

The Need for Interagency Collaboration for Children with Emotional and Behavioral Disabilities and Their Families

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Abstract

Children and youth with emotional and behavioral disabilities often have multiple needs that can require the simultaneous involvement of several child-serving agencies (e.g., child welfare, special education, juvenile justice, and mental health). Unfortunately, disparate definitions and eligibility criteria that are used to identify these disabilities have prevented agencies from collaborating or even communicating about the children with whom they work, resulting in a pervasive lack of coordination among service providers. During the past 15 years, however, there has been an increase in the number of multiagency, community-based programs for children and youth with emotional and behavioral disabilities, sometimes referred to as "systems of care." In this paper, information about commonly used federal definitions of emotional and behavioral disabilities and a description of how variance in definitions and eligibility criteria contributes to the inability of agencies to work together to meet the needs of children and families are presented. Additionally, methods for developing community-level, interagency eligibility criteria for serving children who have needs that cross agency boundaries are addressed. Finally, a recently created system of care, the Dawn Project, located in Marion County, Indiana, is described.

CHILDREN AND YOUTH with emotional and behavioral disabilities¹ have a troubling history in this country. Prior to the passage of the Individuals with Disabilities Education Act² (IDEA; PL 94-142) in 1975, many of these children and their families went without services, both in school and in the community. The enactment of IDEA, often referred to as the special education law, required school districts to provide a free and appropriate education for all children with disabilities. However, 25 years after the passage of the law, outcomes for children with emotional and behavioral disabilities remain bleak (Wagner, 1995; Ruhl & Berlinghoff, 1992). Even with special educa-

tion services, this group experiences high levels of social and academic difficulties and exhibits challenging behaviors that persist over time (Friedman, Kutash, & Duchnowski, 1996). For example, children and youth with emotional and behavioral disabilities receive lower grades and have higher rates of absenteeism and unemployment than any other disability group. This group also is more likely than other disability groups to drop out of school, get arrested, or be placed in restrictive placements, such as separate schools or residential settings (U.S. Department of Education, 1998). Consequently, not only are these children performing poorly in school, they also often require the

¹In this paper, the phrase "emotional and behavioral disabilities" is used to refer to children and youth with a wide range of behavioral, emotional, and mental health needs, who may be receiving services from a variety of providers or going without needed services.

²PL 94-142, originally called the Education of All Handicapped Children Act, was reauthorized in 1990 as the Individuals with Disabilities Education Act (PL 101-476) to promote the use of person-first language.

simultaneous involvement of several child-serving agencies (e.g., child welfare, juvenile justice, mental health). However, these agencies, traditionally, have worked in isolation from each other, resulting in a pervasive lack of coordination among service providers and a convoluted service system that is fragmented and overly restrictive (Illback, 1994).

During the past 15 years, a number of initiatives for improving coordination among the agencies that provide services for children with emotional and behavioral disabilities and their families have been implemented. Beginning with the enactment of the Child and Adolescent Service System Program (CASSP) in 1984, a philosophy about how best to provide services for this population of children and their families began to evolve (Stroul & Friedman, 1986). CASSP emphasized several important principles that have had an enormous impact on service provision (Duchnowski & Kutash, 1996). First, parents should be included as partners in their children's services, both in identifying needed services as well as in designing individual service plans for their children. Second, service systems and providers should be culturally competent, such that services are provided within the unique cultural and ethnic context of each family. Since the enactment of CASSP, several additional principles, including service coordination, local and state level leadership, flexible funding, and individualization of services, also have come to be considered essential to appropriate service provision. When a system of services utilizes and adheres to these principles, the resulting structure often is referred to as a "system of care" (Friedman, 1996), defined as: "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families" (Stroul & Friedman, 1986, p. 3).

