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Interdisciplinary School Practice: Implications of the Service Integration Movement for Psychologists

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The unmet needs of our nation's children and families have continued to increase, especially for impoverished and minority populations. In response, there has been growing support for a service integration approach that emphasizes interagency and interdisciplinary coordination and collaboration, particularly with respect to the role of schools. The American Psychological Association (APA) Task Force on Comprehensive and Coordinated Psychological Services for Children Ages 0–10 endorsed the service integration model and called for professional psychology to take a leadership role in its development, refinement, implementation, and evaluation. The APA adopted these recommendations as policy.

The extent of unmet needs of our nation's children and families is cause for alarm. Current reviews reveal a high incidence of problems associated with poverty, hunger, nonuse of established preventive medical care, crime, violence, fear, diseases (many that were once controlled), substance abuse, fetal alcohol and drug-related disorders, physical and sexual abuse, emotional and physical neglect, youth gangs, youth suicide, youth homicide, sexually transmitted diseases, youth pregnancy, mental illness, academic failure, school dropout, and significant changes in the family unit and extended family (Carnegie Foundation, 1990; Center for the Study of Social Policy, 1992; Children's Defense Fund, 1992; National Commission on Children, 1991; U.S. Department of Health and Human Services, 1990; Hodgkinson, 1992). Solutions to these increasing problems have not been forthcoming. These trends have occurred despite significant increases in child-related

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THE ISSUES DISCUSSED IN THIS ARTICLE are drawn, in part, from the deliberations of the Task Force on Comprehensive and Coordinated Services for Children Ages 0–10 of the American Psychological Association (APA). Opinions expressed herein do not necessarily represent the policies or views of the APA. The Task Force included the following members: James C. Paavola (chair), Carolyn Cobb, Robert J. Illback, Herbert M. Joseph, Jr., Alicia Torruella, and Ronda C. Talley.
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programs and services over the past 30 years. At least part of the problem appears to lie with the manner in which these programs and services are administered and funded. Regulatory bodies associated with funding, credentialing, and delivering services have played a major role in the formation and development of agencies and programs.

For the most part, rules generated by regulatory bodies are intended to ensure the delivery of cost effective and high quality services. However, these core value rules have been modified in response to litigation, potential litigation, professional association advocacy, and the need for the program to be describable in data that are relatively easy to tabulate and monitor. Under such influences, programs have tended to be more alike than customized for clients, to be more narrowly focused than comprehensive, to be more isolated from other agencies and services than collaborative, and to be positioned to better serve the needs of the agency than those of the clients. Current service delivery systems for children and families have been criticized for their lack of responsiveness, flexibility, effectiveness, cost efficiency, and accessibility for clients (Apter, 1982; Hobbs, 1975). These criticisms have especially been applied to public education, public health, child mental health, and social services (Adelman, 1993; Adelman & Taylor, 1993; Behrman, 1992; Holtzman, 1992; Kiesler, 1992; Knitzer, 1982; Tarnowski, 1991; Tremper, 1987; Tuma, 1989). The problems experienced by our children and families are too complex to be ameliorated by narrow, isolated, and often impeding strategies. There is a need for change in regulatory emphases. Complex problems require more complex solutions. Regulatory bodies need to encourage expanding the scope of services, building interagency and interdisciplinary alliances, and providing services where the clients are. The result would be a service delivery system that makes more effective and efficient use of existing resources to the benefit of a wider population of recipients. Service integration is a service delivery strategy within which the above-mentioned needed changes can occur. It provides a conceptual framework for improving outcome and cost effectiveness of service delivery systems by removing interagency and interdisciplinary barriers through increased coordination and collaboration (Adelman, 1993; Holtzman, 1992; Liederman, 1993; Melaville & Blank, 1993; Tarnowski, 1991; Tuma, 1989).

