

CARING ALTERNATIVES: INTERAGENCY COLLABORATION TO IMPROVE OUTCOMES FOR STUDENTS WITH MENTAL HEALTH NEEDS

Carol A. Kochhar-Bryant

Graduate School of Education and Human Development, The George Washington University

Abstract

Current estimates indicate that between 7 million and 12 million children and adolescents in the United States have emotional and behavioral disabilities and are at risk of academic failure, school dropout, incarceration and a lifetime of struggle to gain adult independence. As more of these children participate in general education classrooms and rigorous standardized testing, many exhibit troubling behavior, reflecting inadequate supports for students and their teachers.

Although children with diagnosed emotional disabilities are required by the Individuals with Disabilities Education Act (IDEA) of 1997 to be integrated in schools, many go undiagnosed and receive punitive treatment rather than the therapeutic or educational interventions that they need. Contributing to this problem is the fragmentation of needed services and supports and the failure of schools and community agencies to collaborate to provide them. Over the past 20 years, the adult and child mental health system has embraced the philosophy and collaborative practices of "systems of care," but the educational system has only recently adopted this model.

This four-part paper is based on a synthesis of the needs and barriers to systemic reform identified by state education agencies in 35 states (Kochhar-Bryant, 1999), as well as a recent review of research on service coordination initiatives for at-risk children and youth. It explores the scope and complexity of the problems that state and local education agencies face in response to the mental health needs of youth in the schools, presents promising interagency strategies and evidence of their effectiveness in improving outcomes, and offers and discusses recommendations in nine reform domains.

Introduction

The following vignette describes an actual case of a 16-year-old boy and his family struggling to find the right services at the right time to save him from lifetime failure.

Vignette

The worried family of Eric, a very bright 16 year old, recently attended an interagency team meeting with representatives from the county public schools, mental health services, alcohol and drug services, juvenile services and probation. Eric was failing ninth grade a second time, was on a Child in Need of Supervision (CHINS) petition through juvenile services, was participating in alcohol and drug services by court order, and had been in weekly, private mental health therapy for over a year without progress. While attending school, he was also participating in evening outpatient alcohol and drug treatment services but was regularly failing urine tests and becoming increasingly violent at home. Members of the school special education evaluation team would not refer him for special education because they believed his primary problems were behavioral or "conduct" problems and substance abuse, and not "emotional disturbance" as defined by IDEA. The private mental health counselor who diagnosed Eric as having emotional disabilities said that he could not continue to work with Eric because the youth was "uncooperative and needs to get clean first" or "the family was wasting its money." He recommended residential treatment. The alcohol and drug services staff said they could not refer Eric for residential treatment as long as he was participating in

outpatient treatment. The court would not order residential treatment unless the family was willing to charge Eric with an offense, such as destruction of property or assault or a drug charge. Eric's parents placed him into an intensive day treatment center at their own expense. Only when Eric became uncooperative and, disruptive, and failed classes once again did the interagency team finally recommend residential treatment.

This case illustrates the fragmentation of a system that addressed separate aspects of Eric's problem-substance abuse, mental health and behavioral problems, academic failure-but failed to communicate or coordinate as a system to prevent Eric's ultimate placement outside his home.

There is a sharp rise in the U.S. population of students who, like Eric, have emotional and behavioral needs that place them at risk of academic failure, placement outside the home, school dropout, incarceration, and a lifetime of struggle to achieve adult independence. As more students with disabilities participate in general education classrooms and standardized testing, many exhibit troubling behavior, reflecting inadequate supports for them and their teachers. Furthermore, accumulating state data are revealing unanticipated consequences of the new high-stakes accountability system mandated by the No Child Left Behind Act (NCLB): increasing grade retention and dropout rates (Heubert and Hauser 1999; Kipke, 1999; National Research Council, 1993; Jacob, 2001; Warren and Edwards, 2001). Students with emotional and behavioral disabilities are particularly at risk, and continuing reports on the high number of students with disabilities who drop out of school or are suspended or expelled indicate the need for supportive or alternative learning environments.

This problem has occurred because, historically, children with diagnosable mental illnesses were segregated from general education classrooms and only recently integrated into their community schools by the Individuals with Disabilities Education Act (IDEA) of 1997. Although this law requires schools to integrate children with diagnosed emotional and behavioral disabilities (EBD) into their base schools and into the general education classroom to the extent possible, It has not prevented many students from being inappropriately diagnosed and given punitive treatment rather than the therapeutic or educational interventions that they need. Indeed, the capacity of schools to address behavioral and mental health needs is closely linked to students' access, participation and progress in general education and healthy development in their families and communities.

As the opening vignette illustrates, schools cannot provide all the services that EBD children and their families need. One of the critical gaps in addressing these needs is the fragmentation of services and supports—the failure of schools and community agencies to collaborate to ensure that appropriate and timely services are provided to children and youth experiencing academic failure and social difficulties.

Over the past 20 years, children's mental health services in the United States have embraced the philosophy of “systems of care,” which is based on strong interagency coordination and comprehensive services to children and families to address multiple and interacting needs. However, the educational system has only recently begun to adopt this concept and model to address the mental health needs of students in schools.

This paper explores the scope and complexity of the problems that state and local education agencies face in responding to the mental health needs of youth in the schools, presents promising interagency strategies and evidence of their effectiveness in improving outcomes, and offers and discusses recommendations in nine reform domains.

Part 1

Scope of the Problem

According to a 2001 report by the U.S. Surgeon General, an estimated 21 percent of young people in the U.S. between ages 9 and 17—about 15 million children—have diagnosable emotional or behavioral health disorders, but less than a third get help for these problems (SAMHSA, 2001; Olbrich, 2002). These young Americans—fully one-quarter of adolescents 9 to 17 years old—may be at risk of failing to achieve productive adult lives. They abuse drugs, engage in unprotected sex, drop out of school, and sometimes commit crimes, effectively closing the door to their own futures. The costs to society are enormous, school and social services are overwhelmed, and the costs of rehabilitation are rising (National Research Council, 1993).

Imprecise Data

Figures as to the prevalence of these disabilities remain difficult to estimate. Even IDEA identification of children with these disorders remains far below even the most conservative estimates of the prevalence of severe childhood mental disorders accompanied by extreme functional limitations. And new research shows that schools misidentify a significant number of these children and place them into other IDEA categories or do not serve them at all (Bazelon, 2003). Table 1 provides an illustration of this variation.

Table 1. Variation in rates of identification of children as eligible for special education or mental health services

Source	Eligible children as a percentage of all school children
U.S. Department of Education, Office of Special Education identification of children with emotional disturbance	0.74
U.S. Department of Education, Office of Special Education identification of children with other health impairments	0.40
U.S. Surgeon General's identification of children with mental disorders and extreme functional impairment ^a	5.00
U.S. Surgeon General's identification of children with mental disorders and significant functional impairment ^a	11.00
Highest state rate (Vermont)	1.55
Lowest state rates (Arkansas and Mississippi)	0.08

^a Sources: SAMHSA, 1999; U.S. Department of Education, 2001; Bazelon Center for Mental Health Law, 2003.

Rates of identification of children who are eligible for special education or mental health services vary widely, suggesting a likely under-identification of children. In fact, for more than two decades, the national rate for students identified with emotional disturbance in schools was just under 1 percent and, by 2001, it had fallen to 0.74 percent (Kauffman, 2001). In addition, teachers typically consider 10 percent to 20 percent of

students to have emotional or behavioral problems, but a conservative estimate of students with both severe and chronic problems is 2 percent to 3 percent (Bazelon Center for Mental Health Law, 2003). These percentages contrast with the Surgeon General's estimate that 5 percent of all school-age children nationwide have mental disorders and extreme functional impairment and 11 percent have mental disorders with significant functional impairment.

Multiplicity of Conditions

These figures illuminate the fact that many children live in vulnerable families and neighborhoods where poverty, teen pregnancy, unemployment, substance abuse, and violence are widespread—factors that researchers group as risk factors, push and pull effects, and cultural and social dynamics.

Risk Factors

Historically, the education and social psychology literature has dealt with such children at risk for academic failure by targeting deficiencies within the children themselves as the leading reason for their failure, that is, for their alienation, difficult school transitions, absences, suspensions, expulsions, dropping out, and overall grade failure. Actually, individual student factors, the social and cultural environment, and the school environment all play an important role in academic failure (Garner, Green and Marcus, 1994; National Institute of Mental Health, 2001); Nichols and Good, 2004; Quinn and Epstein, 1998). All of these risk factors are generally clustered into categories of personality and temperament, school achievement, school environment, family, peer group, and community, as is shown in Table 2.

