

Poverty and the Crisis in Children's Services: The Need for Services Integration

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Examined the integrated services paradigm within children's services, which holds much promise as a means to create more comprehensive and coordinated systems of care for children and families living in poverty. I reviewed the development of integrated service approaches and delineated common elements of models and programs that have emerged across the nation. Implications for the practice of professional child psychology are discussed, including professional practice, training, leadership, and research considerations.

Poverty is a pervasive, complex, and refractory problem for a growing number of children and families in society, precipitating a crisis in children's services (National Commission on Children [NCC], 1991). Even a cursory review of relevant data provides clues regarding the proportions of this emerging crisis. For example, presently in the United States, approximately 14% of children and youth (numbering 14,341,000) live in conditions of poverty (Children's Defense Fund, 1992). For children younger than 6, the magnitude of the problem is even greater, with nearly 25% of children living in poverty. About 5 million youngsters live in severe poverty, with family incomes less than half the federal poverty level (NCC, 1991). Poverty cuts across racial, ethnic, and family boundaries, but it is far more prevalent for African-American (44%) and Hispanic children (36%; U.S. Department of Commerce, 1990). In 1991, the poverty rate in female-headed, single-parent families was 55%, more than five times that of married-couple families. Each year, an estimated 10,000 children die from poverty's effects, and the infant mortality rate in this country is higher than 19 other nations (NCC, 1991).

The crisis in children's services now being felt across the entire spectrum of child services (e.g., health care,

education, mental health, and social services) is, to a significant degree, associated with (and complicated by) the crushing influence of poverty. Nearly 1 million infants are born each year without prenatal care, 250,000 babies have a low birth weight, and the epidemic of substance abuse among pregnant women may affect up to 375,000 newborns per year. Less than 50% of young children in urban areas are fully immunized, resulting in a resurgence of preventable childhood diseases. As many as 35% of kindergarten children come to school unprepared for formal education (Children's Defense Fund, 1992). There are currently 2.7 million reports of child abuse and neglect each year. Between 10% and 12% of children younger than 18 suffer from a mental disorder, and nearly 50% are estimated to have serious emotional disturbances (Costello, 1986). Less than 50% get the help they need (Saxe, Cross, Silverman, Batchelor, & Dougherty, 1987). In 1991, nearly 429,000 children were in foster homes, group homes, or institutional settings, which is up from 270,000 in the early 1980s (NCC, 1991).

Moreover, it appears that disparities between the affluent and people who are economically disadvantaged are widening, further complicating service provision (NCC, 1991). The median income of young families with children dropped 32% between 1973 and 1990. Low-income working families experienced a 25% decline in the availability of health insurance from 1977 through 1987. About 40% of Caucasian babies and 90% of African-American babies of teenage mothers are born into single-parent families. (For an excellent analysis of the changing needs and circumstances of children and families, see the recent report of the NCC, 1991.)

The profound effects of poverty on the psychological development and mental health of children are well documented. Persons living in poverty are less able to

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procure adequate housing, health care, educational services, and related social services, and they have been shown to have fewer social and community support systems (Singer & Irvin, 1989). Economic disadvantage also has been associated with health problems (Gortmaker, Walker, Weitzman, & Sobol, 1990), mental retardation (Birch, Richardson, Baird, Horobin, & Illsley, 1970), severe parental stress (Dumas & Wahler, 1983), and mental illness (Belle, 1990),

Given these immense problems, the provision of appropriate and effective services is a daunting challenge for systems of care that serve children and families living in poverty. Despite a proliferation of social, educational, mental health, and other federal, state, local, and private initiatives in the past 3 decades (e.g., Head Start, Medicare, Medicaid, maternal and child health, and nutrition programs), poverty and its sequelae continue to frustrate and impede the efforts of agencies and organizations responsible to serve these persons. Some of these difficulties are attributable to the lack of financial and programmatic resources to meet essential child and family needs (e.g., health care, food, and clothing). However, the "patchwork quilt" of health and human services available in most communities has complicated efforts to respond to needs in a thoughtful and integrative manner. The present child service system tends to be fragmented, inaccessible, duplicative, and ineffective (Saxe, Cross, & Silverman, 1988; Tuma, 1989).

The integrated services movement within children's services holds much promise as a means to create more comprehensive and coordinated systems of care for children and families living in poverty. This article reviews the development of integrated service approaches and delineates common elements of models and programs that have emerged across the nation. Implications for child psychology—to include practice, training, leadership, and research considerations—are discussed.

