and to design an individual education program to address special education needs (i.e., specialized instruction) and any related services (e.g., counseling, transportation) that might be necessary for the student to "benefit from" his or her special education program. This mandate creates both a barrier and an opportunity. Some school staff may fear attending a meeting to develop an individualized service plan, because they fear they will be left "holding the bag." On the other hand, systems of care can provide and cover the costs of supports that otherwise might be placed in an Individualized Education Program. This has been done in some plans that were developed in Narragansett, Rhode Island. The 1997 Amendments to the Individuals with Disabilities Education Act (as well as Rhode Island's new legislation) facilitate the creation of one plan.

All students are required by law to be educated in the environment least restrictive for them with whatever supplementary aids and services are necessary. They can only be removed to a more specialized (i.e., more educationally restrictive) setting if "the student's needs" cannot be adequately met and the more specialized setting (e.g., special class in a regular school, special day school or residential setting) is necessary to meet the special education needs of the student.

Often, the decision can come down to what comprehensive local system of care is in place or realistically can be put into place to address the needs of the student and his or her family. For example, Philadelphia's Consultation and Education Specialists, East Baltimore's school-based clinicians, and Rhode Island's *Project WRAP* enable students to succeed in the local schools who might otherwise have been placed in more restrictive settings.

## **Contracts Define What Teachers Can Be Asked to Do**

There are many school districts where teachers willingly do whatever is reasonably in their power to participate in the special education planning around a student, such as attending special meetings outside the normal school hours. However, teacher union contracts with school officials can be quite specific and this can lead to teachers not being able to do everything that a special education and/or interagency team might desire. This can prove to be very sticky for teams to develop and implement individualized education plans

for seriously emotionally disturbed students within the regular school setting. However, school systems can also address these issues by focusing on both the professional concerns of educators and how they are compensated. Westerly, Rhode Island, for example, provided for staff training in its union contract.

## **HOW DOES THE MONEY FLOW?**

### **Budgets Are Set a Year in Advance and Are Subject to Many Reviews Including a Taxpayer Vote**

The education budget cycle begins a year in advance of the year it will be in effect. In a majority of local school districts this is in October or November. The goal is to have the budget go through multiple reviews and revisions by the local school board so it can be presented to the voting public (i.e., taxpayers) in the early Spring. Effective systems of care must adjust to this budget cycle.

### **Principals and Special Education Administrators Must Live Within the Budget**

Once the budget is approved by the voters, which can take months, it is extremely difficult to convince any school official of the need to spend more than has been approved. Not only is it technically illegal in certain states, it is political suicide for the administrator.

## **WHAT ARE SCHOOLS ACCOUNTABLE FOR?**

### **Adherence to High Performance Standards Is Primary**

The way communities are able to evaluate how well a particular school building or district is doing is to evaluate the academic performance of its students as a whole. The Individuals with Disabilities Education Act now mandates that students with disabilities participate in schoolwide assessments. Successful collaborations must help improve learning as well as behavioral outcomes. Both Westerly and the RITS have communicated their high expectations.

### **Teacher and Administrator Performance Ratings May Be Keyed to Student Test Results**

For this reason, the first priority of the building principal, superintendent, and school boards is to do whatever is necessary to ensure a large majority of its student body performs well on standardized tests. The focus of the education programming and the investment of available funds is designed to get “the group”

to progress as far as possible. Westerly and East Baltimore demonstrate how behavioral and learning supports can be linked to one another for positive outcomes in both areas.

## **WHAT ARE THE BARRIERS TO CROSS-SYSTEM COLLABORATION?**

### **Vocabulary Is Different**

The terminology or jargon used by most educators is in many ways unique to educational professionals, just as the terminology used by professionals in mental health, social services, or juvenile justice is unique to their domains. As a result of these differences, people from different agencies can be confused and unsure in discussions where they do not fully understand what representatives from other agencies are trying to say.

### **Eligibility and Service Criteria Vary**

Public schools do not have waiting lists; schools must serve everyone who is eligible for and in need of special education, regardless of the resources available within the school system. Alternatively, many other agencies, public or private, have waiting lists. Students and their families who are often in desperate need for help from one of the agencies do not have the same “right” to receive the service that they do from the school. They will get the service when — and if — the agency is able to provide it or if someone can manipulate the school district into paying for it which is often attempted.

### **Work Ethics Are Specific to the Values and Culture of Each System**

The following points illustrate the cultural differences inherent to schools and to the other agencies that participate in systems of care.

- Public schools in most regions of the country are open for approximately 180 days each year, rather than year round, as most public agencies are.
- Teachers often work between the hours of 7:00 a.m. and 2:30 p.m., while other agencies are open from 8:00 a.m. to 5:00 p.m.
- Schools tend to focus on the “educational” needs of the children and youth, while community agencies often focus on other needs the student and his or her immediate family members may have.
- School districts often have more complex layers of administration to work through than do the local or regional mental health, social service, or other agencies.



Culturally, schools are often much more difficult to change. Teachers have the ability to resist change that new administrators attempt to make, for they know that, with the precarious politics of the school administrators, the teachers can probably outlast them. School administrators and school reforms tend to come and go more frequently.