Push and Pull Effects

Academic failure in the form of dropping out of school has fallen principally under two categorical influences known as push and pull effects (Jordan, Lara, and McPartland, 1996; McNeal, 1997; Nichols and Good, 2004). Push effects are those factors in the school environment that negatively impact the child or adolescent, causing him or her to reject schooling. The school is only part of the student's social arena, however. Other factors—pull effects, such as cultural expectations, parent influences, employment, and intimate relationships—may disrupt a student's focus on and performance in school. There is also increasing evidence of the role of substance abuse in exacerbating behavioral and emotional disorders in adolescents in all socioeconomic groups (Bazelon, 2000; McCord, Spatz, Windom, Bamba and Crowell, 2000; National Research Council, 1993; SAMHSA, 2001).

Cultural and Social Dynamics

Cultural forces and social expectations can also influence whether adolescents succeed or fail academically. In some cultures, for example, females may not be expected to complete an education because of an emphasis placed on their life role as a mother and wife (Valdivieso and Nicolau, 1994); African-American youths may view unemployment as their fate regardless of the educational attainment achieved (Hodgkinson, 2002; Ogbu, 1990); and poor youth may be pressured to contribute to the family income or to care for younger siblings.

Table 2. Risk factors for emotional and behavioral disorders

Personality and Temperament	School Achievement	School Environment
<ul style="list-style-type: none"> • School failure • Difficult temperament • Early antisocial behavior (such as lying, stealing, and aggression) often combined with shyness or hyperactivity • Inadequate life skills • Lack of self-control, assertiveness, and peer-refusal skills • Low self-esteem and self-confidence • Emotional and psychological problems • Favorable attitudes toward alcohol, tobacco, and other drug use • Rejection of commonly held values and religion • Lack of school bonding 	<ul style="list-style-type: none"> • Academic failure and discipline problems • Poor reasoning ability • Lack of originality • Poor verbal interaction, verbal negativity, expressed inability to perform academically • Poor rapport with teachers, conflict with teachers • General anxiety • Quiet demeanor, withdrawn • Poor work habits • Inflexible, dogmatic personality structure • Restlessness and inattention • Boredom • Low self-concept and inadequate social skills • Lack of parental involvement • Stress and pressures in family and peer group • Sense of alienation and isolation • Different cultural and gender expectations 	<ul style="list-style-type: none"> • Early failure to communicate the student's problem to parents • Inappropriate expectations • Insensitivity to diversity • Inconsistent management and discipline • Non-facilitative school and classroom environment • Awkward or unsuccessful transitions from one school to another • Violence and victimization • Punitive school policies • Deteriorated, poorly managed, and crowded • Negative teacher expectancies and beliefs • Overuse and inconsistent use of in-school detention • Ambiguous, lax, or inconsistent rules and sanctions regarding drug use and student conduct • Favorable staff and student attitudes toward alcohol, tobacco, and drug use • Availability of alcohol, tobacco, and other drugs on the school premises • Unreasonable implementation of zero tolerance policies
Family	Community	Peer Group
<ul style="list-style-type: none"> • Parental psychopathology or criminality • Lax supervision and inconsistent discipline • Ambiguous, lax, or inconsistent rules and sanctions regarding alcohol, tobacco and drug use • Favorable family attitudes toward drug use • Physical or emotional abuse • Parental divorce or marital discord • Family conflict and domestic violence • Social isolation • Lack of family cohesion • Heightened family stress • Unrealistic expectations for children's development • Environmental conditions associated with low SES 	<ul style="list-style-type: none"> • Disorganization • Lack of bonding • Lack of cultural pride • Attitudes favorable to drug use • Lack of resources to support youth and prevent failure 	<ul style="list-style-type: none"> • Susceptibility to peer pressure • Strong external focus of control • Association with delinquent, substance-using peers • Association with peers who have favorable attitudes toward substance abuse • Association with peers who also have poor academic performances or who have dropped out of school

Stigma of Mental Illness

The historical and current stigma of mental illness further influences efforts to define behavioral and emotional disabilities in children and youth. Historically, children with diagnosable mental illnesses have been segregated from general education classrooms away from their peers and have been integrated into their community schools only recently. During the colonial period in the U.S., people with mental illness, described as lunatics, were largely cared for by their own families or placed with families in small rural communities. During the early nineteenth century, systematic efforts to treat mental illness began when emerging social policies created large isolated asylums where persons with mental illness were administered a variety of treatments, some of which are considered to have been abusive (Goffman, 1961). By the late 19th century, reformers sought to improve treatment and curtail abuse and rename asylums as mental hospitals. During the 1950s, several waves of reform culminated in the deinstitutionalization movement that proposed moving patients and care into the community. Since the 1950s, public attitudes have evolved from the unscientific belief that mental illness means psychosis and unpredictable and violent behavior (Swindle, Heller and Pescosolido, 1997).

By the 1960s, Americans had achieved greater scientific understanding of mental illness, expanding its definition beyond biological abnormalities leading to psychoses to include vulnerabilities to social and psychological stress, such as anxiety and depression (Phelan et al., 2000). For example, the public came to better understand the differences among (a) more severe forms of mental illness, such as schizophrenia; (b) less severe forms, such as depression; and (c) general worry or unhappiness among people (Link and Phelan, 2001).

Nevertheless, the stigma of mental illness persists primarily because the public perceives it to be more violent than in the past (Phelan et al., 2000). And, schools' recent emphasis on reducing school violence has led to punitive policies (e.g., zero tolerance) that impact children with behavioral and emotional disorders.

Currently, IDEA categorizes students with emotional and behavioral disorders as having an emotional disturbance (ED), which it defines as follows [Code of Federal Regulations, Title 34, Section 300.7(c)(4)(i)]:

“[Emotional disturbance] 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.”

Even though IDEA legislation makes children with emotional disabilities eligible for services, current definitions have led to misidentification and widespread exclusion of many children who need services, such as children with substance abuse or conduct disorders and children who are solely socially maladjusted.

First, under IDEA, the term "emotional and behavioral disturbance" refers to diagnosed mental health problems that substantially disrupt a child's ability to function socially, academically, and emotionally. This is not a formal DSM-IV diagnosis but rather a term that has been used both within states and at the federal level to identify a population of children who have significant functional impairment due to mental, emotional, and behavioral problems and have a high need for services (SAMHSA, 1999). The IDEA definition does not address substance abuse or conduct disorders, which do not by themselves constitute a serious emotional disturbance, although one or more of these disorders may co-exist with a serious emotional disturbance. Co-existing conditions require a joint planning process which crosses programs and settings.

Second, the official definition of children with "serious emotional disturbance" is persons: (1) from birth up to age 18 and (2) who currently have, or at any time during the last year had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, Section 1912(c) of the Public Health Service Act (Federal Register Volume 58, No. 96, May 20, 1993, pp 29422-29425; SAMHSA, 2001). This definition does not specifically address substance abuse disorders, and it differs from the definition of "serious mental illness" that is applied to adults, age 18, who have diagnosable mental, behavioral, or emotional disorders of sufficient duration to meet diagnostic criteria specified within DSM-IV. Again, this definition excludes substance use disorders unless they co-occur with another diagnosable serious mental illness ([Section 1912(c) of the Public Health Service Act, Federal Register, Volume 58, No. 96, published May 20, 1993 pp 29422-29425]; SAMHSA, 2001).

Third, as defined by the IDEA, emotional disturbance includes schizophrenia but does not apply to children who are "socially maladjusted," unless it is determined that they have an emotional disturbance [Code of Federal Regulation, Title 34, Section 300.7(c)(4)(ii)]. This regulatory "guidance" has led to considerable discretion in the states over who should receive special education services. However, an increasing number of children and youth exhibit emotional and behavioral disorders that are not yet diagnosed and are often accompanied by co-occurring problems, such as substance abuse, which is often considered a form of social maladjustment.

According to the Bazelon Center for Mental Health (2003), the IDEA definition is cited as most inappropriate because many children are excluded on the basis of social maladjustment.-an undefined term. It has been argued that these children intentionally defy authority and break rules and are, therefore, more appropriately referred to the juvenile justice system. However, research finds no justification for a distinction or valid instruments to assess a distinction between mental/emotional disorders and social maladjustment, particularly when both conditions lead to serious functional impairments (Costenbader and Buntaine, 1999).

