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ABSTRACT

This report examines five models of school-based integrated human service programs to evaluate the effects of the programs in light of the growing support for and implementation of these programs. The study examined the following programs: (1) school-based health clinics in Baltimore (Maryland); (2) Success for All (an elementary school-level program at 35 sites nationwide); (3) the New Jersey School-Based Youth Services Program (human services); (4) the New Beginnings program in San Diego (California) providing health and social services; and (5) the Comer School Development Model based on the model developed by J. Comer. The study sought to document some of the characteristics of programs perceived to be effective and to outline some of the evaluation strategies that might lead toward increased understanding of the impact of these programs on the children and families they serve. The report describes each of the programs in detail. A section on lessons from successful programs lists the following seven components important to success: (1) collaborative planning; (2) ownership by the school; (3) principal's role; (4) case manager; (5) shared resources; (6) gradual phase-in; and (7) training and staff development. A section on evaluation issues notes the need for current data and the high burden of data collection as well as the resistance to evaluation of still developing programs. Included are 16 references. (JB)

CDS

THE JOHNS HOPKINS UNIVERSITY

Models for Integrating Human Services Into the School

Lawrence J. Dolan

Report No. 30

March 1992

CENTER FOR RESEARCH ON EFFECTIVE SCHOOLING FOR DISADVANTAGED STUDENTS

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Center for Research on Effective Schooling for Disadvantaged Students
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The Center

The mission of the Center for Research on Effective Schooling for Disadvantaged Students (CDS) is to significantly improve the education of disadvantaged students at each level of schooling through new knowledge and practices produced by thorough scientific study and evaluation. The Center conducts its research in four program areas: The Early and Elementary Education Program, The Middle Grades and High Schools Program, the Language Minority Program, and the School, Family, and Community Connections Program.

The Early and Elementary Education Program

This program is working to develop, evaluate, and disseminate instructional programs capable of bringing disadvantaged students to high levels of achievement, particularly in the fundamental areas of reading, writing, and mathematics. The goal is to expand the range of effective alternatives which schools may use under Chapter 1 and other compensatory education funding and to study issues of direct relevance to federal, state, and local policy on education of disadvantaged students.

The Middle Grades and High Schools Program

This program is conducting research syntheses, survey analyses, and field studies in middle and high schools. The three types of projects move from basic research to useful practice. Syntheses compile and analyze existing knowledge about effective education of disadvantaged students. Survey analyses identify and describe current programs, practices, and trends in middle and high schools, and allow studies of their effects. Field studies are conducted in collaboration with school staffs to develop and evaluate effective programs and practices.

The Language Minority Program

This program represents a collaborative effort. The University of California at Santa Barbara is focusing on the education of Mexican-American students in California and Texas; studies of dropout among children of recent immigrants are being conducted in San Diego and Miami by Johns Hopkins, and evaluations of learning strategies in schools serving Navajo Indians are being conducted by the University of Northern Arizona. The goal of the program is to identify, develop, and evaluate effective programs for disadvantaged Hispanic, American Indian, Southeast Asian, and other language minority children.

The School, Family, and Community Connections Program

This program is focusing on the key connections between schools and families and between schools and communities to build better educational programs for disadvantaged children and youth. Initial work is seeking to provide a research base concerning the most effective ways for schools to interact with and assist parents of disadvantaged students and interact with the community to produce effective community involvement.

Abstract

Given the growing number of school-based integrated services programs and the level of resources supporting these programs, evaluation of the effects of these programs is becoming critical. This report examines five models of integrated services programs -- school-based health clinics, Success for All, the New Jersey School-Based Youth Services program, the New Beginnings program in San Diego, and the Comer School Development Model -- to document some of the characteristics of programs perceived to be effective and to outline some of the evaluation strategies that might lead toward increased understanding of the impact of these programs on the children and families they serve.

Introduction

Our public schools face many challenges in meeting the learning needs of children coping with factors outside the school which inhibit learning. Schools are under increasing pressure from all levels of government and society to better serve their students. Most of the recent school restructuring efforts have centered on early prevention and a variety of academic intervention strategies that target children who are not meeting achievement standards.