Together with other initiatives designed to improve services for children with emotional and behavioral disabilities and their families, the system-of-care philosophy initiated a paradigm shift in how services are provided in the United States (Knitzer, 1996). One outcome has been an increase in the number of multiagency, community-based systems of care that provide services to children and their families (Burns & Burchard, 1998). Moreover, during the past 10 years, a series of federally funded projects have provided some evidence that systems of care can lead to improved outcomes for the children and families

who participate in these collaboratives (Friedman, 1998; e.g., see Hernandez & Goldsmith, 1996). Even so, systems change is a slow process, and we are only beginning to witness the development of a second generation of systems of care that are funded through collaborative local, state, federal, and private initiatives and commitments.

The principles guiding system of care approaches are appealing. However, there are many challenges that impede the ability of multiple agencies to work together. Among the barriers to developing interagency collaboratives, perhaps the most serious, is the variation in how different community agencies define emotional and behavioral disabilities and use these definitions to establish service eligibility criteria (Friedman et al., 1996). In addition to posing barriers to interagency collaboration, such variations also lead to the underidentification and misidentification of these types of disabilities. The following sections of this paper provide information about (a) commonly used federal definitions of emotional and behavioral disabilities; (b) how definitions are interpreted and implemented as eligibility criteria; and (c) how variance in such criteria contributes to the inability of agencies to work together to meet the needs of children and families. Additionally, methods for developing community-level, interagency eligibility criteria for serving children who have needs that cross agency boundaries are addressed, and finally, a recently created system of care, the Dawn Project, located in Indiana, is described.

Defining Emotional and Behavioral Disabilities

There has been little consensus among practitioners and researchers as to how to define emotional and behavioral disabilities in children (Duchnowski & Kutash, 1996; Forness & Knitzer, 1992). Martin, Hallenbeck, Kauffman, and Lloyd (1995), for example, conducted a comprehensive review of the research literature and found 68 labels or descriptors used to refer to emotional and behavioral disabilities. This is indicative of our attempts to describe the numerous characteristics associated with emotional and behavioral disabilities, and has resulted in the creation of multiple and sometimes conflicting definitions for these types of disabilities. The absence of an agreed upon definition impedes the ability of agencies to integrate services for children with emotional and behavioral disabilities and their families (Kutash &

Duchnowski, 1997). Differing definitions produce disparate identification criteria and processes across agencies. Moreover, when agencies use different definitions, there is an assumption that the children who receive services also are different. Thus, for example, schools may not recognize that the children whom they identify with emotional and behavioral disabilities also may be receiving services from community mental health centers or other community agencies. It is possible that children and families could end up receiving counseling from two or more agencies, without the agencies or counselors ever communicating about the families with whom they are working.

Definitions and eligibility criteria also are different across providers because they reflect the specific philosophies or goals of various service agencies, again producing an illusion that different agencies serve different populations. For example, if the purpose of the agency is to treat mental health problems, eligibility criteria will be tied to mental health diagnoses; whereas, if the purpose is removing adolescents who commit crimes from the community, criteria will relate to criminal intent or conviction. As said before, the assumption is that agencies are serving different children; however, children with emotional and behavioral disabilities and their families often are involved with more than one agency or system (Epstein, Cullinan, Quinn, & Cumblad, 1995). Thus, as will be discussed, definitions can impact both service usage, because eligibility criteria limit who is allowed to receive services, and service integration, because an agency's purpose or philosophy may conflict with those of other agencies. Ultimately, these factors, which are interrelated and difficult to untangle, contribute to the inability of service agencies to work together.

Federal Definitions

In this section, two federal definitions are reviewed to provide an example of how disparate definitions of emotional and behavioral disabilities can pose obstacles to interagency coordination. One definition is used by the children's mental health system, and the second is used in the educational system. These two systems are the central suppliers of services to children and youth with emotional and be-

havioral disabilities in the United States (Duncan, Forness, & Hartsough, 1995). First, the definition used by the Center for Mental Health Services, which is specifically based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV; American Psychiatric Association, 1994), states

Children with a serious emotional disturbance are persons from birth up to age 18 who currently or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. (Substance Abuse and Mental Health Services Administration, 1993, p. 29425)

This definition, based on diagnosis, was developed to promote comprehensive system planning and lends itself to interagency collaborative efforts because it is broad enough to encompass the various domains of a child's life (e.g., family, school, community) (Friedman et al., 1996).