Although a school may refer a child for an evaluation because of concerns about persistent, defiant, and acting-out behaviors, the school psychologist must determine whether the child is socially maladjusted or emotionally disturbed. A child can be both socially maladjusted and emotionally disturbed and receive special education services, but he or she cannot be only socially maladjusted yet eligible for such services (Bazelon, 2003). Since IDEA excludes social maladjustment without emotional disturbance from the definition of emotional disturbance, some state definitions and eligibility requirements result in the exclusion of students with conduct disorder (Adelman and Taylor, 2002; Bazelon, 2003; Gonzalez, 1991). Consequently, students with conduct disorders have been found to constitute the largest percentage of students with emotional disturbance who were served in day schools and residential schools (Adelman and Taylor, 2002a; Furman and Jackson, 2002).

According to the Bazelon Center for Mental Health Law (2003), there is currently no psychometrically sound personality test, clinical interview, or observational procedure that can distinguish between emotional disturbance and social maladjustment. Rather, the school psychologist must use a variety of assessment procedures to try to establish the presence or absence of an internal disorder, such as depression, social isolation, phobias or anxiety, when the presenting problem may be aggression, defiance, or general uncooperativeness and disruptiveness.

As a result, mental health organizations and special education advocacy groups have attempted to eliminate the terms, social maladjustment and emotional disturbance, in favor of the term, emotional or behavioral disorder. This conceptual change precludes the need to discover the presence of internalizing disorders in order to qualify for special education services. As of late, Congress has rejected this proposed change of terms (Merydith, 2004).

Therefore, students are sorted into two groups: those who get their education and service needs met under IDEA, and those who receive punitive treatment with interventions, such as in-school detention, suspension, expulsion, or referral to the juvenile justice system (Costenbader and Buntaine, 1999; Council for Exceptional Children (CEC), 1990). These students, who usually have academic difficulties as well, are often "encouraged" to leave school, go to alternative education, or get a GED. However, in most school districts there are too few alternative education spaces to serve all the students who need them.

A recent study by the U.S. Government Accountability Office (GAO, 2003a), the investigative arm of Congress, found that in six states in 2001, an estimated 12,700 parents gave up custody of their children to obtain the mental health services they needed. These children were mostly male adolescents with multiple problems, who exhibited behaviors that threatened their safety and that of others. Their parents were encouraged to take such drastic measures for several reasons:

- Gaps in and limits on mental health coverage;
- Limited coverage by Medicaid, the main public funding source for child mental health services of children who could benefit from mental health services;
- Failure of public systems and private insurers to cover the intensive community-based services that could reduce the need for more expensive residential treatment;
- Limited child mental health resources in schools;
- Lack of coordination (Eligibility requirements for services differ among agencies, making it difficult for children to obtain coordinated care.).

Families whose children have special service needs face rules that limit funding to pay only for the institutional treatment—the most expensive type of service for children—which is not usually what the child requires. In addition, outpatient or home-based services typically are not covered, and services that provide parents with the information, education, counseling, and ongoing home-based support needed to care for special needs children are usually not reimbursable to providers (GAO, 2003a; North Central Regional Educational Laboratory (NCREL), 1996). In response to the GAO's findings, several lawmakers are working on proposals to improve state systems of care for children with mental or emotional disorders.

Although improved public education over the past several decades has reduced the stigma of mental illness, the challenge of distinguishing between emotional disabilities, social maladjustment, and conduct disorders is impeding schools' ability to determine appropriate services and settings for children and youth. Furthermore, concerned about stigmatizing effects as well as costs, many families fail to seek early treatment for their children when symptoms of emotional disabilities or conduct disorders surface (Cooper-Patrick et al., 1997). Families are more likely to pursue treatment and early intervention in schools that have strong public education programs about children's emotional health, strong outreach to families and students, and a system of informal and formal support services (Blank, 2002; Severson, 2003).

Part 2

Complexity of the Problem

Over the past 15 years, children's mental health services in the United States have embraced the philosophy of systems of care, leading to the development of improved interagency coordination and more comprehensive services to children and families. Schools are increasingly recognizing that at-risk children improve their academic performance as the outside-of-school barriers to their learning are removed. One strategy for removing the barriers involves linking students and schools to integrated health and human services by sharing responsibility.

Barriers to Shared Responsibility

Shared responsibility connotes a need for coordination between schools and community agencies, first to form partnerships to provide these services, and second, to ensure that those services aligned with the needs and long-range plans for children and families. Collaboration across agency lines and among public and private providers is one of the most significant–yet challenging–developments in human services in recent years. However, several persistent barriers remain.

1. The increasing complexity of the service system burdens students who have complex needs and require a variety of support services in order to be successful in school and to prepare for successful transition through schooling to post-secondary life. Youth with emotional and behavioral disabilities often need multiple support services to help the family cope as a family unit and the child to participate and progress in education and to function as independently as possible.
2. An abyss, or crack in the service system, presents several perplexing challenges for education and human service personnel. First, frustrations arise when an individual and his or her family must acquire services and supports from several separate and uncoordinated sources; families vary greatly in their capacity to access and effectively utilize services within the system. Second, there are absolute gaps in services (e.g., the absence of counseling services in the school) and a lack of capacity to develop services to address those gaps (Adelman and Taylor, 2002a; Kochhar-Bryant, 2003; Minnesota System of Interagency Coordination, 2001). Third, local systems lack a single access or entry point to help the individual and family select needed services and negotiate among provider agencies.
3. Few partnerships exist to establish interagency cooperation at the state and local levels, and resource mapping and alignment on state and local levels are lacking (Blank, 2002; Chadsey, Leach, and Shelden, 2001; Hart, Zimbrich and Ghiloni, 2001; Kochhar-Bryant, 2003).
4. Among public and private sector agencies, there exist weak functional communication and mechanisms for information sharing, and poor coordination of services and supports across agencies and audiences (Center for the Study of Social Policy, 2004; Johnson and Sharpe, 2000).
5. Local systems currently focus on procedure and maintenance (e.g., eligibility and maintaining benefits) rather than on results (e.g., successful completion of high school, enrollment in post-secondary education, independent living, employment, and reduction of incarceration) (Center for the Study of Social Policy, 2004).
6. High specialization characterizes schools and community agencies that have very different roles and functions, making it difficult to craft comprehensive solutions to complex problems, pool resources, or reduce duplication of services (Center for the Study of Social Policy, 2004).
7. Service agencies operate from a crisis orientation rather than a prevention orientation, and they underemphasize the long-term prevention programs that are necessary to change results.
8. Local systems remain administratively rigid, allowing too little flexibility in communities to determine their own needs or to engage families in seeking solutions and defining outcomes (Blank, 2002; Friesen and Poertner, 1995).

To illustrate the impact of these problems, a youth may receive in-school supports to maintain progress in the general education curriculum, receive therapy from a private mental health agency, receive substance abuse treatment at the local substance abuse center, and attend counseling meetings with the probation counselor at the family and juvenile services office. The family would need to establish eligibility for each of these services.

In fact, the family typically serves as case manager, handling the child's visits to different agencies, maintaining contacts, filling in paperwork, and paying separate fees—an exhausting responsibility for even the most informed and confident parent. Further, often the professionals working with the youth do not communicate with each other or share information because of confidentiality concerns, lack of a protocol for working among providers, or lack of time. Although there are a variety of promising approaches to the problem, the implementation of interagency coordination remains a great challenge for school systems.

A coordinated interagency service system implies a systematic, comprehensive, and coordinated system of education and supportive and human services for individuals who are placed at risk for failure in school and life. It is a system provided in their communities in the most integrated settings possible and in a manner that promotes individual choice and decision making (Kochhar-Bryant, 2003; Kochhar-Bryant and Bassett, 2003). Interagency service coordination involves strategies for mobilizing and organizing all of the appropriate resources to link the individual with needed services in order to achieve IEP goals and successful transition outcomes. In applying this definition, coordinated interagency services in the schools means

- Including activities, goals, and strategies designed to improve the availability of and access to needed services by individuals and groups;
- Using both local and statewide system change strategies to help local education and community service organizations develop interagency collaboration;
- Valuing consumer-centered goal-setting that focuses the coordination efforts on the end results expected for the individual, and on maximizing the individual's level of potential and capacity for personal decision making (i.e., self-determination).

The general goal of service coordination is to ensure that students with complex, multiple needs receive the services they need in a timely manner, and to do whatever it takes. The purposes of service coordination are (1) continuity of support; (2) comprehensiveness and flexibility of services; (3) accessibility to services; and (4) appropriateness of services. Service coordination also helps overcome the rigidity of the system, fragmentation of services, inaccessibility, and inappropriate use of services (Friesen and Poertner, 1995; Kochhar-Bryant, 2003, 1996; Salisbury and Intagliata, 1986). Shared approaches bring the combined thinking, planning, and resources of many agencies to bear upon the problems of the individual in a way that is not only more efficient, but that also improves the life of the individual. As a result, current educational policies now mandate improved coordination between schools and community agencies, but there are gaps in these laws.

