A central premise of the system-of-care philosophy is that no single agency or

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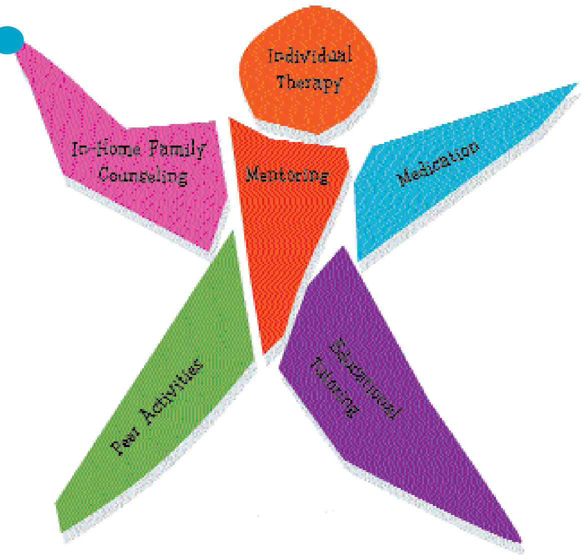
for Students with Emotional and Behavioral Disabilities and Their Families

Jeffrey A. Anderson Brent Matthews



In the Dawn Project, treatment plans are tailored to meet the unique needs of each child and family.

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What systems of care do we have in our schools and communities for students with emotional and behavioral disabilities and their families? This is an important question, because some evidence has shown that systems of care involvement can lead to improved school functioning for students who participate (see Center for Mental Health Services, 1998; see also box, "What Outcomes Can We Expect?"). For example, Rosenblatt and Attkisson (1997) reported academic gains and high levels of attendance for students served in a multisite, system-of-care demonstration project. Few researchers, however, have written about the participation of schools and teachers in care systems.

This article discusses how systems of care use service coordination to create and maintain linkages among schools, families, and social service agencies. It describes how service coordination teams operate and explores the role of teachers on these teams. (Note: We use the term *service coordination* instead of *case management*, which sometimes is considered to have a negative connotation. See Stroul, 1996, for a discussion of the relationship between service coordination and case management.)

Educational Challenges

After the family, schools are the primary stakeholders in the lives of students with emotional and behavioral disabilities (Woodruff et al., 1999). Although educators are concerned with improving educational functioning for all children, students with emotional and behavioral disabilities have continued to struggle in school. As a group, they fail more courses, miss more school, receive lower grades, are retained, and drop out at higher rates than any other disability group (U.S. Department of Education, 1998). They also experience high levels of social difficulties with peers and adults (Friedman et al., 1996). Academically, these students tend to be about a year and a half behind their peers without disabilities in mathematics and reading (Duchnowski & Kutash, 1996), with the disparity increasing over time (e.g., see Anderson, Kutash, & Duchnowski, in press). In sum, students with emotional and behavioral disabilities experience poor outcomes both in and out of school.

Linking Schools and Community Agencies

System-of-care approaches create mechanisms for connecting schools with

From the beginning, leaders from all systems involved must establish memos of understanding that delineate agency and financial responsibility.

What Outcomes Can We Expect from Students with Emotional and Behavioral Disabilities?

Before the passage of the Individuals with Disabilities Education Act (IDEA, Public Law 94-142, 1975, and its 1990 reauthorization, P.L. 101-476), many students with emotional and behavioral disabilities and their families went without needed services, both in school and in the community. The law resulted in increased access to public education and growth in the number and types of social agencies that serve this population of students. Typically, however, these students have not received necessary supports to be successful in school, such as mental health counseling (Knitzer, Steinberg, & Fleisch, 1990). Moreover, although students with emotional and behavioral disabilities often are involved with several child-serving agencies simultaneously (e.g., child welfare, juvenile justice, mental health), these agencies have traditionally worked in isolation from each other. In many communities, this uncoordinated approach has produced a fragmented and overly restrictive system of services for students who have multisystem needs (Illback, 1994).

Consequently, outcomes for students with emotional and behavioral disabilities have continued to be poor (Wagner, 1995). For example, these students have challenging behaviors in a variety of domains that persist over time (Friedman, Kutash, & Duchnowski, 1996). They also have higher rates of unemployment and are more likely than other groups with disabilities to be arrested or placed in separate settings, such as correctional facilities or residential settings (U.S. Department of Education, 1998). In general, research findings have demonstrated that, as a group, these students tend to have the poorest adult adjustment outcomes of any disability group (Kutash & Duchnowski, 1997; Wagner). As Wagner noted, often these students struggle after leaving school before "sinking into unemployment and/or criminal justice system involvement" (p. 105).

