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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Conference Attendees list (partial) (2 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
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FOLDER TITLE:
[National Consensus Building Conference on School-Linked Integrated Service Systems, January 23-24, 1994] [Binder]

2011-0255-S
rc201

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
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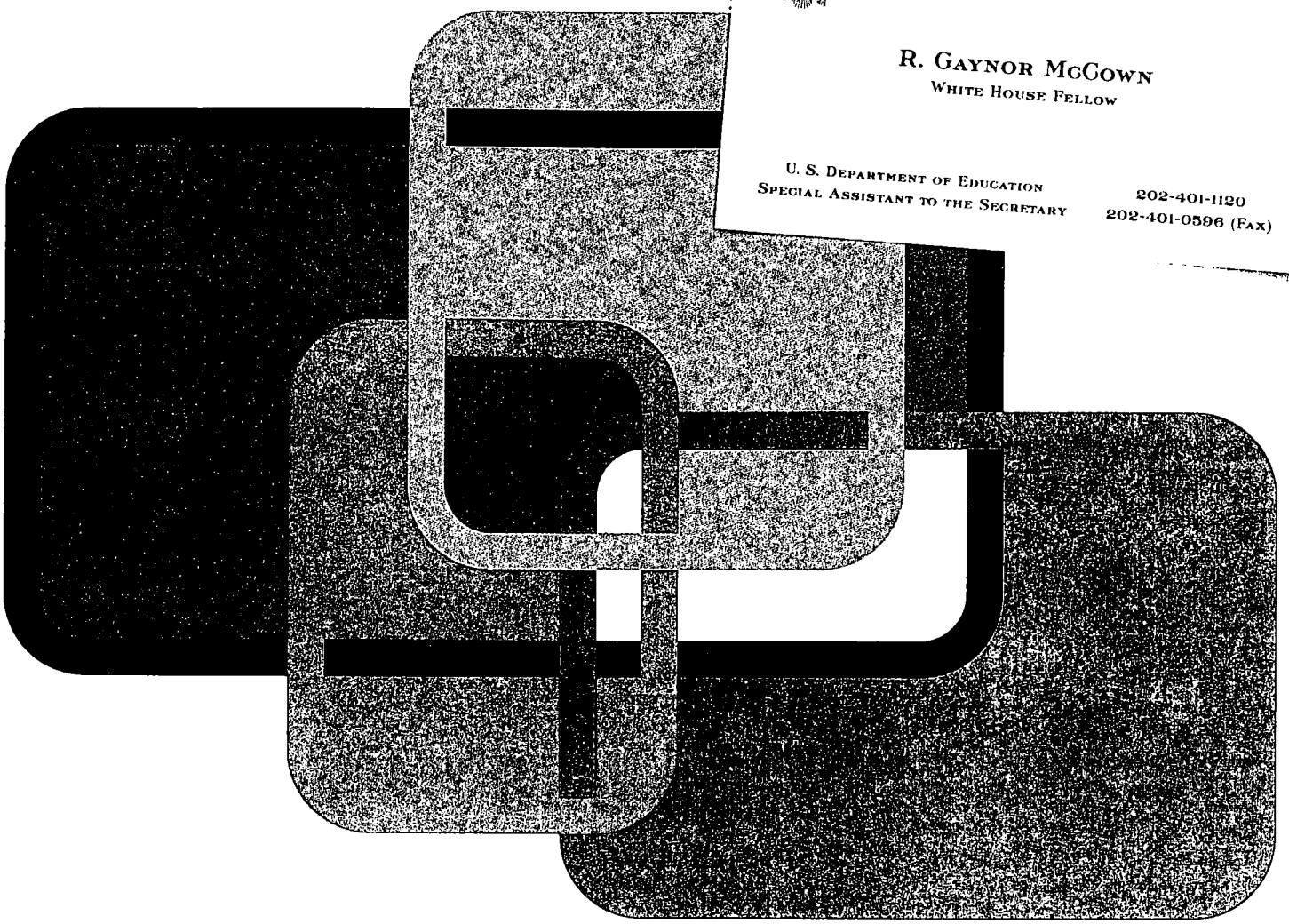

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NATIONAL CONSENSUS BUILDING CONFERENCE ON SCHOOL-LINKED INTEGRATED SERVICE SYSTEMS

January 23 - 24, 1994
Washington, D.C.

Made possible through support from the

Centers for Disease Control and Prevention

Ewing Marion Kauffman Foundation

Maternal and Child Health Bureau
U.S. Department of Health and Human Services

CONTENTS

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1

Divider Title: _____

NATIONAL CONSENSUS BUILDING CONFERENCE
ON SCHOOL-LINKED INTEGRATED SERVICES

THE MISSION

The current, unprecedented efforts by policymakers at all levels of governance to encourage--and often demand--integrated services for children,youth, and families need thoughtful, firm direction and support. The opportunities to improve the well being of the young and of their families have never been greater. The possibilities for falling short of necessary reforms threaten the initiatives so far.

This conference is a unique gathering of organizations concerned with children and youth but not always at the table together. It represents over 50 health care, education, welfare, recreation and related groups/organizations. Its mission is to agree upon a set of principles as a guide for federal, state, and local efforts to put high quality integrated services into place throughout the country. It focuses on developing principles in four areas of concern:

- Elements of effective service
- Funding practices
- Community needs assessment and evaluation
- Structures for coordination

The principles to be designed should address two important goals--assuring effective, efficient services for children, youth, and families and helping the many systems affecting the young and their families to both improve their quality and work together optimally.

The principles are expected to break new ground. However, they will be based upon successful experience so far and visions of the environment sought in the future for our children and their families in this society. The principles will be shared immediately with policymakers at the federal level and disseminated widely by the groups represented at this conference.

The National Consensus Building Conference on School-Linked Integrated Service Systems has been made possible through generous support from the following:

CENTERS FOR DISEASE CONTROL AND PREVENTION

EWING MARION KAUFFMAN FOUNDATION

MATERNAL AND CHILD HEALTH BUREAU
U.S. Department of Health and Human Services

STUART FOUNDATIONS

NATIONAL CONSENSUS BUILDING CONFERENCE ON SCHOOL-LINKED INTEGRATED SERVICE SYSTEMS

SPONSORS

Ewing Marion Kauffman Foundation

Maternal and Child Health Bureau

Centers for Disease Control and Prevention

Stuart Foundations

DATES AND TIMES

January 23, 1994 8:30 A.M. -- 5:00 P.M.
January 24, 1994 8:30 A.M -- 3:00 P.M.

LOCATION

NATIONAL EDUCATION ASSOCIATION HEADQUARTERS
1201 16th Street, N.W.
Washington, D.C.

PLANNING COMMITTEE

American Academy of Pediatrics
American School Health Association
Child Welfare League of America
Council of Chief State School Officers
National Association of School Nurses
National Association of State Boards of Education
National Education Association
National PTA

INVITED PARTICIPANTS

Approximately 50 national organizations that would be involved in the implementation of integrated services systems.

(see reverse side)

INVITATION LIST FOR INTEGRATED SERVICES CONFERENCE

American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Pediatric Dentistry
American Association of School Administrators
American Federation of Teachers
American Medical Association
American Nurses Association
American Psychological Association
American Public Health Association
American Public Welfare Association
American School Health Association
Association of Maternal and Child Health Programs
Association of State and Territorial Health Officials
Center for Population Options
Center for the Study of Social Policy
Children's Defense Fund
Child Welfare League of America
Council of Chief State School Officers
Council of Governors Policy Advisors
Council of the Great City Schools
Family Resource Coalition
Institute for Education Leadership
National Association for the Education of Young Children
National Association of Community Health Centers
National Association of Counties
National Association of Elementary School Principals
National Association of Pediatric Nurse Associates and Practitioners
National Association of School Nurses
National Association of State School NurseConsultants
National Association of School Psychologists
National Association of Secondary School Principals
National Association of Social Workers
National Association of State Boards of Education
National Collaboration for Youth
National Center for Services Integration
National Coalition of Hispanic Health and Human Services Organizations
National Conference of State Legislators
National Council of La Raza
National Education Association
National Governors Association
National Head Start Association
National Health Policy Forum
National League of Cities
National Network of Runaway and Youth Services
National PTA
National School Boards Association
National School Health Education Coalition
National Women's Law Center
National Urban Coalition
Public Education Fund Network
U.S. Conference of Mayors

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American Academy of Pediatrics (Betty Lowe, M.D., Joe Sanders, M.D., Phil Nader, M.D.)
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National Association of School Nurses (Beverly Farquhar, Ann Lowry, Patricia Baum, Judy Ressallat)
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National Education Association (Keith Geiger, Ken Melley, Jim Williams, Diane Shust)
National Parent Teacher Association (Pat Fishback, Marlene Blum, Cathy Belter)

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Center for Population Options (Pam Haughton-Denniston)
Center for the Study of Social Policy (Sara Watson, Ph.D.)
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National Conference of State Legislators (Aaron Bell)
National Governors Association (Margaret A. Siegel)
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Public Education Fund Network (Amanda R. Broun)

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Joy G. Dryfoos, Hastings-on-Hudson, New York, author of soon-to-be-published book Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families. March, 1994

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Karla Shepard, The Conservation Company, Philadelphia, PA

Sheila Sholes-Ross, Center for Early Adolescense, University of North Carolina

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Author Biographies

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Martin J. Blank is the Director of Collaborative Strategies at the Institute for Educational Leadership. He also serves as the Project Director of IEL's Community-Based Services Integration Planning Initiative, which is designed to change the way services are delivered to youth. Mr. Blank recently served as chair of a joint Department of Education/Health and Human Services study group which developed a guidebook, entitled **Together We Can: A Guide for Crafting a Profamily System of Education and Human Services.** He also assisted in writing **What It Takes: Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services,** published by the Education and Human Services Consortium, a consortium for which he serves as facilitator.

Claire Brindis, Dr. P.H., University of California, San Fransisco
Dr. Claire Brindis is an Associate Adjunct Professor in the Department of Pediatrics, Division of Adolescent Medicine at the University of California, San Fransisco, and Executive Director of the National Adolescent Health Information Center. She is also Director of the Center for Reproductive Health Policy Research at the university's Institute for Health Policy Studies. Dr. Brindis has conducted numerous research projects in the area of adolescent pregnancy and pregnancy prevention, and comprehensive school-based health centers in California. Dr. Brindis is the author of **Adolescent Pregnancy and Parenting in California: A Strategic Plan for Action,** and **Adolescent Pregnancy Prevention: A Guidebook for Communities,** as well as a special issue of ETR's **Family Life Educator, "Reducing Adolescent Pregnancy: The Next Steps for Program, Research and Policy"** (Fall, 1990).

Paula Duncan, M.D., Vermont Department of Health
Dr. Duncan is the Maternal and Child Health Director at the Vermont Department of Health. As a pediatric faculty member at Stanford and the University of Vermont Medical Schools, Dr. Duncan worked in school health as a school consultant and the coordinator of the school/community rotations. Most recently she worked fulltime for five years in the Burlington, Vermont, school district as the Health Services Coordinator and during that time became a certified teacher with health education and science endorsements. A pediatrician with a subspecialty in adolescent medicine, Dr. Duncan has been a member of the American Academy of Pediatrics' School Health Committee for three years.

Frank Farrow, Center for the Study of Social Policy
Frank Farrow is currently the Director of Children's Services Policy at the Center for the Study of Social Policy on Washington, D.C. As Director of Children's Services Policy, Mr. Farrow manages technical assistance to states for the purpose of developing innovative children and family service systems that emphasize more cost-effective home-based and community services. He also oversees all children and family services projects. Prior to his appointment as Director of Children's Services Policy, Mr. Farrow served as Executive Director of Social Services Administration at the Maryland Department of Human Resources, Deputy Director for The Center for the Study of Social Policy, and Director of Planning and Evaluation at The Greater Hartford Process and the Community Life Association (CLA) in Hartford, Connecticut.

David W. Kaplan, M.D., University of Colorado School of Medicine
Dr. Kaplan is Professor of Pediatrics, Preventive Medicine and Biometrics, and Chief of Adolescent Medicine at the University of Colorado School of Medicine and The Children's Hospital of Denver. He is member of the Professional Staff of the Institute of Behavioral Science, University of Colorado, Boulder. Dr. Kaplan received his medical degree from Case Western Reserve University School of Medicine, and earned a Masters Degree in Public Health at the Harvard School of Public Health. He did his pediatric residency at the University of Colorado School of Medicine and fellowship in Adolescent Medicine and Ambulatory Pediatrics at Boston Children's Hospital, Harvard University. His current research interest is in process and outcome evaluation of school-based health services. In addition, he is the Director of the National Center for School-Based Health Information Systems funded by the Robert Wood Johnson Foundation, and has authored a software program for school-based clinics, which is in use in over 200 school health centers.

Candace J. Sullivan, Director of the Center on Coordinated Services for Children at the National Association of State Boards of Education
As Director of the Center on Coordinated Services for Children, Candace Sullivan works on policies and programs addressing elementary and secondary education, early childhood and youth development, and housing and community development. She is currently focusing her efforts on an Interstate Coalition on Collaborative Services, an action-oriented "community of learning" aimed at assisting states and localities to overcome operational barriers to collaboration. Candace Sullivan is the author of the following publications: **Code Blue: Uniting for Healthier Youth** and **Bridging the Gap: An Education Primer for Health Professionals.**

Elaine Taboskey Wade, National Association of School Nurses

Elaine Taboskey Wade is presently employed in School Health Services and Health Education in the Washington West Supervisory Union School District in Moretown, Vermont. She was the immediate Past President of the National Association of School Nurses and the Vermont State School Nurses Association. She currently chairs the School Nurse Advisory in the State of Vermont's Department of Education, and the Recognition and Distinguished Service Awards Committee, National Association of School Nurses, Inc.

Federal Officials

The Honorable Christopher "Kit" Bond, U.S. Senator from Missouri (R-MO)
Senator Samuel "Kit" Bond was re-elected to his second term in the U.S. Senate in 1992. He is a supporter of child care and early childhood education. Senator Bond serves on the Labor, Health and Education; Defense; Agriculture; Veterans and Housing; and Treasury Subcommittees of the Appropriations Committee. He is also a member of the Banking, Budget and Small Business Committees. Prior to his election to the U.S. Senate, Senator Bond served as a two-term governor and state auditor. He also served a year as an Assistant Attorney General before running for state auditor. During his second term as governor, Senator Bond launched a nationally-acclaimed early childhood education program.

The Honorable M. Joycelyn Elders, M.D.; U.S. Surgeon General
Dr. Joycelyn Elders was nominated as surgeon general by President Clinton on July 1, 1993. She is the first African-American and the second woman to hold this position. As U.S. Surgeon General, Dr. Elders holds the rank of three-star admiral and also has special responsibilities for PHS' Offices of Population Affairs, Minority Health, Women's Health, and the President's Council on Physical Fitness and Sports. Prior to her appointment as Surgeon General, Dr. Elders was director of the Arkansas Department of Health. During that time, she worked to increase the rate of immunizations, the number of early childhood screening and the number of women receiving early and regular prenatal care. Dr. Elders also played a key role in expanding HIV testing and counseling services, breast cancer screening, and in-home services for terminally ill patients. In 1992, Dr. Elders was elected president of the Association of State and Territorial Health Officers. As a member of the Little Rock Chamber of Commerce, Northside YMCA and Youth Homes, she has also been active in community affairs.

The Honorable Olivia A. Golden, U.S. Department of Health and Human Services
As Commissioner of the Administration on Children, Youth and Families, Olivia Golden oversees a variety of programs for children and families, including the Head Start Bureau, the National Center for Child Abuse and Neglect, the Family and Youth Services Bureau and the Children's Bureau. She has been instrumental in the implementation of the Family Preservation and Support Services program. Prior to joining the Administration, Olivia Golden was Director of Programs and Policy for the Children's Defense Fund and served as the Budget Director for the Executive Office of Human Services in the Commonwealth of Massachusetts. She has also chaired the Advisory Committee on Children and Youth for the city of Cambridge. Olivia Golden recently published a book entitled, **Poor Children and Welfare Reform.**

The Honorable William F. Goodling, U.S. House of Representatives (R-PA)
Congressman Goodling is serving his tenth term as Representative from Pennsylvania's 19th District. He was elected to the U.S. House of Representatives in 1974. He serves on the Committee on Education and Labor as Ranking Minority Member. He is also Ranking Minority Member of the Subcommittee on Elementary, Secondary and Vocational Education. As a strong supporter of high quality education, Congressman Goodling played a key role in enacting the National Literacy Act, legislation designed to combat illiteracy. In 1992, he received the National Center for Family Literacy's first Public Policy Advocate Award. He also supports greater flexibility for education programs and plans to introduce legislation encouraging schools to coordinate social service programs to assist children and their families. Representative Goodling is a member of the National Education Goals Panel. Congressman Goodling is a supporter of child nutrition and child care issues.

The Honorable Edward M. Kennedy, U.S. Senator from Massachusetts (D-MA)
Senator M. Kennedy was elected to the U.S. Senate on November 6, 1962. Senator Kennedy is strongly dedicated to strengthening American families and communities. He is Chairman of the Labor and Human Resources Committee, which is working closely with the Clinton Administration for advancements in the area of jobs and job training, education, health care and national service. Senator Kennedy is also a senior member of the Judiciary Committee, Armed Services Committee and the Joint Economic Committee.