One emerging theme is that schools must be closely tied with other community agencies if they are to have any chance to remove the barriers to learning that result from health, economic, and family support factors. Schools are now stretching the traditional boundaries of their mission, recognizing that many students have multiple needs and that their academic success will require involvement of other agencies and systems. School districts have responded to this need in varied ways with regards to the actual services delivered, the financial arrangements required, and the overall administrative structure needed to support their delivery. The purpose of this report is to describe some of the more promising models of integrated services, to identify characteristics of programs that are effective, to identify some of the concerns that have impeded implementation, and to address some of the difficult issues in designing evaluations of such programs.

A number of recent reports describe the rationale for integration of services, give examples of innovative practices, and provide guidance to schools and agencies hoping to initiate partnerships. Among the most comprehensive have been reports from the Center for Community Education at Rutgers (Robinson & Mastny, 1989), the Committee for Economic Development (1991), the Educational and Human Services Consortium (Melaville & Blank, 1991), and the National Association of State Boards of Education (Levy & Copple, 1989). Each of these reports presents a rationale for schools and human services working together. In general, the foundation for supporting an integrated services model includes the following:

0 Schools are where the children are. Screening procedures, delivery of services, and the continuity of services are enhanced because children are required to be at school for a large percentage of their day. Having a single point of access to services in a non-threatening setting should lead to meeting the needs of more children and families.

0 In Harold Hodgkinson's (1989) terms, schools and human service delivery systems serve the "same client." Not only is there a tremendous overlap in the clients receiving services from multiple agencies, but the problems that are being addressed are frequently the same (Levy & Copple, 1989).

0 Integrating services will reduce fragmentation and duplication. Differing eligibility criteria, treatment goals, and methods can be standardized; and services can be provided in an optimal sequence. Although no systematic evidence yet supports this position, integrated services should be more cost effective. Integrated services should conserve limited financial resources.

0 The indicators of at-risk students -- poverty, teenage parenthood, single parent families, abuse, and poor health -- are all predicted to increase in the future (Natriello, McDill, & Pallas, 1990; National Association of State Boards of Education, 1991). These risk factors are not independent from each other and frequently lead to levels of stress that impede learning. Unless additional efforts are

made to address these factors, readiness for learning will be further hampered.

Thus a mutual benefit should result for both education and human services from integration efforts. Schools need human services if they are to meet their affective and cognitive goals for students, and human services need schools as a means towards improved services, increased access, and as a source of identification of service needs.

Types of integration cover an enormous range. Many agencies have cooperative arrangements to share physical space in or near a school, to use common referral mechanisms, and to share some of the costs of running a service at a school. This is referred to as the co-location of services, which often makes services more convenient for the client but does not include sharing common goals or accountability standards. The integration of services model suggests a unified approach with common goals and a mechanism to share decisions and strategies about children and their families with other service providers. Structured opportunities for decision making, sharing of information, joint planning and follow-up are specifically built into this approach.

The potential relationships between a school and the public mental health system provide an example of the possible configurations. At a basic level of development, a school might have a relationship with a local mental health center to provide services to students and their families referred by the school.

At an intermediate level, the mental health agency might assist the school in identifying students in need of service by training school staff to identify symptoms or even use multi-stage screening tools to assist in the identification process. Mental health clinic staff might participate in diagnostic meetings with school staff, focusing on children having academic difficulty. The clinic might provide or train school staff to integrate prevention oriented curricula into classrooms which target risk factors for later problem outcomes such as depression or substance abuse.

Finally, at an advanced level, clinics might literally set up shop at the school, offering individual and group mental health clinical services as part of a coordinated system of services at the school, including health and social services. These service options might become an integral part of making decisions about students who are in academic or emotional difficulty. From the perspective of the mental health center, this integration permits more efficient use of time, the ability to be in close contact with others involved with the educational life of the child, and a greater level of treatment compliance and continuity of care.

Thus the types of interactions vary widely, from a "find us clients" focus to the agency being a critical part of the school's intervention strategy to assure academic success of all students. One question of interest concerns the limits on the numbers and types of services that might be provided through the school. The mental health agency delivering clinical services to students and potentially to other family members is on the more controversial end of the integrated service continuum. Schools form links with many types of agencies that are not as controversial, including programs such as Head Start, community day care services, school-aged child care, and recreation programs. In the middle of this continuum would be school based health clinics, adult and family literacy programs, and job skills training.