Evolution of the Integrated Services Concept

The growth of children's services can be traced to events beginning before the turn of the century (1880 to 1914), a time of progressive social reform in response to concern about emerging social problems related to industrialization and urbanization (Levine & Levine, 1992). Child-serving organizations have since undergone numerous transformations, most recently in the 1960s, as a function of dramatic concern for such problems as poverty, child abuse, teen pregnancy, decreases in school achievement, learning disabilities, violence, and mental illness. Consequently, social programs targeted toward children and families prolifer-

ated, as exemplified by legislation such as the Community Mental Health Centers Act (Public Law [PL] 99-660, 1970), Title I of the Elementary and Secondary Education Act (1965), the Child Abuse Prevention and Treatment Act (PL 93-247, 1974), and the Education for All Handicapped Children Act (PL 94-142, 1975).

In contrast with earlier program models, the implementation of this array of entitlement programs gave rise to highly specialized, categorical programs targeted toward narrowly defined subgroups, particularly persons who were oppressed, disabled, disadvantaged, or poverty stricken (Attkisson & Brokowski, 1978). Regulatory and funding frameworks were tied to specified eligibility criteria for each of these groups, resulting in a patchwork quilt of programs and approaches at local, regional, and state levels. Unfortunately, these large-scale social programs were often ineffective or exacerbated social problems (e.g., by creating dependency and disempowering families), and questions arose regarding the wisdom of compartmentalizing human services in this manner (Hobbs, 1975).

The emergence of systemic perspectives led to recognition that problems in living experienced by children and families were interconnected and, therefore, required an integrated response (Apter, 1982; Hobbs, 1975). Moreover, it became apparent that there was much duplication of effort across the various service systems; at times, efforts were working at cross purposes (Apter, 1982). Problems of overlapping personnel responsibilities, maldistribution of human and financial resources, ineffective practices, and evaluation findings of nonsignificance called into question the continued expansion of government-mandated entitlement programs and argued for more integrated, accountable approaches (Attkisson & Brokowski, 1978).

As early as 1968, March proposed the neighborhood-center concept, emphasizing comprehensiveness, decentralization, co-location of service components, blending resources from different programs, and the operational integration of services. The integrated services movement took root in the 1970s, when then-Secretary of Health, Education, and Welfare Elliott Richardson became interested in the concept and began to promote it within the federal bureaucracy. Early initiatives included the provision of primary health care through neighborhood health center demonstration projects (Institute of Medicine, 1982) and alternative service delivery models for special and remedial education (e.g., ungraded primaries, collaborative teaching, and curriculum-based assessment) to reduce instructional fragmentation and segregation associated with special programs (Graden, Zins, & Curtis, 1988).

Renewed interest in service integration and system restructuring continues to be fueled in part by concern

for the immense cost and bureaucracy of entitlement programs (particularly in the health care arena), as well as a desire for increased accountability regarding treatment effectiveness (Kiesler, 1992). Further impetus for integrated services derives from the family support and education movement (Zigler & Black, 1989). Dunst, Trivette, Starnes, Hamby, and Gordon (1993) defined *family support* as efforts that aim to "enable and empower people by enhancing and promoting individual and family capabilities that support and strengthen family functioning" (p. 4). Central tenets of the movement, as outlined by Weissbourd and Kagan (1989), include (a) treating adults as capable and competent; (b) building on family strengths, rather than "treating" dysfunction; (c) promoting health and competency; (d) treating families as partners and active participants in program development; (e) using a broad definition of *support*, in relation to needs as perceived and experienced by families; and (f) seeking family independence and interdependence with their community.

The foci of family support programs include developing needs-based resources, facilitating self-help and social support networking, providing useful information on child development and parenting practices, intervening early, and developing community resources (Dunst et al., 1993). Many state and federal programs have adopted policies and practices that are based on family support conceptions (Roberts & Magrab, 1991), and family-centered language has become common across a range of health and human service areas, including education (e.g., preschool handicapped programs), health care (e.g., maternal and child health programs), child welfare (e.g., family preservation programs), and mental health/mental retardation (e.g., respite programs; Dunst et al., 1993).

Essential Aspects of Integrated Services

Although there may be agreement that the current service system for children and families is often fragmented, uncoordinated, and inadequate, there is not consensus regarding the features of a more comprehensive, coordinated, and effective system. Substantial literature has been generated to describe features thought to be indicative of a more responsive system, and these features reflect the values and perspectives of various individuals, families, professionals, and organizations (Edelman & Radin, 1991; Knitzer, 1982; Melaville & Blank, 1991; National Commission on Children, 1991; National Commission on Child Welfare and Family Preservation, 1990; Schorr & Schorr, 1988). The following section distills common elements of the integrated services concept.