### **The Public Perceives Each System's Sphere of Responsibility as Unique**

Even though the special education law requires schools to provide special education *and any related services needed by the student to benefit from their special education*, public schools believe powerfully that other agencies of government (both public and private) must be equipped *and willing* to provide the medical, therapeutic, crisis management or other non-education services that a student and their family need. This is sometimes the belief of the community at large, as well. School boards, the general public, and even central office personnel may express their wish that building-based special education personnel not put into an Individualized Education Program something they believe not to be a responsibility of education if that need can be met through the services that other agencies can provide. Attitudes can change as citizens and leaders develop new understandings of what is possible. This has started to happen in Rhode Island where the success of local initiatives set the stage for the new state legislation.



# Chapter V

## Conclusions

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It is possible to improve outcomes for children with serious emotional disturbance and their families. While many urban schools ignore the mental health needs of most students and push students out, South Philadelphia's schoolwide efforts are helping to create schools that address the mental health needs of all students and keep them in school. Similarly, while many pundits write off "poor, multi-problem families" as being unable to support their children, East Baltimore's efforts have enabled mothers struggling with HIV and addiction to play a healthy and active role in collaborating with schools and clinicians to develop, implement, and monitor interventions for their children — while their children's grades and behavior improve. And while 56 percent of students with serious emotional disturbance nationally drop out of school, only 5 percent do so in Narragansett, Rhode Island.

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*When asked why our dropout rates for serious emotional disturbance students are so low, I immediately think of OPTIONS. This the name of our high school planning center program. It truly captures the spirit of what this community tries to do for our students. Through flexibility, supportive mental health services and a very dedicated staff, teams review all options for these students when trying to make it work. An important note: dropping out of school is never an option.*

— Sandra Keenan, Director of Special Education, Narragansett, Rhode Island

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Changing outcomes for children and youth with serious emotional disturbance and their families is not easy. It requires:

- robust and developmentally appropriate learning opportunities, and supporting youth in using them at home, at school, and in the community;
- strong capacity in homes, schools, and communities to care for and address the needs of children with serious emotional disturbance and their families;
- creative efforts to embrace as well as address diversity;
- persistent collaboration with families;
- child- and family-driven assessments and planning and the monitoring of all interventions;
- ongoing staff development and training that enables individuals to collaborate and to master new ways of doing things; and
- a comprehensive and seamless system of care that provides appropriate, culturally competent child- and family-centered services.

The three sites that we examined have started to do these seven things. In so doing they have produced useful models and results that have led to institutionalization at a school level, and to scaling up at a city (Philadelphia) and state (Rhode Island) level.

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# **APPENDICES**





# Appendix A

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## PROGRAM CONTACT INFORMATION AND MATERIALS

### **South Philadelphia Family Partnership**

Harriet Williams  
Director, Children's Services  
Philadelphia Office of Mental Health  
1101 Market Street, #1201  
Philadelphia, PA 19107  
(215) 685-4736

David Fair  
Administrator  
South Philadelphia Family Partnership  
1101 Market Street, 7th Floor  
Philadelphia, PA 19107  
(215) 685-4742

### **East Baltimore Mental Health Partnership**

Dr. Raymond Crowel  
Director  
East Baltimore Mental Health Partnership  
1235 East Monument Street  
Baltimore, MD 21202  
(410) 614-4054

Dr. Gayle Porter  
Director, School-Based Services Program  
East Baltimore Mental Health Partnership  
1235 East Monument Street  
Baltimore, MD 21202  
(410) 614-4054

**For more information about PAR:**

Dr. Michael Rosenberg  
Chair, Department of Special Education  
Johns Hopkins University  
100 Whitehead Hall  
Baltimore, MD 21218  
(410) 516-8273

**Rhode Island CASSP/Project *REACH***

Sue Bowler  
Director, Project *REACH*  
Rhode Island Department of Children, Youth, & Families  
610 Mt. Pleasant Avenue  
Building #2  
Providence, RI 02840-1935  
(401) 457-4547

**Rhode Island Training School**

Warren Hurlburt  
Superintendent  
Rhode Island Training School  
300 New London Avenue  
Cranston, RI 02920  
Phone: (401) 464-2055

**South Shore Mental Health Center Day Treatment Program**

John Brinz  
Director, ACT Program  
South Shore Mental Health Center, Inc.  
730 Kingstown Road  
Wakefield, RI 02879  
Phone: (401) 783-1150 or 789-1166, ext. 3220

Westerly Public Schools  
Dr. Mark Hawk  
Director of Special Education  
Westerly Public Schools  
44 Park Avenue  
Westerly, RI 02891-2297  
(401) 596-0315

## **CATCH**

CATCH, Citizens Acting Together Can Help, Inc., is a non-profit community based corporation which provides a wide range of mental health and mental retardation services to residents of Philadelphia.

CATCH, working closely with community groups and principals of elementary schools, has established itself as an advocate for the mental health needs of children. CATCH provides comprehensive psychological and psychiatric services for children by closely linking the three most important spheres of a child's life: family, community and school.