From an educator's perspective, many of the benefits of having services available to students in their schools are apparent. However, given the range of possibilities, some up-front criteria for selecting an appropriate mix of services might help optimize service integration opportunities. One criterion might be that the services would provide a balance of early prevention and crisis response. Another criterion might be to insist that if multiple services are available within the school, the staffs of these services communicate with each other at regular intervals.

Structured opportunities for interaction around the needs of children need to be institutionalized.

Finally, selection of services should be based on evidence that the provision of service will lead to the removal of barriers to children's learning -- to more competent students who are better able to take advantage of the learning experiences provided by the school. These selection criteria would lead to a more limited set of options, but with a much greater chance of successful integration and positive outcomes.

Examples of Model Programs

Given the growing number of school-based integrated human services programs and the level of resources supporting these programs, evaluation of the effects of these programs is becoming critical. We have examined a number of schools that emphasize integrated service in order to begin to document some of the characteristics of programs perceived to be effective and to begin to outline some of the evaluation strategies that might lead towards increased understanding of the impact of these programs on the children and families they serve. Many of these programs are in the Baltimore area. Others are among the most discussed programs on the national scene.

School-Based Health Clinics

One of the most promising partnerships is between schools and health departments joining forces on comprehensive school-based health clinics. The delivery of comprehensive health care services to adolescents has been a primary concern of public health officials for some time. In general, school health clinics have met with varied community response, and the effectiveness of the clinics on issues such as cost efficiency and prevention of major public health concerns, such as teenage pregnancy, remain in question (Dryfoos, 1988; Kirby, Wasak, Ziegler, 1991).

The City of Baltimore Health Department has sponsored clinics in three high schools and three middle schools for six years. The goals of the clinics are to improve access to preventive and primary health care, to reach medically underserved adolescents, and to provide referral mechanisms for further care. The clinics seek to enhance primary prevention and early detection of risk-taking behaviors and increase the health knowledge and decision-making capabilities of adolescents.

The primary care model is delivered through a team consisting of a nurse practitioner, community health nurse, medical office assistant, and a case manager. Many clinics have additional personnel in the areas of mental health and substance abuse counseling, nutrition, and health education.

The Baltimore clinics have maintained enrollment of about half the students in the schools they serve. Membership in the clinics requires parental consent. Of the students served, almost fifty percent have no form of health insurance. During a typical year, close to 30,000 visits are made to the six clinics.

A recent evaluation of the six clinics (Dolan, 1989) addressed a number of issues that relate to the broader integrated services question. One of the main factors was the role of the school staff, particularly the school principal, in clinic activities. Principals' perspectives on the role of family planning activities played an important part in whether family planning activities were given a priority in the clinic. The degree to which health education efforts of the clinics were isolated from or integrated into the school curriculum also depended on the degree to which school staff felt they were part of the planning

for the clinic. In terms of evaluation concerns, the Baltimore clinics had excellent descriptive data on membership and the types of services received, but little outcome data on impact on school-related variables such as attendance, levels of tardy behavior, or school dropout. The following evaluation needs were identified:

> Greater knowledge is needed about the base population of students from which clinic members come from within the school in order to address questions about whether non-members need health services, the role of parent consent in non-membership, duplication of services, and other service utilization. Without such information on the total population, it is difficult to know whether current enrollment rates represent a great concern or a great success.
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> A matched design evaluation is needed to begin to link clinic activity (numbers of visits, types of visits, appointment compliance) with readily available school statistics such as attendance, school dropout, and achievement indices. School administrators believe that one of the most important benefits of a clinic within a school is the impact on school attendance.
>
> Given the significant problems associated with teenage pregnancy, evaluation is needed to examine the consequences of clinic family planning activities on the reduction of risk behaviors that lead to teenage pregnancy. Even though there is significant community sensitivity to this issue, one of the main purposes of the clinics is to provide counseling and clinical services in family and reproductive health.

School-based health clinics are often the first linkage a school makes with outside human services. Once established, they often act as a broker to other services in the community. In Baltimore once the clinics were operational, students coming into the clinic for primary health needs were also discovered to have needs in other areas, such as mental health. The clinics were able to bring mental health professionals into the school to assist in meeting the needs of students with problems of depression, substance abuse, and eating disorders.

Although school-based health clinics have limited documentation as to their effectiveness, they represent an important model for how other community agencies can work within the school environment to meet the health care needs of the community and support the goals of the educational system by removing some of the barriers to school learning.

