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Fighting Fragmentation: Coordination of Services for Children and Families

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Fighting Fragmentation: Coordinated Services for Children and Families

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1. This article is based in part on the proceedings of a conference sponsored by the Youth Law Center and attended by Richard Barth, University of California, Berkeley, School of Social Work; Lenore Behar, North Carolina Department of Human Services; Erik Butler, Center for Human Resources, Brandeis University; Paul DeMuro; Sheryl Dicker, Foundation for Child Development; Edith Eddy, The David and Lucile Packard Foundation; Steven R. Forness, UCLA Neuropsychiatric Institute; Laura Grandin; Paul Harder, Harder & Kibbe; Judith H. Jacobs, Ph.D., National Institute of Mental Health; Ann Majure, Arkansas Department of Human Services; Patrick McCarthy, Delaware Department of Services for Children, Youth and Their Families; and Geri Rivard, The David and Lucile Packard Foundation. The authors deeply appreciate their assistance. The research upon which this article is based was made possible by grants from the Foundation for Child Development, Hasbro Children's Foundation, James Irvine Foundation, David and Lucile Packard Foundation, and the Morris Stulsaft Foundation. The authors gratefully acknowledge their support.
I. INTRODUCTION

Carol M. spent most of her life in foster care. When she was 13, her father kidnapped her. When he realized the difficulties of raising an adolescent, he encouraged her to run away. While on the streets, she was arrested for shoplifting and spent time in an adult jail and a juvenile detention center awaiting trial for that offense. After being adjudicated delinquent, she was sent to a state training school (a long term facility for delinquent youths). The staff there determined that they could not serve her because of mental health problems, so they attempted to locate a community placement. The search for a program that could serve a runaway with mental health needs and a delinquent label took a year and a half, most of which Carol spent in isolation. Finally, Carol was placed in a community mental health program. The program provided her with counseling, but did not involve her parents or her grandparents in her treatment or in planning for her release. Seeking to create the family she never had, Carol got pregnant while she was in the program and ran away. The program refused to readmit her and, ultimately, she was released to the custody of her mother. Neither Carol nor her mother received any social services support in adjusting to their new living situation or in caring for her newborn. Not surprisingly, soon after the baby was born, Carol’s mother asked the Department of Social Services to take custody of the infant. The baby was placed in a foster home, and Carol’s mother
abandoned her again. Since then, Carol has spent time in several foster homes and, when these placements failed, in psychiatric hospitals. At 17, she is now pregnant for the second time.

Charles A. was removed from his home at age three and put in foster care. Over the years, he ran away from several foster homes to return to his parents. During one of these episodes, he stole a six-pack of Coke, a criminal offense. He was adjudicated delinquent and sent to a training school at age 10. Reunification services to the family were terminated, since Charles was no longer an "abused child," but a "behavior problem." While in the training school, he spent more than forty days in isolation for attempting to run away to his parents. There is no prospect of his obtaining a permanent placement, or of his family receiving support services sufficient to enable him to return home.

These cases are typical of the way in which children's services are provided in most jurisdictions. A lack of coordination among agencies serving children and families, a narrow focus on the labels children receive when they enter the systems, and a consequent failure to provide appropriate services, are the rule rather than the exception. For example, children labeled "delinquent" are directed toward correctional placements aimed primarily at modifying their behavior, and excluded from programs aimed at resolving underlying family problems. Children labeled "dependent", "abused" or "neglected" receive family support services, but are often not given counseling to help them deal with the psychological problems that arise from disruption of their families. Children with mental health needs are confined to psychiatric hospitals and excluded from most community-based, family-centered programs. As a result, children are unnecessarily removed from their homes and may be relegated to a lifetime of institutional care and dependency on public agencies.

In response to this situation, professionals in children's services fields have attempted to develop "coordinated" or "integrated" systems of delivery of services to children and families. The first part of this article will discuss efforts to coordinate services for children and families, particularly mental health services. It will note earlier efforts to coordinate a variety of social services, describe national reports on the need for coordinated mental health services for children, review the Child and Adolescent Service System Program developed by the National Institute of Mental Health, and discuss two model coordinated mental health programs, one in North Carolina that resulted from civil rights litigation, and another in Ventura County, California, that developed from a legislative initiative. The second part of the article will report initial findings of research begun by the Youth Law Center to identify specific characteristics of effective coordination programs.
II. COORDINATION OF SERVICES FOR CHILDREN