The prevention, treatment and continuing care services offered by CATCH are available to persons of all ages who reside within our service area. All CATCH services are confidential and are offered regardless of race, religion, creed, national origin, or physical handicaps.

## **Family Based Case Management Service**

CATCH's newest program of family outreach service, the Family Based Case Management Service, is designed to expand and enhance the range of services for children and adolescents with emotional disturbances who live with relatives other than their parents. Services include preventive and crisis intervention; and the identification, linking and monitoring of mental health services.

The project's goal is to assist in the develop of academic and behavioral skills to help children effectively participate in school and the community. Treatment includes an individualized, culturally sensitive and holistic assessment of the biological psychological and sociological factors that contribute to the safe and successful development of children.

The Family Based Case Management Service provides an child-focused system that is flexible and committed to advocacy education and empowerment for all children, especially those with special needs. Services include:

- Family education
- Development of a treatment contract with the child, family and provider
- Increased agency collaboration
- Enhanced access to community resources

A Family outreach specialist works with the children, their families, schools and community based agencies to address children's immediate and long term needs to:

- Identify resources to aid families
- Gain access to appropriate
- Coordinate services between agencies
- Evaluate the level of progress

For more information about Family Based Care Management Service, contact CATCH at 336-8933.

## **Guidelines for Provision of In-School Wraparound Services**

1. Prior to the delivery of wraparound, or other in-school mental health services, convene an interagency meeting including, at minimum, the child (mandatory for children 14 and older; for children under 14, if appropriate), the parent, the teacher, the wraparound service provider, the child's case manager (if relevant), the local education agency (LEA) representative (principal or designee).
2. Emphasize the collaborative nature of the meeting with the objective being a positive educational and behavioral outcome for the student, to be demonstrated by improved learning/behavior.
3. Review and/or develop the Behavior Support Plan for the child. Include the child's strengths. Ensure that specific goals are described in observable and measurable behavioral terms.
4. Identify what system (curriculum, model) will be used to improve the student's pro-social skills.
5. Identify who will have the responsibility of developing and monitoring the student's pro-social skills.
6. List the names of all wraparound and/or case management staff who will be in the school and their anticipated schedules. The provider has agreed to ensure that each person listed understands and agrees to adhere to all established school procedures.
7. Specify expected outcomes, interventions, who will perform interventions, and when.
8. Who determines what interventions will be used with the student, and when?
9. Who will be administering and monitoring the student's reward system, the daily report, the point schedule, etc.?
10. What is the plan of action in the event of a crisis situation?
11. Who will be assisting the wraparound staff in the event of a crisis?
12. For Therapeutic Staff Support (TSS) indicate schedule and location for all hours in the school. Attach the schedule to this form, and provide a copy for the teacher, the principal, and the wraparound staff.
13. Determine who will notify the school if the wraparound staff will be absent
14. Determine what the contingency plan will be when the wraparound staff is absent. Indicate how the student will be supported in school when the wraparound staff (TSS) is absent or unavailable.
15. Set up a regularly scheduled meeting time during which all the participants involved in implementing the plan can gather to review progress and revise the plan as necessary.
16. Indicate name and telephone number of Behavioral Health provider who is responsible for services to this child/family.
17. Accompanying form is to be completed by Behavioral Health provider, signed by principal or designee, and submitted to CBH. Leave copy with school.

## **A New Program Expands CATCH's Early Intervention Efforts in Elementary Schools**

CATCH, working closely with community groups and principals of elementary schools in South Philadelphia, has established itself as an advocate for the mental health needs of children. In 1995, the organization enhanced its role with the launch of a pilot program, the Kinship Care Project.

In 1994, the Children's Partial Hospitalization Program and the Children's Outpatient Services were combined to form a Children's Services Unit with increased flexibility in determining the mental health needs of a specific child.

The Children's Services Unit provides comprehensive psychological and psychiatric services for children in the South Philadelphia community by closely linking the three most important spheres of a child's life: family, community and school.

The Outpatient Services for Children has grown over the last three years with the addition of therapeutic staff and the development of a satellite outpatient program operating in a school. Additional services are located at a site on Oregon Avenue. The community and school focus allows CATCH to develop closer ties with the child and his or her environment.

The Children's Partial Hospitalization Program continues to grow with the addition of a new school per year. Currently over 500 children are served at the following schools: Arthur, Barratt, Bregy, Girard, Jackson, Nebinger, Palumbo, Smith, Southwark, Stanton, Stoddart-Fleisher, Vare and Washington.

Because of the cooperation of the School District of Philadelphia, the principals and faculties of the schools, the parent sand the South Philadelphia community, the Children's Services Unit continues to be an excellent model for the effective delivery of mental health services for children.

