Schools and Systems of Care: Challenges and Models for Collaboration from the National Evaluation

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Introduction
- Schools are a de-facto mental health system: 80% of all mental health services provided for children and youth are provided in schools (Burns et al., 1995)
- Schools & mental health systems have different cultures & goals, but have some shared goals: improving social and adaptive functioning; increasing availability, access, & range of services (Kutash et al., 2006)
- Positive Behavioral Interventions and Supports (PBIS) programs have been successful at coordinating the work of schools & mental health

Methods
- Secondary analysis of System Level Assessment (SLA) data and review of local program data on referral sources as reported to the national evaluation of CMHS-funded systems of care
- SLA data are based on face-to-face semi-structured interviews with representatives from core child-serving agencies & family organizations, project directors, intake workers, case managers, direct service delivery staff, & caregivers
- Data on referral sources were gathered through case record review by local program evaluators

Findings
- PBIS was the major planned service intervention strategy used in 4 systems of care funded in 2005
- PBIS was used as one of several strategies in 3 communities funded in 2002-2003 and in 5 funded in 1999-2000
- High levels of school involvement was found in 18 other SOC communities funded between 1997-2004
- In systems of care with PBIS, most referrals were from schools

A Question to Answer
To what extent are the core* child-serving agencies involved in systems of care when PBIS is the program focus?

* The core child-serving agencies generally include child welfare, mental health, education, juvenile justice, and public health.
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PBIS Case Example 1
- PBIS Coordinator & specialists hired through CMHS funding received in 2002
- Referrals: primarily from teachers, guidance counselors & school administrators; very few from other agencies
- Interagency* case review, service array, training (but not in PBIS)
- No formal MOU or blended funding

PBIS Case Example 2
- CMHS funds received in 1999 partially funded PBIS school psychologist, trained core agency staff in PBIS
- High level of school referrals; referrals from other core agencies; only mental health conduct intake
- Shared administrative processes & blended funding across agencies facilitated entry into services; service array includes all agencies
- MOU with schools helps sustain their involvement, less formal agreements with other agencies

Non-PBIS Case Example 1
- Case managers & therapists in schools funded by CMHS grant received in 1999
- Mental health therapist stationed at juvenile justice for initial assessments & referrals.
- Core agency staff make referrals but only mental health staff conduct intake
- Services mostly provided by grant-funded staff, not by other agencies
- Interagency case review, training, outreach, initiation, & planning of services

PBIS Case Example 1 Intake Referral Information

Non-PBIS Case Example 1 Intake Referral* Information
Non-PBIS Case Example 2

- Staff funded by CMHS grant (funded in 1999) placed in schools & other core agencies
- SOC strengthened relationship between mental health & education (e.g. joint crisis response team.) & strengthened relationship with Juvenile Justice
- Interagency work teams focused on specific issues, e.g. children with intensive needs
- All core agencies participated in service planning & case review
- No blended/braided funding (except for residential)

Implications & Recommendations

- Systems of care with PBIS have successfully involved schools, but how can they successfully maintain interagency coordination?
- Can we coordinate more than two agencies in service delivery & administrative processes?
- How can we better estimate how systems of care achieve interagency collaboration, especially with school systems?

References


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