Gaps in Education Laws

Two laws mandate coordinated services to ensure that students with disabilities receive appropriate education and support services. These laws are the Individuals with Disabilities Education Act (IDEA) and No Child Left Behind (NCLB).

Individuals with Disabilities Education Act (IDEA)

In addition to mandating coordinated services, IDEA 1997 requires states to develop interagency agreements among state educational agencies, local education agencies, and human service agencies. Under IDEA 1997 and also incorporated into the current Senate bill to reauthorize IDEA, local education agencies can use funds to develop coordinated services systems at state and local levels. They may use a variety of strategies to accomplish this.

1. Improve the effectiveness and efficiency of service delivery, including developing strategies that promote accountability for results.
2. Require state-level interagency agreements, and coordinate federal, state, and local services and programs, including programs supported under IDEA, violence prevention programs, nutrition programs, Head Start, vocational and technical education, and job training.
3. Allow flexible use of 1 percent of the total state IDEA allocation, and 5 percent of the total local allocation, to build a coordinated services system.
4. Develop and implement interagency financing strategies for the provision of education, health, mental health, and social services, including transition services and related services under IDEA.

5. Provide service coordination and case management that link individualized education programs with individualized service plans under multiple federal and state programs, such as Title I of the Rehabilitation Act of 1973 (vocational rehabilitation), Title XIX of the Social Security Act (Medicaid), and Title XVI of the Social Security Act (supplemental security income).
6. Prepare interagency personnel to work with coordinated services, and implement collaborative and consultative roles for special education teachers in the reintegration of individuals with disabilities.
7. Identify the roles of professional groups and referral agencies in identifying, assessing, and providing services to individuals with disabilities.

Local plans are required to describe how the local education agency will coordinate and integrate services provided under IDEA with other education services at the local educational agency or individual school level. State and local plans are required to ensure that an interagency agreement is in effect to coordinate activities among the following entities:

- State Medicaid program
- Education agencies as part of the statewide workforce investment system
- Vocational Rehabilitation Services
- Statewide Independent Living Council established under section 705, the advisory panel established under section 612(a)(21) of the IDEA (as amended by section 101 of the IDEA Amendments of 1997; Public Law 105-17)
- State Developmental Disabilities Council described in section 124 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6024)
- State mental health planning council established under section 1914(a) of the Public Health Service Act (42 U.S.C. 300x-4(a))
- State workforce investment board

No Child Left Behind Act (NCLB)

The No Child Left Behind Act (NCLB) also addresses local interagency agreements to provide supplemental services for children who need extra support to progress in the academic program. According to NCLB, agreements require the local education agency to develop, in consultation with parents (and the provider chosen by the parents), a statement of specific achievement goals for the student, a method for measuring the student's progress, and a timetable for improving achievement that, in the case of a student with disabilities, is consistent with the student's Individualized Education Program (IEP) under section 614(d) of the Individuals with Disabilities Education Act. References to supplemental services are primarily related to the student's academic progress.

Policy makers recognize the importance of school-linked services and interagency collaboration in promoting students' academic success and general progress through schooling. Where state agencies and schools and communities are restructuring for interagency collaboration, there is emerging evidence of positive impacts on student outcomes.

Unevenness in State Action

National Survey of School Health Policies and Programs

Data about state responses to the crisis derive from the national School Health Policies and Programs Survey (SHPPS). Conducted periodically by the Centers for Disease Control (CDC) SHPPS assesses school health policies and programs at the state, district, school, and classroom levels and assesses all eight school health program components: health education, physical education and activity, health services, mental health and social services, food services, school policy and environment, faculty and staff health promotion, and family

and community involvement. As a result of SHPPS 2000, CDC learned that 36 states currently have a state level mental health and social services (MHSS) coordinator, but only 9 of these states require each school to have an MHSS Coordinator (Kann, Brenner, and Allensorth, 2001). Table 3 summarizes the results of this study.

This SHPPS study found that schools nationwide have improved in establishing policies focused on the health of students. However, mental health policies still lag. Almost 67 percent of schools offer student assistance programs and more than 75 percent provide crisis intervention, counseling, identification of and referral for physical or emotional abuse, stress management, but few states have policies related to their school mental health and social services. Specific data on such policies is not currently available.

Table 3. Summary of the School Health Policies and Programs Survey (SHPPS) 2000 Programs

Programs	Programs and Requirements in States, Districts, and Schools ^a
Organization and Staffing	<ul style="list-style-type: none"> • Have a person who oversees or coordinates school mental health and social services: states, 52.0; districts, 62.6; schools, 77.8 • Require a person to oversee or coordinate mental health and social services: states, 18.5; districts, 40.8 • Have a part-time or full-time guidance counselor: schools, 77.1 • Have a part-time or full-time school psychologist: schools, 66.0 • Have a part-time or full-time school social worker: schools, 43.9
Student Assistance Programs (SAPs)	<ul style="list-style-type: none"> • Offer SAPs to all students: elementary schools, 62.0; middle/junior high schools, 63.1; senior high schools: 64.6 • Require schools to offer SAPs to all students: states, 34.0; districts, 51.2
School-based Health Centers (SBHCs); Services Provided at Other Sites	<ul style="list-style-type: none"> • Have a SBHC that provides mental health and social services to students: states, 9.5; districts, 24.9; schools, 10.4 • Require provision of mental health and social services to students through arrangements with agencies, organizations, or professionals not located on school property: states, 28.6 • Have such arrangements: districts, 59.0; schools, 51.6 • Have such arrangements with a local mental health or social services agency: schools: 44.1 • Have such arrangements with a local health department: schools:, 18.7 • Have such arrangements with a private psychologist: schools, 17.4 • Have such arrangements with a private counselor: schools, 14.3 • Have such arrangements with a local hospital: schools, 14.0
Professional Preparation: Guidance Counselors	<ul style="list-style-type: none"> • Require newly hired guidance counselors to be certified by a state agency or board: states, 98.0, districts, 71.7 • Require state certification: schools, 82.8 • Require a master's degree in counseling: schools, 76.4
Professional Preparation: School Psychologists	<ul style="list-style-type: none"> • Require newly hired school psychologists to be certified by a state agency or board: states, 95.6; districts, 74.3 • Require state certification: schools, 91.9 • Require a master's degree in psychology: schools, 74.8
Professional Preparation: School Social Workers	<ul style="list-style-type: none"> • Require newly hired social workers to be certified by a state agency or board: states, 92.3; districts, 57.3 • Require state certification: schools, 79.8 • Require a master's degree in social work: schools, 65.1

^a All numbers are percentages.

State Perspectives on Addressing Needs of Students With Emotional and Behavioral Disorders

Despite their efforts to address the mental health needs of students in schools, states have reported serious continuing barriers to improvement. In 1998, the U.S. Office of Special Education Programs (OSEP) was authorized to fund five-year, renewable State Improvement Grants (SIGs) to help state education agencies (a) focus on systemic reform, (b) develop capacity for the preparation and ongoing development of educators and related services providers, and (c) to improve results for children with disabilities (Federal Register, Volume 63, No. 95, May 18, 1998).

OSEP required each state that applied for a SIG to conduct in-depth needs assessments to identify services and programs that are in need of improvement. Following the identification of statewide needs, it required each state education agency to develop a State Improvement Plan (SIP) to address these services and programs.

In 1999, this author conducted an analysis and synthesis of 35 SIG proposals. One cluster that is particularly relevant for students with emotional and behavioral disabilities is that of discipline and conduct, suspensions, expulsions, alternative school placements, and absenteeism. Data reported in this section are drawn from the 1998 State Improvement Grant proposals. Almost all of the proposals reviewed discussed difficulty in collecting data on the numbers of students suspended, expelled, or placed into alternative schools as a result of disciplinary actions, and few states were able to disaggregate data on absenteeism for students with disabilities. The author's findings from two sets of state proposals are illustrative.

First, of 11 states that provided information related to discipline, suspension, expulsion, and alternative school placement, 10 expressed difficulties implementing discipline systems appropriately and in accord with IDEA regulations (Alabama, Colorado, Delaware, Hawaii, Indiana, Kansas, Louisiana, Minnesota, Oregon and Virginia). For example—

- Kansas showed no difference between students with and without disabilities in the kind of acts for which they were suspended or expelled. But students with disabilities were twice as likely to be suspended or expelled for those same acts. About 87 percent of these students had been diagnosed as having either behavioral disorders or learning disabilities.
- Minnesota was the only state that had detailed suspension and expulsion data available by type of violations. This state reported that although students in special education represented 10.15 percent of the total school population, they represented 20 percent to 45 percent of all students who were suspended from school. The range of 20 to 45 percent depends upon the category of violation examined: weapons, vandalism, tobacco, threats, sexual offenses, physical assault, drugs, disorderly conduct, attendance, or alcohol.

