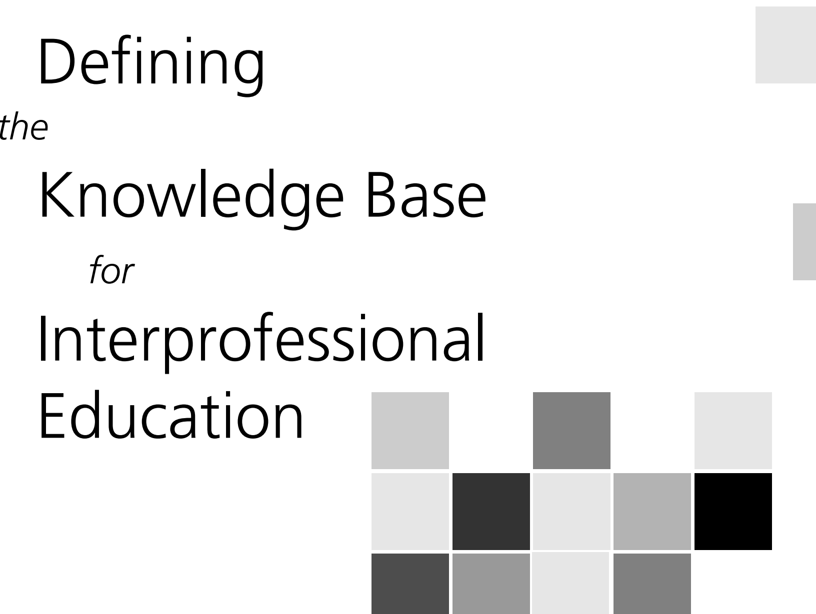
VOLUME ONE

Defining *the* Knowledge Base *for* Interprofessional Education



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Preface

This manual was created by the Interprofessional Education Consortium (IPEC), a group of educators, administrators, consultants and evaluators funded by the Stuart Foundation. The purpose of this Consortium is to define, promote, and sustain interprofessional practice in universities, communities, agencies, and schools by supporting IPE programs and by serving as a leader in interprofessional education.

The IPEC meets in a colloquium almost monthly to work on issues and products relevant to interprofessional education (IPE). This volume represents their first major product. It is intended to assist IPE programs in defining the knowledge base of their curricula. The members of the group that worked collectively to prepare this knowledge base are as follows:

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Introduction

This manual and its companion pieces have been created for college and university educators interested in interprofessional education. The story behind these publications is one of collaboration among representatives of many diverse institutions and programs. Some history of that collaboration will put its development into perspective, and an understanding of how the manual came into being can help give a sense of how it can be used.

The Beginning

Funding from the Stuart Foundation of San Francisco brought together five college and university programs, all involved in interprofessional education. Collectively, directors and administrators of these five programs and their supporting consultants named themselves the Interprofessional Education Consortium (IPEC). Generous grants from the Foundation provided support for members of the Consortium over a four year period, enabling them to meet together, to learn from one another, and to collaboratively produce these practical manuals for educators in the emerging field of Interprofessional Education (IPE). This first manual, *Defining the Knowledge Base for Interprofessional Education*, outlines the knowledge, skills, and values of the field. Its companion manual, *Evaluating Interprofessional Education Programs*, provides a set of evaluation tools to measure the attainment of IPE knowledge and skills, and also to evaluate programs. A third volume, *Creating, Implementing, and Sustaining Interprofessional Education*, will offer additional information relevant to successful IPE program development. It will cover the creation of an IPE program and curriculum, the cultivation and maintenance of community partners, descriptions of model programs, and program sustainability. The Stuart Foundation hopes that with the help of these three manuals, improvements in IPE training will have a positive impact on the communities the Foundation is dedicated to serving.

Participating Programs

The five university programs contributing to this venture are unique. They evolved on different campuses at different times and for different reasons, each taking its own approach to the development of an educational program. Each can serve as a model for others looking either to start up a program or to modify one that may already exist. The fact that they brought different perspectives to the work of the IPEC made the collaboration richer. Briefly, the five programs are as follows.

Center for Family and Community Partnerships

Western Washington University, Bellingham, WA

Housed in the Woodring College of Education, Department of Human Services, this undergraduate program provides interdisciplinary education and interprofessional collaborative experiences so that children served by its graduates may succeed academically. The curriculum in both education and human services is offered through the Human Services Department, and the Human Services degree requires a two-year internship experience in addition to the coursework. Driven in part by this internship requirement, the Center provides extensive technical assistance to schools in the Western Washington University area, supporting family resource center design, group facilitation, community development, assessment and evaluation, and internship development.

Child and Adolescent Development Program

San Francisco State University

The Child and Adolescent Development undergraduate degree was established in 1998, designed as an interdisciplinary, cross-professional program for students interested in studying and working with children, adolescents, and families. It is designed for breadth of knowledge about child and adolescent development and its applications to services for children and families, research, and policy development. All concentrations include research, observation of children and adolescents, and an internship. While the program is academically housed in the Marian Wright Edelman Institute, faculty from over 20 departments across the University teach courses within its framework.

The Rancho Cordova University-Community Partnership

California State University, Sacramento

This University/Community partnership offers undergraduate and graduate students the opportunity to develop interprofessional service knowledge, beliefs, and values while working in interdisciplinary teams with high risk children, youth, and families in a community near the Sacramento campus. The students represent a variety of degree programs housed in the College of Health and Human Services. University faculty and students alike provide services and simultaneously learn interdisciplinary skills through a community collaborative network that includes human service agencies, schools, and community residents.

The Institute for Community Collaborative Studies

California State University, Monterey Bay

Unique and innovative, this undergraduate program teaches and promotes integrative, multidisciplinary, interprofessional, and collaborative approaches to the design and delivery of health and human services. Organized into three parts, the Institute's program involves (1) a collaborative Health and Human Services bachelor's degree; (2) 400 hours of student work in the field in an interprofessional setting; and (3) community programs in interprofessional education and training in partnership with community colleges and agency staff development. In addition, the Institute is involved in family and community measurement and statewide policy development for healthy children and families.

Integrated Specialist Services Program

San Francisco State University

The only post baccalaureate program of the five participants, this is a 19-unit certificate program designed to train professionals from the fields of general and special education, social work psychology, mental health, and other human services to collaborate successfully in serving vulnerable children, youth, and families. The program also serves as a concentration for study in graduate degrees in Public Administration and Education. It explores how people from diverse professional backgrounds can more effectively serve communities and families by working together, and how they can be effective participants and leaders in the emerging integrated services field.

How The Manuals Were Developed

While the Stuart Foundation gave funding to each of the five programs to support the interprofessional education effort on its own campus, the Foundation asked each program to become part of a larger team whose aim was to determine the effectiveness of the educational efforts in the real world. Did training students to work collaboratively in and with communities really make a difference there? Or was it simply another good idea that could not produce measurable progress?

The original team consisted of four program directors and two co-directors, plus a dean. In addition, three consultants were invited from other universities that had experience in offering interprofessional education programs. Also included were an evaluator, a meetings facilitator, and Stuart Foundation staff. Membership changed over the years during which the group met almost monthly; all participants are listed in the preface.

The IPEC group began by crafting a working definition of Interprofessional Education since, as an emerging field, even that basic term lacked common recognition and mutual understanding. After that, the first order of business was to decide what outcomes needed to be measured in order to determine the extent to which IPE training makes a difference in students' performance in the field, and how any such difference is achieved. The questions involved were far more challenging than had been originally expected. What was each program actually training students to think, to value, and to do? Were there any commonalities among the five programs? If yes, then what were they? How were they commonly defined? And how were they to be measured? Thus the work began.

Members of the group agreed that, as educators, their primary focus should be on what they could affect: the outcomes of their educational programs. While community outcomes would be measured by individual programs, the IPEC group itself could be most truly accountable for classroom results. Thus they decided to define the basic essentials that "any IPE program worth its salt" should teach and to emphasize the extent to which their programs would value cross-disciplinary, cross-cultural, and strength-based work with communities and families. But defining the essentials of an IPE program was not simple. It required a laborious journey towards consensus as each member of the team brought his or her knowledge, background, experience, perspective, and curriculum to the process of negotiation and compromise, review and revision. Finally, the team achieved agreement and consensus. The result was a set of seven Core Competencies, with the Abilities associated with each core element, and the Knowledge Base or general body of knowledge that informs the competency area. These are presented in this first manual.

Definition of Key Terms

Here are the four key terms, and the way that they are presented and illustrated in this manual:

Interprofessional Education – As defined by this group, interprofessional education (IPE) is a learning process that prepares professionals through interdisciplinary education and diverse fieldwork experiences to work collaboratively with communities to meet the multifaceted needs of children, youth, and families. It provides the knowledge, skills, and values for individuals to collaborate effectively with others as they serve communities and families in the field. IPE offers a holistic conception of human needs, one that transcends the traditional boundaries and distinctions of the traditional social service fields; it exposes learners to the frameworks and techniques of more than one social service profession; and it builds respect for, and the ability to collaborate with, individuals and groups who bring different perspectives to the solution of human problems (*Knapp, M. et al., 1998*). IPE is a relatively new field, intended to equip graduates to work across disciplines as they deliver services to families and children in an integrated and thus more efficient and effective way.

Core competencies – These are concepts essential to an integrated service delivery system and to interprofessional education. They are the basic standards for a program in this field. As defined by the IPEC group, there are a total of seven core competencies presented in this manual. However, it is likely these competencies will be modified, interpreted, and/or embellished by individual programs as well as by the changing new field of interprofessional education itself. A summary of core competencies is presented on pages 7-10.

Abilities – Mastery of each of the competencies can be demonstrated by certain skills or abilities. In this manual, these are listed immediately after the general definition of each competency.

Knowledge base – Following the broad definition of each core competency, a longer section discusses components of the competency in more specific terms. This is what IPEC has termed the "knowledge base" for this competency. It is a more detailed description of the knowledge, skills, and values associated with a particular competency, and it references literature relevant to the IPE field.

The Audience for This Manual

Primary audiences for these volumes include college and university educators in the fields of education, health, and human services. Secondary audiences include professionals providing training and technical assistance to community partners and community organizations. The manuals are designed for use in educating students about children, youth, and families; but they can be used by a wider audience, including law-enforcement and justice systems, medicine and public health, organizations for seniors, and those involved in community building. The basic precepts can be applied whenever discussion about collaboration or integrating services occurs.

In an academic setting, these manuals will serve as practical resource documents for college and university instructors working with both undergraduate and graduate students. They may be useful as reference guides for course or curriculum development, providing essential information about the integrated services field in general and interprofessional education in particular. This first manual can be used most effectively by instructors who already have some expertise in the general IPE field: it can be best thought of as a springboard for an instructor's own efforts, to be used to trigger ideas, to check content, to provoke reflection. Since IPE programs are so varied across the nation, no single base of information can hope to be complete or to serve the needs of all programs. Therefore, these manuals are intended as resource documents that may be expanded and changed to fit both the needs of a changing field and the emphases of different IPE programs, especially those in the areas of education, health, and human services.

Conclusion

Members of the Stuart Foundation's IPE Consortium recognize that dozens of IPE programs now exist in the United States. They are large and small, undergraduate and graduate, and in various host schools at their universities and colleges. Some of them grant degrees, and others offer a specialization or certificate. In many settings, these programs are outside the regular budgets and majors of their colleges and universities, existing on grants from private foundations or other donors. As these diverse programs become more mainstream, many will need to define the content of their curricula – perhaps modifying their program components – and to measure their success in transmitting interprofessional competencies to students. These three manuals are offered as a foundation for initiating such a process.

The Stuart Consortium members hope sincerely that readers find these manuals useful and that they make a genuine contribution to the emerging interprofessional education field.

Reference

Knapp, M.S., with Barnard, K., Bell, M., Brandon, R.N., Gehrke, N. J., Lerner, S., Rabkin, J., Smith, A.J., Teather, E. D., & Tippins, P. (1998). *Paths to partnership: University and community as learners in interprofessional education*. Lanham, MD: Rowman and Littlefield.

Core Competencies in IPE Programs

Any attempt to offer an IPE program must soon struggle with defining the core competencies of the field. What is it that these programs try to provide for students? What skills should employers expect? This Consortium has defined the seven core competencies that are central to an IPE program. They are as follows:

I. Family-Centered Practice

The ability to understand the philosophy and process of family-centered practice and apply skills necessary to facilitate integrated service provision in collaboration with families, professionals, and community members. This includes the abilities to:

- Understand the ecological/systems views of family development;
- Articulate the history and philosophy of family-centered practice;
- Recognize models of school-based and school-linked services;
- Understand wraparound services and their application to family-centered practice;
- Distinguish between prevention, intervention, and promotion theories; and
- Understand the concept of Family Resource Centers.

II. Integrated Services

The ability to integrate services for children, youth, families, and communities in diverse settings. This includes the abilities to:

- Identify different models and types of integrated services;
- Identify barriers and strategies to overcome challenges to integrated service delivery;
- Establish and maintain governance structures that support collaborative, integrated services for children, youth, families, and communities;
- Identify short and long-term funding strategies and sources of support for integrated services for children, youth, families, and communities; and
- Develop strategies for sustainability of integrated services programs.