Special education, on the other hand, utilizes a definition of *emotional disturbance*, as specified in the federal law, IDEA:

Emotional disturbance³ means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects school performance: (a) an inability to learn which cannot be explained by intellectual, sensory, or health factors; (b) an inability to build or maintain satisfactory interpersonal relationships with peers or teachers; (c) inappropriate types of behavior or feelings under normal circumstances; (d) a general pervasive mood of unhappiness or depression; or (e) a tendency to develop physical symptoms or fears associated with personal or school problems. The term includes children who are schizo-

³In the most recent reauthorization of IDEA (PL 105-17 in 1997), the category "serious emotional disturbance" was shortened to "emotional disturbance" to eliminate the negative connotation associated with the word serious.

phrenic, but does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed. (Federal Register, 1977, p. 163; Individuals with Disabilities Education Act Amendment, 20 U.S.C., 1997)

As would be expected, this definition is specific in its mandate that the disability has a detrimental impact on school functioning; however, its scope is limited because no references to nonschool environments are made. Moreover, individual states are allowed to modify the IDEA definition to meet their own needs (Nelson & Pearson, 1991), producing wide variations in the criteria used to identify children and youth for special education services. As an example, in the State of Mississippi, only .06% of the student population is identified as having emotional or behavioral disabilities, whereas, in the State of Maine, 1.95% of all students are identified in this category (U.S. Department of Education, 1998). Moreover, some states do not include the social-maladjustment exclusion clause in the eligibility criteria for emotional or behavioral disabilities (e.g., the State of Indiana does not use the maladjustment exclusion clause). The wide disparity in the implementation of the federal definition makes it unclear how many children should be receiving services in schools.

Identification Processes

How definitions are operationalized ultimately determines who will receive services from a specific agency or system. Thus, to understand how discrepant definitions impact interagency collaboration, it is necessary to first understand the identification processes used by various child-serving agencies to identify children for services.

Although identification processes may differ across agencies, with the exception of education, a child with a mental health disorder often will receive a DSM diagnosis. The purpose of the DSM is to "provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders" (American Psychiatric Association, 1994, p. xxvii). In the diagnosis process, evidence is gathered from a variety of sources and a decision-making schema may be utilized. Diagnostic tools include interviews, behavioral checklists, pupil

self-report scales, intellectual and achievement tests, and direct observation. Moreover, most DSM-IV disorders have a code that corresponds to the official coding manual, the *International Classification of Diseases* (ICD-9-CM; U.S. Department of Health & Human Services, 1998 Update), permitting data to be collected across sites, both in physical and mental health, and allowing prevalence and incidence rates to be calculated and analyzed. This is important because children can enter the mental health system at a number of points (e.g., emergency rooms, family doctors, schools, community mental health centers, crisis centers, contact with law enforcement), making it difficult to accurately estimate the degree of need in a community for children's mental health services.

Education, on the other hand, utilizes a definition of emotional disturbance that lacks the specificity of the diagnostic categories provided in the DSM-IV. As previously discussed, the definition used in education only relates to the impact that the disability has on school learning. The process of identifying children for special education services takes place in schools and usually starts with a teacher referral (Stone, Cundick, & Swanson, 1988). Assessment follows a referral and should provide information about functioning in several domains, including motor skills, perceptual abilities, intellectual abilities, adaptive behavior, self-concept, personality, and academic achievement. Similar to the mental health diagnosis, types of assessments that are used for evaluating children for emotional and behavioral disabilities include interviews with parents and teachers, behavioral rating scales, self-report scales, intellectual and achievement tests, and direct observation (Whelan, 1995). For example, assessment procedures for a child suspected of having an emotional or behavioral disability may occur as follows: (a) the classroom teacher conducts formal observations and systematically records problem behaviors as they occur; (b) the social worker interviews parents, classroom teachers, and the child or youth; (c) the school psychologist performs intelligence and achievement testing; (d) the parent observes and records problem behaviors that occur at home and in the community; and (e) the team then compiles and reviews the information and determines whether a special education label is appropriate. Typically, community agencies are not represented in this process and, in most cases, there are not mechanisms for linking special education labels with DSM diagnoses.

