Co-ordination of services for children suffering with emotional, psychological, behavioural and social disorders

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In many areas of human services delivery high quality service provision is only possible through inter-agency co-ordination. This article discusses the literature as applied to school aged children and adolescents suffering with emotional, psychological, behavioural and social disturbances although the issues and principles have much wider applicability. Enthusiasm and goodwill are essential but insufficient components of good co-ordination. Also necessary is the development of co-ordinative structures. The paper is the first in a series of three. It defines concepts essential to a discussion of the area, looks at some general issues and describes models used in three American States which could be adapted to local conditions. The second paper will look at the collaborative efforts taken to adapt the ideas presented in this paper in a region of Metropolitan Melbourne and the third will present the model which evolved through the collaborative process.

School-aged children (ie, those between 5 and 18 years) receiving help for emotional, psychological, behavioural and social disturbance require inter-service collaboration if their needs are to be adequately addressed (Human Rights & Equal Opportunity Commission, 1993:644-646). For a small number the issues are so complex that, without clearly defined inter-agency service delivery mechanisms, this co-ordination rarely occurs and clients' needs are either not met adequately or, in the worst instances, not met at all. Particularly in jeopardy are wards of state, the homeless, and those suffering from a dual disability or whose parents suffer with a psychiatric illness. The needs of these clients usually require the involvement of at least some of the following: protective, intellectual disability, juvenile justice, education, physical health, vocational and recreational services, in addition to mental health services. This article looks at some of the complex issues involved in the development and maintenance of successful service co-ordination to this target group.

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Definitions

In order to set the context for this, and the subsequent two articles, it is necessary to define and describe a number of terms. These include the following: emotional disturbance/ serious emotional disturbance; inter-agency co-ordination; multi-agency system of care and the multi-dimensional paradigm required to underpin successful co-ordination structures.

Emotional disturbance

A diversity of understanding of the concept emotional disturbance is reflected in the literature. This paper adopts the following definition:

> *Children who are emotionally disturbed have an impaired capacity to function emotionally, socially, cognitively or behaviourally, at a level consistent with that expected for their age and endowment. Contributing to such disturbance are constitutional and environmental factors including family difficulties and stressful events.*
>
> *Emotional disturbance....may present in a number of ways. While symptoms may include impaired reality testing, autistic behaviours, hallucinations and suicidal behaviour, more often emotional disturbance in childhood presents in other ways - hyper-activity, nightmares, depression, fearfulness, bedwetting, soiling, temper tantrums, stealing, poor impulse control, anti-social behaviour, obsessional behaviour, relationship problems, language problems, learning difficulties, refusal to go to school, unusual eating patterns and physical illness.*
>
> *Many young people at some time in childhood present with one or more of such difficulties, children are not usually considered to be emotionally disturbed unless a pattern of symptoms emerge.*
>
> *(Victorian Dept of Health - Office of Psychiatric Services 1992b:8).*

Serious emotional disturbance

The Draft Policy Statement goes on to describe a child as having a serious emotional disturbance if:

> *he/she has a diagnosable psychiatric disorder and satisfies one or more of the following criteria:*

- *the presenting behaviours are judged to be extreme responses, not in proportion to the immediate circumstances or inappropriate responses for a child of that age;*
- *the behaviours are considered seriously detrimental to the child's growth, development or welfare, or the safety or welfare of others;*
- *because of the behaviours the child is at risk of exclusion from his/her usual environment, home, school or other social setting.*

Frequently, children with serious emotional disturbance have impairments in a number of areas, for example, there may be behaviour problems as well as impairments in language, sensory motor integration, academic performance and social relationships as well as physical illness (Victorian Dept. of Health 1992b:9-10).

Inter-agency co-ordination

Inter-agency co-ordination is a highly complex process both to describe and to implement (Harbin & McNulty, 1990). This complexity is reflected in the following definitions:

> ...the process of linking services at all levels of their planning and provision in order to effectively meet the needs of children and families and to maximise their effective use of resources. Agreement on policy goals, program planning and designated responsibilities of agencies is required. Co-ordinative mechanisms must clearly detail working arrangements to be developed which can promote communication, consultation and co-operative, structured decision-making between agencies. New coordinative arrangements developed will maintain each department's operational responsibilities.
>
> (Final Report of the Inter-departmental Committee on Specialist Child and Family Services, August 1986).