Features of an Integrated Service System

The efficacy of services to children and families can be viewed usefully from the perspective of the families themselves. When examined in this manner (family centered vs. system centered), emphasis is placed on actual service delivery episodes and the impact these have on children and families. When children and families participate in programs that are well-integrated, services (a) are available in close proximity and are accessible without reference to physical, psychological, social, or other barriers; (b) are comprehensive and appropriate, in that they possess features that address priority needs the family has identified, at a level of service sufficient to their need; (c) are formulated and delivered at a high level of quality, such that the family perceives them as an organized whole and can participate in a consistent and effective manner; (d) promote psychological competence and self-sufficiency rather than focusing exclusively on dysfunction and pathology; (e) are oriented toward the full participation and empowerment of family members, such that they attribute change in part to their own efforts; (f) are sensitive to cultural, sex, and racial issues; (g) are driven by concern for the needs and desires of the consumers (i.e., children and families) and emphasize explicit outcomes stated in a positive manner; and, (h) stress prevention and early intervention.

In an *uncoordinated* system, individual providers and/or agencies share some aspects of their work with each other, but they essentially maintain their own sets of goals, expectations, and responsibilities in providing services to children and families. By contrast, the hallmark of an *integrated* approach involves individual providers, agencies, and families developing intervention plans, pooling resources, sharing responsibility for plan implementation, and collaborating on outcome assessment in a collaborative fashion. The greater the number of providers involved (e.g., psychologists, nurses, teachers, social workers, physicians, and day care workers), the greater the need for such collaboration. At a minimum, this may take the form of different providers (from independent agencies) communicating regularly by phone regarding a child or family. Or it may involve regular face-to-face meetings and case conferences among providers. In an ideal situation, providers and family members would work as an integrated team to design and implement needed services through approaches such as neighborhood centers, family resource centers, school-linked services, health care prevention programs, or any number of similar innovative programs and practices.

An integrated delivery system also allows for both ease of entry and flexibility of movement within and between systems of care. For example, if the point of

initial contact for a family is a school setting, there would be clear connections between the school and the array of community services that the family needs, regardless of categorical restrictions or setting. This requires that individual providers and agencies see themselves as part of a larger ecology that is community wide and geared to aiding the overall climate within which children grow and develop. In this context, the specific agency through which a family seeks service becomes less important, in light of increased responsibility on the part of all agencies to consider child and family needs in a comprehensive manner.

Relatedly, the integrated service system would be organized for broad-based accountability, to benefit primarily the child and family but also the community within which the child lives, rather than only the funding entity (e.g., third-party payor). In this conception, service providers are motivated by a consumer orientation (similar to other businesses), with children and families seen as customers with whom one must collaborate (and satisfy), rather than as patients or adversaries. A well-developed, integrated service system would be more closely tied to neighborhood and community life, demonstrating concern for the quality of life in communities through community presence, resource development, advocacy, and community service and, in the process, seeking to enhance the sense of community experienced by children and families (Sarason, 1974).

For coordinated and collaborative service delivery to succeed, funding should be both flexible and shared (when possible) among agencies, such that different agencies are encouraged to develop jointly programs that serve children and families holistically (rather than to compete for funds). Funding and program decisions about how pooled or flexible funds are to be utilized are made from the bottom up by empowered frontline providers who have ongoing contact and communication with consumers (children and families).

Planning for Organizational Change

In restructuring child service organizations to achieve services integration, a number of themes and issues are likely to emerge, including the following: (a) decategorization of programs and services, (b) uniformity of eligibility standards, (c) interprofessional collaboration across levels and systems within the organization, (d) promoting innovation and flexibility, (e) focusing more on prevention and early intervention (as opposed to crisis intervention and remediation), (f) attending to the needs of consumers of services, and (g) facilitating professional development and effective working conditions (Illback & Zins, 1993). To accomplish these goals, a planned change approach is necessary.

Organizational change efforts are challenging to conceptualize and implement. Often, such efforts meet with resistance as the child service organization struggles to maintain homeostasis, leading to failure and frustration. Change initiatives have been shown to fail due to insufficient information about problems, inadequate organizational diagnosis, inattention to organizational readiness for change, simplistic intervention strategies and procedures, and lack of follow-up (Fullan, Miles, & Taylor, 1980).

Although it is not within the scope of this article to explicate the process of changing child service organizations, certain principles of organizational change are summarized: (a) Child service organizations are continually changing and evolving in response to both internal and external factors, implying the need to perceive and utilize accurately this ongoing process in the change effort; (b) change efforts that apply multiple methods and strategies (e.g., training and restructuring) are more likely to result in durable change than are approaches that are unidimensional (e.g., brief training alone); (c) successful change efforts involve balancing and controlling a large number of mediating variables involving people, procedures, and processes; (d) successful change efforts in child service organizations are dependent on timely, accurate, and continuous information about organizational functioning; (e) some child service organizations are more ready for change than others, and it may be appropriate to defer the change initiative until the organization can be made more hospitable to the intervention; (f) organizational change efforts may lead to unintended effects due to the interdependency of the organization's elements; (g) meaningful change is most likely to occur when people within the child service organization achieve a sense of "ownership" of the organizational change effort; and (h) an overriding goal of planned organizational change is the facilitation of self-evaluation and self-renewal processes that become a part of the routine of a more functional organization. (For a more thorough discussion of organizational assessment and intervention in child-serving organizations, see Illback & Zins, 1993).