Prevalence Rates and Underidentification

Underidentification of emotional and behavioral disabilities has been a consistent problem among both community agencies and schools. Underidentification occurs when children and youth with mental health needs are not identified by schools and/or agencies and, therefore, go without needed services. However, keep in mind that knowing actual prevalence rates for emotional and behavioral disabilities will never be possible without adequate definitions and associated identification processes.

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Identifying children as having emotional and behavioral disabilities is complicated because this group is very diverse, presenting a wide range of mental health needs (Phillips, Nelson, & McLaughlin, 1993). Friedman et al. (1996) noted that youngsters with serious emotional disturbance have problems in many domains (e.g., emotional and behavioral functioning, educational performance, social behavior, overall functioning) and have DSM diagnoses that are varied and multiple, with a high prevalence of both mood disorders and disruptive-behavior disorders. Based on their review of the literature, these authors estimated that the prevalence of serious emotional disturbance probably falls between 9% and 19% of all children and youth. Further, it is estimated that a subpopulation of this group, consisting of between 2% and 6% of all school-age children, should receive school-based services under the category of "emotional disturbance," as defined by IDEA (Forness & Knitzer, 1992; Illback, Nelson, & Sanders, 1998). However, a large percentage of children with mental health needs receive little, if any, intervention in the community (Walrath, Nickerson, Crowel, & Leaf, 1998) or in school (Forness & Knitzer, 1992). For example, less than 1% of all students received school-based services in the category of emotional disturbance in 1997-1998 (U.S.

Department of Education, 1998). Given the high rates of comorbidity associated with, and the diverse nature of, emotional and behavioral disabilities, the degree to which children with mental health needs go undetected or underdetected is not surprising. In general, part of the problem of underidentification can be traced to ineffective and overly restrictive eligibility criteria and identification processes. Both the DSM diagnostic system (Duncan, Forness, & Hartsough, 1995) and the special education assessment system (Stephans & Larkin, 1995) have been criticized as being subjective and unstable.

Part of the difficulty, again, is based in the language of the definitions that are used to identify children for services, as well as the mission or purpose of particular systems or agencies. For example, students who are labeled as conduct disorder by a child-serving agency, using DSM criteria, can be legally excluded from receiving services in schools because of the exclusion of social maladjustment from the special education definition (see the definition for emotional disturbance previously described in this paper). Moreover, some states do not allow students who have been adjudicated or involved with gangs to be identified for special education (Edger & Siegal, 1995). Interestingly, social maladjustment has never been defined at the federal level (Bauer & Shea, 1999), which has allowed for ambiguity in how the phrase is interpreted. On the one hand, it has been argued that social maladjustment could be described as an "inability to build or maintain satisfactory interpersonal relationships with peers or teachers" as stated in the IDEA definition of emotional disturbance (Forness & Knitzer, 1992); according to this argument, the federal law contains a "logical fallacy" (Costenbader & Buntaine, 1999, p. 3), simultaneously including and excluding certain students, depending on how the language is operationalized. This implies that the same student may or may not be identified for special education depending on how the definition is interpreted. On the other hand, some educators and policy makers have stipulated that social maladjustment differs from disability because children and youth with social maladjustment *choose* to engage in inappropriate behavior. From this perspective, these children intentionally or voluntarily break rules, instead of doing so because of some underlying psychological problem (Costenbader & Buntaine, 1999), and therefore should not be allowed to access special education services. Unfortunately, the result is that children with conduct disorders are more easily excluded

from schools, when they are identified as *delinquent* instead of disabled. Moreover, without a special education label, schools can serially suspend or expel students, a typical and popular disciplinary option, without being subjected to IDEA oversight (see Costenbader & Buntaine, 1999, for a thorough discussion of the social-maladjustment clause in IDEA). Also, keep in mind that accurately distinguishing between delinquent behavior and mental health problems is complex and difficult, and accurately differentiating between social, emotional, and behavioral problems in children and youth may not even be possible given current technology (Costenbader & Buntaine, 1999).

