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SERVICE COORDINATION IN MENTAL HEALTH SYSTEMS FOR CHILDREN, YOUTH, AND FAMILIES: PROGRESS, PROBLEMS, PROSPECTS

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Abstract

The present article focuses on critical issues in the provision of service coordination to children and youth with serious emotional disabilities (SED) and their families, particularly those concerns most relevant to program organization and administration. Perspectives and issues gleaned from a review of evaluative data, focus group discussions with service coordinators and their supervisors, and clinical and administrative experience within a statewide SED initiative are considered in three areas: (1) roles, responsibilities, and relationships; (2) organizational context; and (3) training and supervision. Recommendations for enhancement of child, youth, and family mental health service coordination are provided.

Within the past decade, case management has emerged as a critical component of mental health services.[1] With the advent of managed care and managed competition in health care reform,[2] case management initiatives will continue to flourish as a means to limit costs and improve mental health treatment effectiveness. Although substantial literature exists on case management with adult populations,[3] the literature is less well-developed within child, youth, and family mental health services. Though not all service coordination initiatives rely on case management, there is a growing emphasis on the use of case managers to coordinate services for this population, particularly program development stimulated by the Child and Adolescent Service System Program (CASSP) for children with serious emotional disabilities.[4]

This article focuses on critical issues in the provision of case management to children and youth with serious emotional disabilities (SED) and their families, particularly those concerns that are most relevant to program organization and administration. The discussion is based primarily on the experience of the Kentucky Interagency Mobilization for Progress in Adolescent and Child Treatment (IMPACT). Within Kentucky IMPACT, it appears that service coordination through case management is a vital link in a

restructured service system that is associated with substantial child, youth, and family gains.[5-7]

After considering the development of Kentucky IMPACT, including a brief overview of prominent evaluative findings, the present article delineates salient service coordination perspectives and issues gleaned from a review of available evaluative data, focus group discussions with service coordinators and their supervisors, and clinical and administrative experience. The discussion about service coordination is oriented around three areas: (1) roles, responsibilities, and relationships; (2) organizational context; and (3) training and supervision. Procedures for enhancement of child, youth, and family mental health service coordination are recommended.

Service Coordination in Child, Youth, and Family Mental Health Systems

The community mental health movement reflected a commitment to serve seriously troubled individuals in their community rather than institutions. Seriously troubled persons needed a wide range of services, such as mental health, health, employment, training, legal, and housing. Often, these services were not available; in many cases, however, the needed services were inaccessible or operated at cross purposes due to restrictions imposed by agency funding, target populations, philosophy and training, and "turf" issues. The nature of this bewildering maze was documented for both adults[8] and children.[9-10] It was apparent that efforts were necessary to develop more broadly based serviceplans, access services, improve interagency cooperation, and coordinate the multiple services required by individuals. These functions became defined as a service in their own right. Specific providers were assigned these tasks as an additional responsibility or as an exclusive role. The most common name for the new role was case management.

Although case management is a relatively new service its application has spread quickly. The literature on case management now encompasses a range of service populations with multiple needs: the elderly, individuals with strokes or head injuries, the developmentally disabled, and a wide array of chronic health conditions. Although there are multiple definitions of the term case management, most practitioners would agree with Solomon's[3] depiction: "a coordinated strategy on behalf of clients to obtain the services that they need, when they need them, and for as long as they need these services" (p. 164). However, the diverse uses of the term in practice have led to the despairing suggestion that the concept constitutes an organizational Rorschach.[11] Research on the effectiveness of case management for long-term mental illness in adults[3,12-13] reveals that case management takes many forms, and research in case management poses numerous methodological challenges.