III. Collaboration/Group Process

The ability to work in teams in interprofessional settings across traditional lines of programs, agencies, disciplines, and diverse communities to establish common missions and purposes, including the abilities to:

- Share resources, expertise, and responsibility to achieve common goals in a collaborative setting;
- Build consensus and sustain participation within an interprofessional group;
- Recognize when it is and is not appropriate to work in a collaborative setting;
- Resolve problems and conflicts, using conflict resolution techniques; and
- Use decision-making processes that are relevant for collaborative groups.

IV. Leadership

The ability to implement and sustain change in interprofessional settings and diverse communities, including the abilities to:

- Develop, articulate, and sustain a vision for collaborative success;
- Ask hard questions about the status quo of the "systems" serving children, youth, families, and communities;
- Involve key stakeholders and key decision-makers in collaborative efforts;
- Recognize and support the emergence of leaders among collaborative participants; and
- Encourage and engage in appropriate risk taking as part of the process of change.

V. Communication

The ability to communicate effectively in interprofessional settings with people from different cultural, social, professional, and organizational backgrounds, including the abilities to:

- Clarify and interpret jargon and technical terms for collaborating professionals, individuals, families, and communities;
- Seek out and accept feedback;
- Express ideas clearly in both oral and written forms;
- Use voice and word choice to help others hear and understand the message;
- Use public speaking and visual materials to inform, persuade, and motivate others;
- Produce written documents and make oral presentations that are understood by community members and professionals across disciplines;
- Listen actively to facilitate understanding; and
- Facilitate communication across multiple language and cultural groups.

VI. Assessment and Outcomes

The ability to understand and implement outcome-based accountability as it pertains to integrated and collaborative services, including the abilities to:

- Determine the strengths, weaknesses, and needs of a targeted program or community;
- Articulate achievable, measurable, realistic outcomes for children, youth, families, and communities;
- Distinguish between process and outcome evaluations;
- Access and use process, outcome, and other data to improve collaborative outcomes and services for children, youth, families, and communities;
- Interpret data in a manner that is comprehensible and useful to members of the collaborative endeavor and the community;
- Assess the functioning of a collaborative endeavor; and
- Analyze and present process and outcome data to develop, monitor, and assess program outcomes and client progress.

VII. Social Policy Issues

The ability to recognize and acquire the knowledge and skills necessary to understand and/or change social policies across multiple systems that affect children, youth, families, and communities, including the abilities to:

- Articulate the history and trends leading to the present integrated services movement;
- Articulate how social contexts and policy affect practice and outcomes for children, youth, families, and communities;
- Maintain awareness of significant changes now pending and their potential impact and ability to generate alternative scenarios for change; and
- Understand how to effectively influence social policy.

I. Family-Centered Practice

Core Competency – The ability to understand the philosophy and process of family-centered practice and to apply skills necessary to facilitate integrated service provision in collaboration with families, professionals, and community members. This includes the abilities to:

- Understand the ecological/systems views of family development;
- Articulate the history and philosophy of family-centered practice;
- Recognize models of school-based and school-linked services;
- Understand wraparound services and their application to family-centered practice;
- Distinguish between prevention, intervention, and promotion theories; and
- Understand the concept of Family Resource Centers.

Key Knowledge Bases

1. What is family-centered practice?

   Family-centered practice (sometimes called family support or family-centered collaboration) is a process and philosophy of service provision by which:

   - Families are considered to have strengths and expertise, and are viewed as a primary resource;
   - Families share power and responsibility in relationship with others providing support and services;
   - Families are considered partners in the design and delivery of services;
   - Families are treated with respect, caring, and a non-blaming attitude;
   - Professionals involved in service provision support and understand the family and practice honest two-way communication regarding decisions involving the process;
   - The family is considered the child's first and most important teacher; and
   - Families benefit from collaboration that takes place among health and human services, schools, families, government, and community organizations.

   Family-centered programs that follow this philosophy may be community-based, school-linked, or school-based *(Anderson, Homan & Lawson, 2001; Berg, 1994; Connard & Novick, 1996; Crane & Dean, 1999; Dunst 1995; Family Resource Coalition of America, 1996; Hooper-Briar & Lawson, 1994; Lawson & Barkdull, 2001; Schorr, 1989; Schorr, 1997; Simpson, et al., 1999)*.

2. What is the ecological/systems view of family development?

This perspective places emphasis on family development in the context of the environment in which a family functions, including their social network, professional relationships, culture, society, and family interactions. Children are studied within the context of the family, and the family is viewed within the context of the community and society in which it lives. One part of the system cannot be understood in isolation from other parts of the system *(Bronfenbrenner, 1979; Chaisson & Mikelson, 2000; Crane & Dean, 1999; Connard & Novick, 1996; Longres, 1995; McWhirter, et al., 1998)*.

3. What are the implications of an ecological and systems view for service providers?

Such an approach requires the following *(Chaisson & Mikelson, 2000; Connard & Novick, 1996; Simpson, et al., 1999):*

- Development of a non-blame orientation through recognition of strengths, rather than a focus on family deficits;
- Instillation of hope, based on the possibility of change;
- Recognition that change in one part of the system will promote change in all parts, and consideration of the implications of change on all related systems;
- Assessments across all systems. Information should be shared and coordinated in a manner that benefits the family;
- Application of problem-solving strategies at both the professional and family levels. Problem-solving techniques should be taught to families;
- Design of treatment plans in a way that is specific to a family's behavioral patterns. In collaboration with the family, goals should be set in a way that takes into account its unique characteristics and strengths, culture and norms;
- Making family-centered practice and integration of services the norm in service provision; and
- Regarding family input as a valuable resource. All family concerns and opinions should be considered in a respectful manner.

4. What is an intervention program or approach for improving the well-being of children and families?

It is an approach that involves the provision of an interrelated set of services, activities, and/or resources designed to eliminate or diminish existing problem situations, behavior, or other phenomena among youth or families (such as disease, delinquency, violent behavior or child abuse). It is problem (or treatment) oriented and remedial in its approach.

5. What is a prevention program or approach for improving the well-being of children and families?

   It is an approach that is designed to prevent the development and/or occurrence of undesired phenomena among youth or families (such as disease, delinquency, violent behavior, or child abuse). This approach is usually focused on the elimination of risk factors related to the undesired phenomenon.

6. What is a promotion program or approach for improving the well-being of children and families?

   It is an approach designed to promote positive behaviors and functioning within families. It is a strength-based approach in that its focus is on the development or promotion of healthy behaviors and conditions. The focus is more on the strengthening of protective factors than on the elimination of risk factors.

7. What is the family support movement, and when did it begin?

   Family support is a process that strengthens families as well as the communities in which they reside. The goal of the family support movement is to provide resources and support that promote the stability, confidence, and self-sufficiency of families.

   Social conditions in the 1960s and 1970s began to alter family patterns and structures. Rising divorce rates, family mobility, increased poverty, and increased numbers of dual income families posed new challenges to American families. In addition, research was beginning to suggest the importance of early childhood development and the impact of external forces on the family. Family Support Programs began to emerge in the early 1970s as professionals, communities, and families experienced disillusionment over the social welfare policies that had been implemented during the previous decade. While social welfare programs had grown in number, children living in poverty continued to be challenged in the areas of cognitive and social development.

   Initially, the Family Support Movement was a grassroots community effort. As its value was recognized, the movement continued to grow in both size and complexity, and now hundreds of programs exist across the nation. State and national funding as well as private foundation and corporate donations support many of these programs. Research is now being conducted in many areas of Family Support *(Family Resource Coalition of America, 1996; Family Resource Coalition of America, 2000)*.

8. What are the key characteristics of the family-centered practice model for providing services to children and families?

- Services and supports are provided to families in ways that empower them. Empowerment occurs when:

  The integrity of families is respected;

  Families are encouraged to take a lead role in the decision-making process; and

  Families are allowed to have a role in determining what they need.

- Several principles guide service planning and provision *(Anderson, Homan & Lawson, 2001; Berg, 1994; Connard & Novick, 1996; Crane & Dean, 1999; Dunst, 1995; Family Resource Coalition of America, 1996; Hooper-Briar & Lawson, 1994; Lawson & Barkdull, 2001; Schorr, 1989; Schorr, 1997; Simpson, et al., 1999)*. Services should be:

  Family oriented, in that they:

  Are responsive to the societal changes in family structure;

  Are responsive to what individuals and families identify as their needs; and

  Meet those needs in ways that maintain their dignity and respect their choices.

  Culturally relevant, in that they:

  Explicitly recognize the culture and beliefs of each family and regard them as resources;

  Provide equal access to culturally unique communities in their planning, programming, and provision of services; and

  Enhance every cultural group's ability to achieve self-sufficiency and contribute in a productive way to the larger community.

  Coordinated, in that they:

  Develop strategies and skills for collaborative planning, problem solving, and service delivery among all participants;

  Encourage coordination and innovation by providing both formal and informal ways for people to communicate and collaborate in planning and programs;

  Allow clients, vendors, community people, and other agencies to creatively provide the most effective, responsive, and flexible service; and

  Are committed to an open exchange of skills and information.

  Locally planned, in that they:

  Operate on the belief that each community has special characteristics, needs, and strengths;

  Include a cross-section of local community partners from the public and private sectors in the planning and delivery of services and supports; and

  Support these partners in addressing the needs of their communities through both short-range and long-term planning and through the establishment of priorities that are within state and federal standards.

- Community-based and preventive, in that they:
  - Encourage and support residents in creating positive conditions in their communities that will promote the well-being of families; and
  - Reduce crises and the need for future services.
- Outcome-based, in that they:
  - Include a fair and realistic system for measuring progress toward both short-range and long-range goals;
  - Use outcomes and indicators that reflect the goals which communities establish for themselves and their children; and
  - Work towards accomplishing these established goals at all levels in all organizations and agencies.
- Consumer-driven, in that they:
  - Are provided in a courteous, sensitive, competent manner; and
  - Support the dignity and respect of individuals and families.
- Creative, in that they:
  - Increase the flexibility of funding and programs to promote innovation in the planning, development, and provision of quality services; and
  - Simplify, reduce, or eliminate rules that are barriers to coordination and quality of service.

9. What is a natural support system?

It is a support system that develops within the natural context of the family or community rather than being designed or provided by professionals or through specially funded programs. In a natural support system, families may identify means of support through their own social networks. These supports could include family, friends, neighbors, clergy, etc. *(Chaisson & Mikelson, 2000; Crane & Dean, 1999)*.

10. What are integrated systems of care?

Based on a philosophy of integrated service provision, integrated systems of care are focused on being child- and family-centered and community-based. Included may be the mental health, education, child welfare, and juvenile justice systems. Families are encouraged to include their natural support systems as well. Services often occur in the family's home or within its community instead of in an agency setting (*Hodges, Nesman & Hernandez, 1999*).

11. What are wraparound services?

Wraparound services are those designed collaboratively by a team of professionals and the family to provide a system of supports to address significant needs in all areas of the family's life in ways that are acceptable to the family (*Burns & Goldman, 1999; Hodges, Nesman & Hernandez, 1999; Lawson & Barkdull, 2001*).

12. How are wraparound services distinguished from other service strategies?

In order to be truly "wraparound" services, they should:

- Be community-based;
- Be individualized and strength-based, meeting the needs of families in order to promote success at home, in life, and in school;
- Be culturally sensitive, culturally competent, and respectful of the values and preferences of each family;
- Be designed in a way that makes families full partners throughout the process;
- Involve an interprofessional team process through which the family, natural supports, and professionals together develop an individualized service plan;
- Have flexible approaches and flexible funding streams;
- Include a balance of professional services, natural supports, and family-identified resources;
- Show an unconditional commitment to serve all children and families;
- Be developed and implemented collaboratively through an interprofessional, community-based collaborative process; and
- Involve measures for outcomes and results designed for the entire system (including the wraparound services) and the children and families receiving the services (*Burns & Goldman, 1999*).

13. What is a Family Resource Center?

A Family Resource Center is a facility that assists families by offering programs and services in a community-based, school-based, or school-linked setting. All services are offered in a manner that reflects family-centered practice and family support principles. The services are culturally competent and reflect the strengths, needs, and desires of families. Family Resource Centers may also be called Family Support Centers or Family Information Centers *(Decker & Decker, 2000; Dryfoos, 1994; Family Resource Coalition of America, n.d.; Johnson, 1993; Knapp, et al., 1998; Lawson & Anderson, 1999)*.

14. Where are Family Resource Centers located?

The location of the Family Resource Center – whether school-based, school-linked, or community-based – should be determined by the needs and strengths of the community, by available space and funding, and by the desires of the families *(Decker & Decker, 2000; Lawson & Anderson, 1999)*.

15. What are the elements of effective Family Resource Centers?

In order to be considered Family Resource Centers, programs must be designed and implemented according to the principles of family-centered practice. In addition, Family Resource Centers should:

- Be embedded in specific target communities;
- Provide services that are convenient and accessible;
- Choose programs through a partnership with families;
- Follow the philosophies of prevention and promotion and create positive community environments;
- Be designed holistically to enhance both individual and family functioning;
- Be culturally competent and respect the dignity of all persons;
- Require staff involvement in the community through outreach efforts and community development strategies;
- Encourage families to strive for self-sufficiency and take responsibility for their own lives;
- Encourage families to utilize all available community assets; and
- Encourage Family Resource Center staff to promote collaborative efforts in the community (*Lawson & Anderson, 1999; Family Resource Coalition of America, n.d.*).