Some Exemplary Programs

Considerable efforts are already underway across the country (many led by psychologists) to implement the services integration paradigm in child-serving organizations. Often, these initiatives originate within a particular service system, but they share an orientation toward family-centered, community-based, and collaborative intervention. All of the exemplary programs described next are targeted toward persons living in poverty (or serve substantial numbers of economically disadvantaged persons).

Family preservation services. Child welfare, juvenile justice, and mental health funds, in addition to private foundation monies (particularly from the Edna McConnell Clark and Annie E. Casey Foundations), are being used to support family preservation projects in numerous states and localities. Modeled after the much-replicated Homebuilders, Inc. program (Kinney, Madsen, Fleming, & Haapala, 1977), concentrated in-home and community-based services are provided by trained workers with small caseloads (as low as two) who are given programmatic flexibility and control of financial resources to meet family needs within a relatively brief time period (4 to 6 weeks). A range of cognitive, environmental, and interpersonal strategies are incorporated into these interventions, which are typically based on social-learning theory, crisis prevention and intervention strategies, and ecological perspectives on child development. The most prominent of these service integration projects have occurred in California, Iowa, Michigan, Minnesota, New Jersey, New York, Utah, and Washington. Target populations include neglected and abused children (Nelson, 1991), seriously emotionally disturbed youth (Hinckley & Ellis, 1985), and serious juvenile offenders (Haapala & Kinney, 1988; Henggeler, Melton, & Smith, 1992).

Despite problems inherent in evaluating community-based programs—including small samples, establishing viable contrast conditions, delineating demographic and program implementation variables, limitations of available instrumentation and choices of outcome measures, controlling for statistical regression effects, and inappropriate statistical analysis (Feldman, 1991; Rossi, 1992)—some important evaluative efforts have emerged. For example, in Washington, intensive family preservation services are used system wide to prevent out-of-home placement (e.g., residential treatment and foster care). A program evaluation examined 1,506 child clients (representing 1,112 families) and found that 16.9% were in out-of-home placements 12 months following intake, which was seen as favorable compared to baseline rates (Bath, Richey, & Haapala, 1992). Predictors associated with placement included child age (infants and adolescents), family income, and parental mental health. Pecora, Fraser, and Haapala (1991) reported on emerging data from a multisite evaluation (also in Washington) wherein data from a subsample of participating families were compared with those not accepted and served in a more traditional manner. Eighty-five percent of the comparison-group children were placed, whereas only 44% of the treatment-group children were out of their homes 12 months after treatment had been terminated.

In a more controlled investigation, children and families who were judged to be at imminent risk for out-of-home placement in Hennepin County, Minnesota were randomly assigned to family preservation ($n = 58$) or traditional service ($n = 58$) conditions, and they were

followed for 12 to 16 months (Schwartz, AuClaire, & Harris, 1991). Similar to the Washington evaluation studies, at long-term follow-up, 56% of the treatment group were placed, in contrast with 91% of the comparison group. Earlier work by these same investigators (AuClaire & Schwartz, 1986) found these two groups did not differ in the frequency of placement episodes per child during the study period, but rather they differed in the duration of placement, implying that family preservation tends not only to reduce overall placement rates but also length of time required in out-of-home placements.

These encouraging findings are tempered by Feldman's (1991) evaluation studies of five New Jersey family preservation programs. Ninety-six treatment (intensive family preservation) families were compared with 87 control (traditional community services) families. Follow-up at 9 months from termination of treatment suggested differences between treatment and control groups on out-of-home placement rates, these results dissipated by 12 months. It appears that the most significant program effects occur during and immediately following the program, but maintenance and generalization of program effects remains problematic.

Much work remains to understand relations among demographic, process, and outcome assessments in family preservation programming. Recently, Bath and Haapala (1993) studied 530 families (854 children) referred to child protective services for maltreatment. They learned that differences between neglectful and abusive families were predictive of placement, the former group having twice as high a probability of placement. Neglectful families were more prone to be poor, headed by a single parent, and have medical/mental health/substance abuse problems. The highest placement rates were seen in families referred for both abuse and neglect. Another evaluation of family preservation services with 10,191 families of status offenders in Florida (Nugent, Carpenter, & Parks, 1993) found three demographic (age, school status, and primary presenting problem), two history (involvement with dependency and delinquency systems), and three service (type of service, number of family sessions, and completion of treatment program) variables predicted positive outcomes in family preservation. (For a more in-depth review of evaluation research issues in family preservation, see Rossi, 1992; Wells & Biegel, 1991; and Yuan & Rivest, 1990.)