Key features of service integration include providing comprehensive, responsive, flexible, coordinated, and collaborative services. These features apply to program planning and development, funding, administration and staffing, applicable laws and regulations, idiosyncratic professional standards, confidentiality, evaluation, and bureaucratic and accountability monitoring procedures. A service integration approach is difficult to establish and maintain. For example, the larger the number of involved agencies, funding sources, and staff, the greater the need for continual communication, collaboration, and coordination (Adelman, 1993; Bruner, 1991; Crowson & Boyd, 1993; Illback, 1994; Melaville & Blank, 1991; Melaville & Blank, 1993; Tuma, 1989). In this article, we review the historical context of the manner in which the service delivery system for children and families has been construed within the past century, with particular reference to the role of schools. We discuss a proposal for systems change that was formulated by the American Psychological Association (APA) Task Force on Comprehensive and Coordinated Psychological Services for Children Ages 0–10 (TFCCPS), and we present a number of model programs and discuss their implications for professional psychology.

Historical Context of Systems Change

Efforts toward a coordinated and collaborative system of service delivery were evident at the turn of the 20th century in response to the high level of unmet needs experienced by children. Similar to current times, poverty, poor health care, youth violence, illiteracy, and the number of youths not assimilated into society as productive citizens were perceived as significant problems. The public schools were viewed as the logical setting within which to address these concerns (Tyack, 1992). The most successful interventions of the time provided a range of medical, dental, psychological, family–social, transportation, supplemental academic, nutrition, and vocational–technical services. These services were, to a significant degree, coordinated through the public schools and involved trained professionals as well as dedicated community volunteers and parents. Additionally, services were provided where the children were, that is, primarily in the schools. The level of coordination and collaboration on the part of agencies, professionals, and the community was impressive (Fagan, 1992; Greene & Simons-Morton, 1984/1990; Tyack, 1992). Thus, social, health, and education reform movements of the late 1800s and early 1900s, with concomitant technological and scientific advances, brought about significant changes in the roles and functions of psychology, public health, and public education (Talley & Short, 1996). The welfare of children became a primary concern. There was an increased focus on child development and socialization. The new emphasis was on protecting and nurturing children; this emphasis was accompanied by a sense of hope regarding the children's impact on the future of society (Fagan, 1992; Garwood, Phillips, Hartman, & Zigler, 1989; Tyack, 1992). Over the following decades, services to children ebbed and flowed as the country dealt with World War I, the Great Depression, and World War II. After World War II, delivery of mental health services shifted from schools and children to returning veterans. However, the mid to late 1950s saw a renewed emphasis on serving mentally retarded children. For example, the number of school psychologists rose from 520 in 1950 to 2,724 in 1960 (Meacham, 1983).

The social reform movement of the 1960s provided the impetus for a major shift in the role of the federal government in child-related policies. An array of legislation addressing children and families was passed in the 1960s and 1970s (Garwood et al., 1989). Overall, the laws of this period focused on providing additional services to individuals who were perceived to have been neglected, oppressed, or discriminated against on the basis of a physical or mental handicap, personal safety, income level, or personal characteristics (such as race, gender, nationality, religion, color, or age). However, these laws (and their attendant regulations) had relatively narrow foci. In an effort to ensure that designated services would be provided to specified target populations, significant restrictions were placed on what services could be provided, by which professionals, and to which eligible service recipients. Programs and services were developed in response to the availability of