A. History of Coordination of Social Services

Public attention to the need for coordination of human services in this country has a significant history, dating back at least a hundred years. During the latter part of the 19th century, this attention was focused primarily on private charitable organizations and agencies: the settlement house was the model for providing a variety of services to children and families.2

The White House Conference on Children in 1909 was an early example of government concern with the issue of coordination of children's services. However, during the first half of the 20th century, interest in coordination of services was still confined largely to the private sector.3

The War on Poverty during the 1960's, under the auspices of the Office of Economic Opportunity,4 supported the expansion of individual programs, but did not focus on linking isolated programs together.5 The Model Cities program in the late 1960's did attempt to bring together disparate services, but expansion of the program from the original six cities to 150 watered the program down and put an intolerable strain on local coalitions.6

In 1971, Secretary of Health, Education and Welfare ("HEW") Elliot Richardson made services integration a top priority of his administration. HEW supported a number of Research and Development demonstration projects labelled Services Integration Targets of Opportunity ("SITO") projects. The SITO projects, however, failed because of its architects' limited understanding of the communities it was designed to serve. The SITO model, while theoretically powerful, did not deal effectively with the political and social realities of everyday life in the target communities. Within a few years, funding for SITO was discontinued.7

The demise of SITO signaled a waning of federal enthusiasm for on-site research and demonstration projects in coordination of services. The few efforts to renew interest during the later 1970's received little attention or support,8 and during the 1980's, under President

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3. Id. at 517-18.
5. Gardner, Failure by Fragmentation, 4 CALIF. TOMORROW 22 (1989).
6. Id. at 22-23.
7. Yessian & Lang, supra note 4, at 519-27.
8. Id. at 527-35.
Ronald Reagan, little attention was paid to improvements in social services delivery.

B. Coordination of Mental Health Services for Children

In the mental health area, the intellectual seeds of coordination of services found more fertile ground. In 1969, the Joint Commission on Mental Health of Children (the "Joint Commission") issued a major report, *Crisis in Child Mental Health: Challenge for the 1970s*. The overall conclusion of the report was anything but hopeful:

> From all of its studies, the Commission concludes that it is an undeniable fact that there is not a single community in this country which provides an acceptable standard of services for its mentally ill children, running a spectrum from early therapeutic intervention to social restoration in the home, in the school, and in the community.9

Despite this dire conclusion, or perhaps because of it, the Joint Commission set out in its report a comprehensive model of coordinated services for mentally ill children. The model envisioned a multi-level "child advocacy system," with "Child Development Councils" to work in local communities, "Child Development Authorities" to oversee the work of several neighborhoods in a region, "State Child Development Agencies" to develop statewide plans and coordinate all services and programs within each state, and, on the federal level, a "President's Advisory Council on Children" and a "Federal Children's Leadership Agency." At each level of the system, the oversight agencies emphasized interagency coordination of services, broad-scale planning, and comprehensive data collection.10

For substantive services for mentally ill children, the Joint Commission developed an extraordinarily comprehensive array of "Community Services and Programs of a Supportive, Preventive, and Remedial Nature." The services consisted of: (a) physical and mental health services (including family planning, systematic prenatal care, comprehensive pediatric and mental health services for preschool children, school health and mental health programs, college mental health services, and remedial mental health services); (b) income assistance, employment, and housing services (including income maintenance services, employment training, and food programs); (c) social services (including programs for preschool children, adoption and foster care services, homemaker services, probation services, legal services, school social services, family and marital counseling, and consumer education services); (d) education and special education services; and (e) work, vocational education, and youth training

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10. *Id.* at 15-23.
Another influential report was published in 1978 by the President's Commission on Mental Health (the "Commission"). In its four-volume Report to the President, the Commission called for a "responsive" social services system, featuring enhanced interagency liaisons, joint planning, and comprehensive case management.\textsuperscript{12}

C. The CASSP Program

In 1982, a report by Jane Knitzer and the Children's Defense Fund, \textit{Unclaimed Children},\textsuperscript{13} brought to the attention of Congress the two million seriously emotionally disturbed ("SED") children in this country who are not receiving adequate services. In response, Congress allocated $1.5 million to the National Institutes of Mental Health ("NIMH") for an initiative to improve service delivery to children with serious emotional disabilities.\textsuperscript{14} The NIMH's response was the Child and Adolescent Service System Program ("CASSP").\textsuperscript{15}

Instead of attempting to develop new technologies for the treatment of mental illness, CASSP focuses on the way in which services are delivered. Its major goals are:

- to improve the availability of continuous care for severely emotionally disturbed children and adolescents, and thus improve the availability and access to appropriate services across child service systems;
- to develop leadership capacity that increases priority in allocations of resources for child and adolescent mental health systems;
- to establish coordination mechanisms and thereby increase levels of collaboration, and ultimately efficiency, of service delivery, among agencies;
- to develop structures for family participation in the planning and development of the service systems, treatment options and individual service planning;
- to insure that all service systems provided by states and communities to SED children from culturally and/or ethnically diverse backgrounds are sensitive to those differences and designed to appropriately fit within the cultural norms of the child or family receiving services;

\begin{footnotes}
\item \textsuperscript{11} \textit{Id.} at 25-95.
\item \textsuperscript{12} \textsc{President's Commission on Mental Health, Report to the President} (1978).
\item \textsuperscript{13} J. Knitzer, \textit{Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services} (1982).
\item \textsuperscript{14} \textsc{National Institute of Mental Health, The Child and Adolescent Service System Program - FY '88 Report} 1 (1988) [hereinafter CASSP Report].
\item \textsuperscript{15} \textit{Id.}
\end{footnotes}
— to develop the capacity for and provide technical assistance on child and adolescent service systems development;
— to evaluate the principals and practices of CASSP.16

CASSP attempts to achieve these goals in several ways. First, it provides direct grants to states or mental health agencies to improve their systems of mental health delivery. These grants focus particularly on integrating services from the mental health, health, education, welfare and juvenile justice areas. The underlying theory is that, if these programs can work together, existing resources for special needs children will be used more effectively. CASSP funded programs are family centered and include special consideration for the needs of minorities. CASSP now funds programs in virtually every state in the country.

In addition to the grant program, CASSP runs a technical assistance and research program. The focus of the technical assistance programs is on study and dissemination of a model system of care for SED children developed by Beth Stroul and Robert Friedman.17 The model provides a continuum of care and lays out a pattern for interaction among all the service systems that impact on SED children.

CASSP also runs research programs through the Florida Mental Health Institute of the University of Florida in Tampa, and the Regional Research Institute of Portland State University in Oregon. These centers are engaged in long-term research relating to the effectiveness of various mental health programs and coordinated service systems for provision of mental health services. They have also conducted conferences and training sessions focusing on working with children in culturally and ethnically diverse families.18

The final component of the CASSP program is evaluation. CASSP has attempted to ensure that each of its projects will be analyzed in terms of both its own goals and the goals of CASSP as a whole. The evaluation requires a self-assessment, an evaluation of individual programs within the coordinated system, and an evaluation of the effectiveness of the entire coordinated systems. Similarly, the Florida Institute of Mental Health is following a group of children served by innovative mental health programs to assess their effectiveness.19

While CASSP-funded programs vary substantially in terms of both their strategy and effectiveness, CASSP has clearly taken a leading role in the development of coordinated service systems. The Stroul and Freidman monograph has been influential by providing a model for service delivery systems. In addition, the research and evaluation

16. Id. at 2-3.
18. CASSP REPORT, supra note 14, at 5.
19. Id. at 6-8.
components of both the individual grants and the technical assistance program offer the hope of developing some more specific analysis of why programs work or fail and of impacts on the target population.

D. The Willie M. Program

In the early 1980's, the concept of coordination of mental health services found practical application in the state of North Carolina. On October 3, 1979, a coalition of private attorneys and public interest law offices filed a landmark class action lawsuit, *Willie M. v. Hunt.*20 The impetus for the lawsuit was North Carolina's extensive use of large warehouse-type institutions for children with serious mental health problems who had been labeled "violent" or "assaultive," and the absence of community-based treatment programs for such children. The named plaintiffs were four children, ages 11 to 16, who needed intensive services but had been committed to ineffective institutional placements.

Eleven months later, the state settled the case by agreeing that the plaintiffs had a right to treatment under the United States Constitution and state and federal statutes. Further, the parties agreed that all of the plaintiffs, the members of the class as well as the named plaintiffs, were entitled to individualized treatment in the least restrictive environment possible. The treatment was to be based on the child's needs, not on the current availability of services. If a child needed a service or placement that did not yet exist, the child was to be provided with services that most closely met his or her needs, and the appropriate services were to be created and implemented as soon as possible.21

To supervise the implementation of the settlement, the parties agreed to the establishment of an independent panel of five experts, the "Willie M. Review Panel ("Review Panel")." The Review Panel consisted of two experts selected by the plaintiffs, two selected by the defendants, and one selected jointly. At least one of the members had to be a psychiatrist or psychologist, and one an educator. The Review Panel was authorized to hire an administrator, and the state agreed to pay all fees and expenses for the Review Panel members. The Review Panel was to have complete access to state and local personnel, placements, and documents relating to the effectuation of the settlement.22