Service providers also may be reluctant to identify children with a mental health designation when mental health issues are not part of their agency's purpose or mission. In a fragmented child-serving system, service-agency representatives are compelled to view problems through the lens of their agency's mission; for example, deciding whether someone exhibiting aggressive behaviors should be imprisoned or "treated" may depend on the philosophy of agency or system making the decision. This can produce a philosophical conflict between agencies. For example, when an agency's focus is public safety versus education, deviant behavior may be associated with criminality instead of disability. Moreover, funding, typically tied to the mission of an agency, constrains the purposes of a given agency. In other words, agencies have to use their funding to provide the types of services they are designed to provide. This makes it difficult or even impossible for agencies with differing purposes and funding streams to share or blend costs and work together. Additionally, philosophical conflicts between systems play out at the service-provision level. For instance, even if practitioners from different systems have the occasion or opportunity to work together, they may do so only reluctantly because the systems in which they work do not share common beliefs, goals, or professional language.

As an example, if a youth who is receiving services at a community mental health center violates probation and is sent into the juvenile corrections system, he or she typically will lose access to the services being provided by the mental health center. Further, in fragmented systems, there are not well-developed mechanisms for corrections to receive adequate information about the kinds of services that this youth had been receiving prior to commitment. Thus, by virtue of changing systems, there is a discontinuity in care—

even if similar services are provided in the new setting. In such situations, even when mental health services are available, providers will have to start over, instead of being able to build on previous work. Furthermore, even when there is a mechanism for the practitioners to interact across systems, there may not be any incentive to do so because of the existing status quo, as well as the "professional distance" between different disciplines. This common scenario highlights the inability and sometimes unwillingness of service systems to work together.

Developing System-Usable Definitions

Despite the limitations created by disparate definitions, identification criteria, and agency missions, solutions for overcoming these challenges have been proposed and implemented in some places. Unfortunately, although there have been proposals for reforming federal definitions, thus far, there is no indication that systemic changes at the federal level are forthcoming. Therefore, the best responses may come at state and local levels, in which stakeholders from various systems and agencies collaborate to develop system-wide criteria for providing services for children and their families. This is an important, preliminary stage when creating systems of care for children and families (Rosenblatt et al., 1998).

Epstein and his colleagues (1995) have identified a series of steps for developing interagency systems. First, a coordinated network of necessary services for children must be developed and maintained for children and youth with emotional and behavioral disabilities and their families (Epstein et al., 1993). It is necessary for all stakeholder agencies to resolve several issues in advance and in writing. Specifically, a memorandum of understanding should be developed that addresses: (a) agency responsibility (i.e., who is responsible for what); (b) when and where collaborative programming for children and their families will take place; and, perhaps the most difficult obstacle to integration, (c) service financial responsibilities (i.e., who will pay for what).

The second step is to define the target population (i.e., those who will receive the services), based on the needs of the local community. Definitions must ensure that specific subsets of the population in need of services are not excluded by incomplete or overly restrictive definitions. For example, in the development of a system of care in the State of Kentucky, stakeholders

adopted a definition for emotional disturbance that included both behaviors listed in DSM-IV and criteria related to legislative mandates and local needs (Illback et al., 1998). Epstein et al. (1995) acknowledged that different care systems may end up with slight variations in how emotional and behavioral disabilities are defined; however, this is to be expected as communities develop criteria that are connected to local needs.

The remaining steps proposed by Epstein et al. (1995) include: (a) reaching consensus about the philosophy that drives the system of care; (b) using state-level leadership to overcome systemic barriers by passing supportive legislation and providing vision and training; (c) conducting a needs assessment in the community to understand the needs of the children and families to be served and the strengths and weaknesses of current service providers; (d) developing and delivering comprehensive services that are individualized, culturally competent, and fully involve families; and (e) implementing multiple evaluative techniques that facilitate system improvement and add to the knowledge base about systems of care.