these categorical funds, yielding a patchwork of fragmented services. The most familiar categorical funds within public education included those created by the Education of All Handicapped Children Act of 1975 and by Title 1 of the Elementary and Secondary Education Act (ESEA; now titled Improving America's Schools Act). These Acts were designed to provide supplemental and education-related services to handicapped and impoverished students, respectively. School-based psychological services expanded significantly under these two programs, with school psychologists numbering over 12,000 by 1978 (Meacham, 1983). The benefits of these programs were most evident in school districts and communities that previously had minimal support services. Although the laws were intended to ensure basic services to targeted populations, the application of these laws had the effect, in many localities, of narrowing the scope of existing comprehensive service programs (Carlson, Paavola, & Talley, 1995). This was especially true for those programs that involved psychologists and those that served broader populations than those designated by the categorical legislation (i.e., all school children versus only educationally handicapped children). Although components of an integrated service model were included within many categorical programs, linkages beyond the confines of these programs were neglected. The bureaucracy and restrictions enforced by state and federal program regulators discouraged school districts from providing any services beyond those specifically called for. Indeed, given the fiscal penalties associated with using these funds to supplant existing funds, school districts found that it was safer to isolate these new programs within the bureaucracy. Consequently, services for youngsters at risk of eventually meeting the eligibility criteria of the designated targeted recipient populations were also limited. In the early 1980s, legislative and regulatory changes were made in an attempt to counter the programmatic isolationism and bureaucracy associated with categorical funding patterns. For example, fiscal supports for several legislative components were consolidated into block grants. Federal block grants allowed states and local agencies more flexibility in blending programs, services, and funds. However, not all federal funding was allocated through block grants; total federal funding decreased, and there was arguably no difference in the level of bureaucracy associated with the new funds allocated from block grants. In addition, federal funds were effectively shifted away from supporting the poor, while tax laws allowed benefits to accrue primarily to the middle class (Garwood et al., 1989). At the same time, integrated service delivery models were being encouraged by private foundations and by some legislation. For example, beginning in 1986, school-based health clinics were developed and funded through the Robert Wood Johnson Foundation (Marks & Marzke, 1993).

Similarly, some state legislation, such as Tennessee's Child Sexual Abuse law of 1985, mandated coordination among district attorneys, law enforcement personnel, protective services personnel, judiciary officers, mental health workers, and education personnel. More recent federal legislation has been enacted (or is pending) that reflects the national call for fundamental change in areas such as education, family support, family preservation, child welfare, and health care. The preponderance of these legislative initiatives calls for more integrated service delivery with regard to planning, program development, and funding of services to youth. Those professions that have been the most involved in developing, endorsing, and participating in service integration models are most often included in the legislation. Thus, frequent references are made to nurses, social workers, educators, and home health workers. Professional psychology has not played a substantial role in this debate, and the corresponding absence of legislative references to the need for psychologists is noteworthy.

Integrating Services to Children and Families

Service integration models are not typically referenced in the psychological literature, but they are quite prominent in literature associated with education, public health, child welfare, and family support. Change toward a more integrated service system has been endorsed and promoted by private foundations such as the Annie E. Casey Foundation, the Danforth Foundation, the Hogg Foundation, the Robert Wood Johnson Foundation, the W. K. Kellogg Foundation, the C. S. Mott Foundation, the David and Lucile Packard Foundation, and the Pew Charitable Trusts. Moreover, service integration has been recommended by a number of national-level committees that are sponsored by private foundations, professional organizations, and governmental agencies.

Most recently, service integration concepts have been included in federal legislation, such as Goals 2000: Educate America Act (1994), as well as in bills currently being debated, such as the Health Security Act of 1994 and those related to youth crime and violence (as cited in Short & Talley, 1994). The current call for integrated service delivery is reminiscent of the paradigm shift espoused by community psychology in the 1960s. That shift involved moving from pathology-based, one-on-one interventions to a community–systems model that emphasized prevention, early intervention, and cost effectiveness (Bricklin et al., 1995). Development of alliances across systems, agencies, and disciplines was crucial. The application of this community–systems paradigm was evident in the development of community mental health centers, the deinstitutionalization of hospitalized mental patients (Kiesler, 1992), the development of mental health consultation (e.g., Caplan, 1970), the organization development approaches (e.g., Bennis, 1969), and the emphasis on prevention and early intervention programs in schools (Cowen et al., 1975; Paavola, Hannah, & Nichol, 1989; Sarason, 1982). The community–systems and service integration paradigms share very similar theoretical and philosophical tenets; namely, both approaches do the following: (a) represent a significant paradigm shift in service delivery beyond providing isolated services; (b) emphasize an interactive process of coordination and collaboration across systems, agencies, disciplines, and services; (c) seek community and family participation in program planning and service delivery; (d) stress prevention and early intervention; (e) emphasize the public sector; (f) validate the diverse roles and functions of various professionals and paraprofessionals; and, (g) advocate providing services where the clients are. Arguably, the major differences between these two movements (i.e., community psychology and service integration) lie not in the models themselves, but within the change in professional sponsorship and expertise.