This definition stresses several important aspects. These are that:

- the purpose of co-ordination is to enable children and families to make the best possible use of existing resources to meet their needs;
- linkages need to occur when services are being planned and implemented as well as delivered;
- both planning and delivery requires a joint understanding of common goals;
- the roles and responsibilities of the parties need to be documented so as to be clearly understood by all.

The following definition by Johnston, Bruininks and Thurlow (1987) stresses similar points and adds several others including the need for agreement, not only about goals but also about underlying philosophies, values and standards of practice. It mentions reasons why co-ordination can be difficult to achieve and maintain, and suggests the importance of basing practice on existing working models and the need for ongoing monitoring and evaluation.

> Achieving more effective and co-ordinated services begins with a coherent policy framework that incorporates greater consistency across public programmes with respect to philosophical values, goals, standards and practices to guide ongoing management of the planning process and delivery of services to the intended population .... application of joint planning and management approaches by largely autonomous agencies to surmount inter-organisational rivalries, limited resources and policy constraints. The application of more effective management practices requires infusion of valid and tested planning models, more accurate information on the needs and characteristics of the individuals ....service availability, and systematic and comprehensive evaluations of program outcomes and costs and benefits.
>
> (Johnson et al, 1987::529)

Multi-agency system of care

It is important to set in place '...arrangements, mechanisms, structures and processes to ensure that services can be provided in a co-ordinated cohesive way' (Stroul & Friedman, 1986:iv). To this end these authors propose:

> ... a comprehensive spectrum of mental health and other necessary services which are organised into a co-ordinated network to meet the multiple and changing needs of severely disturbed children and known as a multi-agency system of care. (Stroul & Friedman, 1986:viii)

[see Fig.1 and Fig.2 for an application of Stroul & Friedman's framework to Victorian conditions].

The following values lie at the core of the system of care. It must be:

- child-centred with services dictated by the child's needs not by what is available;
- function specific not agency specific;
- planned and managed at the community level with fiscal and other resources devolved to the region and pooled by participating agencies. Ready access to such resources enables the flexible tailoring of services so as to really address the child's ongoing needs.

Each of the six service systems comprises several components any, or all, of which may be called upon to meet the needs of a particular child. These components can be found in Fig 2.

Complexity of the multi-dimensional paradigm

Individual disciplines and service providers cannot alone provide the breadth of expertise and understanding required by those with specialised needs. It is thus necessary to ensure the application of a:

> ....multi-dimensional, interactional, developmental paradigm that contains six broad dimensions: climate, resources, policies, people, process and agency.
>
> (Harbin & McNulty, 1990:703-707)

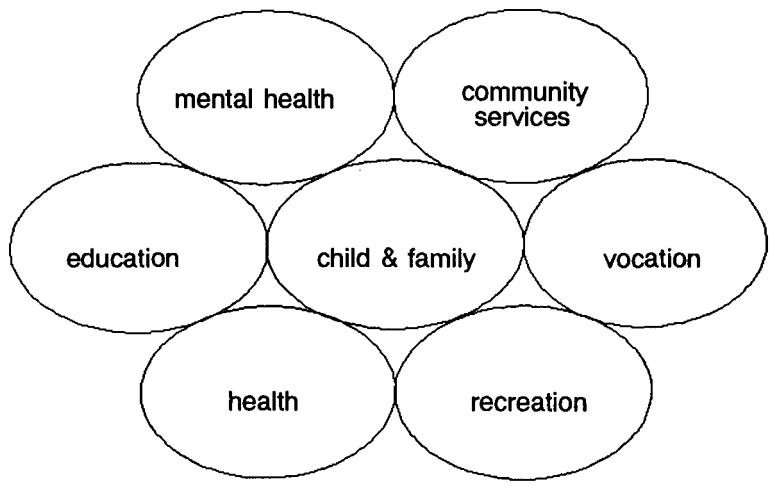

Fig. 1 Multi-agency 'system of care'

Fig. 2 Components of the multi-agency 'system of care'

Mental Health Services	Community Services	Supplementary Services	Educational Services	Health Services	Vocational Services	Sport & Recreational Services
intake and assessment	protective services	income security	mainstream schooling	health education & primary prevention	career education	after school programs
community treatment	physical, sensory & intellectual disability	respite care	with/without integration aid	screening & assessment	vocational assessment	youth groups/ clubs
day programs	juvenile justice	big brother/big sister schemes	special schools	primary care	job survival skills	sporting clubs
inpatient services	substitute services	HACC	special development schools	acute care	vocational skills training	
crisis services	independent living	home help	home-based education		work experience	
consultation	hostel care	family support Families First	school support services		job finding, placement & retention services	
community liaison	foster care				sheltered employment	
education & training	permanent care					

These dimensions are interactive. Sometimes only two interact. On other occasions they may all interact.