The Office of Child Mental Health Services in the Division of Mental Health/Mental Retardation/Substance Abuse Services, a part of the state Department of Human Resources, assumed the responsi-

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22. *Id.,"Third Set of Stipulations"* (filed Sept. 26, 1980).
bility for implementing the settlement. Lenore Behar, Chief of Child Mental Health Services, developed the concept of providing a coordinated array of community-based services and placements, described as "systems of services," for Willie M. children. She used as her guide the 1969 report of the Joint Commission on Mental Health of Children.

Behar's plan divided the state into four mental health regions, with each region further divided into zones, which were usually multi-county areas. Each zone was to contain the complete "system of services" needed by members of the plaintiff class within the zone, with the regional mental health hospitals providing back-up, crisis stabilization, and training. Behar's plan included several key assumptions about the services to be provided:

1. A system of services ranging from highly restrictive settings to settings that approximate normal family living is needed to rehabilitate those youngsters.
2. Children are best served close to their own communities to maximize the possibility of family involvement and to allow for reintegration of the child into his or her natural environment.
3. To deal effectively with these children, the full continuum of care must be in place; discreet components, whether more or less intensive, standing alone, will fail.
4. The system must provide for linkages among the various components of the system, as well as to services from other child-caring systems.
5. There must be flexibility in funding and decision-making to allow the movement of the children through the system as their needs change, and backup services and respite services must be available on a 24-hour basis.
6. There must be a management structure so that shifts in funds and staff are possible to allow for the movement of children, and there can be no admissions criteria or admissions delayed to program components.
7. Individualized treatment and educational planning, with broadly defined case management as the backbone, is essential.

There were many difficulties in implementing Behar's plan. The class numbered more than 1,000 children, far more than anyone had predicted, which greatly complicated the task of identifying and evaluating class members and providing necessary placements and services. There were delays in obtaining funding from the legislature and bureaucratic resistance to implementation of the settlement. Perhaps most important, there were no models to follow from other states for such a massive restructuring of services for children. Dr. James Clements, the chair of the Review Panel, had participated in several major mental health cases throughout the country and had served as chair of the monitoring panel in the Willowbrook case in New York. He led the Review Panel in aggressively monitoring the state's pro-

gress and regularly criticizing state officials for failing to meet the timelines established by the parties for the development of services and placements.

After several tumultuous years, the Willie M. program found stable footing, with regular procedures for identifying and evaluating class members, development of effective systems of services within the operational zones, reliable funding from the legislature, and acceptance of the value of the program throughout the state. To date, the North Carolina legislature has appropriated more than $100 million for the program, and annual appropriations total almost $30 million.

The two keystones of the Willie M. program are the case managers and the management information system. From the beginning of the program, the case managers were seen as active advocates for youth under their care. The case managers are directly responsible for obtaining services geared to the individual needs of the children. Once a child is evaluated and certified for class membership, the local mental health agency and the case manager have 30 days to develop a plan for the child and then 30 days to implement the plan. Instead of multiple agencies picking up fragments of a child’s needs (for example, mental health, social services, juvenile corrections, and education), there is now one decision-making point and one focus of responsibility.25

The Willie M. program manages information through a computerized unit-cost reimbursement system. Rather than making fixed annual grants to service programs throughout the state, payments to a local mental health area are keyed to an “event ticket” and per-day reimbursement costs. The effect of this is to allow the money to flow with the need, instead of flowing to existing programs. As a side benefit, the reimbursement system provides much better statistical data on services provided and financial accountability information than was previously possible.26

The Willie M. program is widely recognized as an important model for mental health services for children. It has been cited extensively in the literature27 and used by CASSP and other funding sources as a guidepost for developing comprehensive and coordinated services.

26. Id.
27. See, e.g., L. Garner, LEADERSHIP IN HUMAN SERVICES: HOW TO ARTICULATE AND IMPLEMENT A VISION TO ACHIEVE RESULTS 18-19 (1989); J. Knitzer, supra note 13, at 97-99; Behar, An Integrated State System of Services for Seriously Disturbed Children, in CHRONIC MENTAL ILLNESS IN CHILDREN AND ADOLESCENTS 131-58 (J. Looney ed. 1988); Knitzer, Children’s Mental Health: The Advocacy Challenge — “And Miles to Go Before We Sleep,” in ADVOCACY ON BEHALF OF CHILDREN WITH SERIOUS EMOTIONAL PROBLEMS (1989).
E. The Ventura County Model

During the early 1980's, Ventura County, California, began interagency efforts to provide services for seriously emotionally disturbed children who were removed or at risk of removal from their homes. These initial efforts involved case management and development of a residential placement program, called Hobbs Landing, as an alternative to the state mental hospital.