Systems of care in child mental health. The Child and Adolescent Service System Program initiative within the National Institute of Mental Health, begun in 1984, promotes systems change in mental health services for children with severe emotional disabilities (SEDs) by encouraging states to provide more comprehensive and coordinated services (Day & Roberts, 1991). A range of regional and statewide systems of

care (service integration) initiatives are underway (many supported by the Robert Wood Johnson Foundation Mental Health Services for Youth Program), emphasizing the following: (a) the development of a full array of community-based services, (b) less restrictive child placement and prevention of out-of-home placement, (c) interagency collaboration in service planning and coordination, (d) flexible and individualized services, and (e) cost containment and efficiency (Stroul, Goldman, Lourie, Katz-Leavy, & Zeigler-Dendy, 1992). States such as California, Georgia, Kentucky, Oregon, North Carolina, Vermont, and Virginia and localities such as Cleveland, San Francisco, and Ventura County (CA) feature such efforts.

Initially funded through a Robert Wood Johnson Foundation planning grant in one region of the state (Lexington and vicinity), Kentucky's Interagency Mobilization for Progress in Adolescent and Children's Treatment (IMPACT) program represents a comprehensive, statewide restructuring of the system of care for children and adolescents with SEDs (Kentucky Cabinet for Human Resources, 1990). The program emphasizes collaboration among social service, education, mental health, and juvenile justice systems through state, regional, and local interagency councils, in addition to extensive case management, parent involvement, and flexible funding (Illback, 1993a). In Ventura County, the Children's Mental Health Initiative, funded by the California legislature, uses collaborative interagency planning to fill gaps in the prevailing service delivery array and develop some new services (Jordan & Hernandez, 1990). A longitudinal project in Fort Bragg (NC) seeks to demonstrate that coordination across the continuum of services and increased utilization of community-based alternatives can impact costs and treatment effectiveness, thereby making services available to more children and families (Heflinger et al., 1991).

Emerging evaluative information has begun to document program efficacy of these system of care initiatives. For example, the Fort Bragg demonstration project found that children in comparison sites were five times more likely to be placed in inpatient or residential settings than those served within the community-based system of care, which experienced an overall reduction from 7% to less than 1.5% of the rate of clients served in hospital or residential settings within 2 years (Bickman, 1993). Overall psychiatric hospitalization admission rates and duration of stay have been reduced in numerous localities as a function of increased community services (Behar, 1992; Georgia Division of Mental Health, Mental Retardation, & Substance Abuse, 1992; Rosenblatt & Attkisson, 1992). Vermont's New Directions program reported a 20% increase in children living at home (Vermont Department of Mental Health & Mental Retardation,

1993). Kentucky's IMPACT program demonstrated an overall decrease in the number of child placements, as compared with placement histories prior to involvement (Illback, 1993a).

In addition to positive findings regarding placement, these programs have also begun to demonstrate change in child and family functioning and family satisfaction with services. One-year follow-ups within Kentucky's IMPACT program (Illback, 1993a) and a Tennessee project (Glisson, 1992), for example, documented substantial gains in behavioral functioning on the Child Behavior Checklist (Achenbach, 1991), as compared to intake and control sites, respectively. Kentucky's IMPACT program families report that they perceive more dense and more helpful support networks, particularly in regard to the use of services such as service coordination, respite, in-home workers, and paraprofessionals (Illback, 1993a). Family satisfaction with services also has been shown to improve, as evidenced by Fort Bragg data showing program parents to be more satisfied and confident about treatment efficacy than controls (Behar, 1992). Improved youth satisfaction with services is seen in Vermont (Burchard et al., 1993), with similar findings for provider satisfaction in Virginia (Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, 1992).

The relative cost-efficiency of these system of care interventions is dramatically shown in the Fort Bragg community mental health project, in which the total average cost per client is 51% lower for program participants (\$5,380) than in comparison sites (\$10,922; Behar, 1992). An analysis of estimated costs of service settings in relation to placement data reveals a substantial reduction (from \$16,987 to \$12,722) in the average annual cost of serving children with SEDs in Kentucky relative to the year prior to program involvement, most of which is attributable to reduced hospitalization (Illback, 1993a).

Family Support and Education Programs

Family support programs are generally aimed at increasing parental competence and ameliorating stress, presuming that healthy family systems will produce children who function higher cognitively, are less at risk for learning and behavior problems, and are more likely to become healthy and productive citizens. Thus, Iowa's Family Development and Self-Sufficiency Program aims to help high-risk Aid to Families With Dependent Children families through support and education activities that include long-term employment services, a preschool program for at-risk children, targeted Medicaid benefits, and transitional child care for those leaving the program. Hawaii sponsors a multidisciplinary Family Support Systems' Healthy Start Home

Visiting Service that provides screening, crisis intervention, parent training, respite care, male home visitors for fathers, and toy-lending libraries (National Commission on Child Welfare and Family Preservation, 1990).