Within service programs familiar to the authors, case management is referred to as service coordination, reflecting two biases. The first acknowledges that most individuals do not like to be referred to as cases or to be managed. The second recognizes that the case management function is only meaningfully defined within a particular service system. In essence:

Case managers cannot do their complex jobs without a service system available; however, it would appear that the service system does not function maximally without the case managers. (p. 194)[14]

Case management for children with serious emotional disturbances (SED) was stimulated by such pioneering work as that of Hobbs, [15] Behar, [14] and the federal Children and Adolescent Service System Program (CASSP).[4,16] The organizational model that has guided much of the case management effort for SED children was set forth in a CASSP technical assistance monograph[17] that refers to case management as one of the "operational services" because of its importance to the effective operation of the system.

The goals of service coordination vary from child to child and are shaped both by the target population and the servicesystem. Thus Stroul and Friedman[17] set forth two core values for more responsive systems of care: (1) the needs of the child and family should dictate the types and mix of services provided and (2) the locus of services, as well as management and decision-making responsibility, should rest at the community level. For these authors, "Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs" (p. 145).[17]

Kentucky IMPACT: Development and Formative Evaluation

In 1990, Kentucky received a \$2.4 million, 4-year implementation grant from the Robert Wood Johnson Foundation for comprehensive, coordinated services to children and youth with serious emotional disabilities in central Kentucky. Bluegrass IMPACT was designed to involve close cooperation among all affected state agencies, schools, and community mental health and mental retardation programs in a 17-county region. Given the early successes of this initiative, the entire state adopted a similar approach, enacted by the Kentucky legislature in 1990 and named Kentucky IMPACT. The approach stipulates that state and federal funds be accessed to provide more appropriate community-based services for children and youth with severe emotional disabilities. Emphasis is placed on interagency coordination, comprehensive service delivery, and limitations on the use of psychiatric hospitalization. There are a number of program components jointly administered by major departments within state government representing social services, mental health, education, and juvenile justice. The efforts of these departments are coordinated by a State Interagency Council (SIAC).

At the regional level, services are developed, coordinated, and administered through Regional Interagency Councils (RIACs). Key agency administrators and a parent are committed to the RIAC by the legislation. The RIAC selects cases to be served, approves child-specific budgets developed by the service coordinator in conjunction with the child service team, and reviews selected cases in an atmosphere of support for the service coordinator.

Core services in each region include (1) interagency treatment planning teams, (2) targeted case management services, and (3) individual family-based support services (IFBSS, also called wrap-around funds) used at the discretion of the RIAC when children's needs cannot be met with existing resources but require that creative, individualized services be "wrapped around" the child. Additional service components that are gradually being developed around the state, but are not yet available in every region, include (1) family preservation programs, (2) intensive in-home services, (3) services to multi-problem children in private child care, (4) small community-based psychiatric residential treatment facilities (PRTFs), and (5) therapeutic foster care.

Within this program model, service coordination is an explicit role that is distinct from that of other mental health professionals. Service coordinators are not considered mental health therapists, and the role of service coordination is not an addition to other duties and responsibilities within their organizations. Rather, service coordinators engage in discreet, role-related activities, including: (1) convening a multidisciplinary team upon referral and entry of a child and family into the system (team development); (2) facilitating the development of a common plan (case formulation and program design); (3) monitoring and evaluating the implementation of the plan (service coordination); (4) serving as the hub for all service-related interaction and system-level collaboration between agencies (interagency collaboration); (5) re-convening the team to address the changing needs and circumstances with the family, to include exiting processes (strategic planning); and (6) preparing a budget for the use of flexible funds (administration).

Analyses of demographic data on 960 children and youth served in the first 2 years of the program reveal a distribution that is characterized by an overabundance of early adolescents--young males with disruptive behavior disorders and older females with depressive and anxiety disorders--and an extensive array of risk factors correlated with child psychopathology (e.g., poverty, family violence, and mental illness). The average number of risk factors per child/family is greater than 8. An exploratory cluster analysis of underlying patterns for these cases reveals three major clusters of problems: (1) families under severe stress with limited support, (2) child and family violence and psychopathology, and (3) extreme family disintegration with a high level of system-dependence. Thus service coordinators struggle daily with an extremely diverse, high-risk, and multi-problem population.