16. What are examples of programs offered at Family Resource Centers?

Although each Family Resource Center should be designed to meet the unique needs of the community and families it serves, the following programs are typical:

- Resources for referral to community agencies;
- Drop-in hours for families to receive assistance without an appointment;
- Life Skills education;
- Family/parent/child activities;
- Child care for parents who are involved in Family Resource Center programs;
- Home visits;
- Health screening and referral;
- Basic needs such as food, clothing, housing assistance;
- Family/parent support and education;
- Adult education programs (G.E.D., adult basic education, English classes);
- Employment assistance;
- Health and nutritional support;
- Case management;
- Family recreational and/or social activities;
- Lending libraries;
- Computer classes;
- One-stop shopping for services; and
- Newsletters (*Connard, Novick, & Nissani, 1996; Decker & Decker, 2000; Family Resource Coalition of America, 1996; Lawson & Anderson, 1999*).

17. What are school-linked and school-based models of service provision?

School-linked services provide assistance to children and families through cooperative arrangements between schools, service providers, and community organizations. School-based services provide assistance to families at the school site or in close proximity to it *(Hooper-Briar & Lawson, 1994; Lawson & Anderson, 1999)*.

18. What types of school-linked or school-based models of family-centered practice exist?

Models that include school-based or school-linked services may be called full-service schools or community schools. Full-service schools are based on the philosophy that no single institution can meet the needs of children and families. They extend the primary mission of the school to include family support through the provision of services and supplementary programs. Community schools act as collaborative leaders by bringing together partners (community leaders, business, government, health, human services) to offer a range of supports and opportunities to children, youth, families, and communities – before, during, and after school, sometimes seven days a week *(Decker & Decker, 2000; Dryfoos, 1994; North Central Regional Educational Laboratory, 1996; Schorr, 1997)*. In addition, transformational models have been suggested that further define the levels of school and community involvement in service provision and family-centered practice. A fully transformational orientation involves the school viewing investment in family and community development as fundamental to its mission. Transformation models include:

- Primary model. The school seeks a primary role in the initiation and promotion of community development activities. It provides active leadership in the neighborhood or community, initiating the development of certain neighborhood organizations and projects. School-based personnel provide ongoing consultation and technical assistance for development efforts, consciously seeking out indigenous leadership. The school becomes a neighborhood center for community development activities. Physical plant resources and resource-generating capabilities are fully utilized. Schools may also work in collaboration with other schools in primary activities to address broader issues.
- Collaborative model. The school seeks to assist existing neighborhood efforts or organizations in development activities. A school may initiate or respond to collaborative overtures, working as a resource provider rather than the primary driving force for change. The school may move from the primary to the collaborative level once neighborhood organizations are sufficiently strong to assume the primary role. Physical plant and resource-generating capabilities are well utilized.
- Supportive model. The school responds to neighborhood requests for assistance with development activities. The school accepts invitations but only infrequently extends them. The school perceives itself as being geographically within the neighborhood but not an integral part of the neighborhood, and it keeps a distance from community life.
- Indirect model. The school initiates activities that improve the functioning of the internal school community with the hope of a carryover effect beyond the school walls. These efforts are primarily educational, often with a focus on teaching students on matters of citizenship. The school sees itself in the role of socializer.

- External health and service provider. The school serves as an on-site health and social services provider. Although activities emphasize service more than development, individual and family growth can occur in this context. Co-location of services from community agencies may complement school efforts. The neighborhood plays a role in program development. This role may run parallel to and support a school's development efforts or occur without any community development intent.
- Internal health and service provider. The school provides an expanded array of health and social services for students and their families. The range of services varies from comprehensive health and social services to the provision of a few selected services. School personnel generally determine which services will be provided, and they are available only to those who have a direct link to the school (*Anderson, Homan, & Lawson, 2001*).

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II. Integrated Services

Core Competency – The ability to integrate services for children, youth, families, and communities in diverse settings. This includes the abilities to:

- Identify different models and types of integrated services;
- Identify barriers and strategies to overcome challenges to integrated service delivery;
- Establish and maintain governance structures that support collaborative, integrated services for children, youth, families, and communities;
- Identify short and long-term funding strategies and sources of support for integrated services for children, youth, families, and communities; and
- Develop strategies for sustainability of integrated services programs.

Key Knowledge Bases

1. What are integrated services?

This is a term that refers to a coordinated, holistic approach to addressing the needs of children, families, and communities, and particularly the needs of at-risk children *(Illback et al., 1997)*.

Integrated services:

- Are usually provided within a context of collaboration and coordination among service providers and organizations;
- Are also usually family-focused, prevention-oriented, community-centered, and responsive to local needs, offering a continuum of service;
- Avoid duplication and gaps in service; and
- Enable personal relationships to exist between families and staff.

Fragmented services, by contrast, are designed and delivered without collaboration or coordination among providers. Fragmented services often conflict with each other in their goals and manner of delivery and may make conflicting demands upon the youth and families who receive them *(Gardner, 1990)*.

2. What models of service integration have been offered for consideration within the field of collaborative community services?

Hooper-Briar and Lawson *(1994)* identified the following models of service integration:

- Home and neighborhood-based services provided either in the home or at neighborhood Family Resource Centers;
- Community-based services offered in various settings such as multi-service centers, public health clinics, human services offices, etc.;
- School-linked services involving partnerships between schools and the health and human services agencies;
- School-based services for children and families located at the school sites; and
- Saturation oriented services combining all the above models into one that is family and child centered, consumer-driven, and developed within the community. Participants are highly involved in the identification of needs and the planning of programs and services.

Hooper-Briar and Lawson *(1994)* also identified the following types of service integration:

- Client-centered integration where integration of services occurs at the level of the person served (e.g., consumer-guided work);
- Provider-centered integration where integration occurs as a result of shared professional specialization and interprofessional relations (e.g., integrated staffing);
- Program-centered integration with sharing of delivery systems for services and goods (e.g., co-location, fiscal linkages, and shared information systems);
- Organization-centered integration where integration occurs at the level of organizational structures and cultures (e.g., in new umbrella organizations or authority systems);
- Policy-centered integration under which local, regional, state and/or national policies provide for coordination (e.g., through coordinated eligibility and access criteria, funding streams, and accountability criteria and procedures).

3. What are the main barriers to the development of integrated services?

- Professional identities. Professions, as well as organizations, tend to develop and use their own identities, including their own approach to assessment, their preferred methods of intervention, and their own language (*Lawson, 1991*). All of these can create barriers to communication and collaboration and thus to the development of integrated services.
- Categorical services. Funding and administrative bodies frequently place limits on how resources are to be utilized. They establish limitations concerning which populations can receive specific services and for how long. Such categorical limitations often make it impossible to develop and deliver services in a collaborative or coordinated fashion (*Gardner, 1995*).
- Competition for resources. Professional organizations often see themselves (sometimes accurately) as competing with each other for limited resources. Funding sources sometimes contribute to such competition, which, when it exists (or is perceived to exist), can become a major barrier to collaboration and coordination of services among the providers.
- Limited resources. Social service organizations often operate on very limited budgets and may, in addition, have time constraints. Collaboration and coordination activities can be time-consuming, and organizations and professionals may not believe they have the time to engage in such activities.
- Service provision history (inertia). Most social service organizations evolved originally with fairly limited definitions of their missions, of the problems they address, and of the methods they should use. Organizations, especially large ones, are very slow to change such aspects of their operations. This inertia may be compounded if there is no evaluation of the outcomes of services. Without such evaluation, organizations often do not feel the need to improve or to change the way they do business.
- Confidentiality issues. Social service and health care providers are often bound by law and/or professional ethics to maintain the confidentiality of persons receiving their services. Fear of violating that confidentiality may lead them to avoid collaborative activities or coordinated services. When organizations do coordinate activities, confidentiality issues may pose problems that must be addressed for the efforts to proceed effectively.
- Organizational structures and procedures. Organizations frequently differ significantly in the structures and procedures they develop to guide the definition and delivery of services. Sometimes efforts to develop services that can be delivered in an integrated, coordinated manner are significantly hampered by such differences. Modifications in structures and procedures may be necessary for effective integration to occur.

4. What actions can be taken to overcome barriers to service integration?

- Focus on outcomes. The need for collaboration and service integration usually becomes clearer and more desirable when there is a focus on the overall outcomes that the organizations want the provided services to accomplish (*Bruner, 1998*).
- Educate funding and administrative bodies. Continued advocacy should be directed toward funding sources (including legislatures) and administrative bodies concerning the need for the development of both collaborative efforts and integrated services to meet the needs of children and families. Great strides have been made in this area over the past few years (especially with funders), but input to funding and administrative bodies is still needed (*Gardner, 1995*).
- Develop memoranda of understanding. A memorandum of understanding is a written document that clarifies issues related to the authority, responsibilities, contributions, rights, etc., of collaborating individuals, groups, and/or organizations. Such agreements can help ease participants' initial anxieties about joining a collaborative effort. They often prove invaluable, since memories of the initial agreements can become fuzzy over time and sometimes lead to disagreements and conflict.
- Develop acceptable procedures for the release and documentation of information. Confidentiality issues need not be problematic if well-written release forms are developed and used consistently. Several different methods for exchanging information have been outlined by Soler and Peters (1993) as follows:

  Informed consent. This involves outlining for signature the type of information required, the purpose for which it is required, and who exactly will receive the information;

  Interagency agreements and memoranda of understanding. These specify what information is to be exchanged between the agencies, including how, why, and between whom the exchange will take place. These agreements will also include assurances that the exchange will be limited to information covered by the specific agreement;

  Court order. These orders make court information available to county departments or vice versa; and

  Informal exchange. This is generally very limited and usually verbal. It should not be done if families object to this type of information sharing.

5. How should collaborative governance for integrated services be structured?

Governance refers to the formal decision-making body and policies that guide the collaborative endeavor *(Karasoff, et al., 1996)*. Local governance partnerships are those that involve community-wide initiatives aimed at improved outcomes for children, youth, and families *(Farrow & Gardner, 1999)*. Governance structures associated with collaborative partnerships differ significantly from traditional structures in many ways.

6. What are the critical issues for consideration regarding collaborative governance?

The following should all be considered:

- Purpose of collaboration. A critical first step is to determine why collaborative governance is preferable to a traditional single agency approach. A group might consider a collaborative governance structure if it had the following purposes:

  To address community-wide goals with a multi-agency solution;

  To engage a wide range of community resources to reach a common goal; and/or

  To reconfigure existing capacities, or develop new ones to address a mutual problem *(Center for the Study of Social Policy, 1991)*.

- Membership. The choice of individuals that make up the governing body is critically important, and the involvement of key stakeholders essential. Membership characteristics are key variables that will affect the collaborative (*Melaville & Blank, 1991*). The following membership qualities should be considered:

  Decision-making authority;

  Status;

  Power;

  Membership in the community;

  Indigenous leadership (those individuals who are natural leaders in the community);

  Consumers (those who use the services);

  Families; and

  Shared commitment (*Chang, Salazar & Leong, 1994; Hooper-Briar & Lawson, 1994; Kadel & Routh, 1994; Melaville & Blank, 1998*).

- Level of formalization. The degree to which the members formalize their relationship will clearly affect the implementation process. In formal partnership ventures, the use of interagency agreements and memoranda of understanding between the agencies are critical features (*Melaville, Blank & Asayesh, 1993*). These agreements provide the technical supports that specify in clear terms the partners' commitments, including each member's agreed-upon role and responsibilities.

- Authority. The authority that a partnership may exercise will be affected by state and federal mandates under which member agencies operate and by the policies and technical agreements of the partnership members (*Center for the Study of Social Policy, 1991; Himmelman, 1991*).

- Accountability. Some members of collaborative endeavors may be accountable to their home agencies in ways that can impact their participation in the endeavor. Such lines of accountability should be clarified, and governance structures and activities should be designed to be consistent with them (*Center for the Study of Social Policy, 1991*).
- Confidentiality. Confidentiality is a cause for concern whenever multiple programs collaborate. Soler and Peters (*1993*) outline several reasons to protect information. Individuals may be concerned about:

    Embarrassing information;

    Discrimination;

    Personal security;

    Family security (i.e., concerns regarding immigration status); and

    Job security.

- In addition, the authors outline the following reasons to share information:

    To conduct a comprehensive assessment;

    To provide the necessary information;

    To coordinate service plans and avoid duplication;

    To monitor services;

    To make services more family-focused; and

    To insure public safety.

- Staffing. Collaborative endeavors are often new entities. Therefore, the staffing needed to support these partnerships is critical. It is important to determine whether staff time is provided in kind by member agencies, or whether there will be paid positions supported by the partners (*Center for the Study of Social Policy, 1991*). It is also important to define clearly who will be supervising the staff and to whom they will be accountable.
- Decision-making. Decision-making is a critical function within any collaborative. Several questions must be considered. How will the partners make decisions? Who will have the responsibility for decisions being implemented? Who will be accountable? A process for decision-making must be agreed upon by all members (*Karasoff et al., 1996*). Several different methods of decision-making may be considered.

It is important to consider both the effectiveness of a decision-making process and its efficiency. In collaborative governance, the use of the consensus model of decision-making is generally preferred. This model requires that all participants in the decision-making process have a chance to influence the decision, feel they understand it, and are able to support the ultimate decision. It is important to involve in the decision-making process both those individuals who have information that is needed and those whose support is required to implement the decision. However, sometimes there is not time for everyone to be involved if the task is to be completed efficiently and in a reasonable time. The group's procedures for decision-making should spell out this and other expected eventualities. Collaborative members' advance knowledge about what to expect can be critical to the success of the effort (*Vroom & Yetton, 1973*).