There have been relatively few controlled investigations of community-based family support programs due to conceptual, practical, and methodological difficulties (Weiss & Jacobs, 1988). For instance, although the logical model for a particular program may suggest that providing social support to families will have an impact on a range of social indicators (e.g., substance abuse, dropout rates, behavior problems, and child maltreatment), establishing a direct, causal relation between the provision of such services and these presumed outcomes is almost impossible.

The inability to formulate and test a clear experimental hypothesis is especially problematic in that these programs are often "sold" to funding sources based on the expectation that they will directly impact certain high-profile indicators. In all probability, family support and education programs will not result in unidimensional change, but rather they should be viewed from a multidimensional perspective. Thus, there is a need to more closely link broad program goals with program design and evaluation, thereby broadening the outcome variables assessed. In this context, Dunst, Trivette, and Thompson (1990) suggested that systematic investigations of family support programs move from documenting the prevention of poor outcomes (absence of problems) to focusing on more positive, demonstrable, and broad-based measures (e.g., strengthening of family functioning and mobilization of resources).

Despite these inherent limitations, evaluation research advocates family support and education programs. Differences between families seeking help from family support programs and a general sample were documented in an evaluation study by Telleen (1990), who compared 79 help-seeking mothers (within a family support initiative) to 56 mothers with similar-age children. The former group reported significantly greater child behavior stresses and were more likely to attribute these to their own limitations. Notably, they did not perceive themselves as being depressed but rather as lacking in parental competence and isolated socially.

There have been some systematic investigations of community-based family support program outcomes. Halvorson (1992) reported on an evaluation of a preventive home-based program involving 12 target families. Reports of participants (i.e., teachers, parents, and children) and observational data suggest positive gains, especially in behavior problems. Utilizing a multiple-baseline design, Caro and Derevensky (1991) documented the effects of a family-focused intervention program for young children with severe disabilities.

Regular home visits and targeted behavior plans developed in conjunction with each family member were associated with positive changes in child management competencies, familial interaction patterns, parental satisfaction, and rates of progress by the children.

Telleen, Herzog, and Kilbane (1989) studied the differential impact of mothers' participation in two common family support programs: self-help discussion groups and parent education. Compared to control groups, they found that, after 3 months of program participation, mothers in both types of intervention perceived less social isolation and parenting stress. They also discovered certain intervention-specific effects, although both methods presume to improve parent-child interaction. Self-help groups appeared to serve as a surrogate informal support network, thereby reducing stress; in contrast, parent education programs appeared to alter maternal perceptions of child responsiveness in a positive direction. Following the initiation of a family support program in Michigan involving the payments of cash subsidies to families with severely handicapped children, Meyers and Marcenko (1989) found that mothers reported significantly less stress and enhanced life satisfaction, coupled with less anticipation of the need for out-of-home placement. Increases in family satisfaction with services following the implementation of a family support program have routinely been shown (Waite, 1988).

Integrated service programs for persons with mental retardation or developmental disabilities are often geared toward parent involvement, comprehensive skill training, adaptation, coping, and social and family support. Dunst, Trivette, and Deal (1988) developed an extensive theoretical framework for conceptualizing what they call "family enablement and empowerment" (p. 6) and validated numerous measures to assess their constructs within a range of human service programs. For example, Project SHaRE (Source of Help Receive and Exchanged) enables families with disabled, handicapped, and developmentally at-risk children to build and maintain social support networks. The program operates as a barter system in which individuals and groups provide assistance to one another based on reciprocal obligation. Utilizing a multitrait-multimethod evaluation design, Dunst, Trivette, Gordon, and Pletcher (1989) demonstrated that participating families can identify and meet their needs, mobilize resources, broaden social networks, and improve personal and family well-being and overall functioning.

More recently, Dunst et al. (1993) published a comprehensive and compelling analysis of the links among family support program elements, differential characteristics, and program outcomes. Based on sophisticated statistical analyses (e.g., structural equation modeling and multiple regression), they reported on data from a national study depicting relationships between family support policies and practices at state and

community levels. Particularly interesting is their analysis of the association between provider helping style and family empowerment.

Despite the promise held out by these and similar findings, family support and education programs are difficult to implement in community settings, and they do not address all of the needs experienced by families. Herman and Hazel (1991) surveyed county mental health authorities in Michigan prior to and following the implementation of a policy change for programs serving individuals with disabilities. Core family support services of case management, parent training, respite, and crisis intervention were supplemented with improved parent involvement, assessment, in-home services (e.g., homemakers and home health), support groups, and counseling services across the state. They found that increases in the overall availability of services were not accompanied by improved access, as defined by the length of time families waited for services. Case management and counseling were noted as being especially difficult to make accessible. Barriers to filling service delivery gaps in family support included limited resource availability (e.g., funding and staffing), insufficient coordination among service components, and lack of commitment to the concept of paraprofessional services.