Robert F. St. Peter, MD; U.S. Department of Health and Human Services
Dr. Robert St. Peter is the Luther L. Terry Senior Fellow and Coordinator of Children and School Programs, in the Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services. He is a pediatrician with experience in health services research, health policy and international health. Dr. St. Peter completed his training in pediatrics at the University of Colorado Health Sciences Center, where he also served as Chief Resident and Clinical Instructor. Prior to joining the U.S. Public Health Service in 1992, Dr. St Peter was a Robert Wood Johnson Clinical Scholar at the University of California, San Francisco. As a Clinical Scholar, he was instrumental in improving the delivery systems for primary care and preventive services to children and their families. His research focused on financial and nonfinancial barriers to health services for children. In his current position with the Department of Health and Human Services, Dr. St. Peter coordinates the children and school programs in the Office of Disease Prevention and Health Promotion.

Terry K. Peterson, Counselor to the Secretary of Education
Before serving as Counselor to the Secretary of the U.S. Department of Education, Terry K. Peterson was the executive director of the South Carolina Business-Education Committee, a committee which monitors South Carolina's comprehensive education reform packages. He served on the Task Force on At-Risk Children and Youth of the Chief State School Officers Association. He was an education advisor to the 1990 National Committee for Economic Development and to the 1992 Education Testing Service project on the National Assessment for Educational Progress. Peterson also served on the Executive Committee of the Center for Policy Research in Education.

The Honorable Janet Reno, U.S. Attorney General
Janet Reno was appointed Attorney General of the U.S. by President Clinton on March 12, 1993. Prior to her position as Attorney General, Ms. Reno served as the State Attorney in Miami, Florida. From 1976 to 1978, Ms. Reno was a partner in the Miami-based law firm of Steel, Hector & Davis. After starting her legal career in private practice, she served as an assistant state attorney and as Staff Director of the Florida House of Representatives Judiciary Committee. She also served as President of the Florida Prosecuting Attorneys Association and was a member of the Special Committee on Criminal Justice in a Free Society of the American Bar Association and the Task Force on Minorities and the Justice System of the American Bar Association. As an advocate for innovative early intervention and prevention programs, Ms. Reno strongly supports Federal, state and local partnerships to combat crime and violence by utilizing our limited resources more effectively.

The Honorable Lynn C. Woolsey, U.S. House of Representatives (D-CA)
Representative Woolsey was elected to the U.S. House of Representatives in 1992 and represents California's Sixth Congressional District. In the House, she serves on three influential committees: Budget, Education and Labor, and Government Operations. As a member of the Elementary, Secondary and Vocational Education Subcommittee, she is working closely with the Clinton Administration on its education reform legislation and on the upcoming reauthorization of the Elementary and Secondary Education Act. She is also playing a leadership role in the development of integrated services policies on the committee. As a member of the Human Resources Committee, she is working to expand Head Start to an all-day, year-round program. Representative Woolsey is strongly dedicated to women and family issues. She was the first newly elected member of Congress to cosponsor the American Health Security Act of 1993.

Facilitator Information

Raymond J. Baxter, Ph.D., Lewin-VHI, 9302 Lee Highway, Suite 500, Fairfax, Virginia. Dr. Baxter joined Lewin-VHI in September 1993 as Senior Vice President. He heads the firm's national pubic policy practice and his consulting focuses on the areas of health systems reform, policy development, operations and administration, strategic planning, and the management of change. He has worked with both state and local governments and has particular expertise in the areas of public health, mental health, long-term care, and HIV-related services. Dr. Baxter has over 20 years of experience in public health management.

Dr. Barbara Bazron is a Vice President of Lewin-VHI. She joined Lewin-VHI as Director of the Center for Substance Abuse Prevention's National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs in 1991. The CSAP National Resource Center is the nation's focal point and repository of information and expertise related to perinatal substance abuse. The Center provides technical assistance, training and information to policy-makers and practitioners. Her responsibilities include the supervision of 30 employees, management of an annual budget of five million dollars and interface with government officials and experts in the field to develop and refine components of the operation.

Rachel L. Feldman, M.P.A., joined Lewin-VHI in July, 1989, as a Project Manager. She has 18 years of experience in the development and management of health care facilities and social service programs as well as expertise in strategic planning and policy analysis. Ms. Feldman has considerable experience in the fields of mental health and substance abuse as well as health care and social services targeted at children, families, and the elderly.

Susanna Ginsburg is a Lewin-VHI Vice President with over 20 years of experience with public health service programs beginning with a review of the evaluation efforts of all Public Health Service agencies in 1972. Since that time, Ms. Ginsburg has conducted a number of studies for the Department of Health and Human Services and private clients related to issues of maternal and child health, substance abuse, primary care and other service delivery issues, health professions, and program evaluation.

Debra G. Morris is a Project Manager at Lewin-VHI. She serves as Deputy Director of Center for Substance Abuse Prevention National Resource Center for the Prevention of Perinatal Substance Abuse of Alcohol and Other Drugs, which is the central repository of information related to perinatal substance abuse of alcohol and other drugs. Prior to joining Lewin-VHI, Ms. Morris was Health Education Specialist at the Emory University AIDS Training Network.

January 24, 1994
Participants for Federal Perspective Panel
National Consensus Building Conference on Integrated Services
8:30 a.m. through 12:00 p.m.
National Education Association, 1201 16th Street, N.W., Washington, D.C.
Main Auditorium

8:30 a.m.
The Honorable Janet Reno
Keynote address by the Attorney General

9:15 a.m. through 10:30 a.m.
The Honorable Edward M. Kennedy
Chairman, Senate Labor and Human Resources Committee

The Honorable Christopher S. Bond
Member, Senate Banking, Housing and Urban Affairs Committee

The Honorable Lynn C. Woolsey
Member, House Education and Labor Subcommittee on Elementary, Secondary, and Vocational Education

The Honorable William F. Goodling
Ranking Member, House Education and Labor Committee

10:45 a.m. through 12:00 p.m.
Terry K. Peterson
Counselor to Secretary
U.S. Department of Education

The Honorable Olivia Golden
Commissioner, Administration for Children, Youth and Families
U.S. Department of Health and Human Services

Robert F. St. Peter, M.D.
Coordinator, School Health Initiatives -- Public Health Service
U.S. Department of Health and Human Services

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January 21, 1994 at 12 p.m.

DRAFT

STATEMENT OF PRINCIPLES

Introduction

The changing environment for growing up in America is unprecedented and in many ways irreversible. Children, youth, and families cannot expect to return to simpler times, their future well being depends in part upon vast human service systems working together efficiently, effectively, and humanely. The leadership of these various systems--education, health, social and other human services--is taking significant steps to make that happen. At Federal, state and local levels, they are endeavoring to create comprehensive support for every child and young person.

Emerging out of these experiences are some common principles. If these were to underlie services in every context and in every place, they would strengthen individual services and help create the seamless, nurturing environment for growing up that our children and families need. The principles are not superficial

or rhetorical assumptions. They are based on knowledge gained from many efforts underway. They do more than just spell out new ways of conducting business in most of our institutions. They would require a transformation in how professionals, agencies, and organizations relate children and families.

Certainly, we do not propose a single model. Our consensus is around a set of values and principles that strengthen the individual visions and efforts of communities and states across the country.

Most definitely, however, we cannot tolerate any delay. The needs are too great and the opportunities for change too prominent for policymaking to ignore a consensus about the future presented in these principles by the leadership of groups committed to the well-being of our young. We want our children to have the best; we have the capacity to create the best; we need support for those goals.

THE BASIC ELEMENTS OF EFFECTIVE SERVICES

The myriad of physical, emotional, and social problems surrounding children, youth, and families today need not overwhelm them. Successful interventions are in place through and across health systems, schools and preschools, social services, child care, and income supports. For children to grow up in supportive environments and for services to realize their full potential, these elements should be part of all initiatives:

1. **Services should be community based and community delivered.** The needs of children, youth, and families can vary dramatically from community to community. Similarly, communities have different strengths and resources for meeting these needs. Services and support programs must, therefore, be locally planned, operated, and evaluated with broad public and private community involvement. Moreover, families and youth should be partners with professionals in defining and delivering services.

2. **Services should be family centered and client driven.** All too often, education, health, and social services do not achieve their objectives because they are designated for bureaucratic needs rather than client needs. Together, families and providers must be able to construct services that are welcomed by families,

support family independence, and strengthen community ties. The desired result will enhance their capacity to draw on their strengths and make sound decisions.

3. Services should be universally available. Children, youth, and families in need are everywhere. Improved, committed services-delivery systems must exist in all communities, providing high-quality education, health, social, family support, and other human services to all who need them.

4. Services should be culturally competent. In some localities, providers and those they serve do not share common backgrounds and/or experiences; services or styles of provision may be valued by some but ineffective and offensive to others. Programs and staff must be responsive to the needs of culturally, ethnically, linguistically, and economically diverse populations.

5. Services should focus on prevention and early intervention. Services that strengthen the ability of children, youth, and families to help themselves often avert the need for acute care when intervention becomes more complex, problematic, and expensive. Greater emphasis must be placed on preventing or mitigating more serious problems by ensuring that all children and youth have a high-quality education, varied opportunities for growth and development, a consistent source of preventive and

primary care, and, when needed, family support and early intervention.

6. Services should be flexible. Adherence to rigid requirements significantly decreases the ability to be effective. Services must be adapted to individual circumstances and provided at convenient times and places. Agency personnel must allow discretion for those in direct contact with children and families. With increased flexibility comes accountability for results based on the outcome goals of the different agencies/organizations and individuals involved.

7. Services should be comprehensive. Children, youth, and families with numerous problems need support and assistance in a variety of contexts. Addressing education or behavior problems without attending to family or health problems is seldom effective. Individualized, inclusive services must be developed, and for seriously vulnerable families, these must be intensive. Round-the-clock coverage must be available under emergency situations.

8. Services should be coordinated, integrated, and collaboratively delivered. Comprehensive services cannot be effectively delivered in piecemeal fashion. To the widest extent possible, professional disciplines must be blended within a

unified structure. Changes in personal circumstances (e.g., marital status or income) must not interrupt needed services.

9. Services should be of high quality. To ensure the highest standards of service, accountability systems keyed to desired outcomes must be in place. Staff must be fully qualified and know how to work effectively with the children, youth, and families for whom they are professionally responsible. They must be able to work on their own in collaboration with others across programs and disciplines.

10. Services should be cost-effective. Resources are too scarce to be invested when they cannot be effective and efficient. Resources must be focused on programs with a high likelihood of demonstrably enhancing life prospects of children, youth, and families at a reasonable cost.

THE ROLE OF FINANCING

Financing strongly influences the scope, characteristics, and effectiveness of services and support available to children, youth, and families. Current financing patterns erect major barriers to coherent and comprehensive services. Changes in financing work only when accompanied by changes in the way services are planned, organized, and delivered; staff are prepared and supported; governance mechanisms are structured; and perhaps most important, how accountability is ensured.

1. Funding should be tied more to desired results and less to specific types of services. New financing patterns must identify the outcomes of services desired for children, youth, and families -- and allow greater flexibility in how dollars are used to achieve these results. This approach requires budget strategies that link decisions about resource allocation to investments that will improve outcomes. It also calls for investments that develop community capacities to set and measure outcomes and evaluate the quality of services. In addition, it requires governance changes to allow regular, ongoing assessment of outcomes that cut across service boundaries.

2. Funding should allow for greater flexibility at the points closest to actual delivery of services. So funding can be responsive to real needs, new financing mechanisms must provide considerable latitude for decisions at the local level. These changes must be accompanied by increased investment in staff development to ensure that both managers and those who work directly with families have the necessary skills for decision making about the use of funds.

3. Funding should be provided in a way that promotes inter-agency and inter-system decisionmaking. At the state, and especially at the community level, new funding mechanisms must require shared decisionmaking about the allocation of dollars across all the education, health, social, and other human services systems affecting the success and healthy development of young people. This does not mean that all funds are to be pooled. However, there must be a resource plan that tracks all funding going to children, youth, and families. Individual funding decisions should take this overall picture into account.

4. Dollars gained by heading off the "cost of failure" and increased efficiency should be invested in prevention and early intervention. Preventive and early intervention services can avoid the need for expensive, crisis-oriented solutions. More

efficient delivery of services can produce such savings. In many instances, the savings are considerable and can be quantified.

5. Funding should protect vulnerable and minority populations. All funding decisions must preserve and strengthen concerns for equity with firm expectations that certain populations be adequately served. This type of assurance need not be as prescriptive as current categorical restrictions. Priorities can be established without rigidly prescribing the services to be provided or the populations to be targeted.

THE ROLE OF NEEDS ASSESSMENT AND PROGRAM EVALUATION

It will be a formidable challenge for communities to establish and measure progress toward the outcomes for which they will be held accountable. Yet, needs assessment and program evaluation are critical to any community's effort to put effective services in place. This is now a major concern of federal, state, and private funders and should also be a priority for communities and sincerely committed to better outcomes for children, youth and families.

1. **Needs assessment and program evaluation should be part of an ongoing process.** Consistent, reliable information will help communities monitor and determine progress toward common goals and increase program effectiveness through midcourse corrections. The result should be current, useful knowledge about services and their integration, as well as insights into how successful programs might be transferrable to other settings.

2. **Needs assessment and program evaluation must be tailored to each community and shaped by community members.** Needs assessment and program evaluation must be conducted by those with community credibility who are broadly representative of the community. These could include representatives of families, public and private agencies, professional associations, those working

directly with families (including professionals in independent practice), community-based organizations, businesses, and elected and appointed officials. This must be done along with the welfare of children at the center because there will be understandable tensions among professionals, community members, elected officials, and other decisionmakers.

3. **Needs assessment should focus on community strengths.** Strengths and available resources must be assessed as well as needs and service gaps as communities consider the outcomes they want and for which they are willing to be held accountable.

4. **Public and private funders should balance requirements for outcomes-based accountability with the need to encourage services innovation.** Accountability systems must not unfairly penalize communities, distort program activities, or inhibit communities from pioneering new ways to deliver services. Similarly, federal and state programs must not pressure communities to achieve outcomes prematurely. Outcomes must be realistic in relation to available resources. Sufficient time must be allowed to test, measure and refine interventions.

5. **Needs assessment and program evaluation should increase the capacity of communities to obtain and define the information they**

need to accomplish their objectives. Developing community capacity to make self-assessments will provide feedback that will improve ongoing interventions and help ensure buy-in. In addition, communities must work closely with external evaluators to ensure that evaluations are useful, defensible, and reflect realistic time frames.

6. **To support new approaches to service delivery, investment should be made in developing multiple strategies for needs assessment and program evaluation.** New systems need new approaches. Current methodologies may not be sufficient to document benchmarks, outcomes, and the key components that contribute to measurable results in the multitude of existing services. Using a variety of approaches compensates for limitations inherent in any one. In some instances this may require investment in new and innovative technologies.

7. **Communities should receive support and guidance in assessing needs and measuring progress.** To date, the complexity of conducting research on integrated services has prevented full assessment of the impact of many efforts. Most communities will only be able to take on these tasks if they have adequate resources and comprehensive, technical assistance. This investment must be a priority even in light of the decreasing resources available for services delivery.

THE IMPORTANCE OF STRONGER STRUCTURES FOR COORDINATION

Creating a comprehensive system of services for children, youth, and families requires coordinating structures that cut across service sectors, agencies, and programs. Such structures are now evolving. They range from informal to legally established organizations, from entities created through memoranda of agreement to groups operating with the sanction of key governmental bodies. Serving as intermediary organizations, they facilitate and negotiate relationships among public, private, and community agencies and independent practitioners. Their aim is to assure a full spectrum of effective and high-quality services that sustain children, youth, and families. Their effectiveness will depend in part upon their developing operational systems and other tools to support collaboration.

1. **The coordinating structure should be a collaborative.** For the coordinating structure to function as a cohesive force, all stakeholders in the enterprise must agree to develop and pursue a shared vision and common goals; share resources, responsibility and accountability; and use their personal and institutional power to change their systems and increase overall community support for children, youth, and families.

2. The coordinating structure should be community based and reflect the diversity and unique characteristics of the community. To be credible and legitimate, the coordinating structure must reflect the racial, ethnic, income, and age characteristics of the community. At a minimum, its members must include representatives of families, public and private agencies, professional associations, those working directly with families (including professionals in independent practice), community-based organizations, businesses, and appointed and elected officials.

3. The coordinating structure should be empowered to govern. An effective coordinating structure must have the legitimacy and authority to make decisions that cut across existing services-delivery systems. It must also have a sufficient mandate from public and private service providers and political bodies--for example, school boards, county government, city government, states, professional associations, and United Way--to plan and implement services-delivery and systems-level changes.

Such a mandate should include significant influence over the use of resources within a community, but does not necessarily include direct authority over resources under the control of other governmental structures. The latter would reach beyond issues of

coordination and collaboration to a fundamental reorganization of state and local governance, as well as change in federal law.)