- Community involvement. The voices of key community stakeholders must be included in the governance process of the collaborative endeavor. Otherwise, the actions of that endeavor will not have the support required to have the desired impact within the community (Dunst et al., 1994). The organizational structure should be designed to maximize this participation. Chang et al. (1994) suggest strategies that can be used to accomplish this:

  Provide translators;

  Choose meeting times and locations that suit both community members and service providers; and

  Encourage the participation of indigenous leadership in the governance process.

- Elements of successful local governance. Several key features are indicative of successful governance structures:

  They are broadly inclusive;

  They have clearly defined responsibilities;

  They earn trust and credibility from their accomplishments;

  They establish close ties with local neighborhoods; and

  Their focus is on results *(Farrow & Gardner, 1999)*.

7. What are the main sources of funding for integrated service programs?

Sources for funding integrated services include:

- Federal, state, and local government funding. Many government programs for children and youth have categorical funding streams, which are too restrictive for use in integrated services programs. However, many such programs also fund pilot programs and provide grants that are designed to encourage innovation. Funds from the following general areas should be explored:

  Family support/social services;

  Health services;

  Mental health services;

  Employment and economic development; and

  Education programs such as those for school safety/violence prevention, education reform, tobacco use prevention, homeless children services, teenage pregnancy prevention, and nutrition education (*Lodge, 1998*).

- The following federal government programs and initiatives should be considered as possible sources for funding:

  Medicaid and Early Periodic Screening, Diagnosis, and Treatment (EPSDT);

  TANF (Temporary Assistance for Needy Families);

  21st Century Community Learning Centers;

  Safe Schools Healthy Students;

  Promoting Safe and Stable Families (Family Resource Centers);

  Center for Substance Abuse (Prevention in School);

  Centers for Disease Control and Prevention (Comprehensive Health);

  Justice Department;

  Department of Agriculture (snacks);

  Corporation for National Service (service learning); and

  Child Care Development Block Grants *(Orland, Danegger, & Foley, 1997)*.

- Private foundation grants are sometimes a possibility for funding, especially if a program is new and innovative, and/or it addresses an interest of the foundation. However, these sources of funds are usually time-limited, and thus must be considered as temporary solutions.

8. What are strategies for funding integrated services?

- Decategorization of funding streams is one of the most promising of potential strategies and at the same time one of the most problematic. Decategorization refers to changing the rules governing the way services are delivered, to whom, for how long, etc. Conceptually, it usually involves having the governing body allow more local control over the rules and regulations. If monies supporting services to children and families through government agencies can be decategorized, it may become possible to replace fragmented services with more integrated services.

  However, for decategorization to occur, a very politicized process of governmental decision-making usually must take place, requiring much political influence or much visible public support.

  There are several funding methods that involve decategorization, as follows:

  Results-based budgeting enables programs to use funds more flexibly to reach agreed-upon outcomes. This process loosens some of the constraints of the categorical funding process while simultaneously ensuring accountability for results;

  Blended funding and pooling occurs when some of the restrictions on the categories are lifted, enabling different categories of funds to be mixed together to fund services that go beyond previous restrictions;

  Block grants, if available, allow for the lifting of many restrictions, since several entitlement programs that were previously separate may be combined into one lump grant; and

  Refinancing may allow programs to be reconfigured as funds are reallocated.

9. How can integrated service programs be sustained?

Sustainability occurs when an integrated service program moves from the sidelines to become a permanent part of the service delivery structure. For example, it may occur when the funding of a program moves from "pilot" to permanent status. The following conditions should be present if sustainability is to be achieved:

- Leadership that is stable and has authority to make policy decisions regarding funding;
- Long-term financing methods that include diversified funding;
- Clearly defined outcomes that are well understood with means for evaluation;
- Visibility; and
- A strong constituency *(Hart, 1999; Melaville & Blank, 1998)*.

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III. Collaboration/ Group Process

Core Competency – The ability to work in teams in interprofessional settings across traditional lines of programs, agencies, disciplines, and diverse communities to establish common missions and purposes. This includes the abilities to:

- Share resources, expertise, and responsibility to achieve common goals in a collaborative setting;
- Build consensus and sustain participation within an interprofessional group;
- Recognize when it is and is not appropriate to work in a collaborative setting;
- Resolve problems and conflicts, using conflict resolution techniques;
- Use decision-making processes that are relevant for collaborative groups.

Key Knowledge Bases

Collaboration

1. What is collaboration?

Collaboration is the process of dealing with problems, issues, or opportunities common to two or more individuals or groups. It involves cooperation, coordination, mutually reinforcing behavior, the development and maintenance of trust, and, ultimately, the integration of activity and effort toward mutually agreed upon goals. At the most complete level of collaboration, participants jointly develop and agree to a common set of goals, sharing responsibility for achieving those goals and utilizing the expertise of each participant in the collaborative.

Collaboration is a means to an end. At some level it is a practical matter occurring when certain people, at a certain time, undertake a certain process *(adapted from Bruner, 1991)*. However, true collaboration also has an “inside,” deeper meaning. The inner life of collaboration is about states of mind and spirit that are open to growth, open to trust, and open to mutual action.

Different levels of collaboration may be involved in a collaborative endeavor *(Collaboration Framework, 1996; Hord, 1986; Loughran, 1982)*. It is useful to identify which of the following three processes is needed to achieve specific goals:

- Communication. The primary activity involves the sharing of information about the community, about the issues of interest, and about each participant's activities. Such an exchange of information involves no loss of agency autonomy and requires minimal involvement by participating agencies. Communication ("networking") is often facilitated by teleconferences, newsletters, conferences, and brown bag lunches.
- Coordination (or Cooperation). The primary activity involves aligning or meshing the efforts of the participating individuals, groups, and organizations to avoid those conflicts and redundancies that may decrease the overall effectiveness of their individual efforts. Joint programs, sharing a resource or facility, and meeting together to share information are examples of coordination. This activity is characterized by more active leadership, which is needed to structure relationships and gain agreements from participating agencies.
- Full Collaboration. The primary activity involves combining resources of the participants and jointly managing them to accomplish identified goals. The resulting collaborative endeavor is a more formal approach than the other two processes, involving a commitment made by members or partners to plan and act together as a whole body. Collaboration requires the creation of joint goals to guide collaborative actions (*Bruner, 1991*).

Community-based organizations usually increase their impact on common issues when they join forces and collaborate. Fully collaborative endeavors involve independent entities that work together to accomplish specific objectives *(Rosenthal & Mizrahi, 1994)*. Such collaboration accomplishes the following (*The Community Collaboration Manual, 1991*):

- Increases personal contact among members;
- Provides defined operating procedures for meetings;
- Creates a sharing of resources needed to achieve agreed-upon objectives which lead to a sense of shared contribution to an interest or to a geographical community; and
- Helps participants recognize that the work of the collaborative endeavor produces a greater benefit than would the efforts of any single member.

2. When is collaboration desirable as a method of addressing health and human service issues in communities?

To achieve satisfactory outcomes for children, families, and communities, human service agencies usually need to be organized in a way that allows their services to be provided in a more integrated fashion. Accomplishing this usually requires changes in agency policies and procedures and increased collaborative behavior among the individuals providing services *(Graham & Barter, 1999; Knapp, et al., 1998; Lawson & Anderson, 1990)*. Collaboration is movement away from professional competitiveness and away from lack of cooperation within bureau cracies and between agencies *(Rosenthal & Mizrahi, 1994)*.

Collaboration captures the need for communities (agencies, professions, and client systems) to make needed changes in the way they work, to rethink current practices, and to develop innovative responses to social problems.

3. When is collaboration the most effective strategy for addressing health, social, and human service issues within communities?

- When there are problems of common concern to individuals and/or organizations within the community;
- When information and knowledge from individuals and/or organizations throughout the community are needed to:

  Accurately and completely understand the nature and scope of the issues or problems; and

  Develop potentially effective responses to the issues and/or problems;
- When the resources of several individuals and/or organizations are needed to implement effective solutions to issues or problems;
- When responses to specific problems or issues can be enhanced through an integrated approach involving several individuals or organizations;
- When it is desirable to expand and coordinate services, or when issues at the community, state, or national levels require a collective response; and
- When a broad base or "critical mass" is needed for greater appeal and visibility providing more resources, power, and influence than can any organization working alone.

4. What are the problematic issues associated with collaborative group endeavors?

Problems include *(Altman et al., 1991; Endres, 1991; Gardner, 2000):*

- Recruiting and sustaining membership from partner organizations. This involves:
  - High face-to-face contact with a broad representation of involved parties;
  - Energetic management; and
  - Attention to both group process and task accomplishment.
- Since plans need to be acceptable to all, collaborative groups may take longer to discuss and settle issues than would individuals or individual agencies;
- At least some agency autonomy must be relinquished. Individuals or organizations often need to make compromises, settling for different solutions than those they would seek if acting alone;
- Conflicting values, attitudes, and beliefs, along with competing interests and cultural or communication differences, can lead to a lack of direction or to political behavior that hinders the ability to reach consensus regarding membership issues; and
- Without adequate leadership, collaborative efforts can stumble over:
  - Unclear expectations, roles and/or responsibilities;
  - Lack of member recognition; and
  - Centralization of decision making.

5. What strategies are best for developing effective collaborative endeavors and actions among individuals, organizations, and groups in communities? *(Adapted from Bruner, 1991 Chrislip & Larson, 1994; Collaboration Framework, 1996; Endres, 1990, 1991; Fisher & Ury, 1981; Gardner, 1994, 2000; Loughran, 1982).*

- Bring the necessary parties to the table. Identify and engage all of the affected and interested groups and individuals in the problem-solving process, particularly those individuals with decision-making authority. Such involvement should be meaningful; when clients and community members are included, their contribution should be relevant to the process.
- Maintain local leadership. Identify leaders by recruiting a diverse membership that is representative of the community. Reach beyond the collaborative, as needed, to find new resources and leadership.
- Be organized. Arrange the meetings to be as effective and acceptable as possible. Be sensitive to issues regarding the time, place, length, and format of meetings and provide materials that will support everyone's involvement. Recognize that your meetings are not the only priority of those involved.
- Establish effective communication among members. Clear communications help develop a common agenda and clarify responsibilities for different tasks. Smaller groups that have a stable membership and work face-to-face on common goals can develop higher trust levels and make a greater commitment to reaching their goals.

- Identify your common interests and develop clear goals. The overriding mission that you have all come together to address needs to be clear to, and accepted by, everyone. Utilize a mutually acceptable process for identifying common goals, developing a common vision, and defining a philosophy of how you want to work together.
- Develop an action plan to guide efforts and activities. Allow sufficient time for group planning processes. Use non-expert language in the planning process and in the documents developed. Frame issues in terms that are understood by members and in terms they can act upon. Emphasize the benefits of member participation.
- Clarify and define roles for each member of the collaborative. Having a clear role helps participants to optimize their contribution of knowledge and skills and to provide leadership as needed. If staff and members are to share roles, provide them with training on how to do it.
- Become results- and outcome-oriented. Outcomes reflect the success of a collaborative mission. By shifting the focus from the collaborative activity to its results and outcomes, you will help ensure that available resources are aligned with desired changes for individuals, families, and communities.
- Identify any problems or barriers to effective collaboration. Do not ignore problems and issues, hoping that they will go away. Address them calmly and rationally, using a problem-solving process through which participants themselves decide on specific solutions to specific problems.
- Use a teambuilding process. Mobilize the experiential capacity of members to identify barriers, accept challenges, and seek opportunities for action.
- Separate the people from the problems. The general rule is to be hard on the problems but soft on the people. Be supportive of each other, especially when you disagree. Respect and trust are keys to success.
- Focus on interests, not positions. Do not get caught up in unproductive arguments that are based on the positions or stances that individuals or groups adopt. Rather, learn what truly motivates people and put it into action, searching for mutual interests among the involved parties, mutual concerns, and options for mutual gain. Be creative in finding or inventing "win-win" solutions. Seek feedback on ways of proceeding that can benefit everyone involved.

6. What conditions are helpful for maintaining a collaborative effort?

A collaborative is maintained by a confluence of internal and external conditions.

- Among internal conditions that may support the collaborative endeavor are these:

  The purpose of the effort has been defined well enough to sustain members' motivation to continue. Each member should understand her or his role in developing solutions for problems at the community level.

  The leadership has provided the structure and resources needed to carry out the mission of the collaborative (and not simply to support individual agencies or interests).

  Members are willing and able to operate collaboratively, which can happen when they possess the knowledge, skills, and attitudes necessary for the following to occur *(Endres et al., 2000):*

    The collaborative develops an environment in which members trust each other and where learning from the collaborative process is valued. This requires that:

      Members understand the meaning and intent of collaboration;

      They engage in, and support others' engagement in, appropriate risk-taking as part of a process of change; and

      The group builds consensus with participation sustained through the use of effective discussion, decision-making, and conflict resolution processes.

    Members subordinate their own agendas or goals to those needed to support the collaborative endeavor. This involves:

      Asking hard questions about the status quo of "systems" serving children, youth, families, and communities;

      Involving key stakeholders and decision-makers in developing, articulating, and sustaining a vision of collaborative success;

      Sharing resources, expertise, and responsibility to achieve common goals; and

      For each member, accepting the roles and responsibilities needed to effectively carry out the work of the collaborative endeavor.