Three other SIG proposals also expressed challenges with implementing discipline systems to meet the requirements of IDEA legislation.

- Michigan reported convening IEP teams in only 26.1 percent of all expulsion cases even though 82.6 percent of all students expelled had either learning or emotional disabilities. Michigan's suspension data could not be disaggregated for students with disabilities, indicating the need to begin to collect baseline data.
- Pennsylvania mentioned in its state cyclical monitoring report that 36 percent of the 103 participating districts had at least one issue out of compliance with IDEA in the area of behavior management policy, more specifically the documentation and implementation of behavior support plans. As a result, 47 appeals related to behavioral issues, support plans, or suspensions and expulsions, were heard in one year.
- Tennessee reported that the number of students expelled or suspended had increased each year since

1991-1992, an increase attributable to the rise in school zero-tolerance policies and stricter discipline standards. Special education students accounted for about 8 percent of the Tennessee suspensions and about 2 percent of the expulsions. The state encouraged many students who were recommended for suspension or expulsion to continue their studies through alternative schools and in-school suspensions, and it actually served about 12 percent of its suspensions through in-school suspension. Of the students placed into such alternative settings, 25 percent did not return to their base schools.

Second, 12 states provided information related to discipline, suspension, and expulsion of students with disabilities (Alabama, Colorado, Hawaii, Indiana, Kansas, Louisiana, Minnesota, Michigan, New Hampshire, Oregon, Tennessee, and Virginia), but only two states, Colorado and Virginia provided data on absenteeism, a key indicator of risk for dropout. However, no states, discussed potential relationships between the shortages of teachers and specialists trained to provide interventions for students with behavioral disorders or emotional disabilities and the increased rates of referrals for disciplinary actions, suspensions, and expulsions.

- One state noted a concern over the increasing use of paraprofessionals to staff special education classes and a parallel increase in behavioral incidents among special education students.
- New Hampshire reported that high school students with emotional disabilities and behavioral disorders (ED/BD) comprise the majority of students in segregated placements in and out of state.
- Most states reported severe shortages of EBD/ED teachers across the board and considered pre-service and in-service training in behavior management as among the highest priorities
- One state reported that a big city public school system was "filling EBD teacher positions with long-term substitutes or short-term contractees or with teachers not licensed in EBD but licensed in other areas of special education who have provisional licenses or variances."
- Minnesota also expressed a concern that families of students who are considered a problem are being counseled to choose between (1) home schooling and "layout" for a year, and (2) "expensive" due process hearings regarding whether the student should be expelled.

Although almost all SIG proposals considered by the author indicated serious needs for training and technical assistance in behavioral interventions, only 13 discussed problems and barriers related to discipline, suspension, and expulsion. This is an important area for further exploration among the states since many report increases in numbers of students receiving special education services who are suspended or expelled and who are transferred to alternative settings or in-school suspension.

Table 4 shows state data on suspension, expulsion, and absenteeism.

Table 4. State data on suspension, expulsion, and absenteeism, based on 35 SIG proposals, 1998

Availability of Data	Funded States	Unfunded States
Provided data on suspension and expulsion	2	3
Provided data on absenteeism	1	1
Addressed major problems and barriers with suspension and expulsion or discipline	6	7
Did not address the issue	9	11

Part 3

Effectiveness of “Systems of Care” Models

Since the 1980s, the schools have started to mirror the children's mental health field in shifting from institutional to community-based interventions. By 2000, 96 percent of children with disabilities received services in their base schools rather than in segregated settings, with 53 percent of these children served in the general education classroom more than 80 percent of the day (up from 43.4 percent in 1994) (U.S. Department of Education, 2003).

However, the education arena lags behind adult and children's mental health services in adopting the concept and model of systems of care. As state and local educational agencies respond to the mental health needs of youth in schools, many are exploring the potential of systemic approaches for positively impacting children's academic performance.

Integrated System Models

A growing body of evaluation data has resulted from research in several human services areas-mental health, social services, child welfare, health care, and foster care. This research has consisted largely of case studies of human services reform efforts at the community or state level. Studies have shown that coordination of services improves student outcomes; expands schools' access to resources; increases efficiency, effectiveness and flexibility; and by engaging students and families, builds stronger schools and communities.

But several factors challenge such evaluation efforts. These include (a) wide variability across sites in how target populations are defined; (b) varied geographic areas in which programs are situated; (c) size of programs (statewide as opposed to single counties or cities); (d) different lead agencies developing programs and constant change in service implementation; (e) variability in the definition of target populations (e.g., some programs focus on children who are referred through the juvenile justice system; others focus on enhancing mental health-school collaboration); (f) significant changes in target populations over time at individual sites; and (g) lack of control groups for comparison (Burns and Goldman, 1999; SAMHSA, 2001; Rosenblatt and Woodbridge, 2003). Although the evidence of the benefits of some of these services is uneven at best, even uncontrolled studies offer a beginning point for studying the effectiveness and feasibility of their implementation.

In addition, evaluating the effectiveness of large-scale systems reform is difficult because these systems are so complex. For example, in Illinois, the Governor's Task Force on Human Services Reform includes a state-level collaborative and decision-making task force; five pilot community demonstration projects-each with a local governance entity and mandated collaboration between the site and local providers of seven state human services departments-and a reorganization of seven state departments into one department of human services. Other states attempting statewide reform include Idaho, Iowa, Maryland, Tennessee, and Virginia (Blank, Melaville, and Shah, 2003; Ooms and Owen, 1992).

Technologies to evaluate such large-scale initiatives are only beginning to emerge. These include microsimulation, experimentation and quasi-experimentation, qualitative evaluation, and case studies (Center for the Study of Social Policy, 2004; Cohen and Ooms, 1993; NCREL, 1996).

Superintendents are being urged to advocate for changes in state and local policy to support new models for coordination of services (American Association of School Administrators, 2000; Blank, 2002; Preister, 1999).

Several studies of service coordination strategies and their impact on outcomes for highly at-risk children and youth with emotional and behavioral disabilities are summarized in Table 5.

Table 5. Summary of studies examining the effectiveness of school-linked service coordination (1995-2003): Studies of Service Coordination Strategies – Givens, Findings, Outcomes, and Impact of Studies

1. *Study of initiatives for addressing school violence: examination of four promising prevention programs* (GAO, 2003b). Finding: A literature review supports interagency partnerships, community linkages, and provision of services among the seven characteristics of schools with promising violence-prevention programs. Outcome: Four programs showed reductions in student offenses, incidents of physical violence, and gang activity.
2. *Study of foster care services in the U.S.* (GAO, 2003a). Finding: Rarely does a single state or local agency have control over the full array of services required to address the needs of increasingly troubled children and families. The fragmented service delivery system exacerbates the problem.
3. *Study of 12 states' coordination of services for children with disabilities* (GAO, 1999). Finding: General problems arise when coordinating IDEA and Medicaid services. Outcome: Improvements in timely access to needed services and Medicaid reimbursements occurred when agency liaisons or Medicaid-school-based services coordinators were used..
4. *Study of coordinated community efforts to serve at-risk teen girls ages 10 and 15* (GAO, 1995b). Finding: Services in the communities visited were not coordinated, and girls had limited access to the array of health and support services. Outcome: Collaborative, school-based, case management efforts in some communities achieved positive outcomes and increased involvement from teens and families. Impact: Reduction in discipline problems and suspensions.
5. *King County [Florida] blended funding project: Pilot evaluation results* (Williams, Vander Stoep, Green, Jones and Trupin, 1999). Given: 12-month follow-up of 25 project participants. Outcome: Among students with emotional difficulties who received coordinated support services, the program achieved a reduction from 84 percent to 48 percent of students who were institutionalized or placed in another setting outside of the community school.
6. *State's pilot child protective services system working study* (Duke University, 2004). Given: This was a study of the outcomes of the multiple response system (MRS) with child protective services in 10 counties. Finding: The MRS increased coordination between law enforcement agencies and child protective services, tailored its interventions to address the individual needs of families, and used other key strategies to protect children. Outcome: The program resulted in improved communication and coordination across agencies.
7. *Evaluation of Comprehensive Community Mental Health Services program data from 22 grantees funded for their first of 5 years of support; included services to approximately 34,377 children ages 5-18 and their families* (Annual Report To Congress on the Evaluation of the Comprehensive Community Mental Health Services Program for Children and Their Families, 1998). Given: This was an evaluation of comprehensive community mental health services program data from 22 grantees funded for their first of five years of support. It included services to about 34,377 children, ages 5-18 and their families. Children from highly stressed families with limited financial resources participated in systems of care. At intake, a large proportion of the children (43 percent) had disruptive behavior disorders although nearly one-third (32 percent) had depression or anxiety disorders. Outcome: Children's functioning and behavioral and emotional symptoms improved significantly after one year of participation in systems of care based on parent, clinician, and self-reports. Behavioral improvements were accompanied by increased school attendance, improved performance at school, and decreased law enforcement contacts. At 1 year, living

arrangements had stabilized for nearly 60 percent of the children with histories of residential instability at intake. Impact: Families were satisfied with services and indicated that they were highly involved in their children's care. Despite the presence of multiple child and family risk factors, children displayed improvement in behavioral and emotional symptoms over one year of services, and this improvement in scores was most dramatic for children at greatest risk.