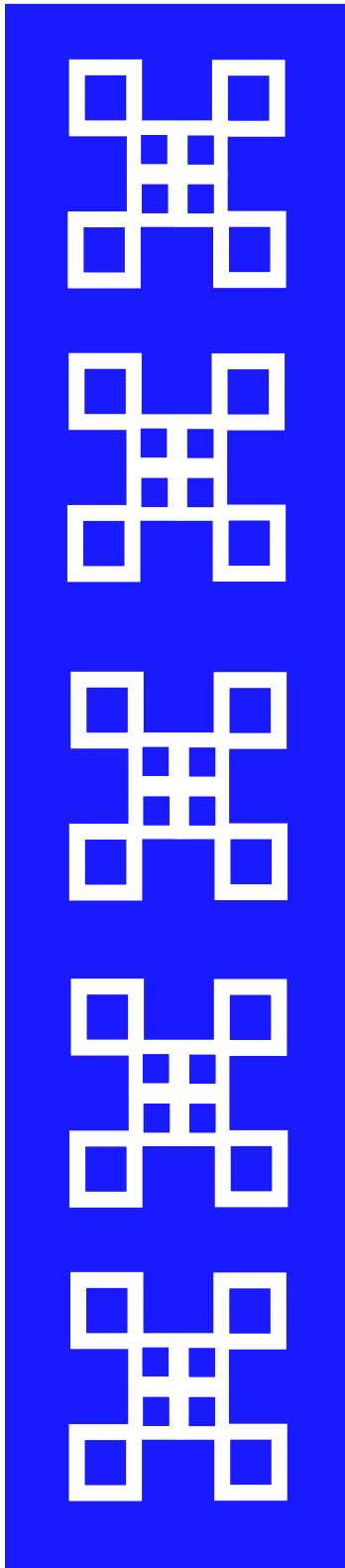
A new CATCH program will broaden the scope of that model. In 1995, CATCH received a five-year federal grant to provide services to children in "kinship care" families who live in South Philadelphia. City-wide there are more than 62,000 children living under the care of a grandparent. Most often these grandparents are raising children because of parent substance abuse.

The Kinship Care Project is designed to expand and enhance the range of services for children and adolescents with serious emotional disturbance who live with relatives other than their parents. It will serve as a pilot effort for the development of a comprehensive system of care for families and children throughout the city.

The project will coordinate the timely delivery of mental health services and a range of other children's and family services. Intensive Case Managers will be lined directly with elementary and middle schools in the targeted community, thereby greatly enhancing the schools' capacity as sites for accessing services.

In 1995, the Kinship Care Project provided social workers for seven South Philadelphia Public Elementary Schools. The program will expand into at least four more elementary and/or middle schools. It will maintain the capacity to follow children who transfer from one of the designated schools to others within the School District of Philadelphia.





## ***The East Baltimore Mental Health***

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***"It takes an entire village  
to raise a child"***

1235 East Monument Street Baltimore, MD 21202

The *East Baltimore Mental Health Partnership* is one of 31 service development and demonstration projects initially funded by the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services. The goal of the *East Baltimore Mental Health Partnership (EBMHP)* is to design and implement a comprehensive and integrated system of care for children and adolescents with serious emotional disturbances living in East Baltimore. The *Partnership* is intended to serve as a "learning lab" to identify best practices in serving children and families, and to assist the city and state in disseminating and adopting best practices as it develops a system of care.

EBMHP services are targeted for children who:

- are 18 years of age or younger;
- have a DMS-IV AXIS-1 diagnosis;
- show evidence of a substantial inability to perform in family, school, and/or community;
- are currently being served, or are in need of services, by two or more agencies; and
- have problems that have persisted, or are expected to persist, for more than one year.

The "Partnership" was developed by a coalition of state, city, and local leaders, including representatives from local family and advocacy groups

ALLIANCE FOR THE MENTALLY ILL	JOHNS HOPKINS HOSPITAL
BALTIMORE CITY COURTS	JOHNS HOPKINS UNIVERSITY
BALTIMORE CITY DEPARTMENT OF SOCIAL SERVICES	LIBERTY MEDICAL CENTER
BALTIMORE CITY POLICE	MARYLAND DEPARTMENT OF JUVENILE SERVICES
BALTIMORE CITY HEALTH DEPARTMENT	MARYLAND MENTAL HYGIENE ADMINISTRATION
BALTIMORE CITY PUBLIC SCHOOLS	MAYOR'S MENTAL HEALTH ADVISORY COM.
CLERGY UNITED FOR THE RENEWAL OF EAST BALTIMORE	MAYOR'S OFFICE
DUNBAR PROJECT	MAYOR'S OFFICE OF CHILDREN AND YOUTH
FAMILY PRESERVATION INITIATIVE	UNIVERSITY OF MARYLAND

The East Baltimore Mental Health Partnership is based on three basic principles:

- A system of care should be child-centered and family-focused, with the needs of the child and the family dictating the types and mix of services provided.
- The system of care should be community-based with the focus of services as well as the management and decision-making responsibility resting at the community level.
- Services should help individuals empower themselves to achieve the highest level of participation in community life.

Consistent with this vision, the Partnership emphasizes the support and empowerment of families and other care givers. Although children with serious emotional disturbances require access to effective professional services, the foundation of any system of care must be the parent, family, and others who care for the child.