A coordinating structure with the formal sanction of the established governance structures has the greatest potential to establish its credibility and sustain itself over time.

4. The coordinating structure should have flexibility in defining geographic boundaries and institutional relationships. Where the state has responsibility for services delivery, the state and its communities must work together to define geographic areas that make sense. Furthermore, communities must be granted flexibility to sort out the relationships among the numerous collaborative and established governance structures in their localities.

5. A coordinating structure should establish and maintain a results-based accountability system. If systemic changes in the way services are planned, organized, and delivered are to be effective and durable, all public and private service providers must be accountable for achieving specified outcomes. Such responsibility includes reaching agreements on outcome measures for child, youth, and family well-being and for the performance of their systems.

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Divider Title: _____

WORKGROUP I *11:00 a.m. - session 1*
CONF. ROOM A *1:30 p.m. - session 2*
Facilitator - Dr. Barbara Bazron

NAME	*ORGANIZATION*
Claire Brindis, Dr, PH	*Institute For Health Policy Studies*
Judy Langford Carter	*Family Resource Coalition*
Rep. Ronald Cowell	*Nat'l Assn. State Bds. of Education*
Beverly Farquhar, RN, BS, CSN	*Nat'l Assn. of School Nurses*
JoAnne Favors, PhD	*National Urban Coalition*
Elizabeth Ford	*Nat'l Assn. for the Ed. of Young Children*
Robert Fox, EdD	*American Assn. of School Administrators*
Keith Geiger	*Nat'l Education Assn.*
Robin Gierer	*Missouri Dept of Social Services*
Rae Grad, RN, PhD	*Institute for Educational Leadership*
Merrie Hahn	*Nat'l Assn. of Elementary School Principals*
Alyce Hill, PhD	*Cities in Schools*
Mayor Dorothy Inman-Crews	*Nat'l League of Cities*
Tom Joseph	*Nat'l Assn. of Counties*
Joe Kimbrell	*Assn. of State & Territorial Health Officials*
David Liederman	*Child Welfare League of America*
Betty Lowe, MD	*American Academy of Pediatrics*
James Price, PhD, MPH	*American School Health Assn.*

WORKGROUP II *11:00 a.m. - session 1*
CONF. ROOM B *1:30 p.m. - session 2*
Facilitator - Susanna Ginsburg

Name	***ORGANIZATION***
Aaron Bell	*Nat'l Conference of State Legislators*
Martin Blank	*Institute for Ed. Leadership*
Marlene Blum	*National PTA*
Deborah Both	*Nat'l Center for Service Integration*
Joan Buckley	*American Federation of Teachers*
Sibyll Carnochan	*Council of Chief State School Officers*
Pat Cooper, EdD	*Nat'l School Health Ed. Coalition*
Kevin Dwyer, MA, NCSP	Nat*'l Assn. School Psychologists*
Maggie Holmes	*Nat'l Head Start Assn.*
Judith Igoe, RN, MS	*American Nurses Assn.*
Linda Johnston	*MCH Bureau- HHS*
Julia Lear	*Making The Grade-GWU*
Lani Smith Majer, MD	*American School Health Assn.*
Karabelle Pizzigati	*Child Welfare League of America*
Steve Roling	*Ewing Marion Kauffman Foundation*
Joe Sanders, MD	*American Academy of Pediatrics*
Nadine Schwab, PNP, MPH	*Nat'l Assn. State School Nurse Consultants*
Karla Shepard	*The Conservation Company*
Brenda Welburn	*Nat'l Assn. State Bds. of Education*
Jim Williams	*Nat'l Education Assn.*

WORKGROUP III *11:00 a.m. - session 1*
CONF. ROOM C *1:30 p.m. - session 2*
Facilitator - Godfrey Jacobs

NAME	***ORGANIZATION***
Cathy Belter	*National PTA*
Christel Brellochs	*Columbia University*
Joy Dryfoos	*Independent Researcher*
JoAnn Gephart	*MCH Bureau - HHS*
Maureen Glendon, CRNP	*Nat'l Assn. of Ped. Nurse Assoc. & Practioners*
Lucy Hackney	*Children's Defense Fund*
Linda Meltzer	*Center for the Study of Social Policy*
Phil Nader, MD	*American Academy of Pediatrics*
Margo Quiriconi	*Ewing Marion Kauffman Foundation*
Judith Ressallat, RN, MSN, MPA	*Nat'l Assn. of School Nurses*
Robert Rinaldi, PhD	*American Medical Assn.*
Bill Shepardson	*Council of Chief State School Officers*
Margaret Siegel	*National Governors Assn.*
Ann Sullivan	*Child Welfare League of America*
William Soult	*Nat'l School Board Assn.*
Sara Watson, PhD	*Center for the Study of Social Policy*

WORKGROUP IV *11:00 a.m. - session 1*
***CONF. ROOM* G** *1:30 p.m. - session 2*
Facilitator - Rachel L. Feldman, MPA

NAME	ORGANIZATION
Patricia Baum, RN, MA, CSN	*Nat'l Assn. for School Nurses*
Jacqueline Danzberger	*Institute for Ed. Leadership*
Paula Duncan, MD	*VT Dept. of Maternal & Child Health*
Juanita Evans	*MCH Bureau - HHS*
Pat Fishback	*National PTA*
Jerry Kitzi	*Ewing Marion Kauffman Foundation*
William Lieberman, DDS	*American Academy of Pediatric Dentistry*
Amelia Loomis	*Stuart Foundation*
Deborah McLellan, MHS	*American Public Health Assn.*
Nexus Nichols	*Nat'l Network Runaway of Youth Services*
Sheila Sholes-Ross	*University of North Carolina*
Diane Shust	*Nat'l Education Assn.*
Candace Sullivan	*Nat'l Assn. for State Bds. of Education*
Damian Thorman	*American Academy of Pediatrics*
Mary Vernon, MD	*CDC*
Deborah Klein Walker	*Assn. of Maternal & Child Health Programs*

WORKGROUP V *11:00 a.m. - session 1*
TRENHOLM ROOM *1:30 p.m. - session 2*
Facilitator - Debra G. Morris

NAME	ORGANIZATION
Diane Allensworth, PhD, RN	*American School Health Assn.*
Amanda Broun	*Public Ed. Fund Network*
Michael Casserly	*Council of the Great City Schools*
Frank Farley, PhD	*American Psychological Assn.*
Isadora Hare, ACSW	*National Assn. of Social Workers*
Pam Haughton-Denniston	*Center for Population Options*
Jeanette Hercik	*Council of Governor's Policy Advisors*
David Kaplan, MD, MPH	*Denver Children's Hospital*
Lloyd Kolbe, PhD	*CDC*
Jane Koppelman	*National Health Policy Forum*
R. Dee Legako, MD	*American Academy of Family Physicians*
Ann Lowry, RN, BSc	*Nat'l Assn. of School* Nurses
Freda Mitchem	*Nat'l Assn. of Community Health Centers*
Adele Robinson	*Nat'l Assn. of State Bds. of Ed.*
Elaine Taboskey-Wade, RN, MEd	*Nat'l Assn. of School Nurses*

OBSERVER WORKGROUP ASSIGNMENTS
11:00 a.m. - session 1
1:30 p.m. - session 2

NAME	*ROOM*
Stephanie Dort Bryn, MPH MCHB - HHS	*CONF. RM A*
Kate Fothergill Columbia University	*CONF. RM C*
Elaine Lawson IOM	*CONF. RM B*
Ann Lewis Conference Reporter	*FLOATING*
Wayne Riddle CRS - Library of Congress	*CONF. RM A*
Valerie Setlow IOM	*CONF. RM G*
Robert St. Peter, MD HHS	*CONF. RM A*
Kathy Sanabria AAP	*TRENHOLM RM*
Laura Sherman Tufts University	*TRENHOLM RM*
Kaye Vander Ven, RN, MPH MCHB - HHS	*CONF. RM B*
Ruth Wasem CRS - Library of Congress	*CONF. RM B*
Judy Wurtzel U.S. Dept. of Education	*CONF. RM B*

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Divider Title: _____

ISSUE PAPERS PREPARED FOR THE

NATIONAL CONSENSUS BUILDING CONFERENCE

ON

SCHOOL-LINKED INTEGRATED SERVICE SYSTEMS

1. ELEMENTS OF EFFECTIVE SERVICES

2. FINANCING SCHOOL-LINKED COMMUNITY SERVICES AND SUPPORTS

3. NEEDS ASSESSMENT AND PROGRAM EVALUATION: ASSURING ACCOUNTABILITY IN SCHOOL-BASED AND SCHOOL-LINKED INTEGRATED SERVICES SYSTEMS FOR CHILDREN, YOUTH, AND FAMILIES

4. DEVELOPING COLLABORATIVE COMMUNITY GOVERNING BODIES: IMPLICATIONS FOR FEDERAL POLICY

ELEMENTS OF EFFECTIVE SERVICES

Prepared for
the National Consensus Building Conference
on School-Linked Integrated Service Systems

Paula Duncan
Candace Sullivan
Elaine Taboskey-Wade

ELEMENTS OF EFFECTIVE SERVICES

IMPORTANCE OF DEFINING ELEMENTS OF EFFECTIVE SERVICES

Children and youth today are coping with a myriad of physical, emotional, and social problems. Yet these need not predestine them to negative outcomes. There are successful interventions operating through the health systems, schools and preschools, social services, child care and income supports. As one examines these successes, common patterns emerge across systems and professional disciplines that characterize effective programs. (Schorr, 1992) This paper will outline what research and experience suggests to be elements of effective services. It will also discuss barriers to communities putting in place such services, many of which can be overcome through the development of more effective service delivery systems.

PRINCIPLES OF EFFECTIVE SERVICES

Elements of our education and human service systems must be radically reconfigured if we are to improve the quality, effectiveness, and impact of education, health, social, family-support, and other programs aimed at improving the life prospects of many of today's children and families. It must be recognized that the problem is not the failure of agencies and programs to collaborate per se, but rather to operate effectively both individually and in tandem towards common objectives. To be effective, services must be:

1. COMMUNITY-BASED AND COMMUNITY-DELIVERED

   The needs of children and families can vary dramatically from community to community. Similarly, communities have different strengths and resources they can bring to bear to address these needs. For this reason it is important that services and support programs be locally planned, operated and evaluated. There must be broad public and private community involvement that includes meaningful input from community youth and all the community members who touch the lives of affected children and adolescents.

2. FAMILY-CENTERED AND CLIENT-DRIVEN

   All too often services are designed for agency administrative convenience. The result is often services that are un-used, or if used, do not achieve their objectives because they meet bureaucratic needs more than client needs. Families and

providers need to build relationships which are characterized by mutual trust and respect. Together they can design services that are more consumer friendly and better meet family needs. In this regard, it is important that services focus on supporting family independence and integration. Specifically, services should enhance individuals' capacity to draw on their strengths and make sound decisions for themselves and their families.

3. CULTURALLY-COMPETENT

This nation is culturally, ethnically, linguistically, and economically diverse. In some localities, service providers and service recipients do not share common background and experience. This creates substantial challenges. Services or styles of services provision that are valuable and welcomed by some may be ineffective and offensive to others. It is essential that services be culturally competent if they are to achieve their objectives. One way to achieve this is to include individuals with appropriate backgrounds on agency staffs. Another is to prepare staff to work more effectively with various population groups through orientation, training, and on-going support activities.

4. PREVENTION AND EARLY INTERVENTION-FOCUSED

Prevention and developmental services that strengthen the capacities of children and families to help themselves often avert the need for acute, problem-oriented services. Notwithstanding, our current systems tend to emphasize services for those with severe problems or in crisis. Intervention at these later stages is more complex, problematic, and expensive. Greater emphasis needs to be placed on preventing or mitigating more serious problems before they occur or get out of control by assuring all children and youth have a quality education, a consistent source of preventive and primary care, and family support and early intervention services as needed.

5. FLEXIBLE

Effective services are adapted to individual circumstances and provided at times and places that are convenient to families. To do this, agency personnel need front line worker discretion. Asking them to rigidly adhere to standardized principles significantly decreases their ability to construct effective service packages. Such increased flexibility must be accompanied by a shift to outcome-based accountability aimed at allowing maximum discretion in how children and families are supported while ensuring that agency and organizational goals are achieved.

6. COMPREHENSIVE

Children, youth, and families with multiple problems need support and assistance in a variety of domains. Addressing education or behavior problems without attending to family or health problems is seldom effective. For this reason, individualized (and for seriously vulnerable families, intensive) inclusive services packages need to be developed. Provisions should be made to assure continuous 24 hour coverage under emergency situations.

7. COORDINATED, INTEGRATED, AND COLLABORATIVELY DELIVERED

Comprehensive services cannot be effectively delivered piecemeal. To the extent possible, there should be a seamless blending of disciplines within a unified structure. Also important is to assure continuity so that a change in circumstances (e.g., marital status or income) does not interrupt services.

8. UNIVERSALLY AVAILABLE

Children, youth, and families in need of assistance should not be penalized for living in certain states or communities. Service delivery systems should be in place in all communities and high quality education, health, social, family support, and other services should be available to all who need them.

9. HIGH QUALITY

Those providing services should be appropriately prepared both to operate independently and with others across programs and disciplines. Accountability systems need to be in place to assure quality that factor in ability to work effectively with clients as well as professional qualifications.

10. COST EFFECTIVE

Resources are too scarce to warrant investment in services with a poor prognosis for success. Attention must be paid to placing resources where there is a high likelihood of their demonstrably enhancing the life prospects of children, youth, and families at a reasonable cost.

OVERCOMING BARRIERS TO EFFECTIVE SERVICES DELIVERY

Some fundamental changes must occur in our current service delivery systems if we are to achieve effective services. In particular there needs to be a transformation in the way professionals, agencies, and organizations interact with children and families. There are actions that can be taken to help assure this occurs. These include:

1. Forming interdisciplinary teams and partnerships

A wide variety of organizations and professional disciplines have responsibilities for improving the condition of children and families. Most recognize that today's children and families have multiple and complex problems that are most effectively addressed in tandem. Accomplishing this requires the formation of interdisciplinary teams and partnerships.

Such partnerships work best when partners share a common vision, have the same or complementary goals, and focus on improved outcomes. This enables them to combine resources, authority and leadership to achieve goals unattainable without collective action. In the process of working together, they develop common language and greater understanding of their partners' organizational and professional culture and structure. This strengthens their working relationships and helps to assure that mutual objectives are met.

2. Developing operating systems and techniques that facilitate interdisciplinary, interagency collaboration

Many partnerships are able to reach agreement on goals and objectives, and prepare plans for how these might be achieved. Where they run into trouble is with implementation. There are serious structural problems affecting effective service delivery that must be addressed if agencies are to operate effectively both individually and in tandem towards common objectives.

A crucial need is to modernize agency administrative practices. Particularly important are budgeting systems that display all resources going to child and family programs (global budgets), software supporting automated streamlined eligibility determinations, and consolidated management information systems.

Also essential is to create systems to blend, consolidate, and link funding streams to form a seamless fabric of services. One promising approach is consolidated state and local plans as have been developed by Indiana and West Virginia.

Major investment will be required to reorient and retool administrators and line staff at state and local levels and in both public and private agencies to assume new and different roles and responsibilities, change organizational culture, and facilitate family and public participation in decision making. Also, many jobs will have to be redefined and provisions made to assure staff have the time and support to build relationships of trust and respect with children and families.

Once some of these fundamental changes are made, it will be easier for communities to design and operate effective service programs. It will also increase their ability to apply promising techniques for cross-program collaboration such as case management, coordinated care, co-location of staff, and one stop shopping centers, to name only a few.

3. Addressing resource needs

Even if all programs collaborated and improved their efficiency and effectiveness there would still be a need to increase the level of resources devoted to children and families. Creative solutions need to be found such as dedicated taxes, community service jobs, and programs to improve community infrastructure.

In any case, where savings are attained through more efficient, effective and collaborative service delivery, they should be plowed back into children's and family programs.

In summary, it is essential to establish effective systems of support for children and families that will ensure all children are able to achieve positive outcomes. Services must be designed to promote the general development of all children as well as respond to the specific needs of children and families experiencing difficulties.

IMPLICATIONS FOR ACCOUNTABILITY SYSTEMS

Standards and systems for quality assurance and cross-sector, performance-oriented accountability will encourage a movement towards more effective services and service systems. This would encourage communities to define the outcomes that they seek in positive terms and align actions to achieve those positive objectives.

Performance-oriented accountability systems need good indicators of progress if they are to be credible. In most instances, it will be necessary to revamp data collection, eligibility, and intake systems in order to jointly track outcomes for children and families.

Accountability systems need to be established at the community level to assure community objectives are accomplished. They also need to be established at the county/municipality and state levels to assure funds are responsibly and effectively used.

ISSUES IN NEED OF FURTHER DISCUSSION AND DEBATE

1. The setting of funding priorities

   The unfortunate reality of resource constraints requires that priorities be established. Among the issues upon which there is as yet no consensus are:

   - Who is served within a continuum? Should there be universal treatment/preventive services for all on a first come first served basis? Or should the most vulnerable families be given absolute priority?