  Sufficient resources exist to effectively address the issues or problems that have been identified. The resources of the collaborating members should be sufficient to address the identified issues or problems. If this is not true, continuation is still possible if:

    Related issues or problems on a smaller scale can be identified that the available resources can effectively address; or

    The resources of the collaborating group can be sufficiently enhanced to enable them to address the issues or problems effectively.

- External conditions that support collaborative efforts include:

  Physical proximity. If members don't need to travel far, it's easier to conduct meetings frequently enough to develop effective collaborative responses. Physical closeness is less of an issue if participants can communicate electronically, but this is not always possible. Although the necessary technology is increasingly available in this country, there are many settings where it is still not accessible.

  The time frame of the issue or problem. Collaborative activities and integrated responses are time-consuming to develop and implement, and it's important to allow enough time to support a collaboratively developed response. Usually, collaborative endeavors are not suitable for issues that demand a quick response.

The above two factors interact. If plenty of time is available, physical distance may become less of a challenge, since collaborative responses may be achieved with relatively infrequent meetings spread over time.

7. How should a collaborative endeavor end?

- A collaborative endeavor will end when any of these points are reached:

  The collaborative effort has been successful, at least to the point that an effective, integrated response has become institutionalized or is no longer needed. (The fact that this point has been reached is not always recognized, especially if the collaborative group has failed to define an end point to their effort.)

  The environment has changed, in that the issues or problems:

    Have abated to a point where the collaborative effort is no longer needed; or

    Have changed in a way that renders the resources of the collaborative inadequate to effectively address them.

  The collaborative endeavor's resources have been exhausted.

- The collaborative endeavor will then either:

  Develop into a new collaborative effort designed to address a new set of issues or problems;

  Mutate into a group that meets for other reasons (for example, continuing to exchange information that has proven to be valuable); or

  Slowly disintegrate, with attendance and membership falling until only a few members are left.

- The ending should be as positive as possible, both out of consideration for the efforts of the members and to increase the likelihood of future collaborative efforts, if they are needed. A positive ending is more likely to occur if:

  The changes that led to the termination of the collaborative have been recognized and discussed;

  The collaborative's successes and members' contributions to them have been celebrated;

  The timing of the ending is right; not too soon (before you are certain the issues and problems have been effectively addressed) and not too late (after the reasons for meeting have diminished, and attendance and membership have started to drop off);

  The ending is clean and quick. Do not "drag it out." Instead, identify possible reasons for future collaboration and define a mechanism for beginning again.

- Viable plans should be made for continued communication among the participants so that relationships will be sustained. These relationships can be invaluable resources for future alliances to address other problems and issues.

Group Process

1. What is a group?

   For our purposes, a group is best defined as "a collection of individuals who interact with each other on a regular basis and see themselves as being mutually dependent with respect to the attainment of one or more common goals."

2. How is information about group process relevant to the understanding of collaboration?

   Collaboration is, itself, a group process. Collaborative community endeavors invariably involve numbers of different groups as task forces, community groups, coalitions, and agency staff work together to identify issues, decide upon courses of action, share resources, and overcome obstacles.

3. What stages of development do groups go through before becoming fully functioning?

   In performing any work with groups, it is very helpful to have some knowledge of the natural stages of development that most groups go through *(Jacobson & Jacobson, 1976; Bennis & Shepard, 1965):*

   - Stage 1 - Orientation. During this stage, members often seek inclusiveness and attempt to identify with the group through a give-and-take relationship. They focus on identifying the task(s) of the group and the ways it will attempt to satisfy their individual needs. They become aware of the initial ground rules for what is acceptable behavior, and they start to see how the group fits into the larger communities from which they come. General agreement on the mission and goals of the group usually occurs during this stage.
   - Stage 2 - Differentiation. This stage reflects the process of organizing to get work done and often involves the following activities:

     Members identify any problems that have arisen related to membership, tasks, roles, and responsibilities. They also become aware of the resources available to move the group toward its goals;

     Members attempt to address problems either individually or by use of the group's combined assets by:

     Clarifying tasks;

     Clarifying and assigning roles and responsibilities; and

     Identifying available resources and planning how to use them.

     Members agree upon the approaches that will be used to overcome challenges both within their group and outside it. They determine how the group will work together to accomplish its task(s).

   Increased interpersonal conflict and competition usually emerge during this stage as individuals bring to the group different ideas about authority, power, dependency, leadership, and strategies. This can be a critical stage of group development, testing the desire and perseverance of members to continue working together.

- Stage 3 - Integration. This stage develops as members begin to resolve problems, evaluate the issues involved with their tasks, and experience success in reaching individual and group objectives. Discussions become more open as people identify opportunities for group movement and for providing leadership. Interpersonal relationships within the group are marked by increasing cohesion, sharing of ideas, providing and getting feedback, and exploring ideas and actions related to the task(s) at hand. At this stage, group members often begin to find that the benefits of remaining in the group outweigh the costs.
- Stage 4 - Maturity. In this stage, the group offers members both flexibility and stability. Members recognize the need for a stable system of norms, standards, and other constants in guiding the behavior of individual members, while at the same time the group remains flexible enough to adapt to changing tasks and other factors. Members value their interdependence within the group, and information flows freely.

4. **What characteristics of groups need to be understood to effectively establish a collaborative community endeavor?**

Such characteristics should include the following:

- Group norms. A group norm is a standard of behavior that is expected of members of a group, such as open discussion, positive reinforcement, and respect for others. Violations of norms can be stressful for the group and may incur reprimands and other group sanctions. In extreme cases, violations will usually result in social ostracism or expulsion of a member from the group. It is often helpful if norms are discussed and established at the outset.
- Group member roles. Roles are the behaviors expected of members who have particular positions within a group. In formal groups, there are usually job or position descriptions that define expectations for specific roles. In many informal group situations, role expectations are developed by the group members themselves and may never be formalized.
- Conformity. Conformity is the degree to which group members follow the rules, behavior standards, and practices established by the group. Conformity can be both helpful and problematic. Groups need a certain amount of conformity to function effectively. However, excessive pressure to conform can undermine the group's ability to reach its objectives, stifling creative problem solving and the identification of important issues *(Janis, 1972)*.
- Effects of group size *(adapted from Bales & Borgatta, 1956):*

  Very small groups (two to four members) tend to show more tension than larger ones. There also tends to be more seeking of each other's opinions, more agreement, and more satisfaction for group members;

  In larger groups, tension is more easily released and information is offered more freely, but large groups also tend to have increased turnover and absenteeism; and

  In collaborative community groups, optimum size considerations often must be balanced against the need for the group to fully represent the community.

- Structural solutions to problems associated with group size:

  If the group is too large to accomplish tasks at hand efficiently, the problem can usually be addressed through the formation of sub-groups or committees, each with defined roles and responsibilities; or

  If there are not enough participants to accomplish the needed tasks, the gap may be filled through the development of auxiliary committees of interested community members; or

  If there are too many participants and some have too little to do, one solution is to rotate tasks among group members.

- Key group maintenance functions, such as *(adapted from Hoffman, 1979):*

  Encouraging input from all participants. This will help ensure that the group identifies resources that might be necessary or useful for accomplishing its goals. Collaboration often requires participation from "unusual" partners from the community. Their information, resources, and commitment to the joint efforts are often needed to be successful.

  Recognizing and dealing with conflict within the group by using team-building and problem solving strategies and tactics. For example, it is important to separate the people from the issues and to focus on those issues, not on personalities.

- Group Cohesiveness. "Cohesiveness" refers to the agreement and mutual support shown by group members toward each other. It affects group unity and the degree to which group members will work toward the same goals *(adapted from Shaw, 1976).*

  Factors that increase group cohesiveness. Group cohesiveness is usually enhanced when:

  - Individuals have the opportunity to gain prestige or status within the group;
  - Mutual respect and trust characterize the relationships and interactions among group members;
  - Group members are in cooperative, rather than competitive, relationships with one another (bearing in mind that individuals from different cultures may view competition, and react to it, differently);
  - Group members can fulfill their individual needs through participation in the group;
  - The group has prestige or status within the members' respective communities. This can be a challenge for multicultural and interprofessional groups, since the same factors that are prestigious in one culture or profession may have the opposite status in another;
  - The group is attacked from the outside, causing members to deal with the external threat.

- Decreased group cohesiveness. Group cohesiveness is usually lowered when:

  Interpersonal conflict results in unresolved disagreements among group members;

  Role conflict results from group members' participation in the group. This conflict may be one of two types:

  - Conflict among members concerning the roles they will play within the group; and
  - Conflicts that group members' participation creates with other roles they play in their professional or personal lives.

Role ambiguity exists within the group. Members are not sure about their role, what they are supposed to be doing, or how they are supposed to be contributing;

Membership in the group places limits on the individual's participation in other individual or group activities;

Respected outsiders evaluate the group negatively; or

Conditions exist within the group that prevent or restrict effective communication. For example, one or two members dominate group activities and prevent other members from participating.

- Decision-making procedures. A variety of procedures can be used to gain member participation in the processes of generating information and selecting solutions. For example:

  Brainstorming. A process in which all members are encouraged to present ideas regarding possible solutions to an identified problem. These are usually written on a flip chart or chalkboard. No comments or criticisms are allowed until all ideas have been presented. Open discussion of each idea or alternative occurs, followed by a voting process to select a course of action. Advantages of this technique include increased participation of all members in the decision-making and the creative generation of ideas for consideration.

  Nominal Group Technique (NGT). A process in which members silently put their ideas in writing, working independently. These ideas are then summarized on a flip chart or chalkboard. Discussion of the alternatives then takes place, followed by a voting process to select a course of action. In addition to the fact that this technique cuts down on interruptions, it has the advantage of avoiding the problems of status pressure, pressure to conform, and competition *(Delbecq & Van de Ven, 1971)*.

  Survey Techniques. Various techniques (such as the Delphi Technique) can be utilized to involve people in the decision-making process when it is difficult for them to come together physically. Such techniques can be time consuming, though modern computer technology can greatly speed up the process *(Dalkey, 1969)*.

- For collaborative endeavors (especially ones that need to be fully collaborative), it is essential that the decision-making processes and procedures create consensus among their membership. Consensus is achieved whenever the decision is accepted by everyone in the endeavor and they become committed to implementing it.

- Behavioral tendencies. The group should understand any predominant group-related behavioral tendencies within the cultures engaged in the collaborative effort. Knowledge of such tendencies will improve the group's effectiveness at:

  Engaging people from those cultures in the collaborative endeavor;

  Developing and assigning member and leader roles where people from different cultures can participate comfortably in the collaborative endeavor; and

  Developing strategies to deal with conflicts that can arise among individuals from different cultures because of differing expectations and styles of interaction.

5. How does conflict affect a group?

Conflict within groups is normal and should be expected; it can occur whenever two or more group members have different agendas. This may reflect differences in perceptions, beliefs, attitudes, values, or needs. Competition can create conflict over such things as position, influence, or rewards. There are often significant differences in how different cultures define and react to conflict, and outcomes may range from disagreement or competition to oppositional or antagonistic interactions among individuals or groups.

- Conflict is destructive when it results in personal and group resources becoming consumed in hostility, bitterness, and/or generally disruptive, nonproductive activity. Group cohesion is invariably lessened.
- Conflict is constructive when differences result in individuals and groups becoming more creative and productive. It can prepare groups for needed change (*Robbins, 1974*).
- Conflict within the group can become constructive if it is directed toward accomplishing accepted group goals, rather than defeating others in the group. Conflict will become more constructive if group norms are established that:

  Encourage mutual respect;

  Encourage sensitivity toward others;

  Emphasize the appreciation of differences;

  Encourage assertive (not aggressive) communication;

  Encourage actively listening to each other;

  Encourage members to agree to disagree;

  Emphasize staying on task and completing tasks;

  Support a clear, accepted decision-making process; and

  Reinforce member acceptance of group decisions.

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IV. Leadership

Core Competency – The ability to implement and sustain change in interprofessional settings and diverse communities. This includes the abilities to:

- Develop, articulate, and sustain a vision for collaborative success;
- Ask hard questions about the status quo of the "systems" serving children, youth, families, and communities;
- Involve key stakeholders and key decision-makers in collaborative efforts;
- Recognize and support the emergence of leaders among collaborative participants; and
- Encourage and engage in appropriate risk taking as part of the process of change.

Key Knowledge Bases

Traditional Leadership Theory

1. What is leadership?

   In the broadest sense, leadership can be described as "the ability to influence others to direct their efforts toward the achievement of a common goal or goals" *(Endres, Simmons & Judson, 2000)*. In collaborative settings, a definition should also include:

   - Having the ability to motivate others, usually by promoting a shared vision; and
   - Having the skills necessary to set clear directions for implementing and sustaining collaborative change in interprofessional settings and within diverse communities.

2. What are the key sources of influence that increase a leader's impact on others *(Adapted from French & Raven, 1968)*?

   - Influence through rewards. This occurs when a leader has the ability to provide rewards to individuals or groups. What constitutes a reward can differ significantly among different cultures.
   - Influence through coercion. This occurs when a leader can cause others to have unpleasant experiences. What constitutes a punishment or unpleasant experience often differs significantly among different cultures. The exercise of coercive influence can be very problematic, since it usually generates undesirable effects such as anger, resentment, and/or disengagement.