In 1985, the California Legislature passed AB 3920, sponsored by Assemblywoman Cathie Wright. The legislation directed Ventura County to develop "a model for a comprehensive, coordinated children's mental health system that can be replicated in other counties."28

The Ventura Model is based on a clearly-articulated core value:

A community-based interagency comprehensive system of care should provide the highest treatment benefit to the child, family and community at the lowest cost to the public sector.

Ventura County officials have developed eleven basic principles that follow from the core value and are remarkably similar to Lenore Behar's guiding principles for the Willie M. program:

1. The first priority target population should be seriously emotionally disturbed, multiple-problem children who are removed or at risk of removal from their home.
2. Emotionally disturbed children should have access to a comprehensive array of services that address the child's emotional, social, and educational needs.
3. Emotionally disturbed children should be treated in their own home, school, or other significant social environment.
4. The families or surrogate families of emotionally disturbed children should participate in all aspects of the planning and delivery of services.
5. The system of care should promote family unity.
6. Emotionally disturbed children should receive comprehensive case management.
7. Emotionally disturbed children should be treated in the local community with management and decision-making responsibility for the system of care resting at the county level.
8. The system of care should promote early identification and intervention for children with emotional disturbances and multiple problems.
9. The system of care should provide on-going monitoring of client outcomes and evaluate treatment benefit and cost.
10. Emotionally disturbed children should receive services without discrimination and service should be specific to cultural differences and special needs.
11. The system of care should establish working linkages with the private sector.29

In addition to the eleven basic principles, Ventura County defines its program by six essential characteristics. The model defines the

28. VENTURA COUNTY CHILDREN'S DEMONSTRATION PROJECT, VENTURA COUNTY MENTAL HEALTH SERVICES, TWO YEAR REPORT ON THE VENTURA MODEL FOR INTERAGENCY CHILDREN'S MENTAL HEALTH SERVICES 1 (Sept. 30, 1987).
29. Id. at 2.
most needy client population for public responsibility (i.e., seriously emotionally disturbed, multi-problem children); identifies family unity and local treatment as the primary goals; establishes an inter-agency network with linkages to the private sector; integrates mental health services with home, schools, juvenile justice, and social service environments; provides a continuum of care, including alternatives to out-of-home placement and hospitalization; and monitors and evaluates clients' outcomes and costs for the system of care.30

Ventura County officials have carefully documented their success in exceeding all goals for the demonstration project, in terms of both cost savings for services and improved outcomes for children in the juvenile justice, child welfare, and mental health systems.31 Pursuant to new legislation, the county is working to adopt the model to mental health services in the county for adults and seniors.32

III. CHARACTERISTICS OF EFFECTIVE COORDINATED SERVICE PROGRAMS

Building on its initial research on the Willie M. program33 and the Ventura County model, the Youth Law Center has begun a project to investigate efforts to coordinate children's services across the country, determine the factors that are necessary for effective coordination of services, and identify barriers to successful coordination. The Center has surveyed the literature in the field, met with consultants in the areas of juvenile justice, child welfare, mental health, special education, employment, public administration, and systems management, and begun site visits to cities, counties, and states that have made significant progress in interagency coordination.

Although the research is still in its early stages, it is evident that effective, well-coordinated systems have certain specific characteristics. The following are elements that appear to be indicative of success in coordinating services to children.

31. VENTURA COUNTY CHILDREN'S MENTAL HEALTH SERVICES DEMONSTRATION PROJECT, AB 377 REPORT ON THE VENTURA COUNTY CHILDREN'S MENTAL HEALTH DEMONSTRATION PROJECT: A 27 MONTH UPDATE AND ADDENDUM TO THE TWO YEAR REPORT ON THE VENTURA MODEL FOR INTERAGENCY CHILDREN'S MENTAL HEALTH SERVICES (Dec. 16, 1987).
32. VENTURA COUNTY MENTAL HEALTH, THE VENTURA PLANNING MODEL FOR MENTAL HEALTH SERVICES (June 1, 1989).
A. General System Values

1. Clear Value Statement

First, a coordinated program must have a clear statement of the fundamental value or values motivating the program. The value statement should describe, in straightforward language, the purposes of the coordination effort. The statement should specify the target population and what is to be done with respect to services for the target population.\textsuperscript{34}

The value statement is a critical part of a program of coordinated services. It provides a philosophical anchor for the program and a basic guidepost for program efforts. It must be sufficiently detailed to provide meaningful guidance: "We'll make it better" is not an adequate value statement. The "core value" and eleven "basic principles" developed for the Ventura County model\textsuperscript{35} offer a clear, concise, yet specific statement of the target population and the goals of the program.