   - Should funding and program priorities be shifted from crisis management and treatment to prevention and early intervention? This would mean that some in serious need of treatment or in crisis would fall through the cracks. Or, should there should be a balance between prevention, early intervention, and treatment, and if so, how?

   - Should resources be allocated across states and localities in such a manner as to assure that those most in need receive the support they need to succeed? Should areas with larger concentrations of families with difficulties disproportionately receive more resources?

2. The extent to which policies and practices are adopted that deal with children and youth as parts of families and with families as parts of neighborhoods and communities. Do we ask school, clinic, and other child and youth-programs to work with the entire family? Do we go even further, and ask that they develop neighborhood and community strategies to encourage healthy growth and development and greater education achievement? How do we weigh the need to work with adolescents in the context of the family with the need to increasingly develop adolescent capacity to make responsible decisions?

3. The extent to which administrative decentralization with front line worker discretion is permitted or required. Sometimes front line discretion leads to decisions that have unanticipated negative consequences that create political flak. Also, front line discretion eliminates the need for a number of mid-level jobs, creating agency staff opposition change. On the other hand, lack of front line discretion seriously handicaps workers in being responsive to client needs.

IMPLICATIONS FOR FEDERAL POLICIES, PROGRAMS, AND PRACTICES

Federal officials need to take leadership in urging states and localities to develop coordinated service systems that can more effectively meet the needs of our incredibly diverse population. In addition, they need to provide states and localities with policy and

administrative support. For example, they need to develop the capacity to encourage and approve consolidated state and local plans (such as have been presented by Indiana and West Virginia) and other inventive state and local strategies for improving child and family services.

States and the federal government also need to modernize administrative practices, make it easier to blend funding streams, and prepare their staff to operate differently. They need to be less "top-down," categorical, and enforcement-oriented to allow more comprehensive, flexible responses to family needs and community priorities. In particular, accountability systems need to be far more oriented towards performance outcomes.

In this regard, federal technological capacity may need to be enhanced so that agencies are better able to accept consolidated applications and reports as meeting the requirements of various statutes thereby encouraging inter-program cooperation. This would also enable agencies to reduce the paperwork burden on states and localities.

Congress should ease the categorical nature of programs. It should refrain from specifying specific administrative processes and requirements. It should also allow some flexibility in eligibility requirements. For example, laws could allow agency discretion to use up to 5% of program funds to be used to provide services to families who fall within the general intent of the law but who do not meet exact technical requirements.

Legislative initiatives should focus on establishing program objectives (e.g., improving adolescent health or assuring all students receive needed preventive and primary health care services) as contrasted with designing programs (e.g., defining in detail what constitutes school-based health clinics). Similarly, they should not dictate lead agencies for multi-program initiatives. Rather, they should recognize that one solution does not fit all and suggest various alternative programmatic and administrative approaches to achieving objectives.

When the federal government undertakes major national initiatives (such as education reform, health care reform and welfare reform), care should be taken so that relate to and reinforce one another. Furthermore, the notion of fostering inter-program, inter-agency cooperation to assure more effective and efficient child and family programs should be embedded in each piece of legislation.

SUMMARY

In conclusion, much is known about what constitutes effective services. What is needed is increased public and private investment in children, youth, and families. Also needed is the political will to make radical changes in our services delivery systems where needed to assure that such investment achieves its objectives.

AN EXAMPLE FROM RURAL VERMONT

One rural Vermont community chose to focus on National Education Goal #1 -- "all children will come to school ready to learn." The community health and social services providers and educators (from both the school and the early childhood education community) joined with parents to review their resources and develop a plan. Although Goal #1 appears to be an education goal, community members had a clear and explicit understanding of the essential links to health and family support services.
Key characteristics of this effort include: community wide support for parent as the child's first teacher, home visits offered to all new parents by elementary school nurse, formal interagency agreements, local decisionmaking about any new money for early childhood programs, parental involvement in guiding information sharing about their family, Parent Child Center parent education programs, childcare, preschools, three year old screening, medical home for every child, and shared leadership. In this early phase, principle players included the school principal, Parent Child Center Director, school nurse,local Public Health office district director and the pediatrician.

The group's clear focus on Goal #1 helped it to establish priorities. The needs assessment revealed that the number and quality of most of the needed services in the community were adequate, but true family-centered coordination was not always present. One new service, offering home visiting of newborns and their families, was begun as a way to welcome the family to the school community, but also to link the family to health and social services as appropriate.

In this community, family support and educational activities take place at school and the Parent Child Center. While other services are integrated with these activities, they are in different locations in town, e.g., the physician office and the WIC/PHN office.

Coordinating a group of service providers who were not previously working together in a systematic way has been facilitated by a shared goal, partnership formation, significant ongoing input from parents, direction from the state education and human service agencies that this collaborative work is very high priority, and the hiring of a professional to staff the planning activities and be responsibile to all the groups for the collaboration itself.

SUMMARY OF INDIANA CONSOLIDATED PLAN

Governor Evan Bayh has submitted a Proposal for a Consolidated State Plan for services to children and families in Indiana for federal approval. The plan encompasses some 199 federal programs administered by six federal departments. The major purpose of the plan is to encourage coordination among programs at state and local levels to streamline services and reduce bureaucracy. The plan extends not only to publicly funded programs, but also to such non-governmental programs chosen to participate.

Indiana will use the Step Ahead Councils already in existence in 92 counties to foster the processes provided in the plan. Cities of over 100,000 may also develop individual plans. Step Ahead Councils are non-profit organizations established to provide accessible and affordable services to Indiana families. They have boards that are broadly representative of the community, with non-providers as a majority of their membership. The Proposal clearly delineates the authority of state agencies to approve local activities that:

- develop local consolidated plans for each county which reflect the views of the community on goals and priorities. These plans are to be family centered, comprehensive and geared to providing efficient and seamless services. County Step Ahead Councils have developed 85 plans of action based on county developed needs assessments.

- (a) establish common application, intake and eligibility determination processes; (b) encourage organizations to share the costs of serving a particular family, child or youth; (c) provide for the joint funding of data management and family information, transportation, and evaluation systems; (d) allow agencies to use work already done by another agency rather than having to repeat it; (e) create protocols for the sharing of confidential information; (f) provide for common approaches to case management or care coordination; (g) encourage the joint use of facilities and administrative supervision of programs operating in those facilities by a single individual; and, (h) promote other activities that improve the effectiveness and efficiency of service programs.

- develop outcome based measures and benchmarks for individual programs to document progress, reduce waste and provide accountability to the taxpayer.

FINANCING SCHOOL-LINKED COMMUNITY SERVICES AND SUPPORTS

by Frank Farrow
Center for the Study of Social Policy

FINANCING SCHOOL-LINKED COMMUNITY SERVICES AND SUPPORTS

"If you want to know what's happening in your service system, watch the dollars."

Gary Stangler
Director, Missouri Department of Social Services

I. FINANCING COMPREHENSIVE SCHOOL-LINKED SERVICES

The financing of comprehensive school-linked community services is a critical ingredient of any community's efforts to improve educational outcomes for children.

In at least three ways, financing determines much about services' scope, characteristics, and effectiveness. The ***availability of funds*** is obviously key, but just as important are the ***ways in which financing is provided*** and the ***priorities and political choices*** reflected in how funds are allocated.

In each of these areas, current financing patterns erect major barriers to implementing coherent and comprehensive services.

Availability of funds. Anyone promoting school-linked services and supports, whether at the federal, state, or local levels, can confirm that dollars for this purpose are scarce. Years of level funding — or, worse, budget cuts — have eroded the availability and quality of the health, mental health, and social services which are typically part of a comprehensive school-linked program.

Within this climate of tight budgets, however, some states and local communities are finding ways to significantly expand funding for school-linked services. The challenge is to seek out new financing sources and draw on resources not traditionally used for these purposes.

For example, a growing number of school districts and communities have been using Medicaid as a way to underwrite school-linked services costs, Outreach, health education, health screening, and case management activities, as well as many therapies and services offered as part of school health and special education programs, can be Medicaid financed for eligible children. Total dollars generated through this mechanism vary by school district, but as an example, the Independence, Missouri, school district now generates an additional one million dollars annually as a result of Medicaid claims.

Another growing source of financing for these services is part of state and local education reform initiatives. With strong advocacy, a persuasive case can be made that school-linked services are not luxuries, but contribute directly to children's success in school. On this premise, Kentucky's, Tennessee's and other states' educational reform initiatives include significant financing for school-linked family supports.

Still other school districts and communities are getting started with comprehensive school-linked services using resources shifted from other purposes. For example, health and social service professionals can be reassigned to work in or near schools; a "family preservation" program which would have existed in isolation can be made part of a broader, school-linked effort; or dollars can be redeployed from a prior user to support school-linked initiatives instead. This technique uses already available resources to support a more strategic, coherent, and comprehensive plan of services.

The point is that dollars for well-crafted programs of comprehensive services can be generated, if people are creative in tapping new funding sources and persuasive about why funds are needed. Thus, while still a barrier, the general scarcity of dollars in this field is not the absolute roadblock that many people assume it to be.

The way in which services are funded. *How* dollars are made available often has as much impact as *the amount* of funding available. Current financing methods pose chronic problems to developing preventive, responsive, and family-oriented services — which are the aim of most comprehensive school-linked service initiatives.

In particular:

- Current service financing is highly categorical, meaning that dollars can often be used only for specific services for specific eligible groups — making it difficult to use any one funding source for a comprehensive service package;

- Current funding is disproportionately crisis-oriented, since most public mandates address problems once they become severe, rather than investing in earlier interventions or supports;

- The intergovernmental complexity of current service financing is a barrier to developing comprehensive services. Because each level of government — state, county, city — exercises different levels of control on different funding streams, setting a coherent agenda with multiple funding sources is difficult or impossible.

This financing pattern, while frustrating, is not accidental. The conglomeration of highly targeted funding streams "cascading" from federal to state to local levels, and earmarked for specific purposes, has evolved in an effort to address specific high priority needs and populations. Viewed as a whole, this funding pattern seems incomprehensible, and difficult for a family or a community to manipulate. Viewed from the perspective of any one special interest, however, this funding pattern may serve to protect that interest.

Thus, any fundamental change to this financing structure must be based on a compelling case that new mechanisms will provide communities with new capacities to meet families' needs, while still meeting the intent of various funding streams.

Priorities and political choices. Ultimately, financing patterns represent choices about how best to spend public dollars. The investment decisions reflected in current federal, state, and local budgets give priority to remediation, rather than prevention of problems, and to assisting families only when they are in crisis or have fallen apart.

Comprehensive school-linked community services argue for a different set of funding priorities and political choices:

- They offer supports at many more points at a child's learning career, so that children are less likely to fall behind.

- They address children's needs in the context of their family, recognizing that a child is unlikely to arrive at school, able to learn, every day, if the family is under chronic stress.

- They recognize that the boundary lines between education programs and social services, mental health, and/or health services are elastic, not rigid, when viewed in context of a child's overall development — and that funding needs to be more flexible across these lines as well.

What seems clear is that the mismatch between these goals and current financing patterns must be resolved if comprehensive school-linked services are to thrive. Individual schools and a handful of neighborhoods have proven that a coherent set of programs can be pieced together from the current "non-system," and outcomes for children can be improved. Even these, however, are isolated instances, and may not stand the test of time. There are no citywide, let alone statewide, examples of school-linked comprehensive systems.

To support such effective systems, fundamental change will be required in financing methods, and in investment choices — changes driven by a new set of principles.

II. NEW PRINCIPLES FOR FINANCING COMPREHENSIVE SCHOOL-LINKED SERVICES

Methods of service financing should be driven by a set of principles that, together, represent a dramatic change from current practices:

1. Funding should be tied more to outcomes, and less to specific types of services.

   New financing patterns should identify the goals and outcomes that they seek for children and families, but allow greater flexibility in how dollars are used to achieve those outcomes. This means that funds will be less tied to specific service methods, and more related to desired goals for groups of families and children. This requires the use of budgeting systems which

link resource allocation decisions to investment strategies which improve outcomes for children. It requires financial systems which track expenditures on the basis of outcome results, not just service type, provider type, and client category.

This also requires the ability to set and measure outcomes, increased capacity to measure quality of service, and changes in governance that would allow regular, ongoing assessment of the accomplishment of outcomes.

While these new measurements and skills are being developed, progress can be made by using funding to pursue outcomes for which there are good measurement indicators, and by using proxy measures when ultimate outcome measures are not available.

2. Financing strategies should provide for flexibility at points closest to the actual point of service delivery — thereby allowing the use of dollars to be more responsive to the needs of specific communities and specific families.

New financing mechanisms should allow considerable decisionmaking at the local level, where allocation decisions can best reflect local needs. In addition, funds should be flexible and allow discretion at the "contact point" with families — i.e., allowing funds to be used for "packages" of services which meet individual child or family needs. These changes must be accompanied by extensive staff development, so that frontline staff and managers' skills reflect this new discretion over dollars.

This flexibility does not mean that funds should be block granted to local communities. State and federal parameters (and expected outcomes) can still be set by higher levels of government, but communities and individual workers should be given more flexibility to use dollars to respond quickly and uniquely to families' specific needs.

3. Funding should be provided in a way which promotes interagency and intersystem decisionmaking.

At present, each agency, or each "system" (whether the school system, child welfare or mental health system, health system, etc.) exerts total control over the funds which flow through that system. Rarely do funding decisions require even the sign-off, let alone the genuine participation of other agencies or systems.

In order to achieve better outcomes for children, however, no system should "go it alone" and no fund source should function in isolation from others. Funding mechanisms should require, at the state and especially the community level, shared decision-making about the allocation of dollars across all the education and human service systems that can contribute to children's outcomes.

This does not mean that all funds are pooled into one pot, but that allocation decisions for each fund source are made in the context of allocation decisions for others.

4. Funding mechanisms must allow the investment of dollars gained by heading off the "cost of failure" — and should allow "borrowing" against that cost of failure.

Most observers of current financing patterns believe that large sums are wasted by investing in remedies for problems that could have been prevented. The difficulty is breaking this cycle. As the costs of these problems increase, it becomes progressively harder to invest in the kind of prevention which could, in the long run, lead to lower costs. Financing systems must provide a means to "borrow" against future resources in order to finance a different pattern of interventions — and to reinvest the dollars that are eventually "saved" by averting some of these preventable problems.

For example, in many communities, children are still placed outside their homes and communities when, with suitable supports, they could live with their families and attend neighborhood schools. "Wraparound" service packages — highly flexible, tailored to individual child and family needs — have proven effective at maintaining even seriously emotionally children at home. However, financing these service packages, since dollars are still being spent disproportionately for out-of-home placements, requires "up-fronting" dollars for investment in wraparound services. Over time, a shift of dollars from more expensive, more restrictive care to community-based interventions could happen systematically.

5. Flexible funding mechanisms must safeguard the needs of vulnerable and minority populations.

Any new funding mechanisms must preserve concerns for equity and assure that vulnerable and low-incidence populations are not overlooked in fund allocation. Part of the motivation for highly categorical funding is to serve the interests of these populations. The danger is that in moving toward more flexible, locally-determined allocation decisions, the needs

of these people are lost because their advocacy can be felt only at higher levels of government.

Thus, new funding mechanisms must identify equity concerns, and could contain firm expectations that certain populations be adequately served. (This type of assurance need not be as prescriptive as current categorical restrictions. Priority can be established without prescribing exactly what services are to be provided or rigidly defining target populations.)

If pursued, these principles create a greatly different climate for decisions related to children's services. Their advantage is allowing a more responsive system of services, one designed to respond to families' and communities' unique needs, and to change as these change.

Implementation of these principles is plausible only if they are accompanied by other systemic changes in the way services are planned and organized, governance mechanisms are structured, staff at all levels are prepared and trained, and — perhaps most importantly — accountability is assured. Several of these topics are addressed in other background papers for this meeting, but the last — accountability — warrants some further comment here.

III. ACCOUNTABILITY AND NEW FINANCING STRATEGIES

A pattern of financing according to the above principles requires complete redesign of the way accountability systems now try to operate in both education and human service systems.

Currently, what accountability exists in these systems is obtained through measures such as the number of people served, the amount of service provided, or the degree to which dollars are spent according to the budget category within which they are allocated. While useful, these measures do not address whether funding is contributing to desired outcomes.

The principles of financing proposed here require major investment in developing the capacity to measure outcomes, rather than just inputs. Further, they suggest that this measurement has to be made "across systems" — that is, across education, health, and human service areas — rather than just within a single system.

For example, if the goal for which funding is provided to a community's system of school- linked services is to "assure that children enter school ready to learn", assessment of progress must be made in terms of the numbers of children who meet that goal. That measurement, in turn, requires agreement on the best indicators of that goal (around which there is now considerable controversy, but also considerable work

underway to develop satisfactory measures). Finally, the measurement is not just of how well the health system performs in achieving this goal, or the school system, but of how well all of the relevant systems perform as a unified **community-based, school-linked system of services and supports.**

This shift from "agency-based" accountability to "community system" based accountability requires that new agencies and organizations develop ways to hold themselves collectively accountable. While this, too, is new territory, the many experiments underway with community collaboratives, community governing boards, and children and family service authorities are the precursors of this new way of maintaining accountability for children and family outcomes.