Duchnowski, Kutash, and Knitzer (1997) have proposed a model in which mechanisms (i.e., leadership, collaboration, and financing) for developing integrated community-based service-delivery systems are coupled with support activities (i.e., training and securing public awareness and support). This model provides a framework for communities as they progress from conception to implementation of a system of care for children and their families. In the next section, the development and operations of an interagency collaborative are described to provide an example of how a system of care can be implemented at the local level.

The Dawn Project

The Dawn Project, currently beginning its third year of operation, is presented as an example of an interagency collaborative effort to serve a specific population of children and youth with emotional and behavioral disabilities in Marion County, Indiana. Marion is Indiana's most populous county with more than 813,000 residents, including more than 216,000 children younger than the age of 18. Demographically, the population of Marion County is 76% Caucasian, 20% African American, and 4% Hispanic. In 1998, there were 6,200 juvenile-delinquency case filings recorded in the county. Further, 840 youth were committed to the Indiana Department of Corrections,

and, of this group, approximately one third had a mental health diagnosis at admission (Indiana Youth Institute, 1999). The current Marion County child-welfare system is responsible for almost 2,000 children, with 901 placed in foster care, 297 in therapeutic foster care, 16 in group homes, and 199 in residential treatment centers in the State of Indiana. The other children are living in their own homes or with relatives. During the 1998-1999 school year, the Division of Special Education placed approximately 60 Marion County students in alternative services: 24 children were in the Dawn Project, 7 were in day-treatment programs, and 27 were receiving residential treatment services (Marion County Office of Family and Children, 1998).

The Dawn Project started in 1997 with a \$75,000 Robert Wood Johnson Foundation Mental Health Services Program for Youth replication grant. The Dawn Project is responsible for creating and providing a coordinated, community-based system of services for children and youth and their families. Part of the impetus behind the creation of this project was the recognition that increasing numbers of children were being placed out of the home, including out-of-county and out-of-state placements. Many of these children had serious emotional and behavioral problems, and it was widely believed that the best treatment for this group occurred in more restrictive settings such as residential placements. To address the escalating costs and ethical implications of out-of-home services, officials from the Office of Family and Children, Juvenile Court, Indiana University School of Social Work, the mayor's office, and several children's services providers came together to examine the existing structure and status of child welfare in Marion County. They found that education, child welfare, and mental health each had separate funding streams and administrative structures, which made it extremely difficult for agencies to coordinate activities and created gaps and overlap in service provision (Indiana Division of Mental Health, 1999).

Next, representatives from the various systems that work with children with emotional and behavioral needs (Indiana Division of Mental Health, Indiana Division of Family and Children, Division of Special Education, Marion County Office of Family and Children, Marion Superior Court Juvenile Division, Marion County Mental Health Association, and family members) formed a consortium that would create a framework to oversee an interagency approach for

children and youth with emotional and behavioral needs and their families. A coordinator was hired and the consortium established a series of task forces to identify the target population, gather provider information, and determine financial arrangements. These task forces also worked to develop a mission statement, a set of core values and beliefs, and a guiding philosophy for the collaborative venture. Each consortium funding partner had both input on and ultimate approval over the eligibility criteria that were established, and it was decided that the Dawn Project would provide services to children and youth who (a) are residents of Marion County, Indiana; (b) are between 5 and 17 years old; (c) have a DSM-IV diagnosis or special education designation; (d) have functional impairments in at least two of the following domains: social, family, community, school; (e) are involved in two or more child-serving systems, i.e., mental health, child welfare, juvenile justice, special education; and (f) are at risk for or already in residential placement. Using these criteria, children and youth can be referred to the Dawn Project by any of the consortium stakeholder payer groups (Indiana Division of Mental Health, 1999).