Preventive health care and health promotion.

Recognition of the interrelatedness of health problems has given rise to integrated program models for preventive health care and health promotion. High rates of pregnancy, sexually transmitted disease, drug use, mental illness, and mortality among some adolescents, for example, necessitate comprehensive and integrated responses that allow for linking services across different health domains and easy access to needed services. Thus, the Michigan Department of Public Health has established Adolescent Health Delivery Demonstration programs for health education, screening, case management, and referral. These programs are located in schools and other community settings and deliver both primary and preventive care. They blend state general funds with local and in-kind contributions, while also providing a billing system to access Medicaid and other third-party payors. Multnomah County (Portland), Oregon established school-based health centers in 1986, using a combination of state, federal, and local funding. Targeted toward providing comprehensive health care for adolescents and reducing teen pregnancy, the scope of services offered includes diagnosis and treatment of minor injury and illness, management of chronic conditions, mental health services, health promotion activities, reproductive health, family planning, and AIDS education and prevention (Oomes & Owen, 1991).

In 1981, seven federal categorical maternal and child health (MCH) programs were consolidated into a single block grant, allowing states and municipalities discre-

tion regarding MCH program development. Foci of the present program include the following: (a) reducing infant mortality, preventable diseases, and handicapping conditions; (b) increasing immunizations and health assessments; (c) promoting maternal and infant health for low income and at risk individuals; and (d) providing preventive and primary health care to children and families. A wide variety of integrated services initiatives have occurred across the country within this program model, often in collaboration with other agencies and organizations (Carlton & Poole, 1990).

School-based and school-linked services. The focus of school-based and school-linked services is to bring nonacademic services that support families and youth into school settings, the only institution with which virtually all children and families have contact. For instance, in the Memphis City Schools, a broad range of educational, mental health, and social services have been integrated within a school-based mental health center, bringing together psychologists, social workers, substance abuse counselors, and paraprofessionals within a coherent and multidisciplinary program. In addition to traditional assessment and treatment programs, the center provides teacher training, substance abuse counseling and support groups, social skills training groups, homemaker services, child abuse prevention programs, teen pregnancy programs, and a host of similar needs-driven efforts—all under the rubric of the school organization (Paavola, Hannah, & Nichol, 1989).

An effort sponsored by the Annie E. Casey Foundation is targeted toward at-risk youth in large urban areas, such as Bridgeport (CT), Little Rock, and Pittsburgh. The program involves screening, developing multidisciplinary support teams, and case management, and it seeks to improve attendance and graduation rates, increase youth employment after high school, and reduce adolescent pregnancy. In *School of the Future*, Holtzman (1992) described an ambitious project (partly funded by the Hogg Foundation for Mental Health) in four Texas cities (Austin, Dallas, Houston, and San Antonio) to foster the coordination and delivery of an extensive array of health and human services through neighborhood schools. Community renewal, family preservation, and child development are all cited as goals of this approach to serving low-income families.

Kentucky's Family Resource and Youth Service Centers were established through the Kentucky Education Reform Act of 1990 (Steffy, 1993). Each school where at least 20% of the student body is eligible for free lunch (a measure of economic disadvantage) may apply for such a center, and by the 1993-94 school year, 373 were in place. These centers provide before- and after-school child care; parent education and training; employment services; mental health counseling; and referral for medical, social, mental health, and family

support services; in addition to community resource development activities.

A formative evaluation of the project (Illback, 1993b), based on 1992–93 data regarding 18,912 families and 21,270 targeted students, indicated that participants exhibited complex and interrelated difficulties, with health, behavior, emotional, and learning problems of greatest concern. Health services and referral emerged as the most frequently utilized services; parent training, child care, and counseling services also were extensively used within these centers. Preliminary outcome data suggested improvements in classroom performance variables (as rated by teachers), but more global measures of change (e.g., grades and achievement) did not register gains. Families reported receiving increased social support from both the program and informal sources in their communities (e.g., relatives, friends, and neighbors).

A related qualitative evaluation (Kalafat & Illback, 1993), based on structured interviews with key informants in 10 sites, revealed that centers helped families gain access to and integrate services, often becoming the service providers of last resort (filling service delivery gaps) in many rural communities. However, centers' ability to maintain focus on their essential mission (promoting school readiness), in light of immense family and community needs, was of concern. The most successful centers were those whose coordinator displayed personal and management characteristics that meshed with family and community needs; particularly salient characteristics were found to be community connectedness, action orientation, and persistence. Variability among coordinators was seen in dimensions such as perceptions of the mission, conceptualizations regarding family support and empowerment, and knowledge regarding best practices for program management and implementation.