IV. ISSUES FOR FURTHER DISCUSSION

The changes proposed in this paper require significant alteration of current funding structures and can lead to significant changes in expenditure patterns. For that reason, they will require change over an extended period of time. They cannot be achieved overnight, nor can they occur fully without substantial work and investment in the new technologies — primarily of outcome measurement and accountability — that are necessary for them to have maximum effect.

However, as states, localities, school districts, and community groups are demonstrating in many areas of the country, progress in this direction can begin. Current funding can be made more flexible, without going as far in this direction as proposed here. Communities can be given more decisionmaking authority over dollars than they now have and can thus respond more directly to family needs. Teachers and frontline human service workers can use discretionary funding to tailor support, teaching, and assistance to the needs of the children and families they work with.

Beginning to move in this direction poses challenges, both substantively and politically. Issues that will need to be addressed include:

1. **Are advocates for specific populations ready to consider exchanging some of the benefits of categorical, targeted funding for the greater flexibility and responsiveness to community needs that should result from these principles?**

2. **Are provider groups willing to forego the close linkage of many funding streams to specific types of service, in the interest of allowing dollars to be more responsive to the variations and changes in the services that individual families may need?**

3. **Are state-level interest groups and state agencies prepared to redistribute decision-making in a fashion that provides local communities — and consumers of services — greater voice in how dollars are allocated?**

4. **Are professionals at all level, as well as political leaders, willing to develop governance structures in which responsibility and accountability are shared among many agencies and many different interests?**

Needs Assessment and Program Evaluation: Assuring Accountability in School-Based and School-Linked Integrated Service Systems for Children, Youth, and Families

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EXECUTIVE SUMMARY: COMMUNITY NEEDS ASSESSMENT AND EVALUATION

Needs assessment and program evaluation should be considered together:

- o as part of a continuum of programmatic efforts needed to increase program effectiveness
- o intrinsic components of the integrated service system
- o part of an ongoing process of monitoring and guaging progress towards accomplishing common goals

They need to:

- o be tailored to each community and be shaped by community members
- o occur through a group that has community credibility, is as broadly representative of the community as possible, and which has established trust among key players
- o be set in a realistic time frame, with a sequence of activities that does not delay implementation
- o allow for evolving goals and mid–course changes
- o not undermine innovation through over emphasis on early achievement of outcome measures
- o rely on data collected in a systematic, useful, and culturally competent manner; combine a number of different methodological approaches that can help document benchmarks and outcomes, as well as the key ingredients that contributed to the measured results; and maintain confidentiality of date as appropriate and informed consent
- o be clear regarding who will provide leadership in conducting each, what expectations are regarding goals to be accomplished, and how information will be used within the community context
- o recognize that outcomes can be measured at: 1) individual level; 2) program level (aggregating client level data); 3) agency or department level (aggregating program information); 4) system level (compiling agency and department outcomes); and 5) community–wide level. These should not be confused and unfair accountability expectations imposed (particularly where multiple agencies work in concert and on multiple aspects simultaneously greatly complicating ability to ascertain cause and effect)

- increase collaborative capacity and participating agency/organization capacity to define and obtain the information needed to accomplish their objectives and obtain and interpret new data as new issues emerge

NEEDS ASSESSMENT

Communities need to: 1) conduct comprehensive community needs assessments to plan services that are based on documented needs and gaps in services and available resources, and 2) evaluate short and longer term outcomes and impacts resulting from service provisions.

Elements of needs assessment include:

- Assessment of strengths and potential resources (formal and informal)
- Assessment of gaps in service
- Feasible strategies for action
- Available models for change
- The creation of a detailed timeline
- The establishment of which individuals and/or agencies will bear responsibility for future steps.

The needs assessment process:

- must be inclusive and engage critical community decision makers including public officials, service providers and program managers, young people and their families, and other key community members
- provides the opportunity for creating and articulating community consensus regarding the priorities which need to be established as part of a comprehensive plan of action.
- is useful for purposes of program management, evaluation, and ongoing monitoring.
- must result in a credible plan of action that is responsive to identified strengths and needs.

A detailed needs assessment helps create the baseline measurement against which the collaborative and the greater community will measure progress in achieving objectives.

EVALUATION

Evaluation should acknowledge the context in which each initiative is taking place (the nature and extent of health, social,and education problems; past initiatives to address these problems; local policies and regulations affecting children and family services; and the resource base within the community).

Evaluation must be defensible and useful, and reflect realistic timeframes.

Evaluations need to address:

- the degree to which the implemention of the project is consistent with the original planning objectives

- whether clients are actually receiving the combinations of interventions originally proposed, whether the intervention is of sufficient strength to have an impact on the system of care and the individual client and their family, and whether there is a logical connection between the types of interventions being implemented and the types of outcomes that are realistic to achieve

- the establishment of comparison standards against which to interpret or measure progress

- the need for interactive and ongoing programmatic feedback to collaborating partners

Evaluation should contribute to increasing the state of knowledge regarding service delivery models -- to the development of universal lessons and frameworks which communities can share and adapt to their specific needs.

POLICY IMPLICATIONS

Communities should have the primary challenge and responsibility of establishing the types of outcomes for which they will be held accountable (acknowledging tensions among professionals, community members, and elected officials and other decision makers).

Federal and state programs should not pressure communities to achieve outcomes prematurely. Otherwise, programs may be tempted to distort program activities away from complex, hard to measure interventions and seek safer though perhaps less effective approaches.

A balance is needed between the pressuring a community to achieve service accountability and encouraging service innovation aimed at accomplishing a set of challenging outcomes.

Needs Assessment and Program Evaluation: Assuring Accountability in School-Based and School-Linked Integrated Service Systems for Children, Youth, and Families

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I. Overview

In a time of rapid change in education, and health and human services systems, it is particularly important to improve our ability to determine whether new services, new relationships among service providers and between providers and communities, and new ways of organizing and financing services are working and worth investing in. Those concerned with the increasing threats to the well-being of children have reached a consensus about the seriousness of the problem, the importance of early intervention and coordinated care, and the need for agencies to go beyond coordination to collaboration, not only among themselves, but in partnerships with the broader community. The purpose of this paper is 1) to delineate the potential contribution of program evaluation, including needs assessment, to improving service integration efforts aimed at children, youth, and families, 2) to recommend principles to guide a comprehensive needs assessment and program evaluation process, and 3) to raise potential issues and problem solving strategies to facilitate the integration of program evaluation as part of building comprehensive systems of care.

Collaborative interagency relationships have flourished in communities across

the country. Yet there is still much to be learned about how collaboratives operate and the conditions under which they are most successful (Mattessich and Monsey, 1992). Part of the problem is that previous attempts at developing effective service integration models have been poorly documented. Evaluation components have often been omitted from service integration projects both in the planning and implementation phases. In other cases, evaluations are conducted prematurely; that is, before new service delivery models have had sufficient time to be operationalized, tested, and refined. In addition, it is not uncommon for community agencies to exhibit strong resistance toward evaluation as it is perceived as a process that interferes with service delivery. Clearly there are special challenges in conducting research in the arena of integrated service systems, including the difficulty of isolating causal factors and establishing cause and effect relationships as a result of collaborative activity.

Concurrent with the renewed focus on service integration is a strong commitment to documenting improved health, educational, and social outcomes. Communities are beginning to recognize that merely documenting the provision of services is not sufficient in assessing whether positive results were achieved. Increasingly, communities will need to conduct community needs assessments to plan services that are based on documented needs, gaps in services, and available resources, and to evaluate short and long-term outcomes and impacts resulting from service provision. As communities consider what outcomes they will be held accountable for, they are eager to know if adequate resources will be made available towards those ends and the kind of local authority they will be given to implement

interventions that are responsive to the needs of multi-problem families.

Additionally, local communities often feel that the problems they are solving are unique to their localities. While there will be a continued need to develop service delivery models that are responsive to local needs, universal lessons and frameworks that can be shared and adapted to the requirements of a specific community are needed. Hopefully, lessons garnered through program evaluations will be shared with other communities as they undertake new approaches to service delivery, possibly circumventing ill-conceived and poorly suited approaches.

There is a need for evaluations which provide information to policymakers, administrators, program planners, public and private service providers, and child and family advocates who look to collaboration as a promising approach to solving pressing social problems. Evaluation can be an important tool in assessing the success of a community in achieving the integrated service system goals of a collaborative. This success often depends on the feasibility of mounting each component of a strategic plan based upon the results of the needs assessment, as well as the degree of integration among the component parts. It would be expected that overall effectiveness would be maximized in those communities in which the components can be fully integrated.

Success will also depend on the context in which each initiative is taking place. A community's ability to successfully implement new systems of care will depend on the nature and extent of health, social, and educational problems, past initiatives to address these problems, local policies and regulations affecting children and family

services, and the resource base within the community. Thus, each site is unique, making the needs assessment and evaluation process more challenging.

II. The Role of Needs Assessment and Program Evaluation in the Creation of School-Linked Integrated Service Systems

Before collaboratives and communities can design an effective school-linked integrated service system and establish the measurable outcomes for which they will be held accountable, communities need to conduct a comprehensive needs assessment. A community assessment is both a product, offering important information about the community and its residents' strengths and needs, and a process by which community members understand community needs and take an interest in working for change (Bruner, Bell, Brindis, Chang, Scarbrough, 1993). Needs assessments and program evaluation should be considered together as part of a continuum of programmatic efforts aimed at increasing the effectiveness of services and supports. In contrast to common perceptions that a needs assessment aims at identifying a community's deficits, it also emphasizes a community's strengths and its ability to meet the needs of children, youth, and families. If conducted with a commitment to actively include community members, as well as service providers, program directors, and policy makers, the needs assessment process provides the opportunity for creating and articulating community consensus regarding the priorities which need to be established as part of a comprehensive plan of action.

The needs assessment process is useful for purposes of program

management, evaluation, and ongoing monitoring. The needs assessment determines the extent of a community problem or area of concern with estimates of need and unmet need among the population, as well as the potential resources and other strengths which the community can bring to bear upon the problem. For example, identifying formal and informal resources should be a vital component of a community needs assessment. Factors such as the capacity of existing programs to serve additional clients, potential service delivery reforms, and the identification of informal leaders who may mobilize the community to establish consensus regarding outcomes need to be considered as part of a comprehensive needs assessment (Bruner, Bell, Brindis, Chang, Scarbrough, 1993).

Data used to delineate existing health, social, and education problems can also be used as benchmarks that help chart the success of a community's new school-linked, integrated service systems. Particularly crucial is the necessity of engaging critical community decision makers, including public officials, service providers and program managers, young people and their families, as well as other community members, in making the investment towards creating a solution. Too often, needs assessment results have been perceived by the community as a mechanism to initiate blame, rather than to implement change. Indeed, the results of a needs assessment can be used to advocate for change.

Inherently, those who conduct the assessment have an ethical commitment to apply and act upon the findings in a constructive manner. Individuals engaged in the process must be sensitive to the potential risks of not acting upon the results as too

many communities have had the negative experience of having hopes raised and later smashed when no actions were taken in light of compelling evidence.

Evaluations need to focus on whether the implementation of the project is consistent with the original planning objectives (fidelity to the model), the extent to which the components have been implemented, if clients are actually receiving the combinations of interventions originally proposed, and whether the intervention is of sufficient strength (e.g. dosage effect) to have an impact on the system of care and on the individual client and their family. Furthermore, there needs to be a logical connection between the types of interventions being implemented and their realistic outcomes under the best of circumstances. Too often communities will possess idealistic goals without the necessary level of resources and infrastructure to assure that these goals can be realistically achieved.

III. Guiding Principles of Program Evaluation and Needs Assessment

Comprehensive needs assessments and evaluation are key to improving integrated service systems.

A plan for ongoing evaluation of outcomes, service provisions, community satisfaction and other variables should be an intrinsic component of the integrated service system. The needs assessment and evaluation process must to be seen as useful and necessary to both policymakers with the authority to make fiscal allocation decisions and to the diverse constituencies within the community. Key decision makers must commit themselves to providing an adequate level of resources to conduct different levels of needs assessments and program evaluation, as well as applying the results of both in developing and shaping policy. The needs assessment and the evaluation should be considered part of an ongoing process of monitoring and gauging progress towards accomplishing community goals.

Evaluation and needs assessment should be tailored to each community.

Both the evaluation and the needs assessment must respect the unique aspects of each setting and the issues of concern to the community. While there may be universal indicators that should be measured across all sites, it is imperative that the community help shape the types of questions to be answered by both the evaluation and the needs assessment process. There is also a need to assure that data are collected in a systematic, useful, and culturally competent manner. Data

collection itself becomes the basis for identifying community strengths and creating consensus regarding shared goals to improve the well-being of children and families in the community.

The feedback provided by the evaluation to the collaborative also results in an iterative process. As the activities of the collaborative change over time, the evaluation will also need to evolve and be flexible enough to adapt to program evolutions; that is, not continue to evaluate the program's previously adopted objectives and activities when they are not longer relevant to the work of the collaborative. This will require careful and frequent monitoring of programmatic efforts, as well as greater flexibility on the part of the evaluation team.

Clarity in the goals of the needs assessment and the evaluation are needed.

An understanding must be established between collaborating agencies and community members before proceeding with a community assessment and program evaluation. They must establish which individuals and agencies will participate in the needs assessment and evaluation, as well as how the collaborative will approach conflicting interests that may arise as information is gathered and interpreted. It is also imperative to clearly define community interest. Furthermore, they must identify leadership roles in conducting the needs assessment and the evaluation, clarify expectations of what goals will be accomplished, and how the needs assessment and evaluation information will be used within the community context.

Both the needs assessment and evaluation should be as inclusive as possible.

Planning and conducting a needs assessment, as well as an evaluation, should be done by a group broadly representative of the community, including children, youth, and families, public and private service providers, policy makers, etc. If a community assessment is to truly address important community concerns and goals, all key stakeholders should become invested in the process. The assessment should be done by the community, rather than to it; the assessment requires both a top–down and a bottom–up approach to planning. Following the needs assessment, the evaluation should also involve key participants in establishing the objectives and outcomes upon which the collaborative and the community will be assessed.

Careful planning of the evaluation and the needs assessment is necessary.

Before the data collection, members of the collaborative must carefully identify what the assessment and the evaluation need to inform the collaborative about and what potential challenges may arise in the process, as well as ways to potentially deal with these problems. The needs assessment and evaluation must be set in a realistic time frame given resources available. A sequence of activities that does not delay implementation efforts to address community goals is necessary. Sequencing of assessment efforts may be necessary as the community answers initial, critical questions in the implementation of early collaborative activities, and continues the assessment through planning additional programmatic efforts and throughout the evaluation. Planning for the evaluation also consists of establishing the make–up of

the data system. Typically, this requires a baseline or intake information, encounter data, and follow up or change measures (parallel to baseline information). The data system established to assess the effects of an integrated service delivery model must combine a number of different methodological approaches that can help document benchmarks and outcomes, as well as the key ingredients that contributed to the measured results.

Collaboratives need to create a program or action model to establish the criteria for evaluation.

In order to assure that the evaluation adequately captures the efforts of the integrated service delivery system, a clearly delineated program or action model should be developed jointly by the collaborating members and the evaluator(s). The model should include the clearest statement possible of what strategies will be used, the intended targets for action, the short term or intermediate results, and the long-term impacts expected. This model can serve as a management tool to maintain focus for the effort and also to guide in the creation of the evaluation system. This type of clarity is needed in order to assure that there is clear consensus of what the program is attempting to accomplish and whether the planned strategies to achieve the proposed outcomes are logical.

The action plan helps systems to define their own criteria for evaluation. Many program efforts fail because the planned intervention is too weak to produce the desired result or because the logical connection between the two has never been carefully examined by program staff as well as the evaluator. Ideally, there should be a theoretical framework for the proposed intervention and anticipated outcomes which is supported by previous research.

Establishing trust is imperative for the success of the needs assessment and evaluation process.

Establishing a high degree of trust within the community, agency

representatives, and policy makers is imperative in assuring that vital information is readily shared. Trust will likely not be established unless issues are resolved concerning the use of the data collected. This encompasses: a) confidentiality of data, b) prohibition of using data for prejudicially labeling and sorting individuals, and c) unfair accountability expectations if communities are unable to achieve their stated benchmarks and outcomes.

Confidentiality of data must be specifically addressed to assure access to data for the evaluation and the needs assessment. This is especially important in longitudinal studies of individuals, as well as linkage of data to other programs and institutions. Consent must be obtained with clear disclosure of confidentiality issues.

Innovative service delivery models require investment in equally innovative needs assessment and evaluation approaches.

Rigorously evaluating integrated service delivery systems is a complex and challenging task. The diversity of outcomes, scope, and service models being tested as part of the service integration effort also necessitates the development of innovative and relevant assessment tools. A combination of quantitative and qualitative data collection approaches and methodologies is needed to develop a comprehensive evaluation of service integration. Data must be collected on a number of different levels, ranging from the evolving process of collaborative and service delivery changes, to the variety of services being provided in a variety of organizational settings to whether multiple child, youth, and family outcomes are being

achieved.