The Partnership uses a three-pronged approach to improving the quality of services experienced by identified children and their families:

- increasing the capacity of parents and caretakers to participate in the planning and implementation of services, both for themselves and for others;
- improving the services infrastructure; and
- working with community agencies and leaders to ensure maximum participation of children with serious emotional disturbances in community activities.

## THE MISSION OF THE PARTNERSHIP IS TO:

- Provide a *coordinated, comprehensive system* of services for children with serious emotional disturbances and their families, with services provided in the least restrictive setting possible.
- Promote *integrated, intensive case management* services for children whose needs require the involvement of multiple agencies.
- *Empower consumers* (parents, other care givers, and the child, when appropriate) to become true partners in the development and implementation of services, and the inclusion of the parent in the development of procedures for client identification, treatment, and program evaluation.
- *Enhance the cultural competence of service providers* and to ensure that services are modified to reflect and understanding of the needs of the cultural groups being served.
- Strengthen mechanisms for the *early detection* of children with serious emotional disturbances and the reduction of disability accompanying these disorders.
- *Develop a transition program for children* with serious emotional disturbances as they age out of child-oriented services.
- *Blend and decategorize funding streams* as health care policy and funding opportunities change.
- *Integrate service delivery and training efforts* so that professionals and community members are knowledgeable about service delivery in systems of care.

## CORE MENTAL HEALTH SERVICE PROGRAMS

At the heart of the *Partnership* effort is a coordinated array of mental health service programs:

The **Family Resource Coordination Unit (FRCU)** provides a mix of home and community based services including individual, group and family therapy, wraparound and emergency support services, traditional case management, and linkages to community agencies. The program is staffed by clinically trained Resource Specialists, Psychiatric Residents, and a team of Neighborhood Liaisons recruited from the community who work with families to promote stability and access to local resources. In addition the FRCU effort is supported by two Parent Liaison staff from an associated family support association. By design the FRCU provides Intensive services to families and children for a period of up to one year. In reality the length of time families receive services is determined by need.

Within the FRCU services are also provided as part of the states System reform Initiative to children who are returning from, or at risk of, out of state placement. The ROS/DOS program effort provides aggressive case management focused on establishing and coordinating the services of a community-based team of providers and supports tailored to meet the needs of the individual child and family.

In addition to a host of flexible and tailored services, the FRCU also provides both mentoring and tutoring programs for children whose emotional difficulties complicate the process of learning.

The **School-Based Program** provides a spectrum of services to the 19 Baltimore City Public Schools located in East Baltimore. School-based services include a traditional array of direct clinical services and an increased emphasis on developing school-level management systems to promote a predictable and conducive environment for children and teachers. The program also provides therapeutic after- and summer-school activities for children with emotional disturbance who are otherwise excluded from participation in such recreational activities.

As part of the program's prevention effort, and based on community needs, the School-based program has also developed a Prosocial Skills Training model that provides opportunities for children at risk of, or exhibiting early signs of, aggressive and or disruptive behavior. The model enables children to learn and practice a variety of skills necessary to function effectively in school and in life.

The **Outpatient Center** provides an array of traditional mental health services focused on meeting the ongoing and long term treatment needs of the child and his/her family. The center's services include off-site evaluation at a local health clinic, and evening and weekend hours.

## **EXPANDED SYSTEM CAPACITY**

To ensure that children and families have the expanded support system necessary to meet a broad array of needs, the EBMHP has concentrated on developing and supporting additional community-based efforts. These expanded services include:

The **Day Treatment** program provides a step-down from inpatient psychiatric hospitalization, or an alternative to inpatient hospitalization for children who cannot be maintained in the community but do not require the restrictiveness of a locked inpatient unit.

In collaboration with **Baltimore City Headstart** the EBMHP has established a series of therapeutic nurseries in area Headstart programs. These programs are designed to meet the mental health needs of children and families when problems become evident in the young child's behavior. In addition to direct services the programs focus on intensive training of Headstart teachers in early identification and strategies for managing troubled children in the classroom, and on parenting skills, resource identification and support for parents.

**Respite** care services are supported to provide a short term alternative to hospitalization or out of home placement.

**The Baltimore City Police - Mental Health Collaborative** was developed to cross-train police officers, members of the community, and mental health clinicians about the impacts of violence and trauma on young children, and to give line officers basic skills in identifying children who might need mental health services. As part of this collaborative, officers have access to on-call mental health clinicians who either respond to the scene where children have been witness to an occurrence of violence or consultant with police officers on the appropriate next steps to take with children who are victims or witnesses to violence.

## **COMMUNITY SUPPORT**

Because families must live and work in the community, local support is an essential component of the system of care. The EBMHP has focused its efforts on identifying and linking families to local service providers.

**Village Centers** provide access to a variety of services such as job training, parenting classes, and substance abuse prevention referrals.

Through EBMHP relationships with **area churches**, families receive spiritual guidance, and material support.