Regarding service delivery patterns, the most frequent, consistent, and durable services within Kentucky IMPACT revolve around service coordination functions. Traditional service coordination services (e.g., family assessment and resource linking) begin at high levels, and gradually diminish to more moderate levels with children and families over time (as might be expected). In contrast, crisis response rates remain generally high throughout participation in the program. Interestingly, service coordinators report that they do not perceive the system to be crisis-driven, but rather that the qualitative nature of the crises experienced by families changes over time, and becomes more manageable and open to instruction. Unfortunately, it also appears that some of the most troubling crises occur when IMPACT services begin to be reduced.

Family support services such as respite and wraparound aides are essential program components and appear to quickly achieve high use rates that are maintained over time. Supervision and coordination of these resources often fall to service coordinators, who confirm that their availability represents an indispensable resource in attempts to respond to family needs. Often, these resources serve as the first line of defense when crises occur.

Service coordinators report that they are continually challenged by the process of sustaining meaningful involvement from all parties, particularly schools. The ability to help a group of individuals (representing their respective systems and organizations) function as a team is a complex endeavor needing sophisticated leadership skills.

A review of data available through the second year of operation documents positive gains for the challenging population being served by the program. There is substantial evidence that (1) children and youth are exhibiting significant, positive behavior change; (2) families generally feel supported by the program; (3) placements are more likely to be stable; (4) psychiatric hospitalization is decreasing; and (5) the approach is cost-efficient. In light of the scope and complexity of the problems experienced by these youngsters and their families, these outcomes are by no means trivial. A review of the data also points to some developmental issues that require ongoing management attention, including enhancing intervention durability, increasing informal supports to families, and reducing restrictiveness of placements. (The interested reader may obtain a more detailed evaluation report from the Kentucky Department of Mental Health.)

Although Kentucky IMPACT remains in its formative stages, it has already transformed the manner in which the needs of children and youth with serious emotional and behavioral problems are addressed. The evidence to date is that the program works, and is delivering on its initial promise to make the continuum of care more effective and responsive. Service coordination has received strong positive reviews from most practitioners, clinicians, families, and local agencies. Most participants and providers have observed clear successes among children served, and even those who are laboring without consistent success feel far less isolated. Most gratifying has been the evidence that the programming is having tippie effects on the service culture, both locally and statewide (to include legislators). However, if these gains are to be sustained, and the program is to continue to develop and improve, a number of complex issues involving service coordination must be resolved.

Emerging Perspectives and Issues

Although Kentucky IMPACT has demonstrated substantial gains, it continues to wrestle with challenges related to service coordination. Emerging perspectives and issues are discussed below to further delineate the topography of the administrative and operational landscape, and to inform other program managers involved with system of care restructuring. The discussion is oriented around three primary themes: (1) roles, responsibilities, and relationships; (2) organizational context; and (3) training and

supervision. Following an exploration of each theme, specific role-related issues are detailed.

Roles, Responsibilities, Relationships

Service coordination is an activity that requires a paradigm shift for mental health practitioners. Instead of concentrating on internally focused individual- or family-level therapeutic interventions, service coordinators serve to bridge interactions between child and family systems and their immediate environment (to include service providers). This requires an alternate conceptualization regarding roles, responsibilities, and relationships.

In order to be effective in their roles, service coordinators must perform as boundary spanners; that is, their work is primarily conducted at systemic boundaries as a means to further the progress of the overall intervention plan. For example, when a child is experiencing severe behavioral problems in school, the service coordinator seeks to interface between child, teacher, parent, and principal in order to resolve conflict, obtain consensus about a particular strategy, and focus the implementation of the approach agreed upon. In order to be effective boundary spanners, service coordinators rely on a special set of skills involving processes of communication, conflict management, negotiation, planning, collaboration, and program management.