Presently, the Dawn Project is funded solely by child welfare, juvenile court, education, and mental health and administered through a contract with Indiana Behavioral Health Choices, a private, nonprofit care-management organization. The project incorporates the principles of a value-based approach to service provision within a managed-care structure, maintaining a \$4,130-per-month capitated rate for participants. Upon enrollment, a service coordinator is assigned to a family. In addition to traditional case-management responsibilities, service coordinators are able to authorize funds so that services can be procured (Russell, Rotto, & Matthews, 1999). Initially, service coordinators form a service team, in which families are the central figures, consisting of practitioners from agencies involved with a family, as well as individuals who provide natural supports to that family (e.g., extended family members, religious advisors, and neighbors). Using family-centered and strengths-based service delivery, the team is responsible for developing a multiagency service plan that incorporates and integrates the family's strengths and needs, other services with which a family may be involved, and existing natural and informal supports. Parents are empowered as equal partners in the development of the integrated service plan and in all deci-

sion making related to service provision. The guiding principle for teams stipulates that if the family is not present, the meeting does not take place. Regular training for service coordinators and other providers ensures that these principles are implemented.

To date, more than 250 children and families have received services from the Dawn Project. The profile of current participants indicates that 68% are male, 70% are between 11 and 14 years old, 51% are African American, 41% are Caucasian, 7% are biracial, and 1% are Hispanic. Approximately 50% of these children experienced out-of-home placements before or upon enrollment into the project. A limitation of the Dawn Project had been its narrow focus on children and youth with the most serious needs (i.e., those at risk for residential placement). However, initiatives have been implemented to increase the capacity of the project to include children who are at risk of developing serious needs, children who are placed in the corrections system, and children who are returning home from state psychiatric facilities.

Several goals have been identified for improving the functioning of the Dawn Project. First, a position currently is being developed for a person who will be responsible for making sure that lines of communications at all levels and in all directions remain open and efficient. Second, the project has started offering trainings to stakeholders from each of the systems about strengths-based assessment and intervention in care systems. Finally, Dawn recently contracted with an external group to conduct a comprehensive, multilevel evaluation of the effectiveness of the program. An evaluation plan is being developed in conjunction with family members, including youth, and stakeholders to explore the profiles of participants and outcomes, patterns of service usage, the functioning of the service-coordination teams, effectiveness, and system-level reform.

Conclusion

In this paper, definitions and identification processes for emotional and behavioral disabilities in children were reviewed and ways community agencies can collaborate to improve the coordination of services for children and their families were discussed. Methods for developing interagency collaboratives were reviewed, and a recently created system of care was described. It is important to note that the topic of the paper is predicated on the assumption that because children and youth with emotional and behavioral dis-

abilities tend to engage multiple systems, it is paramount that the professionals from those systems work together. Although early findings have been encouraging, to date there is only slight evidence to support this claim. Additionally, the systems that provide services to children and families, for the most part, were created to address "pathology" or "dysfunction." Often, however, the children who are referred for special education services (and community services) are those who do not manage well in the existing lockstep educational system. Frequently, these are children who cannot sit still and get bored easily, who have diverse abilities that are not tapped by narrow curricula, or who have learned survival skills that do not generalize well to school or community settings. They are the children who do not follow the rules, who press adult authority, and who question the status quo.

While it is appropriate for a society to try to help persons who are identified as being in need of help, we also need to critically examine how mental illnesses are identified and defined in children and explore what constitutes appropriate help for these children. When professionals view themselves as the experts who know best, they perpetuate approaches in which treatments are applied to people instead of developed in partnership with people. Consequently, as previously discussed, our services for this population of children and their families often have not led to improved outcomes. For example, recent research demonstrates that even after receiving years of special education services, children with emotional and behavioral problems grow into adults with similar problems, who end up unemployed or incarcerated at rates much higher than those of the general population (e.g., see Greenbaum et al., 1998).

This is not meant to imply that we should not provide help to children with mental health needs and their families, but that we need to interrogate the assumptions and values that drive our work, as well as the efficacy of current approaches. An important potential outcome of the systems of care movement can be the discovery of new ways to work across systems and disciplines to include families, build service capacity, and strengthen community. As we begin to integrate service-delivery systems, we have the opportunity to revisit and improve both the meaning and treatment of emotional and behavioral disabilities in children. More important, we have the unique and significant opportunity to include the voices of those

who have long been absent from the dialogue: families, including children and youth themselves.

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