Climate refers to the atmosphere in which co-operation occurs. Climatic factors which can make or break co-ordination include attitudes and priorities of key decision makers and service providers and the value the community places on children and on meeting their needs (Miller, 1991:17).

Resources include money, the number of staff and variety of disciplines involved, the range and quality of generalist and specialist services available to meet the needs of the client group.

Policies include the governing principles existing within and between agencies such as laws, statutes, regulations, eligibility criteria, standards, guidelines and formal inter-agency agreements. Staff at all levels must have a working knowledge of such policies so as to prevent the parochial evaluation of issues and incidents which can arise from ignorance about the interrelatedness of public problems and which results in protective rather than co-operative organisational behaviour (Johnson et al, 1987: 527). The interrelatedness of public problems make it essential that policies developed by different levels of government or different departments do not conflict as this can make a co-ordinated, and in some instances any service delivery, impossible.

The extent to which inter-agency co-operation works depends on the skills, attitudes and time the **people** involved are able to devote. The main participants include '...the facilitator-leader, group members and key decision-makers' (Harbin & McNulty, 1990). Quality leadership and a range of styles is required at all levels.

The way in which the **process** is established and maintained can make the difference between co-operation and collaboration or competition and dissension. It is essential to build in clear channels of communication, proper planning processes, and mechanisms for conflict resolution.

The dimension of **agency** includes such issues as organisational culture and language. The culture includes 'the basic assumptions which influence the beliefs and behaviours in an organisation' (Frederico & Puckett 1992:16). Organisational cultures can be flexible and responsive to change; or bureaucratic and rigid, requiring much skill in order to alter. Different agencies use different language to describe the same phenomenon (Imber-Black, 1988:23), eg, the same child may be labelled as bad, mad, sad, can't add, loyal, sick etc. by different agencies. Since language structures our view of the world, fragmentation between services can be avoided through the development of a common language.

Imber-Black highlights three other agency limitations to co-ordination. First, some agencies ignore the existence of other agencies and their mandates. Such *disengaged* agency functioning can lead to inappropriate trespassing on other agencies' turf resulting in confusion for clients and conflict between agencies. Secondly, the conflict of values between agencies is, at least in part, a result of different mandates, eg, the social control emphasis by correctional services versus the mental health focus on care and personality growth and change. Thirdly, agencies sometimes change their mandate but this does not automatically lead to alterations in the underlying values and attitudes driving the agency's functioning. Clients and other agencies receive conflicting overt and covert messages and collaborative efforts are frustrated and confused.

It could be argued that there is a seventh dimension to the co-ordination process, that of **education.** All involved in the process need to develop new skills, change attitudes and increase their overall knowledge base. Some learning can be incorporated into professional courses but much needs to be learned via staff development, in-service training, joint seminars, team building exercises etc.

Why co-ordinate?

The second paper discusses reasons for co-ordination in some detail. At this point it is sufficient to note that in Victoria it is estimated that 5% of the approximately 1000 cases presenting to most Child and Adolescent Mental Health Services currently, do not have their needs satisfactorily addressed (Victorian Dept of Health - Office of Psychiatric Services 1992a); and that the services which should make up the system of care are frequently highly critical of each other's lack of collaboration and responsiveness to clients (see, for instance, Parliament of Victoria, Social Development Committee, 1991).

Co-ordination structures

Levels of co-ordination

For co-ordination to work, mechanisms and responsibilities need to be established at the federal, state and regional level as well as at the level of service delivery to the individual child (Stroul & Friedman, 1986:115-116; Harbin & McNulty, 1990:701). Lack of space precludes a discussion of the co-ordination issues pertaining to the federal level and the article will focus on such issues as applied to the other three levels.