Implications for Psychology

The concept of service integration has several implications for psychology as a profession. On a general level, integrated service models will increase the amount of broad-based services available to children and families living in or near poverty by increasing access to services, generating new program alternatives, and freeing up funds now tied to rigid eligibility criteria. However, it also seems likely that psychologists will remain one of a number of eligible providers to deliver such services and, therefore, continue to be in competition with other professions to demonstrate relevance and efficacy. Because decisions about service delivery are more likely to be outcome oriented, consumer driven, and cost conscious, the particular strengths of psychology (including its conceptual underpinnings, empirical base, and concern for assessing outcomes) can enable the profession to flourish in such

an environment, assuming the profession is willing to rethink and retool.

As integrated services become more prevalent in child and family service systems, a number of implications for psychological practice, training, research, and leadership are apparent.

Practice

Psychological services delivered within an integrated services framework will look and feel substantially different for practitioners who presently work in relative isolation in service systems that tend not to collaborate and are categorical in their orientation. In more integrated systems, practitioners will be able to exercise greater flexibility in the range of activities with which they engage, and they will not be as constrained in regard to funding source and program eligibility considerations. They will spend more time working as part of a team, in concert with a variety of providers, family members, caregivers, and community members. They are likely to spend more time in naturalistic home, school, and other community settings, in addition to consulting offices. They will routinely work at removing the boundaries between various social systems that impinge on children and families to coordinate activities, manage conflict, and ensure focus and quality of services. Perhaps most important, the orientation to service delivery will shift from an emphasis on ameliorating dysfunction to one of joining with families and helping them develop support systems that will enable them to attain the behavioral changes they desire (Roberts & Magrab, 1991).

It also should be acknowledged that alternative, less costly approaches to addressing child and family needs will increase within an integrated services approach. Thus, although a child problem may previously have been conceptualized exclusively within an office-based psychotherapeutic approach, using an integrated services approach, the psychologist may collaborate with caregivers, friends, relatives, and other community members to meet the needs of the individual.

Training

Service integration has important implications for training psychologists in the direction of greater breadth and flexibility. A psychologist who is serving as the only mental health professional in an elementary school or public health clinic, for example, will need to be competent in a broad number of skills and approaches, ranging from typical developmental concerns and issues to guidelines for monitoring commonly used child psychotropic medications, family interventions, and community consultation. Profes-

sionals who can operate effectively within a variety of human service settings will have greater possibilities of employment in an integrated service system than those whose background is limited to a narrow psychological practice specialty.

Three areas of psychological training appear underrepresented in current training curricula: (a) foundational knowledge about families, organizations, and communities; (b) consultation and education skill development; and (c) program management and supervision skills. Most training programs do not emphasize theoretical and empirical knowledge bases in areas such as behavioral ecology, organizational theory, prevention programming, community psychology, systems of care (e.g., health, welfare, and education), and public financing that lay the foundation for practice within an integrated service approach. Moreover, clinical coursework on family intervention may stress psychopathology from a family systems perspective but may not include family support and education approaches.

Also, consultation and educative functions have been recognized as core competencies for professional psychologists (Illback, Maher, & Kopplin, 1991). Within an integrated service system, psychologists will need more comprehensive training with family-, school-, and community-oriented consultative methods and strategies and collaborate with other professionals (Zins, Kratochwill, & Elliott, 1993). Finally, strategies associated with program management (e.g., planning, budgeting, human resource management, and information systems design) and supervision (e.g., personnel management and administrative supervision) will become more essential components of practitioners' repertoires as their responsibilities shift from direct service providers to coordinators and leaders.

Leadership

Psychologists are in an excellent position to assume leadership roles within integrated service programs, given their level of training and skills. In addition to the more traditional aspects of program administration and supervision, leadership activities can focus on establishing an integrative strategic vision for child-serving organizations, building collaborative teams, and facilitating planned organizational change. Leadership can also be expressed by being an effective team member; competent leaders are also proficient at followership and collaboration.

Research and Evaluation

Psychological research on the efficacy of integrated service delivery approaches for children and families

represents a unique contribution. Such research is distinct from traditional controlled experimentation in that the array of target problems is vast, treatment programs are diverse and multifaceted, and outcome measurement complicated. Practicing psychologists need to become proficient in a broader range of methods and procedures (e.g., quasi-experimental design, multivariate analysis, and program evaluation techniques) in order to conduct such social policy and program-related investigations. Psychologists are also in a unique position to help service systems develop and validate information systems to allow for ongoing program monitoring, management, and improvement.

Conclusion

The overall benefit of changes toward a more integrated service system is greater effectiveness in the use of psychology to advance the public interest. There are at present large numbers of children and families living in or near poverty whose needs in the area of health, mental health, education, and social welfare are not being met. In addition to the personal cost to these individuals, the prosperity of the country suffers from their resultant inability to contribute fully as citizens. By advocating for integrated services, psychology has an opportunity to exercise leadership (in collaboration with other concerned persons and professions) to secure for these children and families their right to effective, responsive, and comprehensive services.

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