Service coordinators often have no role model upon whom to pattern their professional behavior. Therefore, they tend to rely on their own conceptions of what they are to do, or vague and inconsistent messages from persons in their immediate environment (role senders), such as supervisors or colleagues. As part of a training exercise, experienced service coordinators in Kentucky IMPACT were asked to generate a list of role descriptors to elucidate their actual activities; the result is seen in Table 1 and communicates the scope and complexity of what service coordinators feel pressed to do. Clearly, they often feel drawn to fill service gaps personally, creating a supervisory dilemma. Although the lack of a defined role and accompanying performance standards can increase flexibility and innovation, it also leaves service coordinators vulnerable to role confusion, ambiguity, and stress-induced burnout.

Focus-group discussions with service coordinators and their supervisors reveal that roles often are developed in relation to individual training and background. Persons with backgrounds in social work, for example, use a casework orientation. Similarly, those with backgrounds in schools tend to emphasize educational approaches and mental health counselors tend to perform therapy.

It also appears that role performance is a function of the interpersonal style that the individual brings to the job. In this context, a variety of discernible styles have been observed, including (but not limited to): (1) the broker-linker, whose involvement with the family revolves around identifying problems and resources, and ensuring that needed services are accessed; (2) the family friend, who becomes a vital social support to family members under stress; (3) the bureaucrat, who helps the family deal with the regulatory environment, and ensures that the needs of the regulatory environment are satisfied (e.g.,

Medicaid billing); (4) the child protector, who identifies with the victimized child in the context of the dysfunctional family and seeks to inoculate the child against the deleterious effects of the family's circumstances; (5) the advocate, who aligns with the family against ineffectual providers and organizations; and (6) the empowerer, who emphasizes the development of family competencies and seeks to share responsibility for treatment implementation with parents.

These styles are not mutually exclusive; neither is any one approach "correct" in our view. Rather, the most effective service coordinators seem to be able to shift between and among these roles, as a function of needs and circumstances. Conversely, the least effective service coordinators have a limited repertoire of roles that they can perform, which can result in a mismatch between service coordinator style and family needs, thereby reducing intervention effectiveness.

Thus, when viewed from the perspective of roles, service coordination is a complex and often frustrating endeavor in which there is a high potential for conflict, confusion, and isolation. As a result, service coordinators can acquire feelings of powerlessness and low self-efficacy, and may become immobilized or unable to sustain momentum within the initiative. Most fundamentally, we have found that if service coordinators are not themselves empowered to attain and display essential competencies while containing pressure to fill *service* gaps themselves, they are unable to create such an environment for the families with whom they work.

Four issues in which role-related issues play themselves out within IMPACT are (1) interpersonal conflict, (2) availability of expertise, (3) philosophical differences, and (4) caseload.

Interpersonal Conflict. On administrative and policy levels, IMPACT has had few major conflicts, probably due to the early, enthusiastic, and continued involvement of key agency personnel in the planning and implementation process. More frequent conflicts occur on the case level between professionals, particularly when decisions are imminent with which one agency or individual may not agree. Some of these conflicts emanate from striking differences in problem conception, such as clashes between child protective and family systems paradigms. Others are a function of historical tensions between organizations at the local level, or individual persons whose styles do not complement each other. Occasionally, an agency representative will participate in the process without having the authority or support of his or her own organization. Although administrative mechanisms exist for addressing these issues, they have not been universally effective. At the same time, the process has resulted in greater mutual appreciation of the problems other agencies experience, and an improved sense of communality and community on behalf of these children and families.