- Legitimate influence. A leader's position, role, or status within an organization, community, or culture may afford him or her the right to direct the actions of others. Legitimate influence is based upon a mutually accepted perception that the person has the right to influence others. There are significant differences among cultures concerning which individuals may be accorded such status.
- Referent influence. This occurs when individuals identify with a leader and either want to be like him or her in some way or want to earn the leader's acceptance or favor. Such a leader is sometimes referred to as being "charismatic." The characteristics of people who generate such reactions often differ significantly among cultures.
- Influence through expertise. Some leaders exert influence because they are perceived to have special abilities, knowledge, or insight that are valued by others. The attractiveness of a person's "vision" or message is potentially a significant source of such influence. The factors that influence people's perceptions of another's abilities, knowledge, or insight can vary significantly from culture to culture.

3. What aspects of leader behavior is it helpful to understand *(Hersey & Blanchard, 1982; adapted from Stogdill, 1974)*?

In most leadership theories, two leader behaviors are considered to be significant for understanding leadership effectiveness:

- Task behavior which is directed toward the completion of tasks needed for accomplishing a group's goals and objectives; and/or
- Relationship behavior which is directed toward the development and/or maintenance of positive relationships with and among group members.

Recent writings *(Bass, 1997)* have focused on a third type of leader behavior, that of:

- Visioning which is behavior directed toward providing (or encouraging and enabling the group to provide) a guiding "vision" of what the group wants to accomplish, usually including the significance of this accomplishment.

Depending upon the situation, practicing leader behaviors can significantly enhance the effectiveness with which a group functions and the extent to which it accomplishes its goals.

4. What aspects of leadership style is it helpful to understand?

Leadership styles have been described and documented in differing ways in the literature *(adapted from Gastil, 1999; Srinivasan, 1988; and Vecchio, 1997)*. They include:

- Democratic leadership characterized by a predominant tendency to facilitate relatively equal participation by all group members;
- Authoritarian leadership characterized by a predominant tendency to direct, and even control, the behavior of others;
- Relational or relationship-oriented leadership characterized by the tendency to focus on the maintenance of good relationships with group members; and
- Laissez-faire leadership characterized by passive non-direction, with the leader making no significant efforts to guide the group.

The four styles mentioned above describe some prominent characteristics of leaders' styles of behaving in relation to the group. The following two styles describe special aspects of the leader, primarily his or her overall effect on other group members:

- Charismatic leadership *(Conger, 1998; Fiol, Harris & House, 1999)* occurs when personal characteristics of the leader provide a primary source of influence with group members. Members tend to emulate the leader and try to gain his or her favor.
- Transformational leadership *(Bass, 1997)* occurs when the strength and/or attractiveness of a leader's ideas and/or beliefs (sometimes captured as the leader's "vision") exert enough influence on members to bring about significant change in the group's goals and sometimes to change its style of operating. In many ways, transformational leadership can be considered a type of charismatic leadership. It can be effective in leading a group toward certain accomplishments.

5. What determines leadership effectiveness?

No one style of leadership is effective across all situations. Leader style and behavior interact with the characteristics of both the situation and the group to determine the most effective leadership behavior *(Fiedler & Garcia, 1987; House, 1996)*. Across situations, leadership effectiveness is enhanced, at least in terms of followers' satisfaction, when leaders adapt their behavior (and style) to the needs of the group *(Ayman & Chemers, 1991)*. Importantly, being charismatic or transformational can increase a leader's influence with the group, but it will not ensure the leader's, nor the group's, effectiveness. Indeed, charismatic leaders have been known to destroy groups. The overall effectiveness of transformational leadership depends upon the wisdom of the leader's ideas and beliefs, the practicality of his or her vision, and the degree of its acceptance by group members.

Collaborative Leadership

1. What is collaborative leadership?

It is leadership in settings where collaborative interactions, relationships and decision-making among participants are either desired or necessary. It usually involves *(adapted from Johnstone, Dye & Johnson, 1998; Rawlings, 2000):*

- Encouraging effective unions among diverse parties; and
- Facilitating organizational and systems adaptation and growth (often in turbulent environments) through the development of collaborative solutions to problems of mutual concern.

Similarly, Rubin *(1998)* defines collaborative leadership as the skillful and mission-oriented management of relevant inter-institutional relationships. It involves organizing at the inter-institutional level while building and sustaining relationships at both the individual and the institutional levels. Such leadership requires the ability to find common interests in the diverse missions and goals of independent organizations. The collaborative leader should be able to:

- Recruit the right mix of stakeholders and decision-makers;
- Cultivate a shared (collaborative) vision from the start;
- Attend to the self-interests of all participants; and
- Effectively manage the effort, which includes:

  Attending to management details;

  Developing a routine structure and roster of participants; and

  Making good use of participants' time.

2. What characteristics are thought to help collaborative leaders be effective?

Recent literature suggests, in essence, that leaders of collaborative endeavors are more effective if they:

- Are committed to the well-being of all members of the endeavor;
- Respect diverse points of view, being open to others' thoughts and ideas;
- Possess "cultural-functional humility" *(McGill, Slocum & Lei, 1992)*, which refers to the ability to see one's own values, background, and experiences as being no better or worse than those of others;
- Are able to develop multi-frame perspectives *(Selsky & Smith, 1994)* as different images of complex problems emerge (as they usually do) when diverse stakeholders discuss situations and issues;
- Are systemic thinkers *(McGill et al., 1992)* who see connections between issues and events and who strive to conceptualize the whole rather than just the parts;
- Display honesty and integrity, demonstrating those qualities daily, and understand that trust is the

emotional glue that binds followers and leaders together;

- Have high self-efficacy concerning the issues and problems of concern which includes giving them the confidence in situations over which they have no direct control to take steps in those areas where they do have influence;
- Have a high tolerance for ambiguity and thus the ability to function effectively in ambiguous situations;
- Are willing to experiment with new ideas, concepts, and strategies;
- Focus on tangible results, identifying outcomes that can be observed or measured;
- Are willing to take risks and act when the outcomes are not predictable or when it is appropriate as part of the process of needed change; and
- Display "emotional intelligence" *(Salovey & Mayer, 1990)*, which refers to the skills and maturity needed to:

    Recognize, understand, and redirect moods and emotions that have an effect on others;

    Suspend judgement, think through situations, and problem-solve before acting;

    Pursue goals with passion, energy, and persistence;

    Communicate effectively with people from different cultural, social, professional, and organizational backgrounds;

    Reflect upon and learn from experience and apply new knowledge; and

    Understand the implications of style, timing, degree of participation, and other considerations that are essential for promoting empowerment and leadership.

3. For leaders, what knowledge is helpful when they are involved in developing or guiding collaborative community activities?

- Knowledge of community dynamics, political interests, and sources of influence. Leaders within a collaborative community endeavor must have considerable "political savvy" concerning the community and its surrounding environments. Such knowledge is necessary to begin to understand how to get things done within any community environment.
- Knowledge of their own leadership style and tendencies. Leaders' self-knowledge is critically important in helping them understand whether their usual automatic reactions will be appropriate in the different cultural and interprofessional contexts that will arise. The most effective leaders remain aware of how others react to their style and behavior and make appropriate adjustments.
- Knowledge of how to be a change agent in the community. Becoming a change agent requires considerable knowledge and skill, such as knowing how to use empowerment and how to utilize constituency-based models of change that involve asking hard questions about the effectiveness of human services systems.

- Knowledge of the collaborative visions that can guide collaborative efforts. A collaborative vision has particular characteristics that the leaders should understand. Such a vision should:

    Represent strongly held intentions that bind the group members together;

    Reflect the core values and beliefs of the collaborative group, including what they want to accomplish and why it is important;

    Appeal to both logic and emotion;

    Describe how the group intends to impact the world (e.g., its community);

    Help the group select goals and priorities; and

    Generate long-term commitment to the group's success.

- Knowledge of how to develop and sustain indigenous leadership within the community. This includes understanding the need to:

    Recognize and reinforce positive leadership behavior and skills from individuals within the community;

    Encourage the participation of natural leaders in collaborative community efforts; and

    Help natural leaders develop roles in those efforts where their leadership skills can be utilized and further developed.

- Knowledge of factors related to group effectiveness. This includes an understanding of how to do the following:

    Articulate and develop:

        Clear visions (sometimes mission statements) to guide the group's joint endeavors;

        Clear goals and objectives that provide detailed guidance for the group's efforts;

        Clear and meaningful roles for group members, especially those necessary for accomplishing the group's objectives and goals; and

        Clear group norms that encourage collaborative behavior by all group members.

    Develop and implement procedures for measuring and evaluating:

        The attainment of objectives related to accomplishing goals; and

        Members' learning and satisfaction.

    Develop and utilize processes of renewal, such as celebrations of accomplishments, especially when it takes considerable time to complete the group's mission. These can contribute significantly to restoring participants' motivation and commitment to the mission.

The above factors help establish clarity, purposefulness, and a sense of accomplishment for group members. They are all helpful in keeping group participants motivated and directed toward completing the group's mission.

- Knowledge of decision-making within a collaborative group context. This includes understanding decision-making strategies within a group context *(adapted from Vroom & Yetton, 1973; Vroom & Jago, 1988)*. Examples of such strategies include:

  Leaders are principally responsible for making and carrying out decisions. They share the issue or problem with other members as a group, obtain their collective ideas and suggestions, then later make the decision themselves. In a collaborative endeavor, leaders should have the permission of the other members before making and/or implementing such a decision. Otherwise, the decision-making process will likely generate discord within the membership.

  Leaders share the issue or problem with other members. They function together as a decision-making group, generating and evaluating alternatives and attempting to reach agreement on a solution. Leaders agree to implement any solution that has the support of the group.

  Leaders take a less active role in the process. They present the issue or problem to the group and ask them to evaluate the situation and make a decision. They encourage others in the group to assume leadership roles during the discussion and decision-making. This style of decision-making is usually most appropriate when there is a need for additional leaders to emerge and develop within the group, such as when a system of rotating leadership is used.

- Knowledge of criteria on which to base decisions about strategies to use within a group context such as:

  Whether it is important that a single effective solution be identified as opposed to when any number of potential solutions could be equally desirable;

  Whether there is sufficient information to make a high quality decision;

  Whether independent decision-making by the leader will create discord among members of the collaborative endeavor;

  Whether active acceptance of the decision by group members is essential for effective implementation;

  Which style of decision-making is the most likely to bring about active acceptance of the solution from the group members;

  Whether all of the group members share the goals that may be achieved when a particular problem is solved; and

  Whether there is likely to be conflict among the group members when they discuss the issue or problem or choose a particular solution.

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V. Communication

Core Competency – The ability to communicate effectively in interprofessional settings with people from different cultural, social, professional, and organizational backgrounds. This includes the abilities to:

- Clarify and interpret jargon and technical terms for collaborating professionals, individuals, families, and communities;
- Seek out and accept feedback;
- Express ideas clearly in both oral and written forms;
- Use voice and word choice to help others hear and understand the message;
- Use public speaking and visual materials to inform, persuade, and motivate others;
- Produce written documents and make oral presentations that are understood by community members and professionals across disciplines;
- Listen actively to facilitate understanding; and
- Facilitate communication across multiple language and cultural groups.

Key Knowledge Bases

1. What is effective communication?

   It is the information flow that results in a shared meaning and a common understanding for both the sender and the receiver(s) of the information *(Porter & Roberts, 1976)*.

   An important aspect of effective communication within collaborative activities and endeavors is that it empowers all the participants. To do so, communication must enhance the perceptions and beliefs of all participants so that:

   - They are valued and equal partners in the collaboration;
   - All significant information is being shared with them;
   - Their input is being heard and included in the decisions and actions of the collaborative; and
   - There is a sincere and genuine acceptance of and respect for language and cultural differences.

When working with a multicultural community, it is essential that an effective relationship be established before meaningful communication can truly occur *(Green, 1999; Leigh, 1998; Lum, 2000)*. Such meaningful relationships recognize and understanding that multicultural participants live in interdependence with family, extended family, clan, tribe, neighborhood, community, and ethnic organizations.

2. What are the most common barriers to effective communication, and how are they affected by cultural contexts *(Adapted from Callahan et al., 1986)*?

A number of factors should be considered:

- Frame of reference. This refers to different perceptions that the sender and the receiver may have of the same message. Individuals from different cultures may have dissimilar bases of experience which they read the situation in which the communication takes place. The importance they place on certain communications, or even how they interpret the communications, may differ significantly.

  Similarly, communication problems sometimes develop because of philosophical differences among members of different professions that work with children, families, and communities. Such philosophical differences often result in different concepts being used and different meanings being attributed to the same phenomenon. Sometimes these differences result in miscommunication, misunderstandings, and even distrust.
- Filtering. As information is passed on, filtering occurs when the sender of a communication sends only partial information. Often this is unintentional. Differences in experience, values, and motives (albeit unrecognized) account for much unintentional filtering, which is more likely to occur among people from differing cultures or professions.
- In-group language. Specialized words or vocabularies prevalent among occupational groups can hamper communication. A "special language" is most likely to be used by those with professional status – doctors, lawyers, nurses, accountants, psychologists, computer specialists, etc. It can also occur in other groups that share a common experience such as electricians, actors, or police. The specialized language developed by these groups enhances communications among members, but it can pose problems for individuals who are not part of the groups.
- Overload. This occurs when an individual or a group becomes bogged down with too much information. Individuals and groups may respond to overload in a number of ways that can disrupt the effectiveness of the communication process:

  Omitting – failing to process some of the information;

  Erroring – processing the information incorrectly;

  Filtering – separating out some of the information because it seems less significant and relevant than the rest;

  Over-generalizing – categorizing input and using a blanket or general response for each category; and

  Escaping – avoiding the information altogether, sometimes just by "tuning out."