**Families Involved Together**, the EBMHP family support and advocacy organization, provides ongoing peer support, education and advocacy to families who are involved with the many agencies of the EBMHP. The role of FIT has expanded greatly over the past five years to include not only informational and support services, but direct services, and inservice training to staff throughout the city.

**Therapeutic Recreational** opportunities are provided for children whose behaviors or emotional issues place them at risk for exclusion from regular programs.

**Adult Education, Job Training and Substance Abuse** treatment programs form a system of community based services that assist families caring for themselves and their children.

## **LINKAGES TO THE SYSTEM OF CARE**

Key to the success of the EBMHP has been its multi-level approach to linking agencies and service providers into an integrated service delivery system.

At the **Administrative Levels** key city officials and representatives from the Mayor's office, families and community members serve on the EBMHP board. This board serves as the oversight body for the grant related activities of the *Partnership* and provides the high level organizational support necessary to ensure agency commitment to collaborative processes.

In collaboration with city and state agencies the *Partnership* has established a core group of professionals — **Agency Liaisons** — whose role is to approve and coordinate referrals to the *Partnership* mental health services, facilitate communication and problem solving across agencies, and to develop cross-training opportunities between agency staff. These Liaisons are employed by each of the four major service systems and serve as experts in their own systems, helping staff from other agencies to obtain information and resolve problems.

The **Multi-Agency Coordination Committee (MACC)** was developed to provide mid-level managers from participating agencies with the opportunity to design and shape the system of care for children and families, and to develop protocols for collaborative and coordinated service delivery. The MACC also serves as sounding board for assisting line staff with difficult issues in collaboration.

Referrals made by other agencies to the EBMHP are viewed as petitions to join a team of service providers. Each family referred to the EBMHP also becomes part of an **Integrated Service Planning Team (ISPT)**. In addition to the referring agency and mental health staff, team membership may include extended family members, parent advocates, staff from other agencies, school staff, clergy, and *any other person that the parent feels is important to the child's well-being*. This planning team shares responsibility for setting and implementing goals, and monitoring progress. Unlike standing interagency panels *each planning team is built around the particular needs of the child and family*.

The ISPT is responsible for developing and coordinating services to the family. *Emphasis is placed on avoiding unnecessary duplication and on ensuring responsibility and accountability*. The Team monitors progress and acts to adjust plans as circumstances change. As problems arise that require additional input or support, the ISPT is empowered to use wraparound resources, or call on support from the involved agencies.

## **PROGRESS TO DATE**

Through its various programs the *East Baltimore Mental Health Partnership* has served over 4,000 children and families. The program has improved the collaborative efforts of Baltimore City and state child serving agencies, reducing duplication, and waste. The program has strengthened ties between public and community support systems, and helped to make services more accessible to families and children in need.



Among its successes the *Partnership* has helped to divert children from more restrictive settings such as juvenile justice detention facilities, residential treatment, and long-term psychiatric hospitalizations.

As managed care has developed in Maryland the EBMHP has adapted its processes to maintain its integrative approach to care while maximizing the opportunities for sustainability under the new revenue structure. Managed care poses continued challenges and opportunities for the EBMHP system of care.

## **Lessons Learned**

- **Fatigue and Stress** - Considerable time and energy are required at all levels in establishing and maintaining a system of care. If intensive service delivery exhausts line staff, families and supervisors, collaborative meetings are equally exhausting and challenging for administrators.
- **Technical assistance and training** across a wide variety of topics is necessary to ensure success.
- **Constant clarification of values** is also a must. Staff turnover rates are amplified because of the number of agencies involved in multi-agency collaborations, making institutional memory difficult to sustain.
- **Maintaining multi-level linkages** between agencies with both vertical and horizontal lines of communication is essential to sustaining momentum in developing systems of care.
- **Tracking the environment** for key changes is also vital. This is particularly true for issues such as managed care and welfare reform. Knowledge of the states reform policies and plans, as well as national trends has been crucial to adapting the EBMHP programs.
- **Family involvement** at all levels of the system has multiple benefits such as: relevancy and responsiveness of the program, staff education, and building a strong support base for the programs.
- **Cultural competency** remains a vital and often overlooked component of the system of care. Moving new and existing programs toward greater competency requires enormous energy, dedicated and committed staff who spend time on this issue. Integrating culturally competent practices into the system of care is complicated by the many demands of systems — which often provide a convenient excuse for failure to consistently act on this issue.
- **Children whose needs span multiple agencies** require significantly longer periods of intensive service involvement.
- **Ultimately, community-based collaborative networks** do help to integrate services, make it easier for families to access care, and to keep children in their homes and communities.

## **ABSTRACT**

The **Safe and Supportive School Initiative (SSSI)** of the *East Baltimore Mental Health Partnership (EBMHP)* will focus on preventing and reducing aggressive behaviors, while promoting pro-social skills, among high-risk second and fourth graders. The EBMHP is a collaborative partnership between state and city government agencies, local community members and providers, and the Community Mental Health Center of the Johns Hopkins University and the Johns Hopkins Hospital.

The proposed initiative will provide services over the next two years to approximately 2,300 children. These second and fourth grade students attend eight elementary schools in Historic East Baltimore, an area that has been designated a federal Empowerment Zone.