8. *Oregon partner's project: Progress and outcomes report* (Gratton et al., 1995). Given: This was a project in which case management was compared with "usual services" without case management. Outcome: In a 1-year follow-up, children in the Partner's Project scored significantly higher on measures of social competence. They had received more individualized, comprehensive services and a greater degree of service coordination.

9. *Children and Youth Intensive Case Management (CYICM), Expanded Broker Model in N.Y. was evaluated in two controlled studies* (Evans et al., 1996; 1994). Given: This involved a children and youth intensive case management (CYICM) expanded broker model in New York, evaluated in two controlled studies. The case managers were responsible for assessment, planning, linking, and advocating on behalf of the youth and family, had caseloads of 10 children, and were given \$2,000 of flexible funds per child each year to purchase treatment and ancillary services (e.g., transportation and educational aids). Outcome (first study): Children in the program spent significantly more days in the community between episodes of psychiatric hospitalization, and they were hospitalized for fewer days than before enrollment. Outcome (second study): Significant behavioral improvements and decreases in unmet medical, recreational, and educational needs occurred among a random sample of 199 children at a three-year follow-up. Hospital admissions declined fivefold after enrollment whereas among non-enrollees the decline in admission rates was less than half that value (which translated into a savings of almost \$8,000,000 for New York State). Impact: Case management can be as effective for youth presenting with substance abuse problems as for youth presenting with other psychiatric disorders.

10. Randomized trial in North Carolina: youth served by an interdisciplinary treatment team led by a case manager were compared with a control group of youth served by a treatment team led by their primary clinician in the role of case manager (Burns et al., 1996). Outcome: At 1-year follow-up, case managers in the experimental group (team case managers) spent significantly more time with their clients and significantly more time on the core functions of case management (e.g., outreach; assessment of strengths, needs, and resources; service planning and monitoring; linking, referral, and advocacy; and crisis intervention). The experimental group remained in the case-managed program longer, spent fewer days in psychiatric hospitals, and received more community-based services and a more comprehensive array of services. Impact: Parents of youth in the experimental group reported more satisfaction with the service system.

11. *Family Centered Intensive Case Management (FCICM) randomized trial* (Evans et al., 1996). Given: Children were assigned to FCICM or Family-Based Treatment (training, support, and respite care for foster families without case managers). Finding: The findings at 18 months (at discharge) indicated that children in FCICM had significantly fewer behavioral symptoms and significantly greater improvements in overall functioning than those in Family-Based Treatment. Impact: Average annual cost of FCICM was less than half that of Family-Based Treatment.

12. *Never-streaming prevention programs in Baltimore and Fort Wayne Indiana based on prevention and early intervention before the need for special education or remedial services arises* Finding: In Baltimore, Md., never-streaming resulted in a 50 percent decrease in special education referrals in the primary grades. In Fort Wayne, Ind., special education referrals in grades K-3 were three times lower compared to those who did not use never-streaming. These programs are usually funded by reallocating Title I funds and creatively using special education funds and personnel.

Child and Adolescent Service System Program

In 1984, the National Institute of Mental Health's Center for Mental Health Services launched and funded the Child and Adolescent Service System Program (CASSP) under the Alcohol and Drug Abuse and Mental Health Administration Reorganization Act of 1992 (Public Law 102-321). The developers of CASSP pioneered the concept of a system of care—a comprehensive approach to coordinating and delivering an array of services from multiple sources or agencies. The service delivery strategies include case management, team approaches, "never-streaming," preventive measures, and home-based services.

Since then, CASSP principles have become a standard for program design, and all 50 states and numerous communities have received CASSP grants to organize their response to the mental health needs of the most severely affected children and adolescents. However, many communities do not offer comprehensive services according to the CASSP model (HHS, Report of the Surgeon General on Mental Health, 1999).

CASSP provided the conceptual framework for several mental health services programs for youth to develop local interagency models. In 1992, the Center for Mental Health Services embraced the system of care approach to include a comprehensive spectrum of mental health and other supportive services that is organized into a coordinated network to meet the diverse and changing needs of children and adolescents with serious emotional disturbance and their families (SAMHSA, 1999; Stroul, and Friedman, 1996).

The Comprehensive Community Mental Health Services for Children and Their Families Program, also known as the Children's Services Program, (Public Law 102-321) is the largest federal program for child mental health. Now supporting 45 sites across the nation, this Program provides grants to states and communities to improve and expand systems of care.

Since 1994, the Children's Services Program has conducted a national cross-site evaluation, with preliminary evidence indicating some improvements in outcomes, such as fewer law enforcement contacts and improved mental health status. Comparisons are being made between system of care sites and comparable communities without systems of care (Holden et al., 1999), and recent studies of the effectiveness of systems of care have focused on the delivery of community-based mental health services, reduction of hospitalization, and case management for children and families. Few studies have included outcomes related to children's educational progress.

Case management is an important component of mental health services, especially for children with emotional and behavioral disorders. Its purpose is to coordinate the provision of services for individual children and their families who require services from multiple service providers. Case managers take on roles ranging from brokers of services to providers of clinical services. There is a considerable amount of variation in models of case management.

“Wrap-around service delivery” is a community-based solution model for meeting the needs of students who are at risk of being placed outside their community school, in alternative or private settings. This collaborative process focuses on identifying the strengths of the student and his or her family and extended family. Case managers encourage families to participate in developing individualized plans that focus on family strengths in a variety of life domains. These strengths are used as the basis of the wraparound plan. Rather than sending the student to a placement away from his or her school, community, or family, community-based services are wrapped around the student (Friesen and Poertner, 1995; Furman and Jackson, 2002). Research on wraparound is still in its early stages (Burns and Goldman, 1999; Gratton, Paulson, Stuntzer-Gibson, and Summers, 1995).

Communities in Schools Model

An example of an integrated initiative is Communities in Schools (CIS). The nation's leading community-based organization for helping youth succeed in school and prepare for life, CIS operates in 31 states and at 2,700 education sites. It promotes the connection of schools to needed community resources, services, parents, and more than 48,000 volunteers. At the state and local levels, CIS partners with families, schools, businesses, and community leaders to create a support system to ensure that youth have access to programs. The following are examples, cited in Blank, Melville, and Shah (2003), of outcomes in schools using the CIS model:

- Howe Elementary School (Green Bay, Wisconsin): Sixty-one percent of third graders now perform at proficient or advanced levels in state reading tests.
- Marquette Elementary School (Chicago): Reading improvement has exceeded the citywide average. Strong family support has helped cut the student mobility rate from 41 percent to 22 percent between 1995 and 2000, despite a poverty rate of 96 percent.
- East Hartford High School (Connecticut): The dropout rate has decreased from 22 percent to less than 2 percent annually over the last 6 years, and 80 percent of students now go on to two- and four-year colleges.
- Parkway Heights Middle School (San Francisco): Seventy-one percent of parents report spending more time with their children enrolled in Parkway's Families on Track community school program.
- Carson High School (Carson, California): Suspensions have been cut in half, from 10 percent in 1998 to 4.7 percent in 2000.
- St. Paul High School (St. Paul, Virginia): Ninety-four percent of students graduate. Nearly 90 percent meet state reading and writing requirements in core areas, and more than 90 percent pass state exams in biology and geometry.