Differences in language comprehension or processing among people from different cultures can make it more likely that such information overload will occur.

- Status differences. Significant differences in status tend to inhibit communication, especially when communication from individuals of lower status is addressed to individuals of higher status.
- Differences in nonverbal behavior. People from differing cultures may interpret certain nonverbal aspects of communication in very different ways. For example, differences are often found in the meaning of the amount and directness of eye contact.
- Need for personal space. People vary as to how comfortable they are with physical closeness, both in general and during interactions. Consideration of such preferences can be important for determining room layouts, placement of furniture, seating placements for meetings, etc. Uncomfortable intrusion into another's personal space can be a significant barrier to effective communication.
- Time pressures. Time pressures can result in the sender not fully developing the message or transmitting it incompletely. On the other hand, the receiver may not take time to capture the full intended meaning of the message.
- Space considerations. The layout of chairs, tables, equipment, etc., can greatly affect interaction and communication during meetings. Also, intrusive noise and visual distractions can disrupt the effectiveness of the communication process. Attention to the design of meeting space can help alleviate or minimize many barriers to effective communication, including those related to differences in culture, ethnicity, professional, or status relationships.
- Different learning styles. People vary as to how they best assimilate information. Written materials are an effective medium for many individuals but not for those who cannot read well – or even for some of those whose reading skills are adequate. There is also a wide difference in the way people process auditory and visual information. If the medium of communication does not match the learning style of the audience, communication effectiveness is diminished.
- Language barriers. The fact that participants may speak a language other than English may be an obvious barrier to communication but one that is easily overlooked. The extent to which people understand English may be hard to assess. Some who appear to have a verbal command of the language may have a limited comprehension of it. Some may be able to comprehend more than they can verbalize. Literacy should not be assumed in the participant's original language, nor in English when it is learned as a second language. Translations may not always be effective; participants may speak a dialect rather than the assumed dominant language of their country of origin. In some cases, the best opportunity for communication may be in a third language if participants are multilingual (for example, Laotian and French).
- Lack of cultural congruence. A major barrier to effective cross-cultural communication is lack of cultural congruence. This occurs when there is insufficient sensitivity to and understanding of the cultural differences in the sending and understanding of both nonverbal and contextual information *(Lynch & Hansen, 1998)*. Cultural congruence is a significant bridge in the establishment of an effective cross-cultural relationship *(Gomez & Roy, 1985; Leigh, 1998)*.

- Technological barriers. In our highly technological society, it may be easy to assume that every group and/or collaborative member has access to computers, the Internet, and email. Relying solely on such means of communication can result in the exclusion of a number of participants. Even telephones cannot be taken for granted.

3. How can such barriers to effective communication be overcome *(Adapted from Callahan, Fleenor & Knudson, 1986)*?

- Empathy. Probably the most important factor is for the sender to develop an awareness of the needs and motives of those who will receive the information, and vice versa. This is especially true within multi-cultural and interprofessional contexts.
- Effective timing. Attention needs to be paid to the timing of message so that they are sent when most likely to be received. There can be significant differences in when it is most effective to send messages to people from different cultures.
- Regulated information flow. The flow of information can often be regulated to increase its effectiveness, avoiding problems that can occur when there is too little information or too much. Again, the optimum flow may differ with people from different cultural backgrounds.
- Feedback. Effective feedback mechanisms need to be developed to help ensure that the information received is the same as the information that is sent. This can be challenging in multi-cultural settings because people from differing cultures are often not equally comfortable with or equally adept at utilizing different feedback mechanisms.
- Effective listening. Developing the listening skills of all involved will greatly improve the communication process. Here are some helpful guidelines from "Ten Commandments for Good Listening" *(Dans, 1972)*.

  Stop talking,

  Put the talker at ease,

  Show the talker you want to listen,

  Remove distractions,

  Empathize with the talker,

  Be patient,

  Hold your temper,

  Go easy on argument and criticism,

  Ask questions,

  Stop talking.

- Assertive communication. Assertive communication occurs when individuals clearly state their thoughts, ideas, or needs in a non-attacking, non-threatening manner. It is to be distinguished from aggressive communication, which occurs when individuals belittle or attack other people's thoughts, ideas, or needs. Whereas in assertive communication, people talk about themselves; in aggressive communication, the focus is on others. Passive communication occurs when individuals do not clearly present their thoughts, ideas, or needs. Assertive communication is usually effective during collaborative activities and efforts, whereas both aggressive and passive communication can create problems.
- Managing communications. This involves adjusting aspects of the communication process to consider multiple cultures and languages as well as differing professional or philosophical frames of reference. Adjustments may be needed in the provision of space, in the use of communication materials, and in choice of language. For example:

    The design and utilization of the physical layout can help minimize problems associated with concerns about such matters as personal space, status differences, or visual or auditory distractions, etc.;

    Communication materials and styles of dissemination should be of a type that can best address differences in education, learning styles, etc. Multi-media presentations will often maximize communication effectiveness; and

    It is important to use inclusive language that carries similar information to all participants. Words and phrases that are highly "jargonized" should be avoided, as should language that may be interpreted very differently by people from different professions or cultures.

- Overcoming language barriers. Two approaches are helpful in minimizing any language barrier: use of interpreters and the translation of written materials. The following guidelines may prove helpful when using an interpreter *(adapted from Parnell & Paulanka, 1998)*.

    If possible, use interpreters rather than translators. Interpreters provide meaning for words while a translator simply replaces words from one language with those from another;

    Use dialect-specific interpreters to provide the most accurate translations;

    Plan extra time that is required by the interpreting process;

    Avoid the use of children as interpreters;

    Remember to maintain eye contact with both the participants and the interpreter;

    Keep in mind that participants need time to think in their own language;

    When you speak, speak slowly and without exaggerated mouthing or loudness;

    If there are social class differences between the interpreter and participants, be alert to the fact that the interpreter may not translate or pass on information that he or she views as unimportant; and

    Translate written materials to facilitate communication for those who are literate in their language.

- Developing cultural competence. Knowledge of the various cultures represented in a collaborative is essential for the establishment of cultural congruence and the facilitation of meaningful communication. Cultures differ in how much is communicated directly with words and facts, how much through the context of the situation, and how much through nonverbal cues and indirect expressions. For example, some cultures rely more than others on precise, linear verbal communication. Others rely less on words and more on nonverbal cues, shared experiences, history, implicit meanings, and affiliation *(Lynch & Hanson, 1998)*.

  Gaining an experiential understanding of particular communication processes is a first step in establishing the cultural competence needed to achieve cross-cultural communication. For full comprehension and understanding, it is also important to become familiar with other aspects of a culture that are relevant to communication such as body language, verbal and nonverbal expressions, relationship protocols, male/female relationships, child rearing practices, clothing, and etiquette. Effective communication with multicultural participants can be enhanced through the following *(Dresser, 1996; Green, 1999; Lum, 2000):*

  Placing a primary focus on the development of a relationship before focusing on business, problem solving, or data gathering;

  Assessing processes used by participants as they communicate and adapting to them (e.g., significance of the nonverbal, etc.);

  Understanding and using principles of relationship protocols in regard to expressions of respect to participants, family roles, family members, elders, and related significant others;

  Working to understand what participants themselves value and what is meaningful to them; and

  Taking the role of newcomer and inviting the participants to take the role of guide/teacher of their culture. Have them show you how they define issues and provide keys for problem solving.

- Technological barriers. Use non-technological means of communication such as postal mail, posters, word of mouth, church bulletins, and/or word of mouth to reach those who have no Internet or telephone connection.

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VI. Assessment and Outcomes

Core Competency – The ability to understand and implement outcome-based accountability as it pertains to integrated and collaborative services. This includes the abilities to:

- Determine the strengths, weaknesses, and needs of a targeted program or community;
- Articulate achievable, measurable, realistic outcomes for children, youth, families, and communities;
- Distinguish between process and outcome evaluations;
- Access and use process, outcome, and other data to improve collaborative outcomes and services for children, youth, families, and communities;
- Interpret data in a manner that is comprehensible and useful to members of the collaborative endeavor and the community;
- Assess the functioning of a collaborative endeavor; and
- Analyze and present process and outcome data to develop, monitor, and assess program outcomes and client progress.

Key Knowledge Bases

Community Assessment *(see Cornerstone Consulting Group, Inc. n.d.; Kretzman & McKnight, 1993)*

1. What is a community?

   It is a society of people, including their organizations, with defined geographical boundaries. They share common interests, privileges, and rights and are affected by each others' behavior and actions They sometimes share a common sense of identity because of such factors as:

   - Ethnicity or cultural heritage;
   - Similar beliefs and values; and/or
   - Geographical proximity.

2. What is a community assessment?

It is a determination of the needs, strengths (protective and resiliency factors), and/or limitations (risk factors) of a community relative to specific problems and/or issues such as providing for the well-being of its families and children.

3. What is a protective factor?

It is a variable or characteristic whose presence decreases the likelihood that certain problems (e.g., delinquency, teen drug abuse) will occur or develop.

4. What is a resiliency factor?

It is a certain type of protective factor, namely a characteristic that a person possesses (e.g. positive self-esteem; clear, positive goals; good social skills) whose presence decreases the likelihood that the person will engage in certain problem behaviors (e.g., delinquency, teen drug abuse).

5. What is a risk factor?

It is a variable or characteristic whose presence increases the likelihood that certain problems (e.g., delinquency, teen drug abuse) will occur or develop.

6. What factors should be included in an assessment of a community's needs in relation to its children and families?

- A determination of the general state of children's and families' functioning and well-being in relation to their:

  Health;

  Nutrition;

  Education;

  Cognitive/emotional development; and

  Social/moral development.

- A determination of key community risk factors that impact the health and well-being of the youth and children such as levels of:

  Poverty;

  Population turnover;

  Violence;

  Drug/alcohol abuse;

  Unemployment; and

  Single-parent households.

7. What factors should be included in an assessment of a community's potential ability to address the needs of its children and families?

- A determination of key community factors that protect against the development of health, emotional, social, and behavioral problems by youth and children such as the availability of:
  - Schools that provide a safe, supportive, productive atmosphere;
  - Safe, supportive, engaging, after-school programs;
  - Safe, supportive, recreational facilities and programs;
  - Positive peer groups and activities;
  - Adequate, accessible health care for families and children;
  - Adequate police protection; and
  - Effective social support systems for parents.
- A determination of the community's ability to provide for its children and families in each of the areas such as the community's:
  - Organizations and service providers;
  - Access to organizations and providers elsewhere; and
  - Resources for developing needed programs and/or activities, such as:
    - Financial resources;
    - Knowledgeable, skilled community members; and
    - Natural support providers, both individuals and groups.

8. Where can one locate data and information that can be used to assess the well-being of children and families within a community?

- The local Health Department can often provide such indicator data as:
  - Prevalence of births to teenage mothers;
  - Average birth weights of area children;
  - Prevalence of a number of health problems and issues among area families and children; and
  - Presence of health care and related facilities.
- The U. S. Census, the state, or sometimes the county can often provide such indicator data as:
  - Prevalence of single-parent families;
  - The ethnic make-up of the community;
  - Average income per household; and
  - Population turnover.

- The state's Department of Education, in printed matter or on the web, and/or local schools can usually provide such indicator data as:

  The percentage of children within each grade who are performing above, at, and below grade level;

  The prevalence of various types of learning disabilities within each grade;

  Truancy rates; and

  The percentage of children qualifying for free and reduced lunch programs.

- State and/or local law enforcement agencies can provide such indicator data as:

  Arrests by geographic area for youth gang-related, drug related, or violent behaviors; and

  Arrests by geographic area for various adult criminal activities.

Outcomes

1. What are the important features of an outcome-based approach to community planning and development *(Schalock, 1995)*?

The purpose of an outcome-based approach is to focus on the impact of a program or agency on the well-being of clients and on the community. It shifts the focus from "what are we doing" (process) to "what we did" (outcome), and the difference that the program or agency produced in the life situations of clients and community. This approach looks at specific measurable outcomes, goals, or objectives in relation to program activities. Note that the terms 'goals,' 'objectives,' and 'outcomes' are not used consistently in literature or in practice, which can be very confusing. Regardless of the terminology used, outcome-based approaches in human services generally include the following:

- The identification of one or more long-range goals, objectives, or outcomes that a program would achieve, if successful, to benefit clients and the community;
- The identification of one or more short term/intermediate goals, objectives, or outcomes related to the longer range goals or objectives;
- The identification of specific, measurable indicators to measure these goals, objectives, or outcomes;
- The specification of program activities that should achieve the desired goals, objectives, or outcomes; and
- The collection of data measuring activities and outcomes.

2. What are the major concepts involved in an outcomes-based approach?

Again there is little consensus on use of the following terms, but they are often applied as follows:

- A goal. This is a condition or end state that you are trying to achieve or attain. Goals vary as to how specifically they are stated or defined. Broadly stated, goals are often philosophical in nature and sometimes become mission statements. An example would be, "Our goal is to make our community a decent place to live." Such goals do not easily lend themselves to measurement until they become more specific.
- An objective. Much more clearly specified than a goal, an objective is an end state that you want to achieve. Examples could include, "to decrease crime," "to increase affordable housing," or "to increase the number and quality of recreational facilities."
- An outcome. This is a specific result that indicates the extent to which an objective has been achieved or accomplished. The term can also be used to determine the extent to which a broader goal has been attained.
- An indicator. Usually referred to as data, this is information that is used to measure progress towards a goal, objective, or outcome. Indicators can focus on assets or strengths as well as needs.