Psychology no longer plays such a pivotal role. For example, service integration has legislative, fiscal, and regulatory support from government and private foundations (not unlike what the community–systems model initially experienced under the Community Mental Health Center's Act of 1963); however, for the most part, the service integration model is being championed by public health, education, and child welfare, rather than by psychology and mental health.

Responding to the increasing problems of children, the APA's Board of Professional Affairs, in conjunction with the Psychology in the Schools Program, commissioned a task force to develop recommendations regarding the delivery of services to children. As a result, the TFCCPS was established in December 1991. The Task Force was composed of clinical and school psychologists who were working with children and adolescents in the following settings: an urban, hospital-based psychological services program; an urban school system's in-house mental health center; a private community agency that provides child and family services; a traditional psychotherapy practice; and a state department of education. In addition, there were a number of university-based liaisons to the Task Force from various APA Divisions and other professional groups concerned with children and families. The Task Force determined that solutions to improving psychological services to children necessitate fundamental changes in how service delivery systems are established, funded, organized, and administered. In response to the need for a framework that emphasizes systemic change, the Task Force adopted a core set of principles derived from the available service integration literature. Adaptable to a diverse array of clients, services, settings, administrative structures, and funding sources, the approach allows for the delivery of a comprehensive array of services, while also addressing the criticisms of current systems of care (e.g., fragmentation, ineffectiveness, and cost inefficiency). Thus, the Task Force agreed on the following conceptualization of service integration (Paavola et al., 1995):

> The efficacy of services to children and families can be viewed from the perspective of the families themselves. When examined in this manner, emphasis is placed upon the nature of service delivery events or episodes that occur and the impact these events have on children and families. Within a well-integrated program, typically, services are available in close proximity and are accessible without reference to physical, psychological, social, linguistic, sexual orientation, or other barriers; services 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; services 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; services serve to promote psychological competence and self-sufficiency rather than focusing exclusively on dysfunction; services are oriented toward full participation, partnership, and empowerment of family members; services are sensitive to cultural, gender, racial, linguistic, class, disability, and sexual orientation issues; and, interventions 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. (pp. 21–22)

The final APA Task Force report (Paavola et al., 1995) included a recommended policy statement that called for leadership from the APA in the service integration movement. The proposal was adopted as APA policy in August 1994. In part, that policy calls for the APA to work with other organizations in developing supportive legislation, interdisciplinary training, and research on integrated models of service delivery. Additionally, the policy states that the "APA will support federal, state, and local government, agencies, and schools in developing service integration models that meet the psychological, educational, and mental health needs of consumers, with particular emphasis on the needs of children and families" (p. 34).

Exemplary Programs and Projects

A number of excellent examples of coordinated interdisciplinary and interagency programs are detailed elsewhere in this issue. The following provides a sampling of the various interventions, agencies, and funding sources being blended for the benefit of children and families. Note the collaborative involvement of federal, state, and local government (statutes, regulations, and funding) as well as of public education, public health, mental health, private foundations, day care, law enforcement, and social services agencies.

Child Welfare and Social Services

Funding from child welfare, juvenile justice, education, and mental health departments is blended with private foundations and local monies in support of family preservation (e.g., see Kinney, Madsen, Fleming, & Haapala, 1977; National Commission on Child Welfare and Family Preservation, 1990). These funds are being focused on children who are at risk for becoming wards of the state (e.g., in emergency protective services, foster care, corrections, residential or hospital treatment programs). Such programs can be found, for example, at the state level in Michigan (Families First), Iowa (Family Development and Self-Sufficiency Program and Child Welfare Decategorization Project), Tennessee (Children's Plan), and Hawaii (Family Support System's Healthy Start Home Visiting Service) or in more localized efforts such as in St. Louis (Walleridge Caring Communities Program).