Oregon Services Integration Program

Another example of the integrated model is the Oregon Services Integration program. This program integrates state human services with schools, county governments, tribes, non-profits, and other partners and engages many human service, education, and other partners in designing and implementing shared strategies to achieve better outcomes for children and youth. The Oregon Department of Human Services, Services Integration Program (Ragan, 2003) addresses such outcomes as alcohol and drug use, access to social and health services, abuse prevention, and school performance improvement. The models currently used to implement service integration strategies are resource centers, multi-disciplinary teams, information and referral networks, system/policy change, and family advocacy models. Guiding principles for service integration projects include the following:

- Share responsibility among partners for client, program, and community betterment outcomes.
- Use a systems approach that includes multiple partners sharing resources, blended service, and planning strategies; holistic supports for consumers; pursuit of goals and outcomes shared by the Department of Human Services (DHS) and the community; and regular evaluation of outcomes and performance measures.
- Focus on residents or clients who formerly, presently, or who may in the future be using DHS services.
- Use multilateral agreements among primary service providers, advocates and DHS divisions, program offices, and local agents.
- Use substantial client and community involvement through activities, such as steering committees, plan development, focus groups, and outreach.
- Work on several levels of integration, including weaving together programs procedures, priorities, resources, staff, supervision, case plans, intake and referrals; and reforming systems to better support integration.

Part 4

Discussion and Recommendations to Improve Coordination of Services

Improving services for children and youth with emotional and behavioral disabilities is a complex challenge. As formulated by the author (Kochhar, 1999), approaches to service reform and improvements that are occurring in the states and local communities can be clustered into nine categories, which are first listed and then detailed as follows:

1. Improve system coordination and access
2. Reduce policy complexity and fragmentation
3. Close service delivery gaps
4. Reduce organizational barriers
5. Align with educational reform initiatives
6. Develop personnel
7. Address demographic changes
8. Strengthen local capacity building through technical assistance
9. Provide funding and reallocation of resources

Improve System Coordination And Access

Several barriers prevent schools and community agencies from linking to share responsibility for improving services to children and youth with disabilities. For example, most states report very weak implementation of interagency agreements and ineffective linkages for supporting children with emotional disabilities as they make multiple transitions between elementary, middle, high school and post-secondary settings. Yet systemic improvement depends upon these linkages. The U.S. Government Accountability Office (GAO) categorized service coordination efforts as either system-oriented or service-oriented, depending on their goals (GAO, 1992).

- System-oriented efforts have ambitious goals that focus on reforming the delivery system. These efforts are intended to: (1) develop new human service delivery systems or alter the way existing agencies are structured, (2) create new services to fill gaps in available services or address unmet client needs, and (3) reduce conflicts and inconsistencies among service programs to make it easier for clients to apply to and be accepted by programs. To accomplish their goals, these efforts seek to change the way agencies plan and fund programs.
- Service-oriented models have more modest goals and attempt to link clients to existing services and unite various service providers without altering program budgeting or funding processes, service agency responsibilities, or organizational structures. These efforts link clients with existing services through such methods as the collocation of providers and the use of case managers. In general, there have been limited attempts at system level reform, and most state and local initiatives to coordinate services fall into the service-oriented model.

Researchers concur that a long-range, coordinated, interagency plan for a system of education and support services is needed for students with emotional and behavioral disabilities in integrated settings. Such a plan should include support for children from early childhood through high school and should include the critical passages or transitions between educational settings.

Recommendations

Action steps for improving system coordination and access at both levels have been addressed by several researchers (Adelman and Taylor, 2002b; Bazelon, 2003; Blank, Melaville and Shah, 2003; Center for Child

and Family Policy, 2004; Center for the Study of Social Policy, 2004; Furman and Jackson, 2002; Merydith, 2004; U.S. Surgeon General, 2001). They include the following:

- Develop a common language to describe children's mental health, emphasizing adaptive functioning and taking into account ecological, cultural, and familial context. A common language is important to facilitate service delivery across systems.
- Develop a universal measurement system across all major service sectors that is age-appropriate, culturally-competent, and gender sensitive to (a) identify children, including those with special healthcare needs, who may need mental health services; (b) track child progress during treatment; and (c) measure treatment outcomes for individual patients.
- Modify definitions and evaluation procedures used by education systems to identify and serve children and youth who have mental health needs, particularly those with substance abuse disorders that co-occur with other diagnosable disorders. These definitions and procedures should facilitate access to, not exclusion from, essential services.
- Seek corrective action in states whose dropout, suspension and expulsion data reflect inappropriate identification and intervention policies and practices regarding students with emotional or behavioral disorders.
- Provide access to services in places where youth and families congregate (e.g., schools, recreation centers, churches, and others).
- Support the development of coordinated responses by emergency medical providers (e.g., paramedics, emergency room personnel) and community mental health service providers to expedite appropriate treatment and/or referral for children presenting with emergency and traumatic episodes in hospital emergency rooms.
- Address issues of confidentiality in ways that respect a family's right to privacy, but encourage the coordination and collaboration among providers in different systems.
- Encourage family organizations to help family members access information on enhancing children's mental health and the availability of effective treatments for mental illness so that they can make fully-informed decisions about interventions offered.
- Include youth in treatment planning by offering them direct information, in developmentally appropriate ways, about treatment options. As much as possible, allow youth to make decisions and choices about preferred intervention strategies.
- Use family advocates, such as family members with prior experience, to assist families in interacting effectively with complicated service systems such as healthcare, education, juvenile justice, child welfare, and substance abuse treatment.
- Provide a mechanism for input from youth and families in setting a national mental health agenda and in assessing policies and programs to promote mental health services delivery.

Reduce Policy Complexity and Fragmentation

Barriers to coordination between state and local agencies occur when multiple reform initiatives occur simultaneously in schools and school-linked agencies.. For example, schools may be facing new federal regulations, new state laws and regulations, and court orders to initiate systemic change (Kochhar, 1999), while mental health agencies are also undergoing restructuring. These conditions often lead to confusion in policy implementation, ambiguity and conflicts over roles and responsibilities for services to children, and ultimately, unintentional exclusion of students from needed services.

Recommendations

- Align mental health service definitions, and coordinate the identification mechanisms used by child mental health systems and schools' child-find and pre-referral policies.
- Coordinate IDEA placement policies with alternative education placement policies.

- Align IDEA and NCLB relative to discipline policies and the protection of access to alternative education settings.
- Align zero tolerance policies with policies related to alternative education placement and support services for students with diagnosed and undiagnosed emotional and behavioral disabilities. For example, if a student who has violated school policy has been diagnosed or identified as a student with possible EBD, then school personnel should carefully examine the history of services and needs of the student both within the school and in the community and consider such information in determining an alternative placement.
- Coordinate school suspension and expulsion policies and practices with community-based probation policies and provide bridge supports to students who are out of school.
- Align positive behavioral support initiatives (PBS) with school safety and violence prevention initiatives, mental health services, and IDEA interim alternative educational settings.

IDEA legislation protects access to alternative education opportunities for youth with emotional and behavioral disorders. Current law and regulations provide key supports to students with disabilities by

- increasing flexibility in discipline practices;
- allowing school personnel to discipline students with disabilities in the same manner as students without disabilities—with restrictions (IEP review and behavioral assessment; 45-day limit without review);
- allowing the regulated placement of students, without parent permission, in Interim Alternative Educational Settings in certain situations involving weapons, illegal drugs and injurious behaviors;
- guaranteeing a Free and Appropriate Public Education and needed services to assure progress in the general curriculum for students with disabilities who have been removed from school, regardless of the severity of their behavior;
- limiting the amount of time that a child with a disability can be removed from his or her current placement for disciplinary reasons without a change in placement;
- requiring a Manifestation Determination of the relationship of a behavior to a student's disability;
- requiring a Functional Behavior Assessment and "positive behavioral interventions, strategies and supports" to address behaviors that impede learning and to prevent the behavior from recurring (National Association of School Psychologists, 2002).

These key provisions assure that students with disabilities receive services to address challenging behaviors and continue to receive a Free and Appropriate Public Education. However, the uneven implementation of IDEA provisions is resulting in the denial of appropriate educational services. The National Association of School Psychologists (2002) has issued five research-based cautions and recommendations:

- Zero tolerance policies refer to the expulsion or suspension of students as a consequence of serious acts of misconduct, particularly the possession of weapons or drugs. Although zero tolerance policies were developed to assure consistent and firm consequences for dangerous behaviors, broad, automatic application of these policies has resulted in a range of negative outcomes with few if any benefits to students or the school community. Rather than increasing school safety, zero tolerance often leads to indiscriminate suspensions and expulsions for both serious and mild infractions, and studies have shown that minorities and students with disabilities constitute a disproportionately large percentage of expulsions and suspensions. Yet, 95 percent of students in special education who are suspended or expelled do not exhibit the violent or aggressive behaviors that are the intended targets of zero tolerance policies.
- For offenses addressed by zero tolerance policies, more effective alternative strategies include systemic schoolwide violence prevention programs, social skills curricula, and positive behavioral supports (American Academy of Child and Adolescent Psychiatry, 2002).