2. Family-Centered Orientation

The system should be focused on helping the family restore its ability to function, rather than treating the child as an isolated unit. Intake staff should regard the family as a dynamic organization with strengths and weaknesses. The "family focus" of a coordinated service program seeks to actively involve significant others with the child and in selecting and monitoring the services to be provided.

3. Broad Community Involvement

A successful coordination effort requires the involvement of all interested sectors of the community: agency administrators, line staff, unions and other employee groups, community groups, the courts, the legal community, legislators, and children's advocates. The effort not only requires cooperation across agency lines,\textsuperscript{36} but across racial, ethnic, and linguistic lines.

Community involvement may also include the use of private sector social service agencies. The private sector has several important roles

\textsuperscript{35} See supra text accompanying note 29.
to play in a coordination of services project. The first is variety; the private sector can often provide types of programs and services, technical expertise, and management experience that are beyond the ability of public agencies. The second is flexibility; while public agencies are often prohibited from taking on specific functions by custom, policy, statute, or regulation, private providers can tailor their efforts to fill the particular gaps in the public sector. Third, the private sector can often access resources, such as funding from foundations, which is restricted or completely unavailable to public agencies.

4. Involvement of the Educational System

Most discussions of coordinated services involve the child welfare, juvenile justice, and mental health systems, since children at risk are most readily identified in those systems. In a coordinated system, however, it is also important to involve the educational system, for several reasons.

First, all children go through the educational system, so it is the best vehicle for broadly reaching children and families at risk. Second, the educational system offers a means to reach children and families at risk early, when problems may be more manageable. Many youngsters in state juvenile correctional institutions, for example, have learning disabilities or other educational handicaps that were not identified early. Third, the educational system has value as an indicator of future problems; children who fail in the educational system may experience difficulties in other areas of their lives.

B. System Processes

1. Accessible Intake Location

The intake system and procedures should be readily accessible to children and families. In this context, "accessibility" has several components. First, intake should be physically accessible to children and families. It should either be brought to the clients (e.g., in their homes, schools, workplaces, churches, or community centers) or conducted in a location that can be reached by public transportation and is clearly identifiable. Intake should be conveniently available to working parents and to adolescents in school, so it must operate outside the usual working hours of 9:00 a.m. to 5:00 p.m. Appropriate intake pro-

cedures for handicapped and non-English speaking clients should be available.

Intake should also be *psychologically* accessible; it should provide an environment in which children and their families feel comfortable. The physical location should be clean and hospitable, and agency staff should treat children and their families with respect.

Most importantly, intake should be *functionally* accessible. There should not be any artificial barriers to the provision of services, such as a label previously applied to a child ("dependent" or "delinquent") or identification with an agency (Social Services or Probation Department) that previously had jurisdiction over the child.

2. Evaluation of All Needs at Intake

Staff at the intake office should evaluate all needs of the children and their families.\(^\text{40}\) The medical model, treating observable symptoms and current injuries, is not the goal. Rather, intake staff should dig below the surface to reach underlying problems. Most children and families at risk have multiple problems that cut across traditional disciplines — rarely are they just cases of delinquent behavior or parental neglect.

To enable staff to make the proper evaluation, it may be necessary to change the staff training.\(^\text{41}\) Staff must have interdisciplinary training so that they can understand the multi-faceted problems children and families experience, and the appropriate responses to those problems.\(^\text{42}\) Staffs also need interagency training so that staff in each agency can understand the resources, procedures, organization, terminology, and even the jargon of all other agencies.

3. Case Management

The agency must designate an individual or group responsible for helping the family determine what services are necessary and appropriate, and how to obtain those services. This function is often called case management.\(^\text{43}\)

In an effective coordinated system, the case manager (as in the *Willie M.* program) or the case management committee (as in the

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\(^{40}\) Hagebak, *supra* note 39, at 580.

\(^{41}\) Bernard, *supra* note 34.