Success for All

A push for more integrated services in the school often comes about as part of an overall school restructuring effort. The Success for All program attempts to ensure that every student in a high poverty school will succeed in acquiring basic skills in the early grades (Slavin, Madden, Karweit, Dolan, & Wasik, 1992).

The model is currently in place in thirty-five schools around the country. Success is defined as performance in reading, writing, language arts, and mathematics at or near grade level by the third grade, maintenance of this status through the end of elementary grades, and the avoidance of retention and special education. The program incorporates research-based preschool and kindergarten programs, one-to-one tutoring in reading to students (especially first graders) who need it, frequent assessment of progress in reading, and a family support program which includes integrating other human services into the elementary school.

The family support team works in each school to help parents ensure the success of their children in school, focusing on parent education, parent involvement, attendance, and student behavior. The team consists of existing or additional staff such as parent liaisons, social workers, counselors, and staff of other social and health agencies

in the community. Students are primarily referred to the team when they experience continued academic difficulties. In this respect -- focusing on referrals due to poor academic or social progress of children -- the scope of the team may be more limited than in other service integration and family support models. In many sites a full-time social worker provides on-site clinical services and coordinates the activities of the family support team. Most teams meet on a weekly basis. At the meetings, the team not only determines school-wide programs but also develops action plans to meet the needs of students referred because of academic difficulty.

In Success for All schools, the majority of which serve large numbers of disadvantaged students, many students need a range of community services if they are to succeed in school. Family support teams attempt to make linkages for school-based services. These linkages vary from school to school, depending on needs and the resources in the community. For example, many of the family support teams provide community health and mental health services at the school. One Success for All site has a public health nurse practitioner and a part-time pediatrician who provide on-site medical care, while others are connected with a family counseling agency which provides school-based services. Other on-site services include school-aged child care, family literacy and job training programs, and mental health counseling.

Another natural association is with agencies that provide services to families to meet basic needs such as food, clothing, and shelter, or heat. The family support team works with parents to identify needed services and establish a link with local agencies to make community services most accessible.

One school has worked with local agencies to have a food distribution center at the school. Other schools have worked with local agencies to provide a clothes-and-shoe-bank on the premises. Other agencies often lend staff to the school to work on common goals. For example, a Department of Social Services social worker is the attendance monitor at one site and is able to effectively use that system to improve attendance.

The experience with family support activity in Success for All suggests that service integration will vary greatly from school to school. Also, teaming of staff from multiple agencies around students takes time to develop and to overcome some of the historical baggage that has separated agencies, such as treatment philosophies and accountability standards.

Because the family support team is part of a larger school restructuring effort, it is difficult to separate the effects of the family support team activities from the effects of other components of the model. In general, Success for All has led to improvements in attendance and reduction in referrals to special education. The amount of children involved with family support team interventions is estimated to be about twenty percent of the elementary school population.

Parent involvement in each of the sites has increased with each year of the program. Although few outside agencies were involved with the schools in the early stages of the program, their numbers have grown as family support teams become more sophisticated in meeting the needs of the students and their families.

Success for All is one example of a comprehensive system for school change aimed at assuring that every child is succeeding in school that incorporates integrated family support services built around the needs of the children as a key element of the approach.

New Jersey's School-Based Youth Services

Many states are attempting to improve coordination among human services. The State of New Jersey is at the leading edge with its School-Based Youth Services Program (SBYSP, New Jersey Department of Human Services, 1990). In operation since 1988, SBYSP has at least one

demonstration site in each of the state's twenty-nine counties. The program is supported by the Department of Human Services, with host communities required to contribute twenty-five perecent of the total cost of the program.

SBYSP provides health, individual and group mental health services, recreation, and employment services to high schools and vocational schools. The programs are open to all students in the school and include a range of interesting activities, not just crisis response. The lead agency of eleven of the programs is the school district, with the reminder managed by a variety of other providers (hospitals, mental health, and non-profit agencies). All programs are housed in or close to school grounds. The project staff estimate that one in three teenagers within the involved schools are served by the program. The mental health services -- family therapy, individual counseling, and substance abuse counseling -- are the most utilized services in the program.