Using EBMHP mental health staff the initiative will provide a multi-level intervention, based on a schoolwide comprehensive behavior management model referred to as **Prevent-Act-Resolve (PAR)**. The initiative will introduce two components:

- a focused PAR intervention targeted to second and fourth grade teachers for one hour per week for ten weeks; and
- intensive Pro-social Skills Training (PST) to reduce aggressive behaviors and promote pro-social skills.

To ensure the initiative's sustainability, we will provide additional training to teachers and administrators during the summer months between Year One and Two on implementing PAR and on providing PST in classroom settings.

A multi-level process and outcome evaluation will focus on changes in the levels of aggressive behavior in the population of second and fourth graders, the PST training groups, and the school as a whole. Students long-term patterns of aggression will be tracked through the third and fifth grades and beyond, through the EBMHP's collaborative relationships with other agencies, including the Departments of Juvenile Justice and the Baltimore City school system.

## **PROJECT REACH RI**

Project **REACH RI** is a five-year service system development grant awarded by the Center for Mental Health Services (CMHS) to the RI Department for Children, Youth, and Families. The grant seeks to enhance the state's mental health service delivery system in several ways by:

- identifying and providing a full continuum of services needed by children and youth with severe emotional and behavioral problems;

- supporting a highly flexible model of service that is child/family driven and community based, and funding identified service gaps;
- enhancing the cultural competence of the system in planning, access, and in service delivery;
- building multi-agency collaborations for child and family services at the public and private levels; and
- through both a state specific and national evaluation protocol, to develop better information about what works in meeting the needs of these children and youth.

Project **REACH RI** focuses on those children/youth and their families who meet federal standards for severe emotional and behavioral problems. Children eligible for *REACH* funds:

- are between birth and twenty-one (21) years of age;
- have an emotional, behavioral, or mental disorder diagnosable under the DSM IV (with an exception of “V” codes — substance abuse and developmental disorders unless they co-occur with another diagnosable serious emotional disturbance);
- have a disability that has been or is potentially ongoing for a period of one (1) year;
- are in need of multi-agency intervention; and
- are at risk for out of home or more restrictive placements due to emotional/behavioral problems.

*Children accessing Project REACH RI may or may not have legal status with DCYF.*

## **RHODE ISLAND CASSP/LOCAL COORDINATING COUNCILS**

### **Purpose**

An LCC is a network of families, service providers, advocates, and community resources brought together to develop a coordinated system of care that will support the maintenance of children and adolescents with serious emotional disturbance and/or out-of-home placement in their local communities, through a multi-agency planning process, and the empowering of communities to care for their children and families.

The Department of Children, Youth, and Families has developed contracts with each of the eight Local Coordinating Councils (LCCS) in Rhode Island. Each LCC represents the geographic area of the mental health center catchment areas. All of the LCCs with the exception of Providence, are located in the community mental health centers for their catchment area. The Providence LCC is housed at John Hope Settlement House.

The guiding principles of the LCCs include:

- integrated services across providers
- child centered, strength-based services
- family-driven service planning
- culturally competent services
- flexible services close to home
- integration of natural community supports
- community ownership

### **Activities**

The LCC meets monthly and is responsible for:

- assessing the service needs of families and the community;
- identifying system barriers that impede effective service delivery and development;
- outreaching to families and local community organizations and agencies;
- advocating for systems change;
- development of procedures to conduct individual case reviews for children and adolescents referred to the LCC and implementation of these reviews;

- familiarization with resources in the community and available to the LCC;
- dissemination of information regarding activities in Children's Mental Health at the state and local level, and within specific task forces of both the LCC and the Community Mental Health Advisory Council; and
- gather data about involved families to demonstrate needed services, barriers and outcomes for the evaluation of the *REACH* Services Initiative Grant.

## **Case Review Process**

- 1) Referrals can be made by anyone involved with the child/youth and should be made to the LCC Family Service Coordinator (FSC). The FSC is an individual who is either the parent or a family member of a child with serious emotional, behavioral, or mental disturbance experienced at managing social service and mental health systems.
- 2) The FSC is responsible for gathering referral information and meeting with the family to describe the case review process and goals once eligibility has been determined. Eligibility for case review is based on the existence of a serious emotional/behavioral/or mental disturbance, risk of out of home placement /return from out of home placement, and the need for multi-agency, coordinated services. Referrals should be made as soon as it becomes apparent that a child/youth is in need since planning takes time.
- 3) After talking with the family, the FSC will then schedule a date, usually within 4-6 weeks, when the family can meet with the Case Review Team. All interested parties will be invited to the review by the FSC.
- 4) Team members at the Case Review may include representatives from:
  - Local School District's Special Education Department
  - Community Mental Health Center's Children's Services
  - Family Member and Advocates
  - Community Service Providers
  - Department of Children Youth, and Families
- 5) At the Case Review, the family will be asked to identify their needs. It will be explained that the team is there to explore possible resources and think creatively to identify creative problem solving alternatives. The case review is not the time to challenge family member, providers, or service systems, but to problem solve with all participants involved. The team, including the family, develops an Individual Service Plan (ISP) that identifies needs, possible providers, funding sources, and individuals responsible for following through with tasks to implement the plan.
- 6) The FSC assists the family and/or any identified case manager to connect with identified providers, ensuring that the ISP is implemented. The FSC does not provide "case management" itself nor is the Case Review Team a service provider. If warranted, additional Case Reviews will be scheduled at various intervals.