Availability of Expertise. Service coordinators and interagency personnel vary in expertise, as do other professionals and family members who comprise the service team. The process by which team decisions are made runs the risk of producing a plan that is unduly influenced by the stronger personalities or dynamics of the particular group,

rather than based on the needs and preferences of the child or parents. Service coordinators may not arrive with requisite skills in case formulation, goal setting, team management, discussion leadership, conflict management, or specialized case consultation (to name but a few of the areas of required expertise). Although there is an appeals process to be used when services that parents request are denied, this is underused and does not fully address the need for expert leadership from the service coordinator.

What is the role of the service coordinator? To what extent is the team like an orchestra with the service coordinator making little of the noise but choosing the score and directing the process? Is the service coordinator like staff support to a treatment committee, which is not primarily responsible to choose the direction and focus the plan, but instead facilitates plan implementation and brings problems to the attention of the committee? This issue has been most acute among some staff wherein the degree of case direction provided by an in-home worker, therapist, service coordinator, or school support specialist is debated. What happens, for example, when an experienced respite worker or tutor becomes heavily involved with a family and the service coordinator is less experienced? What happens when the family has a strong alliance with a worker providing crisis response, but has a more strained relationship with the service coordinator? Should roles shift? If so, how and when?

Philosophical Differences. Sometimes in subtle fashion, philosophical differences among staff have been encountered. The importance given to the child, the family system, or alliances with a school or other system may skew the direction of intervention. Similarly, persons with disparate backgrounds and training may use different approaches to treatment. These differences may be explicit treatment orientations, as in the difference between behavioral and psychodynamic paradigms, but more often they relate to beliefs about the relative worth of specific treatment activities, and how they should be sequenced and emphasized. Providing opportunities for staff (including service coordinators) to articulate and resolve these philosophical differences constructively is central to effective team building. Unfortunately, sometimes the process results in adversarial groupings around particular orientations or issues, limiting team effectiveness.

Caseload. service coordinators routinely report that manageable caseload size is associated with success, but designing an equitable system that ensures an appropriate number of cases, given demand for services and practical and financial constraints, is problematic. Optimum caseloads range from 10 to 15, but staff departures have left some service coordinators with caseloads as high as 20. Some regions have developed a weighting system for limiting caseload size with numbers assigned to cases based on levels of intensity; however, they have found it is difficult to define what those intensity levels are and how they can be measured. Part of this debate relates to developing better exit criteria and determining when cases are to be terminated or placed on monitoring and follow-up status.

Organizational Context

Service coordination occurs within a broader organizational context that can either be facilitative or troublesome. All organizations have underlying belief systems and methods of operation, some of which may embrace service coordination as a legitimate function. However, it has been our experience that service coordinators do not fit neatly into traditional niches within their mental health organizations, and many of their activities are either poorly understood or even actively resisted by others within their organizations.

As advocates for integrated, community-based services, service coordinators represent paradigm pioneers in child and family mental health. Whereas the traditional mental health paradigm emphasizes office-based individual- and family-level psychotherapy, sometimes accompanied by psychotropic medication, the new paradigm emphasizes home- and community-based service, including a broader range of intervention modalities (e.g., respite, individualized wraparound services). Instead of focusing on psychiatric diagnosis, psychopathology, and dysfunction, this model is characterized by competence building, family support, and parent-professional collaboration.

Given these contrasting belief systems, it should not be surprising that service coordinators are regularly faced with problems such as tuff battles, questions of competence, and regulatory gridlock within their settings. In addition, they often are poorly remunerated (in relation to other program professionals), overworked, unappreciated, and, in general, devalued. Such conditions inevitably give rise to high turnover rates and ineffective functioning, despite service coordinators' typical youth and enthusiasm.

Salient issues related to organizational context variables within Kentucky IMPACT include (1) implementation problems, (2) terminating clients from service coordination, (3) involving other mental health professionals, and (4) broadening the base of community involvement.