- IDEA includes provisions for the implementation of "positive behavior interventions, strategies and supports" when a student's behavior "impedes his or her own learning or that of others." Regulations further require that such supports be based upon Functional Behavior Assessments (FBA), which provide data about the relationships between challenging behaviors and various child and situational factors. This allows for the development of an effective Behavior Intervention Plan (BIP) to prevent serious and repeated disciplinary infractions. Current law emphasizes safeguards and positive support provisions when students with disabilities are involved in disciplinary actions, but a current, comprehensive assessment (including FBA) should be required for any student suspected of having a behavioral disability and be prepared prior to the development of all IEP behavior intervention plans. Schools and districts should be strongly encouraged (through funding incentives) to develop proactive systems of behavioral supports at the classroom, building, and district levels. IDEA regulations apply not only to direct implementation of supports for individual students, but also address the broader issues of school safety and climates conducive to learning for all students.
- IDEA specifically prohibits suspension or expulsion that results in the cessation of services, including those instructional services and supports specified on the IEP for a student with disabilities. Instead, IDEA provides for alternative educational placements and continuation of IEP supports, thus ensuring the safety of all students while assuring ongoing instruction. Cessation of services has serious negative consequences for students with disabilities, often leading to school dropout, failure to earn credits for graduation, and risk for arrest. Through the IEP team process, the IDEA provisions for Interim Alternative Educational Settings (IAES) allow school personnel to quickly intervene and remove from the classroom or school a student with disabilities who engages in behavior that seriously threatens the safety and well-being of self or others. The rules specify that, for certain dangerous behaviors (e.g., possession of a weapon or drugs and the threat of injurious behavior), school personnel can treat the student with disabilities the same as any other student, with certain restrictions.
- IDEA stipulates that an IAES must (a) enable the student to continue to "progress in the general curriculum," although in another setting, and to continue to receive those services and modifications that will enable the child to meet the goals set out in the IEP; and (b) include services and modifications to address the behavior and prevent its recurrence.

Close Service Delivery Gaps

Many barriers to service improvement occur because of absolute gaps in or absence of available services, such as those related to assistive technology; career, vocational, guidance, and counseling services; and instructional materials for accommodating students with disabilities in the general education classroom.

Recommendations

- Create district and school-level policies related to school mental health and social services.
- Provide the infrastructure for cost-effective, cross-system collaboration in the identification, service and treatment coordination, referral to specialty services, and development of integrated community networks to increase availability of mental health services for children before crisis or academic failure occurs.
- Provide flexibility for schools in the use of Title I funds to combine services to students with disabilities and those designated as at-risk under Title I.
- Co-locate services in schools to improve accessibility.
- Review caseloads for key support personnel, such as school social workers, counselors, and guidance personnel; determine if adequate case management can be provided.

Reduce Organizational Barriers, and Align With Education Reform Initiatives

Barriers to interagency coordination occur when existing organizations resist change in their systems that would allow new relationships and service delivery structures. Recommendations include the following:

- Realign special education roles to support students with EBD in general education.
- Include in school reports, data on transfers of students from base schools to private mental health program or residential services.
- Provide supports for students preparing for standardized testing and retesting.
- Provide transition supports for students in critical transitions between elementary and middle school, middle and high school, and high school to post-secondary programs.
- Conduct systematic evaluations of the effectiveness of organizational restructuring and new relationships.

Develop Personnel

This category of barriers is associated with developing comprehensive and effective systems of planning, delivering, evaluating, or coordinating professional development to support students with disabilities. The complexity of the policy and regulatory landscape makes it very important that leaders be prepared to address the mental health needs of students. Development of professional competencies to serve students with EBD in an environment of coordinated services requires strategies that address reforms in eight areas: professional standards, teacher preparation programs, teacher assessment, state licensure and certification, induction to the profession, continuing professional development, school cultures/learning communities, and recruitment. Their roles have not yet been defined in the system.

A statewide system of personnel development dedicated to the long range coordinated interagency plan for the system of services, which includes pre-service and in-service personnel preparation and the training of parents is needed.

Recommendations

- Examine the potential relationships between the shortages of teachers and specialists trained to provide interventions for students with behavioral and emotional disabilities and the increased rates of referrals for disciplinary actions, suspensions and expulsions.
- Examine the potential relationship between the increasing rate of use of paraprofessionals to staff special education classes and a parallel increase in behavioral incidents among special education students.
- Review school policies related to crisis intervention for students who may exhibit signs of emotional and behavioral distress.
- Clarify standards for teacher roles in terms of general knowledge and competence for intervening with students with EBD, diagnosed or undiagnosed.
- Clarify standards for guidance and counseling roles in terms of competence to work with students with EBD.
- Clarify standards for educational leadership and principalship roles in terms of competence to work with students with EBD.
- Revise teacher and leadership licensing and preparation standards to address competence to conduct and lead interagency coordination initiatives.
- Review child and adolescent mental health professional preparation to address school linked services coordination.
- Review school counselor preparation and licensing to include content related to EBD students and risk factors.

- Examine preparation of probation and parole personnel and family and juvenile services workers for content related to students with EBD and school coordination.

Address Demographic Changes

Barriers to cross-agency planning for adequate responses to student mental health needs depends upon schools' ability to track shifts in the demographics of students and personnel.

Recommendations

- Measure changes in the size of specific disability populations.
- Track changes in the economic status of student and family populations in the community as a factor in the increased need for mental health supports.
- Analyze student population factors associated with increased risk for dropout and need for mental health interventions, including increased numbers of immigrant children from war-torn countries and increased numbers of children in single parent families.
- Analyze increases in risk factors in the student population such as a rise in substance abuse, police involvement, gang activity, school violence and bullying, teen pregnancy, and other behavior associated with the need for mental health and crisis intervention.

Strengthen Local Capacity Building through Technical Assistance and Reallocation of Resources

This category of barriers refers to the challenges of leading and funding local responses to meet the educational and support needs of children with EBD while also complying with the mandates of IDEA and NCLB. The Surgeon General's report (SAMHSA, 2001) recommends improving the infrastructure for children's mental health services, including support for scientifically-proven interventions across professions.

Recommendations

- Link schools with local, state, regional, and national technical assistance agencies, such as the Special Education Regional Resource Centers and the National Technical Assistance Center for Children's Mental Health.
- Engage technical assistance specialists from state educational resource centers to help local schools develop interagency agreements with community service agencies.
- Encourage state educational resource centers to promote interagency collaboration and to disseminate effective practices.
- Encourage the health care system to respond to mental health prevention and treatment service needs through universal, comprehensive, and continuous health coverage.

Closing

The complex challenge for states in responding to the mental health needs of children and youth is enormous. Yet that challenge is dwarfed in comparison to the burgeoning costs to the community for failing to act. These costs are on the rise for individual families who must seek private services or alternative placements for their children who cannot be served in the base school. The costs are growing for schools that must seek new resources, such as police presence, metal detectors, and crisis intervention support to intervene in growing school violence, vandalism, and general stress among children. And the costs are growing for communities that bear the burden of school dropout, rising delinquency, violence, accidents, substance abuse, and extended dependency.

This paper has provided evidence that collaborative models for promoting mental and behavioral health and for coordinating services for children and youth with emotional and behavioral disabilities are showing

evidence of improved outcomes. These models are based on the assumption that children are best served holistically in a system that can address all the dimensions of a child's needs in a well coordinated manner. There is accumulating evidence that when schools take a nonpunitive approach to children who exhibit signs of social, emotional, and academic stress, and provide early and timely interventions and supports—whether students are diagnosed or undiagnosed—student outcomes improve. The philosophy, practices, and policies that promote systems of care models should be encouraged and adopted in the education arena.

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Biography

Carol A. Kochhar-Bryant, Ed.D., is Professor of Special Education at The George Washington University. Dr. Kochhar-Bryant has designed advanced graduate programs in special education, education of at-risk youth, youth with traumatic brain injuries, and interdisciplinary leadership training. She consults with public school districts, state departments of education, and federal agencies. Her research and evaluation experiences include special education research with the World Bank, evaluation of state special education systemic reform initiatives, six special education Federal Regional Resource Centers, special education services in a 22-site juvenile and adult correctional education system, non-profit youth service agencies, job training and employment preparation programs, and community-based service programs such as case management, residential services, vocational services, and respite care. Also trained in mental health counseling, Dr. Kochhar-Bryant has directed residential services for individuals with disabilities, community service coordination/ case management services, and worked in in-patient psychiatric services. She is past President of a Division of the Council for Exceptional Children.