Both needs assessments and program evaluation allow for understanding the extent and prevalence of a problem, the effectiveness of interventions being tested, as well as their contextual meanings. Program data are important for reporting and accountability, and should be used internally as feedback for program improvement. The range of outcomes to be measured require: 1) the use of valid and reliable instruments when available; 2) training of staff using assessment tools at the family and community level; and 3) "family friendly" assessments that can be used to assess changes over time (Family Impact Seminar, 1993).

Quasi-experimental approaches may not readily lend themselves in the evaluation of service reforms until there is greater clarity regarding what the interventions actually entail and the program has achieved a certain level of service maturity. Evaluation designs that allow for the assessment of program impacts, as well as for the assessment of the components that are considered to be responsible for the observed effects are needed. Given the difficulties of pure outcome research when program goals are broad, services are both flexible and comprehensive, and the impact is likely to be long term rather than immediate, there is a clear need for more sophisticated, systemic evaluation designs which use a broad range of process and outcomes indicators. Careful study and analysis of the changes in the program or service reform is an important aspect of the reform movement. Communities need assistance in developing new measures and collecting new kinds of information. Additional issues arise when attempting to extrapolate results achieved in tightly

managed, smaller programs to large scale implementation.

Site-level and cross-site evaluation designs need to be explored, as well as the development of standardized data collection tools.

Site level studies, wherein questions pertaining to what kinds of strategies were introduced to improve the system of care, whether these strategies were successful in changing the service system and how the community changed over time, are needed. In addition, cross-site designs are needed to compare and synthesize information about sites' characteristics and experiences using a similar approach (e.g. collaboratives aiming at integrating services) to help elucidate strengths and weakness of different models.

Increasing the capacity of communities to engage in a needs assessment process and self-evaluation activities should be part of the legacy of the integrated services movement.

The collaborative should also be committed to increasing the capacity of participating agencies and organizations to engage in a self-evaluation process, as well as remaining open to an external evaluation. Increasing the capacity of communities to fulfill these extremely challenging tasks requires investment in comprehensive and tailored technical assistance for communities, particularly as public and private funders at the local, state, and federal level require evaluation and needs assessments activities.

Commitment to outcomes accountability should not restrict communities from testing new service innovations.

While the commitment to assessing the effectiveness of programs through a focus on outcomes accountability will likely increase over time, funders, providers, and communities need to maintain a strong commitment to develop and test innovative approaches. In clarifying a set of outcomes to which communities will be held accountable, there is a strong possibility that communities, concerned about the possibility of being penalized for not reaching the established outcomes, may hesitate from developing new strategies. A balance is needed between the probable pressure a community may feel to achieve service accountability and the necessity of encouraging service innovation aimed at accomplishing a set of challenging outcomes. Given our relatively limited knowledge of what it takes to accomplish a set of complex social, health, and educational outcomes, communities, fearful of being penalized for potential failure, may settle for a limited set of strategies rather than feel the freedom to test new approaches. Communities may have much to learn and share from the opportunity to engage in " thoughtful failures" (Bruner, 1993). This necessary flexibility may provide the opportunity to test a new array of services in the process of furthering our understanding of what works best for whom and under what circumstances. Though service accountability is still needed within this framework, communities should be provided the opportunity to test new strategies that may best fit their communities without fear of being penalized.

IV. Accountability

At a time when there is renewed federal and state attention to performance measurement and outcomes driven funding, communities face the challenge and responsibility of establishing the types of outcomes for which they will be held accountable. A major debate exists regarding who selects the set of outcomes upon which communities will be held accountable. Tension exists on different levels. Outcomes selected by professionals may not coincide with those desired by the community; in addition, there is federal, state, and local tension regarding whose outcomes will be adopted. Ideally, for communities to accept an outcomes-based accountability system, it is vitally important that those outcomes be established through a local consensus building process that insures that clients, public and private providers, administrators, local policy makers, and the larger community all have a major role to play in establishing the set of outcomes. If state and federal categorical programs are to become more flexible in terms of rules and regulation, communities will soon encounter a growing demand for evidence that particular outcomes are being achieved at the local level. However, if professionals and communities face too many unrealistic pressures to achieve outcomes accountability prematurely, programs may soon be tempted to distort program activities away from complex, hard to measure interventions and seek safer, though perhaps less effective approaches, such as continuing to emphasize the provision of services, rather than what outcomes are achieved (Schorr, 1993).

In order to be effective, the process of selecting outcomes must be placed

within the larger context of strategic planning. Thus, a comprehensive and ongoing needs assessment and evaluation process is needed to help gauge not only outcomes, but the evolving goals of agencies, the needs that those goals address, the resources available, and the various activities applied to achieving those goals. Communities will need a step by step process for developing outcomes and benchmarks so that local programs can gain the necessary skills not only to define locally prioritized outcomes, but also to determine how the selected set of outcomes can be achieved. Ideally, the outcomes selected are developed by the community, based upon the results of their needs assessment, and in conjunction with state, federal government and private funders.

One promising strength of collaborative efforts is that developing a set of common outcomes serves to assure that accomplishing such outcomes is a shared responsibility. There is the inherent acknowledgment that for many outcomes, multiple agencies need to work simultaneously and in concert in order to reach a common goal. For example, an outcome of reducing the incidence of teenage pregnancy requires that a number of different and complementary community agencies work simultaneously and in a reinforcing manner to assure that shared outcomes are achieved. This strategy includes schools devoted to improving the academic success of at-risk adolescents, the business sector developing meaningful job development opportunities for both males and females, drug and alcohol prevention agencies promoting the reduction of drug and alcohol use among adolescents, as well as family planning agencies working with parents and adolescents to increase responsible

sexual behavior. Integrated service initiatives encompass more than a single program and more than a single agency.

As outcomes receive greater attention, it will be important for the evaluation of cross system reform efforts to also focus on the service system capacity and the intensity of the interventions being tested. Ideally, outcomes should be established only after assessing whether the level of resources allocated to achieving them is appropriate. Communities need to question whether the proposed intervention is strong enough and there is a sufficient level of resources to have an impact on the selected set of outcomes. The omission of resources from the equation results in an unfair measure of the program's effectiveness because the proposed intervention has no clear relationship to intended outcomes (Young, Gardner, and Coley, 1993). Thus, a comprehensive needs assessment can provide the necessary context within which the collaborative develops a set of feasible outcomes and establishes how to better allocate resources based upon community indicators.

There are five levels at which outcomes can be measured: 1) the individual; 2) an aggregate of client data for individual program outcomes; 3) an aggregate of program information for agency or department outcomes; 4) the compilation of agencies and departments' outcomes for system or community outcomes (e.g. the child welfare system, the alcohol and drug treatment system, the education system); and 5) community wide outcomes which measure community conditions in their entirety (McClosky, 1993). It is important not to confuse these different levels or to impose unfair accountability expectations. For example, it is not fair to measure the

performance of an agency and then compare it to community wide conditions, expecting that a single agency should be responsible for impacting the overall community (Young, Gardner, and Coley, 1993). However, in order to assure broadened levels of accountability, there need to be clear linkages between these levels of outcomes. For example, agencies can use benchmarks to measure progress as shared resources and complementary strategies are implemented across agencies.

Another important area of accountability pertains to confidentiality standards being utilized with the data being collected from a community and how the information will be used. Many communities have made major inroads in their ability to gain informed consent from consumers that allows for the sharing of family information across different systems of care, while maintaining professional levels of confidentiality and protection of different kinds of information based upon client preference. However, there is a high degree of mistrust among both professionals and consumers that must be faced regarding how the shared information will be used. Consumers in particular often have misgivings that data will be used to track or sort children, youth, and families, furthering levels of stigmatization.

The use of outcomes data also has implications for accountability as well. There is a high degree of professional concern regarding what the consequences will be for not achieving established outcomes, who will bear the brunt of responsibility, as well as what the funding and resource consequences will be if outcomes are not achieved. The question of how outcomes will be used, for example, as a framework

for delineating progress and providing feedback to communities, or as a standard against which funding decisions and judgments are made, must also be considered.

Increasing the likelihood that individual agencies, collaborating agencies, and communities in general will be held accountable for achieving desired outcomes requires a thorough and systematic planning process, consensus about priorities and a realistic set of outcomes based upon resource allocation. It is also imperative that sufficient time be given to test and refine interventions as progress is measured. This major shift in accountability will be challenging for most communities to meet without the commitment of the collaborating partners, a strong level of technical assistance and shared expertise, and an environment in which communities are encouraged to test new approaches while maintaining a high degree of accountability. Process and outcome evaluations are thus key in assisting communities to monitor change over time and to assure that level of accountability.

V. Special Challenges in Conducting Needs Assessment and Evaluation and Implications for Federal Policy

A number of special issues arise when conducting needs assessments and program evaluations that must be acknowledged and resolved at the community, state, and federal level. The following is a brief review of the range and types of challenges that arise and potential strategies to resolve problems that are often encountered in assessing school-linked integrated service delivery systems.

How do we insure balance and reconcile the needs and priorities of the community in relation to professional perceptions?

The needs assessment process must include the broad array of community voices that are heard in the shaping of a collaborative effort. This process will likely require the ability to work together in reconciling the identified needs of communities which may contrast with the perceptions of professionals and other "experts" in the field. Interwoven in the process are key questions regarding the level of commitment to increasing the skills and capacity of communities in establishing their own agendas and how power is shared among professionals and community representatives.

Federal policy should make sure that developing skills to conduct a needs assessment is an important part of capacity building and that communities are engaged in all aspects, including conceptualization of the types of questions to ask, data collection, interpretation of data and helping to create the consensus necessary to establish priorities for action.

How can we connect needs assessment data to realistic community goals and outcomes?

While collaboratives may have strong ideals about what they wish to accomplish, it is important to develop a realistic road map of what the community wants to achieve in the area of integrated service systems. Using this framework, communities can collect information that substantiates the existing "state of the state". The community can consider what components of the needs assessment must be

completed first and to what level of specificity. The collaborative also needs to develop the capacity to interpret the implications of the data and ways to prioritize competing needs. In light of existing resources, federal policy should help communities create a framework for establishing a realistic set of outcomes that can be met within a reasonable timeframe.

How can we create useful evaluations?

Part of the complexity of conducting effective evaluations is the challenge that arises as changes at many levels are pursued simultaneously. It is anticipated that the service delivery system will change as will the outcomes for the children, youth, and families the system serves. Thus, the evaluation must proceed at many different levels, must include outcomes that reflect different disciplines, and must often, therefore, be collaborative ventures themselves.

Evaluation must be considered to be an important process for documenting both the planning and implementation phases. Evaluation data must be presented in such a manner and with the level of frequency which makes it a valuable part of program development. Federal policy should support the funding of program evaluation at the local and national level to document the impact of the integrated services movement.

How can we make evaluations defensible and useful?

Evaluations must be conducted in a thoughtful and competent manner. From

a technical and scientific standpoint, defensibility means building in evaluative controls that enable the evaluator to rule out alternative explanations for the outcomes experienced by individuals and groups served by the program. From a political standpoint, the findings of an evaluation must: 1) be able to withstand charges of bias from those opposed to the program, and 2) be responsive to the questions that are most relevant to policymakers. Regardless of whether an external evaluator or staff within an agency conduct it, the only defense against politically motivated criticism is the technical strength of the evaluation. Evaluation results can help program managers and policymakers make mid-course adjustments that bring the program more closely in line with its objectives, and over time, produce continuous improvements in services (Usher, 1993). Thus, federal policy should support the types of evaluations that are both useful for program management, as well as policy formulation.

What should be the timing of the evaluation?

Expectations that positive client and family level outcomes will emerge rapidly following changes in the system place an unrealistic burden and threaten the viability of service reforms. As the focus of many collaborative efforts is on service delivery improvements, which in themselves may have many implementation challenges, it would be premature to anticipate that dramatic changes in outcomes will be quickly documentable. Indeed, an outcome-based evaluation conducted prematurely is likely to produce negative findings. Funders and other policymakers must be well informed

regarding the difficulties of either quickly or convincingly demonstrating impacts upon outcomes by initiatives (Bruner, 1993). A combination of evaluation frameworks are needed to document the progress communities are making in implementing interventions that have the likelihood of demonstrating improved child, youth, and family outcomes. The evaluation timeframe needs to consider both the planned and real time frameworks that occur as communities undergo the planning and implementation of integrated service delivery systems.

Though complex, it is also vitally important to verify whether the new system caused the measured changes. A satisfactory answer to this question can only be obtained when some comparison standard is available as part of the outcome and impact evaluation. While it is unlikely that communities will randomly assign families to either receive new integrated services systems or not to receive them, it is important to establish a comparison standard against which to interpret or measure progress. Perhaps the rate of change in an outcome of interest can be compared in two schools, one with a new service delivery system and one without; perhaps two communities can be compared. Sometimes county wide or city wide rates of certain behaviors can be found to be useful for comparison. In choosing a comparison, however, it is always important to choose a standard that is as close as possible to like persons, communities, agencies, or families being served with the exception that they did not receive the intervention being evaluated. Federal policy should support evaluations that can help answer this variety of questions.

VI. Summary

Creating new service delivery approaches requires careful planning, a comprehensive needs assessment process, as well as a commitment to program evaluation. Conducting a thorough and inclusive needs assessment process, with emphasis on both the strengths and limitations of communities, helps to create the baseline for future program evaluations and measuring changes over time. The evaluation of collaboratives and integrated service delivery systems poses a special challenge and complexities for both program staff and evaluators. Because there has been so much interest in the area of service integration, and because of the limited knowledge about what works in this arena, it is vitally important that program evaluation play an integral role in assessing and identifying effective interventions. Non-traditional evaluation methods, particularly a strong emphasis on interactive and ongoing programmatic feedback to the collaborating partners from the evaluation, are needed. It is also important to ascertain what to measure as part of the integrated service delivery system, how to measure outcomes, and how to include evaluation as part of the collaborative service delivery agenda. As communities become increasingly pressed to be accountable for their efforts and in the outcomes they achieve, collaboratives will require needs assessment and evaluation tools to assure that their efforts are on track and that mid-course corrections can be made in meeting some of the most challenging endeavors.

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DEVELOPING COLLABORATIVE COMMUNITY GOVERNING BODIES: IMPLICATIONS FOR FEDERAL POLICY

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Across the country, people in the education, health, and human services arenas are organizing collaborative strategies at the neighborhood, community and state levels to create a more responsive and effective system of services to improve outcomes for children and families. These collaborative groups share a common understanding of basic flaws in the current system of services. The system is seen as: 1) crisis-oriented; 2) dividing the problems of children and families into rigid and distinct categories that fail to reflect the inter-related causes and solutions; 3) unable to meet the needs of children and families due to a lack of functional communications among public, private and community-based agencies; 4) too specialized, thus limiting the capacity of agencies to craft comprehensive solutions to complex problems; and 5) inadequately funded.[1]

Stakeholders in the current system are recognizing that the manner in which the existing systems are governed -- with multiple governing entities, independent agencies with distinct legislative mandates, and requirements for overlapping groups -- is a major barrier to building a more effective system. As a result, state and local leaders are giving increased attention to establishing governing bodies that cut across all systems, other agencies and programs to create a comprehensive, accountable system of services for children and families.

The objective of this paper is to help build a shared vision of a Collaborative Community Governing Body. Briefly defined, a Collaborative Community Governing Body is:

- *Collaborative*: partners agree to pursue a shared vision and common goals, share resources, responsibility and accountability, and use their personal and institutional power to change systems.

- *Community-Based*: it engages a diverse and inclusive group of stakeholders from all domains of the community, and recognizes its responsibility for gaining the commitment of the community to its shared vision and goals.

- *Empowered to Govern*: it has the authority and legitimacy to make decisions that cut across existing service delivery systems, and has a sufficient mandate from local and state political bodies to perform its role in planning and implementing service delivery and systems level changes.

This paper begins with a brief description of the evolutionary process that collaborative groups typically experience. This will illustrate the complexity of their development. It then describes key elements of Collaborative Community Governing Bodies, raising relevant questions along the way. Finally, it tackles the issue of how federal policy could nurture the development of such bodies. As we begin this discussion, it is important to recognize the complexity of the governance issue. "At its heart, governance is a set of interwoven political issues, concerned with power, control, accountability and the sources of legitimate authority. Governance addresses the question of who is in charge of carrying out effective services programs across agencies that are autonomous, but that must work together to change outcomes for children and families".[2]

THE EVOLUTION OF COLLABORATIVE ENTITIES

Collaborative groups, irrespective of how they are created, move through an evolutionary process to define their mission and role at the neighborhood, community and larger jurisdictional levels, and gradually take on increasing formal power and authority. Together We Can, a recent publication of the U.S. Departments of Education and Health and Human Services, outlines five stages in this process. (See Exhibit 1.)

Taking cognizance of the evolutionary development of collaborative entities is crucial to understanding the complexity of the reforms that are being attempted. Policy makers too often seek to reform systems by legislating new structures and responsibilities and hoping that this will result in better the outcomes. Experience tells us that this approach is akin to "rearranging the deck chairs on the Titanic." The process of building new governance entities is infinitely more difficult -- involving fundamental change in the attitudes, beliefs and behaviors of individuals and institutions.