In response to such poor outcomes, educators have begun to improve coordination among the agencies that provide services for students with emotional and behavioral disabilities and their families (Anderson, 2000). In 1984, with Congressional funding appropriated, the National Institute of Mental Health initiated the Child and Adolescent Service System Program (CASSP), which was created to promote system of care development. CASSP, which provided grant funding to states and local communities, started an evolution of practical and philosophical perspectives about how best to provide and coordinate services for these students and their families (Stroul & Friedman, 1986). CASSP articulated several important principles that have had an enormous effect on subsequent service provision (Duchnowski & Kutash, 1996; see box, "Core Values for Systems of Care"). A system of services that uses these principles often is called a *system of care* (Friedman, 1996), defined as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families" (Stroul & Friedman, p. 3).

community and social service agencies and are designed to facilitate collaboration among parents, teachers, and other service providers so that services for students with multisystem needs can be coordinated (Woodruff et al., 1999). Several key components of IDEA are congruent with the guiding principles of a system of care (see box, "Core Values for Systems of Care"), including parent participation, individualized educational planning, and placement in the least restrictive environment. In a well-functioning system of care, schools (which traditionally have attempted to implement the principles of the IDEA in isolation) have the support of child- and youth-serving organizations in the community. In these care systems, community-based service providers who work with families to support young people in the home and community become collaborators with teachers, helping to link the home, school, and community. A central premise of the system-of-care philosophy is that no single agency or system can do it alone (Knitzer, 1996).

Service Coordination Teams

When schools identify students for special education and develop plans to meet the needs of these students, a multidisciplinary team is formed. This team develops and monitors an individualized education program (IEP), ideally, in collaboration with the student's parents or caregivers. The IEP becomes a legal document that outlines the student's educational and behavioral goals and objectives and provides a school-based plan for meeting those goals and

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Core Values for Systems of Care

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services, as well as management and decision-making responsibility, resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve (Stroul & Friedman, 1986, p. 18).

objectives. Although the IEP is focused primarily on concerns related to a student's educational needs, system-of-care approaches are designed for students who have serious and complex needs that extend beyond the capacity of school or any single organization (Anderson, 2000).

All care systems use some form of service coordination, which Stroul (1996) described as connecting the variety of systems, agencies, and individuals, including the family, that participate in the care of a child and ensuring effective, ongoing communication among everyone involved so that services and interventions are consistent and directed toward common goals. Often, this process is managed by a service coordinator whose role is to convene and guide a multiagency service coordination team (e.g., see Indiana Behavioral Health Choices, 1999). Although similar to multidisciplinary IEP teams, service coordination teams are responsible for organizing and managing *all* services a child is receiving (Friesen & Poertner, 1995).

Teams meet regularly and work together to build on strengths in order to overcome challenges and meet needs.

Team Composition

Service coordination teams tend to be made up of five or more people who will be involved with the student and family on a continuous basis. Membership is fairly stable over time: parent(s) or caregiver(s), student (when appropriate), the service coordinator, teacher(s), service providers, and other family or community members. Additional team members may include a probation officer; a child welfare case worker; and other providers, such as therapists or counselors. All members of the primary team should have, or will develop, ongoing relationships with the student and family and attend all team meetings. The team may occasionally include additional family members, neighbors, and others who work intermittently with the family (e.g., school principal). Depending on the family's network, team composition may vary; however, at a minimum, teams include family members and the people who support them.

Service coordination plans *support*, not *blame*, parents.

Team Functioning

Typically, service coordination teams will develop and implement a multisystem service coordination plan. Although this plan does not replace the IEP, it can be thought of as a comprehensive IEP that encompasses multiple domains, including home, school, and community (e.g., see Eber, Nelson, & Miles, 1997). Development of the service coordination plan begins when the service coordinator convenes the team to discuss and document the strengths, concerns, and needs of a student and family (see Indiana Behavioral Health Choices, 1999). Team members use strengths-based assessment to identify the skills, resources, and abilities of the child and the family (Stroul, 1996). This approach recognizes that all children, families, and environments possess strengths and assets that can be used to overcome challenges and meet needs. According to Rapp (1998), "The strengths assessment process does produce the information needed to develop effective interventions" (p. 94). Again, this is similar to the purpose of an IEP team, except that service coordination teams are concerned with student functioning both in and out of school.

Whenever possible, the team supports families as most able to achieve success and independence in their own homes and communities. This is comparable to the least restrictive environment requirement of IDEA, and differs from philosophical perspectives that blame families and communities for students' problems. A fundamental principle for service coordination teams is that a family member will be present at every team meeting. Thus, teams must remove any barriers that prevent family involvement at meetings, including transportation needs, time and work conflicts, and childcare needs. Unlike IEP teams, which typically meet annually, service coordination teams meet much more frequently—at least monthly and at other times as necessary for consultation or problem-solving. Within the confidentiality of the team, members share information honestly and openly about both successes and weak-

A system of care is a comprehensive array of mental health and other services, organized into a coordinated network.

An Example of a System of Care

What is the Dawn Project? Dawn is a system of care in Marion County, Indiana, that is responsible for providing a coordinated, community-based network of services for children and youth with multisystem needs and their families. Dawn serves children who (a) are a resident of Marion County, Indiana; (b) are between 5 and 17 years old; (c) have a DSM-IV diagnosis or special education label; (d) have functional impairments in at least two of the following domains: social, family, community, school; (e) are involved with two or more of the following systems: mental health, child welfare, juvenile justice, special education; and (f) are at risk for or already in residential placement. The Dawn Project is funded by special education, child welfare, juvenile court, and mental health, and is administered through a contract with a nonprofit care management organization. Dawn adheres to the system-of-care principles (see box, "Core Values") and uses a managed-care approach to contain costs, maintaining a rate of $4,130 per month for each child in the Project (Anderson, 2000).