Health Care

The move to establish school-based health clinics and other interagency health services on behalf of children and adolescents has been remarkable. Over 500 such clinics have been established in less than 10 years (e.g., see Association of Maternal and Child Health Programs, 1990; Dryfoos, 1993; Marks & Marzke, 1993; Oomes & Herendeen, 1989; Oomes & Owen, 1991). There are many examples of related programs located in public schools that serve pregnant and parenting students and provide on-site day care for their babies and infants, such as the ones in the Memphis City Schools.

Mental Health Services

Excellent examples of coordinated and collaborative mental health services to children and families can be seen in programs such as the National Institute of Mental Health's Child and Adolescent Service System Program, Kentucky's IMPACT pro-

gram, and California's Children's Mental Health Initiative. Positive results of these efforts have been documented (e.g., see Day & Roberts, 1991; Heflinger et al., 1991; Illback, 1993; Jordan & Hernandez, 1990). Similarly, local programs like the Memphis-based University of Tennessee Day Treatment Program for emotionally disturbed children and their families is an excellent example of interdisciplinary and interagency coordination and collaboration.

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. Exemplary programs are found in Kentucky's Family Resource and Youth Service Centers, the Memphis City Schools Mental Health Center, Texas' Schools of the Future, and California's Healthy Start Support Services (e.g., see Holtzman, 1992; Illback, 1992; Paavola et al., 1989).

Community-Based Collaboration

The Pew Charitable Trusts are sponsoring communitywide, longitudinal projects for impoverished families with young children (Center for Assessment and Policy Development, 1992). Another example is the Memphis-based Free the Children program, sponsored primarily by the Shelby County mayor's office, with significant participation on the part of local, state, and federal government; private foundations; business; social services agencies; public housing; law enforcement; education; day care; and corrections.

Implications for Psychology

Recent child-related social and legislative reforms in this area have occurred without the active and visible participation of psychology. The absence of psychology in the policy development of these national reforms is reflected in the corresponding relative absence of psychologists among the legislated lists of service providers within integrated service systems. Designated providers include professionals and paraprofessionals who often have no systematic training in psychology or its equivalent. A central legislative initiative is the Goals 2000: Educate America Act (1994). This Act calls for a comprehensive pattern of services addressing health, mental health, and social issues as well as education. Other legislative initiatives (including health care, juvenile justice, youth violence, and educational research) contain language ensuring consistency with the Act (Short & Talley, 1994). Past APA President Frank Farley (as cited in Short & Talley, 1994), argued, "Psychology is the core science of mind, and without psychology's signature on the blueprint for education reform, reform will fail. Therefore, it is imperative that we advocate for a psychology of education reform" (p. 1). Similar arguments can be made for reforms in health care, criminal justice, child care, and Head Start. Psychology has much to contribute, and without psychology's active participation these reforms are in jeopardy. In addition, the service integration model itself can benefit from the scrutiny, evaluation, and recommendations of psychology because there are unresolved issues involving the scope, definition, interactive processes, effectiveness, and cost-efficiency of this paradigm (Crowson & Boyd, 1993). Issues, such as the following, will need to be addressed assertively by psychologists and by the APA leadership.

Conceptualization

A service integration model will require changes in how most psychological services are provided. Such changes include the following:

1. Emphasize the importance of evaluating effectiveness and accessibility from the perspective of children and families.
2. Adapt effective intervention strategies for use with impoverished and minority children and families.
3. Establish the comprehensive service integration model within the context of primary care systems, such as health care, education, recreation, child care, and social services.
4. Emphasize comprehensive, interdisciplinary, and interagency services provided in the naturalistic settings of home, school, and community.
5. Emphasize primary and secondary prevention.
6. Expand beyond the role of direct service provider to one of consultant and preceptor.