EXHIBIT 1 – STAGES OF COLLABORATIVE DEVELOPMENT

Stage One: Getting Together. A small group comes together to improve services for children and families. They identify other community representatives with a stake in the same issues, and make a commitment to collaborate.

Stage Two: Building Trust and Ownership. Collaborative partners establish common ground by learning about the needs and the strengths of families and children in their community and about services and resources that already exist. Using this information, they create a shared vision of what a better service delivery program would look like, and develop a mission statement and set of goals to guide their future actions.

Stage Three: Developing a Strategic Plan. Partners agree to explore options that flow from their common concerns and shared vision. They focus on a specific geographic area, population or problem, define measurable outcomes, and design a prototype service delivery system. Partners develop interagency agreements to formalize their working relationships, a key milestone in building a governance group.

Stage Four: Taking Action: Partners begin to implement the prototype. They use the information from experiences with the prototype to adjust the policies and practices of the organizations that comprise the prototype service delivery system. Partners design an ongoing evaluation strategy that helps them to identify specific system-change requirements.

Stage Five: Going To Scale. Partners take steps to ensure that systems change strategies and capacities developed in the prototype are adapted, expanded, and recreated in location throughout the community where pro-family services are needed. They work to establish a Collaborative Community Governing Body as a permanent vehicle for reform and systems guidance.

AN EMERGING VISION FOR COLLABORATIVE COMMUNITY GOVERNING BODIES

This section examines six aspects of the development of Collaborative Community Governing Bodies: roles; geographic boundaries and institutional relationships; membership; authority and legitimacy; and legal structure. Exhibit 3 concludes the section presenting examples of developing CCGBs.

Roles

Collaborative Community Governing Bodies can be viewed as evolving along a continuum from informal to formal, from voluntary to legally established, from entities created through the mutual will and commitment of partners and formalized through memorandum of agreement to groups with the sanction of key governmental bodies. These groups are, by and large, functioning as negotiators and facilitators of change, using the credibility, commitment, and clout of the people and institutions involved to promote change. The roles that these Collaborative Community Governing Bodies are, or should be playing, are summarized in Exhibit 2. Note that the list of roles does not include authority over the resources that previously have been under the control of other governance structures (e.g., autonomous agencies, departments and/or state and local governments). Existing collaboratives are endeavoring to achieve this authority through a collaborative process; whether this is workable is a serious question. At the same time, granting a CCGB legal authority over existing resources goes far beyond issues of coordination and collaboration to a fundamental reorganization of state and local governmental bodies, and basic changes in federal law. Some individuals believe that independent structures with that authority may be necessary for systems reform to be successful. If such a structure emerges, it will be through an evolutionary process and entail extensive public debate.

There also are serious questions as to whether bodies operating through personal commitment and memoranda of understanding are sufficiently durable to transcend changes in political and professional leadership. Collaborative Community Governing Bodies with the formal sanction of the established governing bodies (school boards, county government, city government, states, community college districts, United Ways) clearly have greater potential to establish their role and sustain themselves over time, but here too, people question whether a CCGB has the capacity to reform systems without some additional official powers. (See Section III re: policy implications).

Exhibit 2 – Emerging Roles of Informal Collaboratives

1. To develop a shared community vision for children and families and build commitment, support and responsibility for achieving that vision, including:

   - educating the community about the needs of children and families;
   - mobilizing the political will of the community to work toward better outcomes for children and families.

2. To establish and maintain an outcomes-based accountability system, including:

   - defining outcome measures for child and family well-being, systems performance and community capacity;
   - instituting a system for holding all public, private and community agencies accountable for achieving those outcomes.

3. To function as an intermediary organization to facilitate and negotiate relationships among public, private and community agencies in order to create a system of effective, quality, primary, preventive, family support and early intervention services that will provide sustained support for children and families, rather than crisis-oriented services.

4. To develop and implement a strategy for creative use of community resources (financial, physical and human) to support a system of effective services, including:

   - facilitating and negotiating the redeployment and redirection of existing resources;
   - creating flexible pools of funds to creatively support a primary/ preventive services approach;
   - gaining maximum advantage from federal entitlement programs while simultaneously ensuring the reinvestment of local and state dollars in child and family services;
   - leveraging private and community resources to fill gaps in the public system.

5. To create an infrastructure that will support and strengthen the system, including:

   - supporting the development of policy and data systems (for management information, eligibility determination, single family assessment) to undergird an outcomes-based accountability system;
   - creating an interdisciplinary staff and leadership development strategy;
   - developing budget, personnel and management systems to support service delivery reforms.

6. To work to change laws, regulations, and practices at the federal, state, local and agency levels which may serve as barriers to more effective services and supports for children and families.

Geographic Boundaries and Institutional Relationships

The array of services for children and families is now delivered through a pluralistic intergovernmental system, and a diverse private support system. In this context, communities should have the flexibility to define geographic boundaries for CCGBs which facilitate planning and management of an effective child and family services system. On the intergovernmental side, states, counties, cities, and local school districts all play different roles, and those roles vary with particular programs and services. In some states, the state itself has major responsibility for human services delivery; in others the responsibility is delegated to the county. Education is the purview of local boards of education whose geographic boundaries often are inconsistent with those of local governmental jurisdiction. Cities, except where they also function as counties, generally play a more limited role in human service delivery although they have major responsibility for housing, employment and transportation. Individual programs are frequently required to become part of larger substate districts which do not always reflect their needs.

Private funders of human services often operate across state, county and city boundaries. United Ways, for example, service multi-county areas, counties with major urban centers, metropolitan areas, or metropolitan areas which stretch across state lines.

In this context, decisions about geographic domain are best made at the community level. In states where counties have major responsibility for human services, the county will be the natural geographic area. Where the state has responsibility for human service delivery, the state and its communities will have to work together to define geographic areas that make sense.

A subset of the geographic boundary question concerns relationships between the CCGB and other jurisdictional areas -- cities, school districts, generally recognized neighborhoods, and other collaborative entities. This is particularly important in large jurisdictions where CCGBs may be perceived as "centralized" decision-making vehicles. On the other hand, an important systems reform goal is to "decentralize" decisions, so they are to be made as close to the front-lines as possible.

Some California Counties are considering the creation of formal governing vehicles that would be CCGB counterparts for the neighborhood. Soon, the Sandtown-Winchester neighborhood initiative in Baltimore soon will raise the neighborhood governance question with the city, and the state of Maryland. The link to neighborhoods is especially relevant given the growing emphasis on incorporating effective service delivery strategies within a comprehensive neighborhood development strategy.

CCGBs also will have to sort out their relationship with other collaboratives in their area. In many states and communities, there is now a proliferation of collaboratives, often due to government and foundation requirements. These collaboratives can develop their own "turf" and may perceive CCGBs as infringing on their domains. For example, formal agreements are being developed for the provision of school-based health services among schools, universities, hospitals, managed care groups, private donors and others (in cities like Denver and Kansas City). CCGBs need to define their relationship with such groups. In Kansas City, the city-wide Local Investment Commission has helped to resolve this question by facilitating the creation of an independent collaborative entity to manage the school-health clinic initiative, and designating representatives to the entity's board. In Alameda County, the Urban Strategies Council has been convening eleven issue-focused collaboratives to explore common goals, including their relationship with the County.

As CCGBs evolve and sort out these relationships, one can envision their having a network of flexible, creative relationships that draw on the assets of an array of organizations and institutions in their communities.

Membership of Collaborative Community Governing Bodies

CCGBs must bring together a diverse group of people representative of stakeholders in an effective system of services and support for children and families. A list of partners and the rationale for their involvement includes:

- *Families:* The needs, strengths and voices of families must drive changes in the system. They are its customers.

- *Front-line workers:* The conditions under which they work are critical to achieving positive outcomes. Their voices must be heard as well.

- *Neighborhood/Community-Based Organization leaders:* Building neighborhood capacity should be a core component of systems reform, if self-sufficiency is a goal. Neighborhood leaders bring this perspective.

- *Public sector organizations* (e.g., schools, major health and human services agencies, housing agencies, courts, police, and other). These institutions have the authority, resources and mandate to support children and families.

- *Private agencies* (e.g. United Ways, hospitals, universities, and non-profit providers) These institutions control private dollars that support children and families.

- *Business and civic leaders:* Individuals outside the system must be present at the table. Business and civic leaders can push for systems change while helping to generate community support and resources.

- *Elected and appointed officials:* They are important allies and should not be isolated from the reform process. Their specific role should be a matter for locally determined and reflect the political culture of individual communities.

In selecting CCGB members, particular attention must be given to community demographics. If CCGBs are to build credibility and legitimacy, they must reflect the racial, ethnic, income and age characteristics of the community.

There also should be equality at the table. Representatives of families and neighborhoods should not be overwhelmed by the public sector or other groups. If necessary, they should receive special training and support to facilitate their effective participation.

Finally, there is no formula relative to the size of the CCGB. Inevitably, tension will exist between the value of inclusiveness, and the potential for the group to become unwieldy. This tension can be managed by effective leaders who have the capacity to employ shared leadership strategies that facilitate involvement.

Authority and Legitimacy

As suggested earlier, Collaborative Community Governing Boards need both authority and legitimacy to be effective. This task is made difficult by the fact that direct control of money and programs now lies with institutions designated by the categorical program system, not with a CCGB-like entity.

A key step toward real authority and legitimacy for the CCGB is formal sanction by key units of government (state, county, city, school board) and other major human services financing organizations, (the United Way, community foundations). Legislation, executive orders and formal policy decisions of existing governing bodies can give the CCGB the formal authority to carry out its roles. This authorization would give the CCGBs license to work to influence the policies and management of major institutions and other organizations within the delivery system, but not necessarily the power and legitimacy to make it happen.

Effective collaboratives derive their power and legitimacy from the people and the institutions who come to their table, and the fact that the participants view the collaborative process as part of their real institutional decision-making processes. This requires that CCGB members not only reflect the criteria noted earlier, but that they consciously work to build a culture of collaboration within the group, and across all agencies and systems.

Since every stakeholder will not have a seat at the governing table, tensions about the representativeness of the CCGB are inevitable. To address this issue, the CCGB must ensure that its decision-making processes are open, accessible and inclusive. It must engage widening circles of stakeholders - through committees and tasks forces by creating substantive opportunities for input from citizens, families and front-line workers and other means.

Finally, the CCGB must demonstrate its value to the service delivery system by achieving tangible results or "small victories." Such victories might include publishing a community profile defining the status of children and families; mediating a difficult service delivery problem, e.g., how to sustain the operation of school-based health clinics; pooling resources for out-of-home placement to create a community-based service delivery system; or developing an interdisciplinary training and professional development strategy. Each of these victories enables the CCGB to gain the credibility and influence to achieve broader changes.

The bottom line is that even where CCGBs are endowed with certain power and authority by existing institutions and governments, they must earn the credibility and legitimacy to bring that agenda to life.

Legal Structure [3]

There are two major legal options for organizing CCGBs. One option is for the CCGB to function directly under the auspices of city, county or state government. In such instances, the CCGB would be a commission or board with its power and authority granted through legislative or executive order. This approach has advantages and disadvantages. "On the positive side, it establishes legal authority, initial public credibility and the support of the governing administration. It also provides a `political home' for the collaborative. On the negative side, the politics of local government can sometimes consume a collaborative's energy and divert its goals." A CCGB inside local government also is working for reform from within the system, and may not have the independence to challenge old ways of doing business. If it is staffed from within a particular agency, rather than at the Executive level, it may still be viewed as `categorical' in character, or seeking to garner additional power to that single agency, rather than functioning as a facilitating entity.

Another option is to create a totally new legal entity. It could be a public-private intermediary chartered for this purpose, or a newly established non-profit organization. A new entity has the advantage of beginning with a new mission that is "less likely to be confused with that of existing governmental bodies. From the start, it can establish its new purpose, new ways of operating, and perhaps most importantly, its independence from existing special interests among current services. The disadvantages involve the sheer administrative difficulty of starting any new organization." As with many other aspects of building CCGBs, there is no proven formula for their legal structures.

Exhibit 3

Examples of Collaborative Community Governing Bodies

The variation in these examples and their evolutionary character suggests the need for continuing flexibility so that states and communities can create governing bodies most appropriate to their policy and service delivery environments, and continuously make changes based on their experience.

1. **STATE-MANDATED ENTITIES - MARYLAND:** Growing out of its focus on reducing out-of-home placements, the State of Maryland is now requiring each county to create a Local Planning Entity (LPE). The LPE is responsible for interagency planning, goal-setting, resource allocating, implementing and monitoring state funded/ supported interagency services to children and families in the local jurisdiction. Presently, the LPE has direct authority over pooled funds for out-of-home placement from the State Departments of Juvenile Justice, Education, Human Resources (child welfare) and mental health, as well as Part H Infant/Toddler funds. The LPE must be appointed by local government and have representatives from education, social services, juvenile services, health, mental health, core service agencies and local government who have the authority to obligate agency resources. It may be composed of up to 49% private citizens. The LPEs may operate within County government or as independent non-profit organizations. The LPE does not replace other county commissions and advisory councils and in fact, sorting out its relationship to these groups has been an important priority.

2. **STATE-INCENTIVES FOR GOVERNING BODIES. OHIO:** The state of Ohio is organizing seven county-level Family & Child First Councils on a demonstration basis. These councils mirror a similar state entity created by the Governor. The state has outlined a series of five major outcome categories that address indicators of child and family well-being and measures of systems change that each county must work to achieve. The local council must reflect the "cultural diversity of the county or counties it represents and reflect a blending of persons and organizations currently active in the local Cluster, the Early Intervention Collaborative and other coordinating entities in the family serving system". There is no limit to its size. A list of required members of the council includes representatives of major education and human service agencies, local government and parents. Optional membership may come from: business, religious, neighborhood, United Way, law enforcement, media or other groups. County Commissioners may designate any participating public agency or a not-for-profit organization as fiscal agent for the project. This council does not replace existing groups.

3. **STATE-CHARTERED COMMISSIONS - MISSOURI:** Where the state plays a direct role in operating the human services delivery system, it may choose to create CCGBs. The Missouri Department of Social Services chartered the Local Investment Commission (LINC) in Kansas City, Missouri to play this role. It's structure is unique: LINC is a 23 member citizen's commission including neighborhood, civic, business, foundation leaders and parents. Professionals do not serve on the Commission, but are part of a professional cabinet of local public and private agency leaders who advise the Commission. The Commission's role reflects the roles for CCGBs outlined earlier. LINC must use its state-granted authority, and the power and legitimacy of its local leaders to negotiate change in policy, budget and service delivery with the State Department of Social Services and other state departments and private agencies. It does not have direct control over resources. The state of Missouri also has created a state-level Family Investment Trust (FIT) to facilitate systems reform at the state level. It is a public-private entity whose membership includes a bi-partisan group of citizens and the Directors of the Department of Education, Health, Mental Health and Social Services

4. **A PUBLIC AND PRIVATE INTERMEDIARY - GEORGIA:** The Savannah-Chatham County Youth Futures Authority was chartered in 1988 by the state legislature. It started with 15 representatives designated by the state, county, city and local school boards and six ex-officio members; in 1991, the Authority was expanded to 32 members, including the United Way, Savannah Commission on Children and Youth and community and neighborhood representatives. YFA's mission is to develop a comprehensive plan that private and public agencies will use to deal with child, youth and family issues.

IMPLICATIONS FOR FEDERAL POLICY

There are numerous barriers to creating viable local Collaborative Community Governing Bodies. The litany is well known: turf, attitudes, egos, special interest lobbies, professional boundaries, narrow academic preparation, a categorical system that is over-regulated and inflexible, multiple eligibility, reporting and accounting requirements and many others. "Normal agency structures of authority reinforce the status quo... agencies operate their own programs, using their own eligibility requirements, categorical funding streams, and compliance reporting to assure their accountability to narrow purposes as specified by funders and legislatures. Governance issues are created when agencies try to come together to reshape systems so that they can move toward attributes of effective services and overcome normal ways of operating which block these attributes."[4]

The emergence of CCGB-like groups is a challenge to the categorical system. If we believe the categorical system must change, then we must consider new federal policies to strengthen the role of these collaborative community governing bodies as evolving vehicles for systems reform. The following suggestions are based on the key premise: the trade-off between the federal government, and states/communities is this: greater flexibility and discretion for implementing an outcomes-based accountability system.

Granting CCGB Real Review Powers

Office of Management and Budget Circular A-95 allowed local governments to review and comment on proposals submitted to federal agencies as part of an effort to support coherent community planning. The expectation was that this procedure would enable local government to influence these proposals. The review process occurred after proposal submission, however, and proved to be a very weak device with negligible impact. Implementing a stronger version of the A-95 process with CCGBs in the review role, could strengthen CCGB authority and legitimacy significantly.

One option is to grant CCGBs the authority to certify formally plans and proposals for all federal funds in the children and family services arena, in advance. Proposals submitted without CCGB certification would not be eligible for consideration. Such a provision would require that there be serious local consultation and collaboration in the planning process, and give CCGBs some real leverage to bring various services and providers together.

A less radical departure from the existing system would give priority in the proposal review process to plans and proposals that demonstrate explicit connections with the CCGB reform agenda, and perhaps include letters of support from the CCGB as well. This would give CCGBs the ability to influence the character of service delivery plans, without making them a formal gatekeeper.