Why was the Dawn Project started? The impetus behind the creation of the Dawn Project was the recognition by community leaders that increasing numbers of children with serious emotional and behavioral needs were being placed out of the home, including out of the county and out of the state. Moreover, key stakeholders from education, child welfare, and mental health acknowledged that each system had separate funding streams and administrative structures, which created gaps and overlap in how services were provided and made it extremely difficult for agencies to coordinate activities (see Indiana Division of Mental Health, 1999, for more information about the creation of the Dawn Project).

What is the goal of the Dawn Project? In addition to improving functioning for children and families who participate, Dawn strives to increase the use of community-based supports and decrease reliance on restrictive types of services, such as residential placements. At enrollment, a service coordinator brings together family members; providers from each agency involved with a particular child; and other people who provide natural supports to the family, such as relatives or neighbors. Together, the team develops, implements, and monitors a multiagency service coordination plan. Teams also use or create nontraditional types of services when needed, to ensure the success of the child and family (Matthews & Leffler, 2000).

One widely used nontraditional support in Dawn are educational and community mentors. Mentors provide flexibility, working with the child in a variety of settings, instead of providing a specific service, such as counseling. For example, mentors may focus on helping a child develop appropriate social skills in school or making and maintaining friendships in the neighborhood. Mentors also can help a child develop good study habits or work to build positive relationships between parents and school personnel. Both parents and teachers have reported how helpful this flexibility is for helping children get along better in the home, school, and community.

nesses of various aspects of the service coordination plan so they can update or modify it as necessary (Friesen & Poertner, 1995). When team members differ in their opinions, the team actively works to find resolution (Indiana Behavioral Health Choices, 1999).

Service coordination teams should address the financial aspects of implementing a service coordination plan. A fear among some educators is that something agreed to in a team meeting would, in turn, require a financial commitment by the school district. However, financial obligations related to the plan are not the responsibility of the school, unless this is something that has been decided and explicitly agreed to during a service coordination team meeting. In such situations, a district-level special education director, or representative with the authority to make such decisions, should be involved in the process. From the beginning, leaders from all systems involved must establish memos of understanding that delineate agency and financial responsibility—who is responsible and who pays (see Epstein et al., 1993, for a discussion about the process of developing a community-based system of care).

Participation of Teachers

Service coordination teams are incomplete without the involvement of teachers. Because, traditionally, classroom teachers learn to work alone, their initial involvement on a service coordination team may seem overwhelming to them. The challenges of having another meeting and having to collaborate with people who have different perspectives can seem like a burden. But teachers soon discover the many benefits of participating on a well-functioning service coordination team.

Primarily, teachers find that they are not alone in trying to help a student with multiple challenges achieve success. Team participation also provides teachers with opportunities to understand the student from a variety of perspectives and allows teachers to better connect with the family and community. For example, if the student is a struggling reader, the team could develop a plan to work on reading in nonschool environments, such as arranging for the after-school program to include some computer-based reading instruction interspersed with typical leisure activities. While reading would continue to be a goal area on the student's IEP, it also could be included in the service coordination plan.

As appropriate, the service coordination plan can incorporate and extend the goals of the IEP to include out-of-school environments. For challenging behaviors, the service coordination team could broaden a student's school behavioral support plan to include the community and home. Likewise, the teacher might work with the team to explore why something working outside of school is not working in the classroom. For example, the team could

Mentoring, which pairs a student with an adult, is a popular type of service in the Dawn Project.

examine why a student who gets along well with peers during cooperative activities at the Boys' and Girls' Club is not performing well in small-group classroom activities. Although participation on a service coordination team may require several additional hours each month for meetings and collateral activities, the additional time, in turn, provides teachers with additional problem-solving partners (see box, "An Example of a System of Care", p. 37).

Final Thoughts

As Rosenblatt and Rosenblatt (1999) pointed out, "Success in school provides the foundation for a productive future for children and adolescents" (p. 21). System-of-care approaches facilitate cross-systems collaboration, resource sharing, and working with students and families from a strengths perspective. By learning more about the multiple environments of a student's life, professionals gain a more holistic view and understanding of needs and strengths. Moreover, when working collaboratively across systems, teachers find they have many willing "co-educators" who are striving for the same goal—success for students who often have had a long history of failure.

> **"Success in school provides the foundation for a productive future for children and adolescents."**

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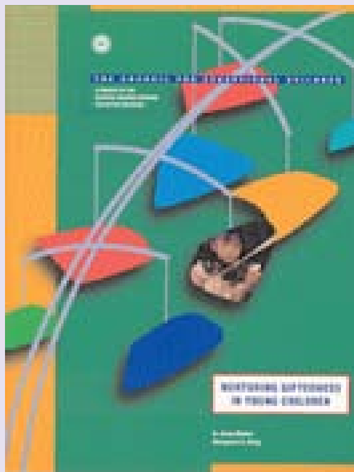

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