One aspect of the New Jersey program that is critical to its success is the process of collaboration with the schools. Although some services must be part of each local program, there is no one State-level mandated program. This permits the model to adapt to local needs and concerns and have school staff help plan what the optimal program should look like. School administrators and staffs work directly with the project administrator and staff from the beginning. Project staff include a project manager, an employment specialist, a nurse, a part-time physician, and a human services coordinator. Project staff attend all faculty meetings and participate in school activities. Part of the program is the establishment of in-house teams to share information about programs and students in need of service. The programs start out with a core set of services, but the experience has been that other community agencies join the effort over time. Recently the program has expanded to include some elementary and middle school sites. Other states, such as Iowa and Kentucky, are now implementing comparable programs.

Although the New Jersey program is recognized as exemplary for its program operations and management, it has not yet conducted program evaluation. Good descriptive data of the types of services provided, the risk factors of the users of the services, and the demographic profiles of the students receiving services are available and point to a high utilization rate by the appropriate types of students. Surveys of school staff concerning their reactions to the youth services indicate a positive reception to the services implemented.

However, critical questions remain unanswered about the effectiveness of services, whether the services are going to the most needy students, whether this investment of state funds has been cost effective, or whether the program affects school outcomes such as attendance and dropout.

The "New Beginnings" Program in San Diego

The San Diego School System entered into a partnership with local health and social services departments to plan for a new middle school which opened in mid-1991. The school serves a highly mobile population that has tremendous social service needs.

The San Diego project began with a careful needs assessment process that pinpointed some of the critical needs within the school catchment area (San Diego City Schools, 1991). Agencies shared data on all residents in the catchment area and found that over a third had been involved with three or more agencies, and half were known to the welfare system. The assessment revealed the specific level of services already provided and the amount of fragmented resources flowing into the community. It was discovered that the Department of Social Services was using the equivalent of eight full-time staff in this catchment area.

Based on this level of current involvement, the staffs of the agencies are planning a family center at the school to deal with a variety of family support activities. The intent is not to

place more resources into the community but to coordinate existing services more effectively through the easing of regulations and the use of family service advocates. Part of the model will include extensive cross-training among the agencies on issues of identification and referral. These sessions will include classroom teachers, to better equip them to handle emerging problems and to know at what point to get help from the family center.

All families that have children in the school will receive a family assessment to target health, mental health, and other needs. Management information systems from the different agencies will be coordinated to avoid unnecessary paperwork in establishing eligibility for available services and in tracking which services are received across agencies.

San Diego is planning an extensive evaluation of the model. A high quality evaluation is likely because the planning process has been so deliberate, the level of agency cooperation high, data linkage strategies are in place, and they are beginning in just one school catchment area. The program's data sharing and family registration/assessment process will enable it to address a variety of key evaluation questions usually left unanswered, such as whether the services are being delivered to the right people, what the optimal combinations of services are across agencies, and what the impact is of the services over time.

Comer School Development Program

An increasing number of schools across the country have become involved over the past twenty years with a school change process called the School Development Model (Comer, 1980; Comer, 1988) developed by James Comer, a community oriented psychiatrist committed to expanding the role of schools in dealing with the needs of children, particularly disadvantaged students in urban settings. The School Development Model (SDM) posits that the effectiveness of schools depends on their ability to meet the mental health and social needs of students and their families. Schools need to become less isolated from the communities in which they exist; community participation, particularly from parents, at all levels of school functioning is critical. The process of school change evolves over many years.

A core element in the model is the creation of a school management and governance team which includes the principal, teachers, parents, and other members of the school community. The team deals with issues of school climate, staff development, and program development, and arrives at decisions by consensus.

Other components of SDM include an active parent involvement program, a curriculum that deals with the social competence as well as academic competence of the students, and a team approach to dealing with the mental health concerns of the school -- concerns of the staff and community as well as students. The mental health team should not act as a special education screening committee, and greater consideration should be given to mental health prevention activities than to crisis response activities.

Given the commitment to community involvement in the school coupled with an emphasis on the development of the whole child, SDM schools encourage community services involvement. In the New Haven CT schools -- Comer's original SDM sites -- it would not be unusual to find health services, school-aged day care, members of local mental health clinics sitting in on mental health team meetings, parent education classes at all hours of the day, and close ties with local housing agencies. It would not be unusual to have some school meetings take place in local housing projects.

Because the model encourages local solutions to local problems, the actual configuration of outside agencies involved in the schools will vary from SDM site to SDM site. Most have strong relationships with local mental health and social service agencies.