Eliminate Requirements for Categorical Collaboratives

Federal policy should no longer require the creation of separate collaboratives, councils, or advisory groups for individual categorical programs. State and communities should have the flexibility to decide what structure will best achieve the goals of interagency involvement and broad participation. Such flexibility would enable states and communities to organize themselves in ways that make sense in their own political environments, rather than having to respond to a "one size fits all" model. Eliminating the overlap and duplication would also free up staff resources for strategic planning and program development.

Shift away from a designated "lead agency" model

A cornerstone of the categorical system is the legislative designation of "lead agencies" in federal laws that govern education and human services. Such a designation contributes significantly to the institutional behavior that makes the creation of a system of effective, primary preventive services so difficult. For new federal initiatives, particularly those that seek to promote systems reform, to maintain the "lead agency" model contradicts the spirit and intent of collaboration. Two alternatives warrant consideration:

- Federal law could give CCGB-type entities the authority to designate the lead agencies for particular programs. The lead agency designated by the CCGB would, of course, have to satisfy federal financial and program accountability requirements.

- Legislation might designate a fiscal agent, rather then a lead agency. Policy control would lie with the CCGB. The financial, personnel and contractual policies of the fiscal agent would govern the management of the program.

Recent Experience with Lead Agency/ Fiscal Agency Strategies

Recent experiences in Texas and California shed light on the fiscal agent concept alternatives. The fiscal agent approach has proven workable in the Texas Children's Mental Health Initiative. The local Mental Health Authority is the designated fiscal agent, however, policy control is given to an interagency management team whose members are designated in the legislation. The Mental Health Authority is a member of this management team, but the team selects its own chair. While there have been administrative bugs to iron out, this approach has given ownership of the children's mental health initiative to all the partners. The fact that partners are designated appears to be critical here.

The California Healthy Start Program to foster school-linked services makes the schools both the fiscal agent and the agency responsible for organizing the collaborative effort. Partners are not specifically designated, and guidelines make clear that the decision about the program administrator is left to the collaborative. A recent report indicates that while the "Healthy Start initiative has lent essential support to service integration and school-linked services, [it has] brought its own barriers to service integration..." A key barrier is that "the initiative is too school-centered or 'educentric.' Because the grant goes to the local education agency, schools automatically assume a leadership role because they are accountable for the money. Because other agencies do not have the directive to collaborate as schools do, they are not always as willing to participate or lend resources to Healthy Start. Instead of building on the attitude that all the actors are joining together to collectively improve outcomes for children, a perception has arisen that the purpose is to help schools with the problems they face. Many sites think the grant should have been given to a joint governance body that would share accountability for funds."

Experiments in Decategorization

"Breaking the Categorical Mold", prepared by Charles S. Bruner, offers mock guidelines for a federal demonstration initiative to support state and community redesign of services and supports to vulnerable families.[5] These guidelines propose experiments which engage states and local communities in building a reformed service delivery system using all major federal funding sources. CCGBs would be the focal point for community planning; states would be partners with communities in this process. CCGBs would be expected to develop relationships with neighborhoods, municipalities and school districts within their geographic domains. The federal government's role would change from one of regulatory control over action taken at the state, the community and the neighborhood levels to one of leadership, facilitation and technical assistance. Federal officials would identify the range of flexibility that can be achieved without the need for statutory changes, and the statutory changes that should be sought to achieve sufficient flexibility to meet community needs.[6] A further step would be to seek legislation for a series of demonstration sites that would be granted greater flexibility. The new Empowerment Zone legislation and the establishment, by the President, of the Empowerment Board are important steps in this direction, but do not move so far as the "Breaking the Categorical Mold" guidelines suggest.

Federal officials also could formulate demonstration strategies that allow communities to pool funds in often overlapping prevention and education programs in alcohol and drug abuse, health education, AIDS prevention, and violence prevention. These programs are serving the same client.

Training and Technical Assistance

The federal government presently has no explicit program of training and technical assistance to support the creation of entities such as Collaborative Community Governing Boards or cross-systems service delivery reform. Private foundations, states and local communities have been carrying the bulk of the responsibility on their own. Federal training and technical assistance is still tied to the categorical systems. The federal government should explore its authority to redirect funds from categorical training and technical assistance activities toward more comprehensive community approaches that support CCGBs. It could also provide incentives for universities to revise their pre-service and in-service curricula on developing people who can function in a reformed system. If greater flexibility is needed in existing legislation to pursue this approach, the Executive branch should seek that authority.

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5

Divider Title: _____

- work force
- health research
- functioning (core functions of public health)
- public access

- School Based Centers will be considered Essential Community Providers

Concept Paper

for a

NATIONAL CONSENSUS BUILDING CONFERENCE

on

SCHOOL-LINKED INTEGRATED SERVICE SYSTEMS

Building New Systems to Meet the Needs of Children

OVERVIEW

The American Academy of Pediatrics, American School Health Association, Council of Chief State School Officers, Child Welfare League of America, National Association of State Boards of Education, National Education Association, National PTA, and the National School Nurses Association are seeking funding for a national consensus-building conference on what principles must underlie a high quality school-based or school-linked integrated service system for children and youth. These national organizations have formed the Integrated Services Conference Planning Committee, hereafter referred to as the "Committee."

For purposes of the conference, an integrated service system is defined as a community-wide system designed to provide coordinated multidisciplinary services which effectively and efficiently use community resources to meet the needs of infants, children and adolescents from birth to age 21. These services include education, health and social services, family support, juvenile justice, substance abuse, recreation and other services. The conference intends to focus on the principles undergirding such a system.

The Committee proposes to bring together approximately 50 organizations that would be involved in the implementation of integrated service systems and for the first time to build consensus on a clear set of principles in four key areas. These are:

- ☞ Coordinating bodies
- ☞ Funding practices
- ☞ Community needs assessment and Evaluation
- ☞ Elements of Effective Service

These principles would serve as a guide to policymakers on the principles that underpin the basic elements that constitute efficient and effective integrated service systems so that they can make informed policy decisions. The principles will reflect a strong understanding of the need for local flexibility and the need for all participants to be equal partners in the decision-making process. Acceptance of these principles will help establish integrated service systems that maximize available resources and ensure quality services. The conference will take place in Washington, D.C. on January 23rd and 24th 1994.

BACKGROUND AND NEED FOR CONSENSUS

Today morbidity and mortality for school-age children and youth are most often linked to complex behavioral patterns and psychosocial risk factors, which can be influenced by education. If children are going to be ready to learn and we are going to reduce the overwhelming violence among today's youth, new strategies must be developed to meet these complex set of conditions. Prevention and/or treatment of these conditions often requires a multidisciplinary approach for families as well as their children involving: education, case management, social services, recreation, mental health counseling, dental services and nutritional support as well as traditional health services. Significant financial, geographic and psychosocial barriers exist that prevent children and youth from obtaining these important services. There is an unprecedented movement underway on the local, state and national levels to create integrated service systems using schools to overcome some of these barriers to care. Hundreds of definitions and action plans for integrated services have been described. These services range from professionals consulting over the phone with school-based personnel, to comprehensive on-site health, social, mental health, and family support systems. While many communities are defining their own version of what constitutes integrated services, there is no nationally recognized agreement on what elements should be included in an integrated service system. Nor has there been any significant discussion on when and if such systems should be used in all communities.

In the backdrop of these grassroots efforts, the Clinton Administration is promoting the advancement of integrated service systems across the country through education, social service, and health care reform legislation. One example of this is the President's education reform legislation, Goals: 2000, in which every state would be required to develop a plan on how they would structure integrated service systems to support achievement of national education goals. Additionally, health care reform legislation is expected to make school-linked and school-based services eligible providers of health care services.

The Congress is equally active. Legislation has been introduced in both the House and Senate which would provide significant new federal funding to communities to develop integrated service systems. This legislation is likely to be discussed in context of the reauthorization of the Elementary and Secondary Education Act, a multi-billion dollar federal aid program which reaches nearly every one of the 110,000 schools in the United States. In addition, there are several other major legislative proposals which could significantly impact the ability of communities to provide integrated services, such as welfare reform, the reauthorization of the Individuals with Disabilities Act (IDEA), Head Start, and child care legislation. While there is wide agreement on the general concept of integrated services, there is no widely accepted set of principles governing the implementation of such services. The integrated services conference would provide clear direction for policymakers supporting the development of these integrated service systems.

CREATING A FRAMEWORK

The Committee and the conference participants, through pre-conference meetings, have identified a number of tentative principles for a successful integrated services model. The conference will expand on these core principles and attempt to develop broad consensus on a model system. This consensus will then be used to guide policy decisions on the design of integrated service systems. **A basic premise of this framework is that integration will reduce bureaucracy and improve the quality and nature of services -- not just simply provide for their co-location.**

COORDINATING BODIES

A successful integrated service system will require models of interagency collaboration if long-standing barriers to effective implementation are to be overcome. An interagency body with real authority is necessary at the local level to coordinate integrated services. This coordinating body should include representation from both the private and public sector and be given sufficient authority to insure agency participation, accountability, and funding ability. It should function on the basis of principles rather than regulations to allow for the unique needs and resources of each community. The roles and responsibilities within the coordinating body must be clearly defined and a process for conflict resolution must be established. Responsibilities must be defined for coordinating body staff and for agency staff who are collaborating on joint projects with coordinating body staff. It is important that the agenda of no single institution predominates and that the focus of this body remain on the desired outcomes for children.

FUNDING PRACTICES

Limited and restrictive funding programs are a barrier to implementation of effective integrated service systems. Individual services draw from a myriad of federal, state, and local funding sources, each with their own eligibility requirements. These new integrated service systems will mix funding to increase comprehensive services while maintaining the integrity of the original funding source and its intended target population. Funding must be made more flexible to allow for more responsive service delivery systems. Effective local plans and programs should incorporate multiple funding sources and cut across traditionally separate service domains. In addition, administrative systems and practices need to be established and maintained that support cross-program activities.

COMMUNITY NEEDS ASSESSMENT AND EVALUATION

A comprehensive community needs assessment must be performed in order to identify the existing resources and gaps within a community. The needs assessment is the responsibility of the local coordinating body and should include broad-based community input in the form of public hearings or focus groups. It must address the needs of children from birth to age 21 and their families. It should not be limited to school-aged children. Priorities should be set based on this assessment and should build on community strengths. In addition, the needs assessment should identify barriers to full implementation of services and evaluate ways in which these can be overcome.

The components of an integrated service system need to be defined in context of the community needs assessment. These services may include health services (preventive, primary care and specialty referrals), education and social services, substance abuse treatment and counseling, recreational programs, juvenile justice programs, school to work programs, mental health counseling, dental services, vision, hearing and speech, and any other services which the community identifies within the local needs assessment.

A plan for ongoing evaluation of outcomes, service provision, community satisfaction and other variables should be an intrinsic component of the system. The process should involve both self-evaluation and independent review and should provide the program with constructive feedback. The state may play a role in this evaluation process. In addition, programs must be held accountable for the achievement of desired outcomes. New systems must be given sufficient time (three to five years) to establish modified service systems prior to evaluation. Developing a coordinated evaluation system between the various disciplines must also be explored.

ELEMENTS OF EFFECTIVE SERVICE

Ensuring that children receive quality care and services is of paramount concern. Quality assurances must be in place on the first day of operation. These new systems must ensure that each of the various disciplines provide for the highest possible quality standards. Of special interest in school-based and school-linked programs is the need for a medical home which is guarantees continuous delivery of quality services 24 hours a day 365 days a year. All services identified in the community needs assessment should be tailored to the individual community, but must share basic principles such as being family and child focused, confidential, easily accessible, culturally competent, flexible, and developmentally appropriate. Operational issues must be addressed and administrative practices modified to allow for case management and other inter-program, inter-agency activities.

PROCESS

The Committee proposes a multi-phase process for achieving consensus.

PHASE ONE: ***PRE-CONFERENCE EDUCATION***

A common understanding will be built and definitions of issues by commissioning five papers and holding pre-conference meetings. The papers will discuss basic concepts and create draft principles within the following topics: (1) Coordinating bodies, (2) Funding practices, (3) Community needs assessment, (4) Elements of effective services, and (5) Evaluation. The pre-conference meetings will be with all conference participants in November and will measure areas of agreement and disagreement and provide a forum for conference participants to share ideas on the structure of the conference before the conference begins.

PHASE TWO: ***BUILDING CONSENSUS***

Day one of the conference will use workgroups and working plenary sessions to discuss a "draft consensus statement on the principles of integrated services." At the end of day one the conference should have the first draft of a final statement.

PHASE THREE: ***ENSURING USEFULNESS***

The first draft of the final paper will be presented. The remainder of the morning will dedicated to hearing the views of Congressional and Administration officials regarding principles of integrated services systems.

PHASE FOUR: ***STATEMENT OF PRINCIPLES***

The second-half of day two will be used to consider the federal officials comments and finalize a statement of principles on school-linked integrated services.

PHASE FIVE: ***DISSEMINATION AND EDUCATION***

The closing exercise and follow-up activity will be a discussion among the national organizations participating in the conference as to how each will disseminate the statement of principles among its members and to the Congress and the Administration; make plans to educate the membership about integrated services; and to encourage joint education at local and regional levels among the membership of the various national organizations.

BENEFITS

THERE ARE MANY POTENTIAL BENEFITS TO CHILDREN AND YOUTH WITHIN EACH COMPONENT OF AN INTEGRATED SERVICE SYSTEM. THE FOLLOWING ARE EXAMPLES WITHIN ONE OF THOSE COMPONENTS, HEALTH.

* provide a medical home to children and youth
* provide all needed preventive and acute health care
* provide mental health, dental health, vision, hearing and speech
* are well coordinated with education and social services
* have culturally and linguistically competent staff
* provide easy referrals within and across services
* facilitate efficient information exchange among providers
* operate with understandable and compatible rules and requirements across different settings especially for programs with combined funding
* are able to design comprehensive multidisciplinary solutions to complex problems because of collaborative team efforts
* focus on family strengths and individualized family focused planning
* creating linkages to continuance health services

In addition, these health services will be convenient and accessible in a manner which encourages families and youth to seek care early and experience improved health and education outcomes through:

* lower rates of absenteeism
* earlier detection of treatable physical and emotional health problems that interfere with educational achievement
* coordination of medical treatment with education and social service needs, especially for chronic and multifaceted problems
* healthier behavior choices on the part of youth as the health care, educational and community messages sent will reinforce and support each other

The education, health and social services, employment, human services professionals will find their work more effective, especially when they are dealing with children and families with multiple needs and limited financial, educational or emotional resources. These benefits include:

* streamlined straightforward referral process with guaranteed follow-up
* availability of and funding for new services to meet the needs identified in the assessment process
* a clear understanding of community needs and input in establishing priorities
* ability to concentrate on their professional expertise, knowing that the community will meet the additional education, health or social service needs of the child and family
* knowledge of progress in other areas of child or adolescent's life

INVITATION LIST FOR INTEGRATED SERVICES CONFERENCE

American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Pediatric Dentistry
American Association of School Administrators
American Federation of Teachers
American Medical Association
American Nurses Association
American Psychological Association
American Public Health Association
American Public Welfare Association
American School Health Association
Association of Maternal and Child Health Programs
Association of State and Territorial Health Officials
Center for Population Options
Center for the Study of Social Policy
Children's Defense Fund
Child Welfare League of America
Council of Chief State School Officers
Council of Governors Policy Advisors
Council of the Great City Schools
Family Resource Coalition
Institute for Education Leadership
National Association for the Education of Young Children
National Association of Community Health Centers
National Association of Counties
National Association of Elementary School Principals
National Association of Pediatric Nurse Associates and Practitioners
National Association of School Nurses
National Association of State School NurseConsultants
National Association of School Psychologist
National Association of Secondary School Principal
National Association of Social Workers
National Association of State Boards of Education
National Collaboration for Youth
National Center for Services Integration
National Coalition of Hispanic Health and Human Services Organizations
National Conference of State Legislators
National Council of La Raza
National Education Association
National Governors Association
National Head Start Association
National Health Policy Forum
National League of Cities
National Network of Runaway and Youth Services
National PTA
National School Boards Association
National School Health Education Coalition
National Women's Law Center
National Urban Coalition
Public Education Fund Network
U.S. Conference of Mayors

January 24, 1994
Invited Participants for Federal Perspective Session
National Consensus Building Conference on Integrated Services
8:30 a.m. through 12:00 p.m.

8:30 a.m. **Keynote address by Attorney General Janet Reno**

9:15 a.m. through 10:30 a.m.

The Honorable Edward M. Kennedy
Chairman
Senate Labor and Human Resources Committee

The Honorable Christopher S. Bond
Member
U.S. Senate Banking, Housing and Urban Affairs Committee

The Honorable Lynn C. Woolsey
Member, House Education and Labor Subcommittee on Elementary, Secondary, and Vocational Education

The Honorable William F. Goodling
Ranking Member
House Education and Labor Committee

10:45 a.m. through 12:00 p.m.

Terry K. Peterson
Counselor to Secretary
U.S. Department of Education

The Honorable Olivia Golden
Commissioner, Administration for Children and Families
U.S. Department of Health and Human Services

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