The State Level

Writers stress the essential nature of the state's role in the establishment and maintenance of co-ordinative mechanisms but do not give clear directions as to how such co-ordination should proceed. Hommonhoff and Maltz (1991:356) indicate that collaboration at the local level must be *paralleled by strong state leadership* in relation to policy and planning. They also stress the need for the development of a legislative mandate for *cross system collaboration*; Tropman (1974:154-155) points out that the extent to which inter-organisational activity occurs is in direct proportion to the resources devoted to such inter-organisational function by the state. This resource allocation in turn depends on the extent to which the *executive corps* regards allocation of financial and other resources to this activity as an investment. Harbin and McNulty (1990:710) present the following models for co-ordination of services for the *early intervention* target group. These are: representatives from service agencies, consumer groups and providers; a small policy making group of high level decision makers; or some combination of the above. Each alternative provides the leadership for these co-ordinative mechanisms by designating the lead agency role to one of the agencies involved in the co-ordinative process.

Stroul and Friedman (1986:115-117) confine their discussion of co-ordination at the state level to listing the following responsibilities while acknowledging that mechanisms need to be developed in order to ensure that these responsibilities are carried out. Such responsibilities include ensuring that:

- the full range of required services exists;
- standards for service delivery are established;
- service and service delivery is monitored and evaluated;
- consultation, advice and technical assistance is available to help regions carry out their responsibilities effectively;
- limited, specialised services are provided at a state level for rare problems;
- a strong and effective service system is developed and promoted;
- mechanisms required to delegate control over fiscal resources to the regions are in place so that services can be tailored to the needs of the child as appropriate.

The Regional Level

Stroul and Friedman (1986) stress the need for the control over resources (including fiscal resources), as well as the responsibility and authority to make decisions with respect to individual youngsters, to be devolved to the regional level. They present three alternative structures and suggest that choice depends in part on the structure of the state system and its approach to regionalisation (Stroul & Friedman, 1986:117-119). The alternatives mooted are: management by a consolidated agency, management by a lead agency and management by multiple agencies through formal agreement.

1. Management by a Consolidated Agency

Here all children's services are provided, either directly or contractually, by one department. In a variation of the model most of the services are provided by one department with certain services (eg, mental health) provided by a separate department. This is known as a quasi-consolidated agency. Even in the consolidated management model, educational and recreational services are usually provided separately. With the major, if not total, responsibility for children's services lying with the consolidated agency, it also manages the system of care. This model is particularly useful when regional geographical boundaries created by different government departments do not coincide because it can, to some extent, '... alleviate the obstacles to the agencies working effectively together' (Stroul & Friedman, 1986: 117). The model can be found in the American states of Florida and New Hampshire. Theoretically the model has much to recommend it but the services will still require a considerable amount of internal co-ordination which may be no less problematic.

2. Single Agency as a Lead Agency

Here a single agency is designated (by agreement, by legislation, by the court or by a high level of the state executive branch) as the lead agency with the responsibility for managing the system of care. All agencies involved accept this decision and abide by it. An essential aspect of this model involves the clear specification of the roles and responsibilities to be played by each agency (Stroul & Friedman, 1986:118). Criteria for selection of the lead agency must of necessity be based on expertise (see case management below for an elaboration of the issues). The model is implemented in North Carolina.

3. Management by Multiple Agencies (Cluster System)

> A cluster is an inter-agency group which meets regularly to plan service and funding for multi-need children .... Clusters do not just access existing resources for the children they serve, but rather they assess needs and create services with their own flexible pool of funds.
>
> (Fuller-Torrey et al, 1990:69)

Both regional and state representatives of the key child service agencies meet regularly to review individual children whom the system has not adequately served. They develop plans to meet the needs of these children and their families. Funding, planning and service delivery are joint ventures. The inter-agency agreement details planning, problem solving and conflict resolution mechanisms to address difficulties which may arise. To work, the cluster system must be based on mutual respect and understanding among agencies of the contributions and philosophies of each. This model is used in Ohio.

Also essential for success in all models is high quality case management which forms the backbone of co-ordination at the level of service delivery to the individual client.

Whichever system is used it will depend for success on close co-operation between the core agencies. This co-operation is essential in the development, implementation and management stages of the system of care (Stroul & Friedman, 1986:xv). Also essential for success in all models is high quality case management which forms the backbone of co-ordination at the level of service delivery to the individual client.

Co-ordination at the level of the individual child

According to Stroul and Friedman (1986:119-121) and Behar (1985), co-ordination at this level is based on collaborative case management, advocacy, joint discussion and decision making at key points in the involvement with each individual client.