- 7) If a child/youth moves out of the LCC catchment area for more than ninety (90) days the case will be transferred to the appropriate new LCC. The "receiving" LCC will schedule a transition meeting before or within one (1) month of the child's move. The "sending" LCC FSC will participate in this transition meeting. Following receipt of a release of information copies of the ISP and other related material will be forwarded to the receiving LCC.

Presently, Project *REACH RI* provides support for the following initiatives

- 1) Local Coordinating Councils (LCC's) in each of the eight (8) mental health catchment areas receiving funding to support a child and family driven, multi-agency planning process which can identify and coordinate services to children and youth with serious emotional disorders. Each LCC employs a Family Service Coordinator (FSC), who works directly with the family to help them navigate the system of mental health, educational social, and health services to provide efficient and comprehensive programming. Each LCC also has available funding for *short, planned respite* for parents, for *highly flexible, individualized* services for each child ("*wrap around funding*"), and *therapeutic recreational services*. Children can be referred by any community or state agency or by parents.
- 2) Children's Intensive Services (CIS) delivered through the Community Mental Health Centers provide the therapeutic foundation for Project *REACH RI*. These services are targeted to children at imminent risk of placement or returning to their homes from placements and provide an intensive and flexible menu of services according to child need. Children/youth may have 3-5 contacts per week with the provider and receive a range of services, including in home behavior management, individual and family counseling, case management, and medication monitoring.
- 3) Day Treatment Programs began in July, 1996, in school systems in four (4) of the LCC areas to provide coordinated educational/mental health/social services at the local level in school settings to eighty (80) children at substantial risk of out of school or district placement due to serious emotional disturbance. All have reached the full implementation stage and are serving children and youth with severe needs at the local level. These programs were awarded through competitive bid in Providence, Pawtucket/Central Falls, Kent County, and Washington County.
- 4) Therapeutic Foster Care combines a normalized, home based setting coordinated with therapeutic services provided by trained care givers. Therapeutic foster care is appropriate for those children, ages 5-18, with the most severe mental health problems for whom a more intense level of foster care is required. The therapeutic foster care home is preferably in or close to the child/adolescent's community to maintain ties with and/or facilitate reunification with the birth family as legally and clinically appropriate. The Groden Center and Casey Family Services have each been awarded contracts to provide such specialized foster. Groden Center will be servicing six (6) children with a focus on dually diagnosed children/youth with serious emotional disturbance and developmental delays while Casey will have twelve (12) slots for children with serious emotional disturbance.





## **Appendix B**

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# **National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance**

### **TARGET #1: EXPAND POSITIVE LEARNING OPPORTUNITIES AND RESULTS**

To foster the provision of engaging, useful, and positive learning opportunities. These opportunities should be result-driven and should acknowledge as well as respond to the experiences and needs of children and youth with serious emotional disturbance.

### **TARGET #2: STRENGTHEN SCHOOL AND COMMUNITY CAPACITY**

To foster initiatives that strengthen the capacity of schools and communities to serve students with serious emotional disturbance in the least restrictive environments appropriate.

### **TARGET #3: VALUE AND ADDRESS DIVERSITY**

To encourage culturally competent and linguistically appropriate exchanges and collaborations among families, professionals, students, and communities. These collaborations should foster equitable outcomes for all students and result in the identification and provision of services that are responsive to issues of race, culture, gender, and social and economic status.

### **TARGET #4: COLLABORATE WITH FAMILIES**

To foster collaborations that fully include family members on the team of service providers that implements family focused services to improve educational outcomes. Services should be open, helpful, culturally competent, accessible to families, and school- as well as community-based.

## **TARGET #5: PROMOTE APPROPRIATE ASSESSMENT**

To promote practices ensuring that assessment is integral to the identification, design, and delivery of services for children and youth with serious emotional disturbance. These practices should be culturally appropriate, ethical, and functional.

## **TARGET #6: PROVIDE ONGOING SKILL DEVELOPMENT AND SUPPORT**

To foster the enhancement of knowledge, understanding, and sensitivity among all who work with children and youth with and at risk of developing serious emotional disturbance. Support and development should be ongoing and aim at strengthening the capacity of families, teachers, service providers, and other stakeholders to collaborate, persevere, and improve outcomes for children and youth with serious emotional disturbance.

## **TARGET #7: CREATE COMPREHENSIVE AND COLLABORATIVE SYSTEMS**

To promote systems change resulting in the development of coherent services built around the individual needs of children and youth with and at risk of developing serious emotional disturbance. These services should be family-centered, community-based, and appropriately funded.