Despite the number of sites and number of years some sites have been in existence, the SDM schools have not been extensively evaluated.

The few available reports are generally positive regarding academic gains, school adjustment, and school climate (Haynes, 1991). Again, as with many school restructuring models, it would be difficult to separate out the effects of other services being integrated into the school setting.

Also, given the whole child orientation of the model, evaluations should include assessments beyond academic achievement and attendance. Indicators of social competence, staff morale, school climate, school motivation and parent involvement would be more valid in evaluating these programs.

More research on what makes for effective implementation of this model should also be a priority, centering on the training needed to become effective members of the teams, the processes of adoption of the program, the styles of leadership that are necessary to fulfill program goals, and the level of additional resources necessary to implement the model.

The SDM program develops a climate in schools which is open to partners in the community working with the schools to improve the education of children. The collaborative processes and shared decision making strategies developed in the school management and policy team and the mental health team are exactly the processes that would permit productive partnerships with community service providers.

The five models presented above demonstrate the range of school-based integrated services. They were selected from a much wider pool of service integration models from around the country. Some of the models are quite prescriptive, others are more loosely structured. Some are part of a larger school restructuring process, others more focused on specific services. All attempt to broaden the human service safety network that supports the schools in achieving their goals for children.

Communities need to make several decisions in order to successfully link services into educational settings. Among the most critical are:

What is the range of services the school wants? Should the strategy be one of a select focus or a more comprehensive set of service options?

Should the focus be on the child or the family?

Should the criteria for evaluation focus on school-related variables or other indicators of psychological and physical well-being?

Who should control the service delivery -- the separate agencies, the school administrator, or a case manager responsible to multiple agencies?

What is the balance between crisis intervention and prevention services?

Should the services be available to all students or only to students who have specific risk factors?

Should the services supplant the family or support the family to provide the necessary environment for children to learn?

Communities will respond differently to these questions in light of their level of need, available resources, and their views of where the boundaries of the school's mission should extend.

Lessons from Successful Programs

Our examination of school-based service integration models across the country has identified a number of characteristics that distinguish programs that have been well received by key constituents, have lasted over an extended period of time, and have reduced the risk behavior of large numbers of students and their families. Among the most common components are the following:

Collaborative planning. The foundation of any successful service integration is substantial collaborative planning built on mutual respect and trust. All parties must be willing to negotiate on equal terms with the realization that standard operating procedures will be changing. Most programs spend at least a year assessing needs, organizing staff, and working thorough policies and procedures prior to implementation. Community involvement in making decisions about services is critical and representatives of the community need to be active members of the planning team. It is important that the initiator of the collaboration represents a neutral position regarding the agencies involved.

Ownership by the school. The school's administration and staff need to be involved in the decision making about the service integration and feel some sense of ownership. If the introduction of new services is viewed as just one more burden the school must take on, the likelihood of success will be greatly reduced. In this age of site-based management, programs thrust onto schools without significant amounts of participation and negotiation by school representatives will not be well received.

Principal's role. School principals often have to redefine their roles and take on additional responsibilities of coordinating services. Principals need to take the time to become knowledgeable about other human services and be willing to share the responsibilities for children's development. If the administrative obligations of the principal are already too high, additional staff to assist in coordinating services will be necessary.

Case manager. Many programs that involve a comprehensive set of services from multiple agencies succeed because one person is in charge of making sure the bottom line is achieved -- that the child and the family are getting optimal support, starting from referral, to service delivery, and to follow-up. This person is often not aligned with any one agency. Many programs refer to this person as a case manager. The San Diego program refers to them as family advocates. The role requires a wide variety of skills. This person must be knowledgeable of the policies and procedures of the agencies involved, command the respect of the various staffs, and be able to get outside agencies and schools to communicate with each other about children. Successful programs have regular opportunities for representatives to discuss children and programs.

Shared resources. Agencies need to stretch their boundaries. Many of the programs share management information, develop common eligibility procedures, pool financial resources, share staff, and minimize regulations that interfere with collaboration. In some cases, the historical baggage of fighting for turf and limited resources is difficult to overcome.

Gradual phase-in. Given the complexity of service integration, new programs should be phased in over time, beginning with the highest priority services. A first-stage critical mass of services might include health, mental health, and social services. Building a positive foundation, not overburdening schools, and developing positive working relationships among a few services will lead to greater acceptance and less stressful implementation of additional services in subsequent years.