\(^{42}\) Hagebak, *supra* note 39.


The term "case management" has acquired a somewhat negative connotation from traditional social services case management, which, in many jurisdictions (as a result of high caseloads or too many crises or professional burn-out or bureaucratic lethargy), is limited to a passive monitoring of children's or families' status.
Ventura County model) must have both access to a wide range of services and authority to engage those services on behalf of individual children and families.

The case management function is the pivotal function in a coordinated system. It requires dedicated, well-trained, creative people. It is not the place for staff learning their way around the system or for on-the-job training. Rather, it is the place for the most highly-skilled and experienced agency staff.

4. Service Plan

The system should have a written service plan for each child or family served. One model for the service plan is the Individualized Education Program ("IEP") required for handicapped children under the Education for All Handicapped Children Act. Like the IEP, the service plan should list specific goals, set timelines for accomplishment of those goals, and describe the specific services needed. The service plan should set forth the rights and responsibilities of all parties, including the child, other family members, the service providers, and the case manager.

Further, as with the IEP, it is important to have active client involvement in the development of the service plan. The time to get family members committed is when the goals and means for reaching those goals are being planned, not after some person who works for the county decides that a child needs therapy three times a week and his mother needs homemaker services and alcoholism counseling.

5. Dispute Resolution

A system needs a means for dispute resolution, whether the dispute is between children and their families, on the one hand, and agency staff and administrators, on the other, or between staffs and administrators of different agencies within the system. The method of dispute resolution need not be overly formal, but it should include basic elements of due process to guarantee fairness, including notice of complaints, an opportunity to be heard by a neutral decision-maker, and a record of the decision resolving the dispute.

C. Ability to Provide Quality Services

1. High Quality Services

It is important that the individual services available in a coordinated system be of high quality. This may seem obvious, since it is hardly worthwhile to effectively coordinate services that are them-
selves inferior, but that is precisely what does happen in many coordinated systems. The State of Florida, for example, has integrated services by statute for many years. Yet juvenile justice services in Florida have been notoriously deficient, with abusive practices in state institutions and chronic overcrowding in juvenile detention facilities. Child welfare services have also been inadequate in many parts of the state.

At a minimum, the individual services — whether juvenile justice, child welfare, mental health, educational, or any other — should meet all state and federal legal requirements, as well as all applicable professional standards. That in itself is no small task, as the plethora of lawsuits against county and state agencies attests.

2. Flexibility in Funding

A coordinated program must be able to overcome barriers to effective needs-determined use of funds. These include local restrictions on the use of funds, as well as less obvious limitations like agency customs and traditional practices. The service system should have a means of gaining access to flexible funding for experimentation, pilot programs, incentive programs for staff, specialized training and technical assistance from outside offices, and continued funding for services when demonstration funding is exhausted.

D. System Management

1. Information System

A coordinated services program needs an effective information system to measure effectiveness, maintain financial accountability, and cumulate data for reporting purposes. The system should cut across agencies and, ideally, should be the same system for all involved agencies.

48. HRS Neglects Kids, Critics Say, Miami Herald, April 23, 1989, at 1B, col. 1; Healthy Babies Languish In Hospital, Miami Herald, July 28, 1988, at 1A, col. 1.
50. Mittenthal, supra note 43.
51. Frumkin, Evaluating State Level Integration of Human Services, 7 AD. IN Soc. WORK 13 (1983). Hagebak, supra note 39; Mittenthal, supra note 43, at 146;
cies, with identical or compatible intake forms, computer programs, and reporting formats. The information system must obtain all relevant information from children and families, make that information readily accessible to those who must make evaluations and secure appropriate services, and keep track of the children and families both during and after the time they receive agency services. As noted earlier, the information system is literally the core of the Willie M. program in North Carolina.

2. Measurement of Effectiveness

A coordinated system needs methods of measuring progress or effectiveness. The fact that a system coordinates some services (or operates under an umbrella department, or is administered by a lead agency) does not necessarily mean that the services provided are better or more helpful to children and their families. Indeed, an emphasis on coordination may hide underlying deficiencies in individual components of the system.

Two kinds of measurements are needed. Objective measures may include such statistics as annual counts of child abuse reports, children in foster care placements, admissions to juvenile corrections facilities and mental institutions, school dropouts, and babies born to teenage mothers (all of which should decrease), and figures on new programs developed, hours and types of training available to agency staff, and dollars saved in providing “hard” or “soft” services (all of which should increase).