1. Case Management

The co-ordination models described above all emphasise the critical role played by case management in ensuring that clients receive services according to their changing needs over time (Behar 1985; Harbin & McNulty, 1990; Stroul & Friedman, 1986; Fuller Torrey et al, 1990). The form it takes depends on the regional structure adopted. Case management can be defined as:

> ... the mechanism for connecting and co-ordinating the various components of a service delivery system into a comprehensive service package designed to meet the needs of an individual child and his/her family.... [it] involves assessing the needs of the child and family, developing service plans, co-ordinating [and] monitoring service delivery, evaluating services and advocating on behalf of the needs of the child and family.
> (Specialist Child & Family Services Report Series, 1990:14)

Case management services are targeted at:

> ...people with a range of complex, multiple needs who require access to a diverse range of services. The aims are development, co-ordination and delivery of a comprehensive service delivery package.
> (Community Services, Victoria, 1992 :11).

The need for an effective case manager is argued for strongly in the literature. For example:

> Without such a primary service person responsible for the co-ordination of the treatment plan, it is nearly impossible to assure adequate service and proper placement for a seriously emotionally disturbed child or adolescent.
> (Stroul & Friedman, 1986:21)

> Case management is the element of planning and co-ordination that holds together the workings of all the agencies concerned with the child, the energising factor that has propelled the service plan into the reality of service delivery, the case advocacy strength that has sustained a commitment to each child and an optimism about each child's capacity to change.
> (Behar, 1985:194)

Case manager accountability depends on the regional structure in operation. In some instances case managers are regular employees of the regional co-ordinating body. On other occasions they are employed by the agency contracted to provide the co-ordinating service. Either way it is not advisable for the case managers to be involved in a primary treatment role because this compromises their independence and ability to review progress and advocate on the child's behalf. Case managers should carry a case load of not more than ten to twelve cases (Behar, 1985: 192; Stroul & Friedman, 1986:95). Behar, herself, has a clear preference for case managers to be located in the mental health system. She bases her view on the belief that the role requires special knowledge of child and adolescent mental health issues and a familiarity with diagnostic and treatment concepts; and skills which include the capacity to match the services to needs of the child throughout the period of involvement with the system of care. Stroul and Friedman do not appear to invest the case manager with the high level responsibility for the mental health component of care and so take a more flexible approach. (They do not make it clear who should be responsible for the above issues if the case manager does not have the skills upon which Behar lays so much store.) They consider that where the case manager is organisationally located depends on the circumstances. The role includes:

- co-ordinating the comprehensive interagency assessment of the child's needs;
- planning services to address the needs of the child/family;
- arranging for needed services;
- linking the various parts of the child's system, including family agencies, school and significant others;
- monitoring the adequacy and appropriateness of services;
- ensuring the continuity of service provision;
- advocating on behalf of the child and family;
- establishing links with adult services to facilitate transition where required.

In spite of the different terminology, the role of case manager as described in the Corporate Client Services Model (CCSM) (Community Services Victoria, 1992) is very similar to the one above. The main difference is that the CCSM takes the view that the provision of direct intervention (counselling, support, advice) is a part of the case manager's role. Stroul and Friedman (1986:95), and Behar (1985:194) disagree that this merging of the two roles should regularly be considered appropriate. Behar does say that there are occasions where it can be done satisfactorily but views these as the exception rather than the rule. It is likely that the special needs of youngsters with multiple and serious emotional disturbance would require modification to the CCSM model in order for it to succeed.

The capacity of case managers to advocate, co-ordinate and act as broker is limited unless they are

accorded a status of both independence and influence within the overall system (Stroul & Friedman, 1986:95). In addition, a good relationship with the child and family is essential for the service to be delivered in a personal way. Finally case managers must be able to devise creative and intense interventions at short notice. This requires frequent contact with all those involved as well as access to finances and the mandate to spend the money in ways which best meet the needs of the child, whether it be in therapeutic foster care, respite care, an integration aide, extra clothing, violin lessons etc. (The need for the case manager to have access to finance and the mandate to spend it appropriately in the client's best interest is a major issue and one which will be discussed further in the third paper.)

2. Advocacy

Knitzer considers the advocacy component of the case management role sufficiently important to consider it separately. She defines advocacy as follows:

> ...the effort to improve the quality of services and strengthen the rights and protection accorded to children. (Knitzer, 1984b as quoted in Stroul & Friedman, 1986:98).