Training and staff development. Extensive training and staff development of all involved parties is necessary for human service agencies and schools to learn about each other. School staff must be trained in identifying students in need of intervention, knowing how to deal with some of the problems within the classroom, and knowing where to turn for more help. One of the fears of placing additional support services into the schools is that teachers may feel less responsible for the needs of children. Any service integration model needs to work with teachers to be the first line of defense for the problems students face. Only when a difficulty occurs in this first level intervention, the classroom, should there be multiple avenues of support available to assist the teacher. The goal is to support, not supplant, the teacher.

Not all efforts to establish an effective integrated services program fare as well as those we have described. Some programs have tried to do too much, too soon, and without the appropriate level of ownership from the schools or the human service agencies. Others have been unable to overcome the turf battles around issues of treatment philosophy, financial accountability, confidentiality, regulations, and leadership roles. Even the most effective case managers find it difficult to coordinate a fragmented array of service options.

Some sites reduce the level of planning and quality of staff when attempting to replicate service integration models that have proved successful elsewhere. Others have found that expected cost efficiencies have not resulted and the political support for the program diminishes. Costs in some cases might increase in light of more children and families receiving services. Establishing an effective integrated services program take time, patience, and hard work.

Evaluation Issues

Program evaluation of school-based integrated services is viewed as a double-edged sword to those involved in development and implementation. Most programs need data on who is being served with what types of services, provided at regular intervals, in order to fine tune the program as it evolves.

Although the burden of data collection is often high and often involves merging data from multiple agencies, most programs find this type of descriptive information to be valuable and worth the investment of resources.

However, summative evaluation of program impact on targeted program and school-related outcomes is resisted -- and premature pressure to evaluate still developing programs is a valid concern. Questions of program impact need to be addressed, but not before the program reaches a stable level of activity. For some programs this could be many years. The evaluation timeline should focus on getting good descriptive data to program staff in the early stages, with a gradual shifting of attention to more outcome-based evaluation in the later stages of program implementation. This is essentially the approach taken by the State of New Jersey to evaluating the School-Based Youth Services Program.

Upfront discussion of the evaluation plan should include representatives from all service providers. Agencies have different approaches and value different types of outcomes. School administrators will want to see attendance and student achievement in the outcome profile, health department staff will want to see information on teenage pregnacy, social services may be more interested in statistics of abuse. At some point a joint plan for evaluation, with agreement on the selection of outcome measures, is necessary.

Because of the complexity of many of the school-based service integration models, the type of evaluation selected is often a qualitative, case-study approach. These evaluations describe the range of services and the numbers of students served, present case studies of students and their families in which the program seemed to have an impact, and balance those with some case studies in which the program was unable to meet the needs of child. This approach, blended into a quantitative presentation of historical trends of attendance, achievement, and special education referrals, effectively presents what the program is accomplishing.

Most program evaluations do not include the use of control groups and random assignment to different treatment conditions. In fact, because the programs are often placed in schools that serve the most at-risk populations (e.g., Success for All and the School Development Model), the most realistic approach to evaluation may be to rely on historical data and community statistics, providing they conform to the school catchment boundaries. Evaluations that attempt to follow individual children over time also confront high rates of mobility, which add to the difficulty of carrying out long-term impact studies.

What is exciting about the approach being initiated in San Diego is not only their ability to know who is served by their program, but also who is not served and whether they need support services. The program's family assessment and registration process permits these questions to be addressed for the first time in an evaluation of integrated human services.

Another reality in evaluating service integration models is difficulty in establishing the causes of measured outcomes. Many programs, such as Success for All and the School Development Model, are embedded in larger reform efforts. For example, if a school's attendance goes up or down, to which factors do we attribute cause? Is it the health clinic? The academic program? The availability of a social service worker to help with chronic attendance problems? It is difficult to tease out the relative effectiveness of different services that are provided.

These evaluation concerns are very significant. Fortunately, most programs make sense at face value to policy makers and to the communities in which they are placed, even without substantial evaluation support. But given the limited and even decreasing resources of our human service delivery systems, these concerns need to be addressed more systematically not only to optimize the potential of school-based services in meeting the needs of students and their families, but also to ensure continued efforts to implement these programs.

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