Subjective measures are also needed, including measures of the quality of services provided within the system, the quality of coordination in the system as a whole, the quality of life for those working in the system, and, most importantly, the quality of life for those receiving the services. These issues are inherently more difficult to assess, since they involve evaluations of complex and multi-faceted processes (like degree of interagency cooperation), reporting by clients and staff of somewhat vague and yet very personal reactions and experiences (like “satisfaction” and “dissatisfaction”), and standards for services (as in child welfare and juvenile justice) upon which there is no universal agreement in the relevant professions.

Nevertheless, while thorny, these problems are not intractable. Our penchant for numbers and outcomes that are readily measurable may give us great ability to compile voluminous reports, but little ability to determine whether we have accomplished anything truly

52. Mittenthal, supra note 43.
53. See NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, CHILD WELFARE LEAGUE OF AMERICA, YOUTH LAW CENTER, NAT’L CENTER FOR YOUTH LAW, MAKING REASONABLE EFFORTS: STEPS FOR KEEPING FAMILIES TOGETHER 82-91 (1997).
worthwhile. 54

3. Planning Mechanism

In addition to the ability to modify the available array of services, a coordinated system needs a mechanism for overall planning. 55 Coordinating services for children and families is a complex process that requires a sustained effort over a long period of time by a wide variety of agencies and groups in the public and private sectors. The system needs a mechanism for continuous planning that extends from the first efforts to bring agencies together on specific projects to the development of coordinated policies and programs. 56

4. Development of Additional Services

The information and evaluation services should be part of a flexible system that develops new services in response to the needs of children and their families. The Willie M. decree, for example, states that if specific services needed by children in the class are not available, the state will undertake to provide those services.

Coordinated systems will often experience a need for new services, as new disasters such as AIDS and crack cocaine impact on children and families at risk, and as new programs and services are developed and implemented in other jurisdictions. One of the hallmarks of an effective system of services is the capacity to provide new services, either by creating them within the public sector or purchasing them from the private sector.

5. Communication Capability

A coordination system should have a communication capability. Cities, counties and states all over the country are interested in coordination and integration of services, particularly for children and families at risk. Despite decades of interest, there are few materials available that are practical, useful and reliable. It is important that those who develop coordinated systems write about their experiences, document their successes, and alert others to their frustrations.

54. See, e.g., Frumkin, supra note 53, at 15 (quoting Austin, Analyzing Services Integration: Issues for Research (paper prepared for the 39th ASPA National Conference on Public Administration, Phoenix, AZ, April 1978)): "He summarizes his findings by concluding that 'the most striking aspect of the review of research and administrative reports on services integration efforts is the lack of significant findings.' We simply are not sure that the performance matches the promise."


56. See, e.g., Ross, Implementing a New Service Model for Children and Youth, 4 CHILD CARE Q. 112 (1975).
6. "Reverse Discrimination" in Funding

Once a system has defined its target population and effectively coordinated services to that population, there may be complaints from those who are not in the target population, particularly those who just barely fail to make the definition. The complaints may be that so many resources are directed toward the target population that other children and families, with their own deep-rooted and serious problems, suffer from service deficits. Thus, while the Willie M. program has been extremely successful for seriously emotionally disturbed youth who are violent or aggressive, there have been concerns that North Carolina has short-changed seriously emotionally disturbed youth who are not violent or aggressive, as well as developmentally disabled youth and children with other mental or emotional handicaps. The irony in this is that, in terms of availability of services, some children may be better off by being more dysfunctional.

There is no easy answer to this problem. Theoretically, state and local budgets should not establish a dictatorship of the zero sum gain, and human services agencies should not have to choose between programs for violent emotionally disturbed children and those for children with developmental disabilities. In practice, of course, that is often what happens. The answer may lie in developing a coalition of agency administrators and children's advocates that can effectively combat the "either/or" funding dichotomy.

Moreover, it is important to put this issue in perspective. In North Carolina, without the Willie M. program, it is doubtful that emotionally disturbed children would have received even a fraction of the resources made available for them over the past nine years. In addition, the Willie M. program has raised the level of public awareness of the problems of all emotionally disturbed children throughout the state.

IV. CONCLUSION

A review of social service systems that work with children and their families clearly demonstrates the need for coordination in the provision of services, both to avoid duplication and to reduce the gaps in availability of services. There have been some successful efforts at coordinating these services, primarily directed by mental health systems. A first step toward improving coordination is to identify characteristics of effective coordination programs. This article is the beginning of an attempt to identify such characteristics.

57. Bernard, supra note 34.