Implementation Problems. IMPACT programming is sufficiently unique to create numerous problems within established mental health agency structures. What new medical records will be needed? Who is the custodian for the record? Which existing records procedures can be modified and which must remain in place? Billing procedures, accounting systems, databases, and personnel categories have all undergone some changes. For the first time, service coordinators have checking accounts because the immediate needs of the program are often too great for petty cash accounts and too cumbersome for regular purchasing procedures. No mental health programs hire as many temporary staff who work flexible hours. The training needs of the program are unique.

As a consequence, parent mental health agencies have had to make far-reaching changes to accommodate the program. Sometimes this process has not been smooth. Some regions have established standing committees to deal with ongoing procedural problems created by the new programs. These adaptations have been at least as difficult as obtaining changes in the target population, and contributed to respect for the inertia that can accompany any change effort. Interestingly, problems inherent in the bureaucratic structure of the traditional system have become more transparent as a function of this

process and more open to discussion. Unfortunately, service coordinators have had to bear the brunt of some of these discussions and often have become distracted from their primary mission.

Terminating Clients From Service Coordination. In the initial enthusiasm associated with program development, there was a tendency to be the all-purpose service provider for SED children. It has been important to realize that a child should not remain in IMPACT any more than he or she should remain in a hospital. An emergent emphasis has been on the early development of clear exiting goals and criteria. These goals do not require that the child or family be problem-free, but rather that they should be able to continue to progress using other existing services within the community. In practice, this has been difficult for service coordinators to implement, given the complexity and chronic nature of the target population.

A major issue affecting exit planning relates to whether certain services (in particular, those requiring IMPACT wraparound dollars) can be provided without being linked to continued service coordination. Some situations have been stabilized using services purchased on a continuing basis by the IMPACT program (e.g., after-school aides and respite care) and current policy only allows such services when the core service--*service coordination*--is provided. The limiting nature of this policy may be ameliorated (in the future) by the extensive use of service coordination outside of the IMPACT program (in part, due to its demonstrated success), which has served to strengthen interagency collaboration among local agencies. Potentially, exiting cases could be assigned to a non-IMPACT case manager (who might have a larger caseload), if available, or a parent; one of the interagency team members continuing to work with the child could assume service coordination responsibilities and continue to access integrated services.

Involving Other Mental Health Professionals. Because IMPACT is based in the community mental health center, many of the therapists for the children and families are employees of the agency. Although this should facilitate access and collaboration in the interagency planning process, it has not always been the case because of resistance, bureaucracy, logistics, or funding patterns. Some referred families already are involved with therapists in other agencies or private therapists, and it has proved difficult to fully involve these persons. Many private therapists are not accustomed to team planning. It has taken concerted efforts on the part of service coordinators to interface with all these individuals and enable their inclusion.

Broadening the Base of Community Involvement. IMPACT has discovered that some agencies and organizations not involved in the early planning process now are needed to achieve the level of coordination and resource development required. Hospitals, which initially perceived the program as a threat that might discourage inpatient admissions and treatment, now see it as an important source of referrals and a key element of aftercare--or at least a place to refer patients in lieu of more comprehensive discharge planning. Several incidents have heightened awareness that the police must become informed and cooperative members of the service team. As the need to foster development of informal sources of social support has become clearer, increased involvement of community

organizations and networks has been sought, including church groups, fraternal service organizations, extended family networks, friends, and neighbors. Of necessity, this has required that service coordinators not only become familiar with these resources but creative about how to help families access them.

Training and Supervision

As a relative newcomer to the mental health marketplace, *service coordination* as a field is not yet sufficiently developed to evidence clear training standards or best-practice guidelines. Thus individual programs and projects often establish entry criteria, and these vary considerably. Service coordinators are commonly trained at the bachelor's level in psychology, social work, or a related human service field (although not necessarily), and most undergraduate courses are theory-oriented, providing minimal training in intervention processes. Those trained at the master's level are more likely to have acquired a systematic professional perspective and related therapeutic skills. However, there is still a tendency for their training to be somewhat fragmented. Irrespective of level of preservice training, most have had no exposure to principles and procedures of service coordination.