Leadership

The APA's adoption of a service integration model for the delivery of services to children and families places psychology on the national children's agenda along with other professional organizations. The APA's central office staff has already begun to incorporate a service integration approach. This effect is apparent in their successful programs addressing the needs of rural areas, the disaster response network, work with the State/University Interdisciplinary Collaboration Project, and programs regarding HIV and AIDS. Furthermore, the various APA directorates meet regularly to discuss coordinated planning issues related to children and youth. Now, state psychological associations need to join with the APA in taking a visible and active role in developing future legislation related to children and families. A comprehensive plan is needed that addresses national, state, and local issues. In addition, the APA directorates and state psychological associations need to take a leadership role in educating and assisting psychologists in order to ensure their effective participation in the application of this paradigm shift. This leadership role includes the following:

1. Expand further psychologists' level of participation with other professional organizations in developing and implementing policy and programs.
2. Develop a marketing strategy that identifies the unique benefits of including psychologists in this new paradigm as planners, trainers, evaluators, administrators, and direct service providers.
3. Sponsor with other organizations national-level conferences on service integration.
4. Develop training programs and materials that focus on the unique skills needed to function effectively within the context of a coordinated and collaborated system (with an emphasis on emerging leadership styles).

5. Develop and disseminate strategies to ensure the inclusion of psychologists in state and local planning.

6. Develop and distribute program evaluation strategies appropriate to the complexities of the service integration model.

7. Provide on-site consultation in program development, administration, and evaluation.

8. Develop creative service delivery models that are readily adaptable to various primary care settings.

9. Develop interdisciplinary standards and guidelines for practice and supervision.

10. Encourage the establishment of interdisciplinary course work and practice and internship sites within service integration programs (e.g., see May, 1986, and the State University Interdisciplinary Collaboration Project).

Settings

As discussed previously, key features of the service integration model include providing comprehensive family-centered services in naturalistic and primary care settings. These settings include homes, health care sites, child care sites, schools, and (for many families) social service agencies. Service strategies such as a one-stop-shop, family preservation, and wraparound services are consistent with this model. Perhaps the most striking effort in the past decade to coordinate services has been the establishment of some 500 school-based health clinics (Brellochs & Fothergill, 1993; Dryfoos, 1993; Marks & Marzke, 1993). There are still a number of coordination issues to be worked out, especially involving interagency governance and the inclusion or expansion of mental health and preventive services, but school-based health clinics, school-based mental health clinics, and family resource centers offer much promise for the involvement of psychologists. A detailed discussion of this emerging service delivery model occurs elsewhere in this issue (see Carlson, Tharinger, Bricklin, DeMers, & Paavola, 1996).

Training

Psychology and psychologists must take a leadership role in the planning and advancement of the integrated service delivery paradigm shift at the national, state, and local levels. Such leadership would be reflected in the increased number of (a) publications by psychologists addressing theoretical constructs, intervention strategies, program designs, model programs, evaluation strategies, research data, innovative models, and desirable skills and roles; (b) interdisciplinary and interagency service programs administered by psychologists; (c) interdisciplinary university training programs involving psychologists; (d) consortium internship programs; (e) practicum and internship placement sites for psychology students; and (f) university course work involving psychologist instructors. This is an excellent opportunity for psychology to help advance the public interest. Training will play a major role in preparing and supporting psychologists in this effort.

Summary and Conclusions

The unmet needs of children and families have continued to increase despite a corresponding increase in legislation, funding, programs, and service providers. These conditions are particularly serious for impoverished and minority populations. Support has grown for a paradigm shift in service delivery strategies toward the use of coordinated and collaborative services. This shift to a service integration model has received much support from private foundations and, more recently, federal legislation. The national-level leadership in policy development and new legislation has come from education, from public health, and from child welfare but not from psychology. Psychology has much to offer reform movements in mental health, education, juvenile justice, and child care. The APA recently adopted a policy that (a) calls for children and families to be placed as a priority on social and political agendas, (b) endorses the service integration model, and (c) commits to increased involvement with other organizations in policy and program development. Full and immediate implementation of this policy is essential, both at the national level (through APA) and at the state level (through state psychological associations).

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