There are two levels of advocacy, case advocacy which is concerned with ensuring that the child and family receives the necessary services and benefits; and class advocacy which seeks improvements in services, benefits and/or rights on behalf of all severely emotionally and behaviourally disturbed children and adolescents. The latter is a lengthy process requiring collaboration with the client group and their parents. Both forms of advocacy are vital to high quality service delivery and neither have traditionally been part of ongoing practice for seriously disturbed children (Knitzer, 1982). Highly complex skills and much perseverance is required to perform both sets of tasks effectively.

3. Case conferences and case review committees

In some systems of care, a case review committee exists as a permanent part of the structure. This committee is responsible for making decisions about entry, choice of appropriate service and regular reviewing of the client's progress. Stroul and Friedman (1986:119-120) argue for two committees, one to consider entry into the system of care and the other to monitor the progress of the programs and the extent to which they continue to meet the clients' needs. They consider a division of labour necessary in order to prevent the gate-keeping role occurring to the exclusion of the monitoring one. When only one committee exists, it becomes the case manager's role to ensure this does not happen. Where residential treatment is a part of the plan, procedures need to be built in to ensure that children do not fall between the cracks of the mental health and the social services agencies as each agency defines its own exclusion criteria without reference to the other (Stroul & Friedman, 1986:120). An example would be the mental health service deciding that the client is not suitable for their service because the difficulties do not warrant a psychiatric diagnosis and the social service agency saying that the behaviour is too disruptive to be contained in their program. The best way of avoiding such a scenario is by the two services having joint decision-making responsibilities.

The alternative to a permanent review committee is to convene case conferences at critical decision making points in the treatment process. This is the procedure used in the Victorian system. This ad hoc arrangement rarely succeeds in really complex cases as it is unable to provide the case manager specifically, and the system of care in general, with the support required to ensure successful functioning.

> *...whatever else it may be, co-ordination is not easy. On the other hand, it is not impossible either.*

Conclusion

> Better co-ordination has a niche in the hierarchy of virtues close to motherhood and applepie ... and it is so easy. All it requires is common sense, goodwill and opportunities for those whose activities are to be co-ordinated to confer regularly .... why then is it that there is apparently so little of it?
>
> (Bardach, 1978:132-133)

As is evident from the issues raised in this article, whatever else it may be, co-ordination is not easy. On the other hand, it is not impossible either. Essential for success is the development of a model suitable to and taking account of local conditions and organisational arrangements; appropriate monitoring devices to ensure that the client group receives the best possible service; and the structures to ensure a strong inter-agency case manager role. The third article will attempt to meet the challenge of developing a model which would sit comfortably in the Victorian context. ♦

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Book Review

Task-Centred Social Work

by Mark Doel and Peter Marsh

Aldershot, England: Ashgate Publishing, 1992, 136 pp.

In today's climate, human service agencies are under increasing pressure to demonstrate, rather than assert, the outcomes of their programs. In conjunction with this, many services are now delivered on a short-term or time-limited basis. What is needed is a clear outline of how to do such short-term, outcome-oriented intervention. This concise book fills this need, for it is a comprehensive handbook on task-centred social work. This is a model of practice in which there is an agreement between client and worker on the former's problems, the tasks to be jointly undertaken to deal with these problems, and the goals that should be reached at the end of an agreed time limit.

The book briskly outlines the research basis and ethical issues involved in task-centred practice, and then proceeds with a lucid discussion of how to do task-centred practice. Included is a discussion on defining problems, negotiating a written agreement of tasks and goals between worker and client, undertaking the tasks and assessing outcomes. This discussion is illustrated by an on-going case study that threads through the five main chapters. In the appendix is a helpful checklist for practitioners and a bibliographic guide to the task-centred practice literature.

The task-centred practice model contains much that is useful. The emphsis on clear outcomes will appeal to agencies under increasing pressure to systematically monitor their programs and document specific outcomes of their services. In addition, those interested in client empowerment may find considerable appeal in the approach. Doel and Marsh note that the task-centred model enables clients to set goals for themselves and rejects the 'pathology' context that has hitherto characterised much of social work assessment. But the model is not appropriate in all circumstances. How well it would work with many involuntary clients, who may well not agree with a human service agency's view of their problems and indeed resent being compelled to use such an agency's service is open to question. Further, social workers are often confronted with clients undergoing repeated crises, circumstances which would cause difficulties in reaching agreed goals.

Nonetheless, this book should prove an invaluable aid to practitioners and administrators concerned about successful social work practice. It should be of particular interest to those working with children and families, where the task-centred model of negotiating goals to be met in time-limited intervention should have particular appeal for agencies under pressure to show the outcomes of their programs.

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