Of course, the lack of training and experience in service coordination can be an advantage because these individuals can invent their roles without preconceived notions. This perspective implies that these individuals will have an immersion experience that allows them to formulate their activities based on the needs and circumstances they confront, supplemented by on-the-job training. Although there are many creative and innovative service coordination programs developed in precisely this manner, it seems that just as often service coordinators, in the absence of guidance, find themselves quickly operating under conditions of high stress, lose focus, and the resulting programs are at risk for serious disorganization.

A primary mechanism used by mental health systems to compensate for the relative lack of training and experience in the field is clinical supervision. Such supervision can serve to provide support and assistance to practitioners in areas such as case formulation; working through difficult intervention processes; and fostering sensitivity to practical, legal, and ethical dilemmas. Regrettably, consistent and specialized (e.g., child-oriented) clinical supervision is not routinely available to service coordinators in some organizations. Often overburdened with administrative and fiscal details, supervisors may lack the time to actively supervise programs or people. Moreover, some supervisors have little training in either programmatic or personnel supervision, after being promoted to administrative positions from direct service roles. As a consequence of these and related factors, service coordinators may be left to operate in a vacuum, which can be disempowering.

Two issues are of current concern within Kentucky IMPACT: (1) stress and social isolation and (2) job satisfaction and staff retention.

Stress and Social Isolation. As a new and innovative program, there has been a tremendous push to get underway, meet new challenges, respond to the crises of the children and families, and pursue necessary training--all at the same time. Often, service coordinators have been asked to maintain a frantic pace of programmatic activity without the opportunity to think and plan in a reflective manner. For the program to continue to be sustained and renewed, there is a need for more relaxed times in which misgivings can be shared and stress processed. Specifically, the need to articulate and institute an explicit program of social and emotional support for service coordinators and other involved staff has become eminently clear.

Job Satisfaction and Staff Retention. Discussions with practicing service coordinators reveal their perception that they must sink or swim. In fact, they report a threshold that occurs at about 9 months when the new service coordinator either has developed a role and style that is comfortable for him or her, or leaves his or her position extremely frustrated. Persistent stress, fragmented role development, and lack of support are associated with employment dissatisfaction and low employee retention rates. Those who remain may be vulnerable to problems of attitude, productivity, and a sense of not being grounded in their work. Thus IMPACT experiences an enormous need to recruit, train, support, and retain talented individuals in this role.

Implications for Mental Health Service Delivery

There are some who argue that the use of case management in *mental health* programs is not feasible and is unrealistic. For example,

Is it realistic . . . to expect case managers to be politically savvy organizational change agents as well as expert diagnosticians and therapists? Does it make sense to hire young, inexperienced and low-paid individuals who lack professional authority; give them few resources and little or no formal organizational clout; and then expect them to work miracles in overcoming serious deficiencies in a poorly funded service delivery system? Is case management nothing more than a seductive notion for those who would like to think that society's care of its needy citizens can markedly improve without more money being spent? (p. 141)[13]

In contrast with this pessimistic appraisal, our experience with service coordination for children, youth, and families with serious emotional disabilities causes us to conclude that service coordination is both vital and viable. Despite all of the difficulties referenced in the preceding sections, the model remains compelling as an essential mechanism to ensure comprehensive, high-quality, and integrated services for this population. The service coordinators with whom we work tend to be young, enthusiastic, and surprisingly unjaded in their approach, remaining hopeful and engaged despite the challenges of their work. In addition to their remarkable commitment and dedication, they are also pragmatists, interested less in theories than in what works, and willing to take whatever steps are necessary to accomplish their mission.

There is little doubt that the positive formative evaluation data emerging from Kentucky IMPACT are attributable, in large part, to the efforts of these individuals. For this reason, we believe that further development and improvement of this and similar programs hinge on efforts to strengthen and professionalize service coordination within the child mental health marketplace. The following recommendations are offered in this vein:

1. Establish a core set of service coordination skills, to be emphasized through competency-based preservice and in-service education, including case formulation, child and family intervention strategies, consultation processes, program planning and evaluation, conflict management, and team building.
2. Encourage participation by service coordinators in the development of professional organizations, with the express purposes of providing mutual support and creating best practice standards for the profession.
3. Collaborate with colleges and universities to design (or modify) undergraduate and graduate curricula to better prepare individuals for this challenging role. Given the highly practical nature of service coordination, it seems likely that field-based, supervised experiences will be especially important components of training. However, such training will be useful only to the extent that it is built upon a foundation of theory that helps service coordinators to have clear conceptions about practice. Although the essential elements of service coordination theory in child and family mental health have yet to be specified, our view is that a thorough grounding in areas such as family systems theory, social influence processes, behavioral-ecological approaches, integrated services, and team and work group development is vital.
4. Strengthen the support available to service coordinators within mental health organizations by sanctioning and valuing the role, providing both administrative and clinical supervision, respecting and protecting caseload levels, encouraging participation in professional development opportunities and interaction with peers, explicitly reinforcing successes at family and program levels, and reducing bureaucratic and interpersonal barriers to the integration of service coordination activities into the routine of the organization.
5. Supplement and enhance the efforts of service coordinators through selective and appropriate use of clinical and programmatic consultants to provide technical assistance, training, and support. Such efforts are most effective when used regularly, such as during staff meetings or within a Grand Rounds format. Periodically, IMPACT service coordinators present problem cases to the regional interagency council for assistance, which has the added advantages of addressing interagency problems and mobilizing new resources.
6. Provide regular opportunities for peer involvement to share information and ideas, discuss common experiences, and provide mutual support. Within IMPACT, quarterly 2-day meetings allow for such interchanges in settings conducive to reflection, renewal, and re-tooling. service coordinators can operate more freely and that serves to empower and

enable their efforts. In this regard, the key strategic practices within IMPACT have been interagency committees of parents, providers, and administrators at the local and regional levels that, when fully functional, create and support an environment that is conducive to service coordination.

Summary

This article focused on critical issues in the provision of service coordination to children and youth with serious emotional disabilities and their families, particularly those concerns most relevant to program organization and administration. Perspectives and issues gleaned from a review of evaluative data, focus group discussions with service coordinators and their supervisors, and clinical and administrative experience within a statewide SED initiative were considered in three areas: (1) roles, responsibilities, and relationships; (2) organizational context; and (3) training and supervision. Recommendations were provided for mental health programs seeking to enhance child, youth, and family service coordination.

Presently, Kentucky IMPACT is pursuing these and related ideas through a comprehensive strategic planning initiative designed to strengthen and support successful efforts already underway across the commonwealth. Service coordinators, direct service providers, family members, administrators, and a range of other involved parties have participated in a series of meetings to delineate the essential issues that represent barriers and facilitators to effective program implementation. Based on these data, a statewide strategic plan will be agreed on and resources allocated in support of key strategic objectives. Central to this emerging plan is the perspective that service coordination is the fundamental link between children and families in need, and the service system that is responsible to serve them. It is anticipated, therefore, that a major focus will be on empowering and supporting persons who perform this indispensable role.

Table 1

Service Coordinator Self-Generated Role Descriptors

Case manager	Home improvement specialist
Gofer	Resource developer
Mediator	Supervisor
Decision maker	Researcher
Therapist	Group therapist
Facilitator	Adversary
Financial consultant	Team nurturer
Public relations person	Motivator
Paper pusher	Teacher
Computer operator	Transporter
"Miracle worker"	Banker
Implementer	Educator
Crisis manager	Homemaker
Advocate	Team leader
Coordinator	Listener
Babysitter	Trainer
Problem solver	Watchdog
Conductor	

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