There are three basic types of data gathered in human services research:

- Baseline data – desired outcomes (results) gathered before a program of intervention is begun.
- Process data – information about activities undertaken, characteristics of those served, and/or of services that were provided. Some commonly used process data include:

  Number or types of individuals served;

  Types and hours of service provided; and

  Increases in the facilities or resources available within a community.

- Outcome data – outcomes (results) that have occurred. It is best if such data measures again the original baseline data after the activities and/or services have been provided.

  - Among children, outcome evaluations often measure:
    - Increases in desirable or healthy behavior or conditions such as:
      - Progress in growth and development including cognitive, social, fine motor, and gross motor development;
      - Progress in school;
      - Increases in age-appropriate behaviors; and
      - Involvement in extracurricular activities.
    - Decreases in risky or unhealthy behavior such as:
      - Overly aggressive behavior;
      - Overly shy, withdrawn behavior; and
      - Acting out behavior.
  - Among youth, outcome evaluations often measure:
    - Increases in desirable behavior or conditions such as:
      - Progress in school including improved attendance, behavior, and grades; and
      - Involvement in positive activities such as sports and social clubs.
    - Decreases in risky or unhealthy behavior such as:
      - Substance use;
      - Early and unprotected sexual intercourse; and
      - Criminal or delinquent behavior.
  - Among families, outcome evaluations often measure:
    - Increases in healthy and desirable behavior or conditions such as;
      - Increase in parenting skills;
      - Improvement in parent-child interactions; and
      - Increase in communication among family members.
    - Decreases in unhealthy or non-desirable behavior and conditions such as:
      - Domestic violence;
      - Child abuse; and
      - Lack of parental supervision.

Among communities, outcome evaluations often measure:

Increases in desirable conditions such as:

- Local workshops regarding career and educational planning;
- Extended family planning services; and
- Resources related to preventive health care.

Decreases in undesirable conditions such as:

- Unsuitable, unsafe housing;
- Poor educational or job opportunities; and
- Crime.

- What are the two most important characteristics of outcome indicators (evaluative measures)? To be useful in evaluating the extent to which something has occurred, indicators must be:

  Reliable – or able to produce the same result when multiple, or repeated, measurements are taken under the same conditions; and

  Valid – or able to really measure what they are supposed to measure.

- What are the usual components of an evaluation system? Most evaluation systems are designed to collect the three types of data described above; namely baseline data, process data, and outcome data.
- What is the logic model *(Julian et al., 1995)* of community human services planning? It is an outcome based model of planning and evaluating interventions and their effects. It can be based on protective factors (strength), or on risk factors, or on a combination of the two. The focus of the logic model is on:

  Identifying both the short-term outcomes and the long-term outcomes that you hope to achieve through your efforts;

  Delineating the desired changes in protective factors and risk factors that will achieve these outcomes; and

  Developing interventions to decrease the risk factors and/or increase the protective factors. This means specifying the processes to be instituted and/or the actions to be taken, including by whom, for whom, and by when.

3. How are collaborative community endeavors most effectively evaluated?

The most important information and concepts required for such an evaluation are identified below including types of assessment: research design, research style, and methods of gathering and presenting data.

- What types of assessments are generally used in community-based, human service research? There are several types of evaluations that are commonly used. They include:

  Needs and strengths assessments of individuals and communities, which measure what particular protective factors or risk factors exist within identified group(s) or area(s) (*Kretzmann & McKnight, 1993*);

  Process evaluation, which measures activities, actions, strategies or interventions, and also the characteristics of those individuals or groups toward whom they are directed;

  Outcome evaluations, which measure short-term results (outcomes), long-term results (outcomes), or both, and

  Cost-benefit or cost-effectiveness evaluations, which measure the costs associated with producing particular outcomes.

- What are the more common research designs?

  Experimental designs. These are the strongest options for determining whether a change has occurred and whether an evaluated program or action was the cause of that change.

  These designs include:

  The collection of evaluative information both before interventions are undertaken (pre-tests) and after the interventions are completed (post-tests); and

  The utilization of randomly created control groups that receive no interventions but for whom the pre- and post-test information is also collected.

  Experimental designs are much easier to use in laboratory research settings, where extraneous factors can be more easily controlled or eliminated than in community-based research, where such control is usually difficult or impossible. Therefore, research in community settings often utilizes one of the other following research designs.

  Quasi-experimental designs. These usually have either pre- and post-data collection or control groups, but not both. Such designs sometimes utilize various techniques to try and emulate the presence of either pre-test information or control groups.

  Survey or descriptive designs. These are less rigorous but can yield valuable information for use in describing population characteristics or in evaluating change in such characteristics over time.

An important element of any of these designs is the selection of a sample of participants that is representative of the larger population of concern. Either a random sample (participants selected randomly) or a convenience sample (a sample of participants that is easily accessed) can be used. Whenever possible, random samples are preferable because they are more likely to be representative of the entire community or population of interest. If it is not possible to use a random sample, every attempt should be made to include a sample that represents the diversity of the community, both demographically and in terms of level of involvement in program activities and program impact.

- What are some action research styles that are particularly useful in collaborative settings?

Action research *(Miller, 1991)* has become quite popular in educational settings over the past several years. It is an umbrella term for a host of activities intended to foster change on the individual, group, organizational, and/or community levels that empowers those engaged in providing professional services and activities to evaluate the effects of those practices and activities and to make desired changes in them. Action research can also be used by individuals collaboratively engaged in various practices and activities. It usually involves interdisciplinary teams that implement interventions and/or activities through recurring cycles of planning, acting, observing, and reflecting. It is a process of self-examination by those involved in the doing. Here are the three general types of action research that have been identified in the literature *(Stroecker, 1999)*:

Technical action research. This involves the active use of a facilitator who leads the participants into exploring some aspect of their practices or activities. The facilitator usually acts as the project director and sets standards by which the outcomes are judged.

Practical action research *(Scherer et al., 1993)*. The participants take a more active role in the process. Outsiders may work with the participants to help them articulate their own concerns, plan strategic action, monitor the action, and/or reflect on processes and consequences. The facilitator's role is to provide a sounding board for the participants to try out ideas and to provide training or technical assistance when requested.

Emancipatory action/empowerment research *(Fetterman, Kaftarian & Wandersman, 1996; Reason, 1999)*. This type of action research shifts responsibility for the process entirely to the participant group. When facilitators do participate, they share responsibility equally with other members. Facilitators act as moderators who help build group understanding of conditions necessary for the action research process. Decisions are made in a democratic fashion and are guided by the participants' criteria for change.

- What are some action research techniques that are particularly useful in collaborative settings? Here are some examples:

    The review of available records, such as school records, police and court records, government statistics, etc. The main advantages of this technique are that:

        It is often a cost-effective way to gather information; and

        It is often a source of very rich and varied information about communities and populations.

    The main disadvantages of this technique are that:

        Sampling bias may be unknown;

        Validity of the information is often impossible to determine because you have no control over the way it was collected and may not even be able to determine how it was collected; and

        Relevance of the information may be a challenge since it may have been collected for reasons not related to the current project.

    Written questionnaires, usually collected from samples of individuals or families within a community or population. Their main advantages are that:

        They are a cost-effective way of gathering information from a large population of respondents; and

        They can be mailed, e-mailed, faxed, or group administered.

    Their disadvantages are that:

        Return rates may be low when questionnaires are mailed necessitating relatively large mailings for the amount of information received; and

        Sampling biases are difficult to control due to potential differences between those who return the questionnaires and those who do not.

    Face-to-face or phone interviews, also usually conducted with a sample of the community or population of interest. Their advantages are:

        More complete, higher quality information than is obtainable from written questionnaires because the interviews are more personal and ambiguities in respondents' answers can be clarified; and

        A random sample is easier to achieve if interviewers are persistent and random replacements are substituted when individuals cannot be reached.

    The disadvantages are that:

        Phone interviews are usually significantly more expensive than questionnaires; and

        The data collection may take considerably more time.

    Focus Groups, convened with samples from the communities or population of interest. The main advantages of this technique are that:

        Focus groups are usually less expensive to conduct than interviews; and

        The group interaction sometimes produces additional information beyond what is obtained from individuals interviewed alone.

The disadvantages of this technique are that:

- Sample bias is more difficult to avoid; and
- Some information may be lost. This is especially true for information that people would be reluctant to divulge in a group setting.

Observations of people or phenomena of interest, usually performed by individuals who are trained in observational recording techniques. The advantages of this technique are that:

- It is often possible to obtain information from people behaving in their natural state; and
- Such information is usually less biased by people's self-protective perceptual tendencies than information obtained in other ways.

The main disadvantages of this technique are that:

- It is usually costly in both time and money; and
- Sampling biases are usually difficult to avoid.

- What are some other significant choices and factors in the evaluation of collaborative, interprofessional endeavors?

Research designs can be either:

- Longitudinal. They follow the same people, communities, or other entities over time; or
- Cross-sectional. They examine data across communities or groups at one point in time.

Measurements of most kinds can vary as to the extent to which they are:

- Structured. They follow a well-defined format concerning exactly how, when, where, and under what conditions they are obtained;
- Unstructured. They follow a flexible format that may be adjusted according to the conditions or surroundings, the community, the population, etc.;
- Open-ended. They allow the respondents great latitude in their answers and responses; or
- Close-ended. They ask for specific, delimited answers (often from a clearly defined menu of choices).

For evaluating collaborative endeavors, measures exist for examining:

- The progress and health of collaboratives including their perceived progress, their similarity of vision, and barriers to their work; and
- The characteristics of service delivery systems including their governance, funding integration, collaboration, comprehensiveness, and other characteristics.

Statistics can be used to:

- Summarize data (e.g. the average);
- Measure how strongly various factors are related; or
- Measure whether relationships, changes, or differences are statistically significant.

Statistical significance means that a finding is unlikely to have occurred by chance alone. The use of statistics helps in deciding when to pay greater attention to a finding in a sample.

- Should findings be presented as aggregated or disaggregated data?

  Aggregated data. These are presented in summary form to give a broad picture of program or client outcomes. Data presented in this way can give an overall picture of program and client-related activities, services, and outcomes without disclosing information about specific clients and programs. For example:

    A demographic profile of active clients;

    Overall changes in knowledge for clients who have completed a health worker training course; or

    The number and types of referrals provided during the last month.

  Disaggregated data. These present information by individual program or client. This is useful for the analysis of specific programs or for tracking the progress of a particular family or child receiving specialized services. To protect a program's or a client's confidentiality, identification numbers are often used instead of names and identifying information may be disguised.

    Programs may use disaggregated data in case planning but use aggregated data when presenting major findings and outcomes to funders and the general public.

    Disaggregated data can be used to present information on subgroups of the population to see if there are differences by age, gender, income level, etc.

- How can qualitative data be used in conjunction with quantitative efforts to evaluate collaborative, interprofessional endeavors?

Qualitative data collection may include information collected by any of the data collection methods outlined above. Questions are often unstructured but center around a general theme or themes. The collection of such data can be used to investigate contextual and extenuating circumstances influencing quantitative findings such as the effect of staff turnover on client satisfaction and outcomes.

Qualitative data collection can also allow for the monitoring of progress towards long-term outcomes where measurable change will not be quantifiable until several months or years after the initial information is collected.

It may be most appropriate to use a combination of methods. For example, efforts to affect systems change on issues related to teen pregnancy prevention in a particular community would probably be best tracked over time by both quantitative and qualitative data, showing interim progress towards long-term outcomes.

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VII. Social Policy Issues

Core Competency – The ability to recognize and acquire the knowledge and skills necessary to understand and/or change social policies across multiple systems that affect children, youth, families, and communities. This includes the abilities to:

- Articulate the history and trends leading to the present integrated services movement;
- Articulate how social contexts and policy affect practice and outcomes for children, youth, families, and communities;
- Maintain awareness of significant changes now pending and their potential impact and ability to generate alternative scenarios for change; and
- Understand how to effectively influence social policy.

Key Knowledge Bases

1. What is the significance of understanding the social context for working collaboratively to provide integrated services for children and families?

   The social contexts and policies have historically played an important role in determining the nature and provision of integrated services in the United States. Understanding them is important for:

   - Understanding the current climate and issues surrounding integrated services;
   - Building effective strategies for:

     Providing these services;

     Changing existing institutional systems to support collaboration; and

     Influencing the development of supportive social policies.

2. What are the significant aspects of social policy that affect services for children and families?

The federal government is the major source of funding for services to children and families and has thus played the dominant role in setting social policy. In addition, social policies with a significant effect on services for children and families may be enacted at the state and local level. Social policies delineate the following:

- The locus of responsibility for providing and funding services to those in need including the respective roles of the federal, state, and local governments and of community-based organizations;
- What services will be provided;
- How services will be provided and by whom, including professional licensing requirements;
- The orientation of these services and their relative emphasis on promotion, prevention, intervention, and crisis response;
- Who is eligible to receive services and how eligibility is to be determined;
- How services are funded. Specifically:
  - The amount of funding relative to the needs of the population;
  - How funding is directed: whether to a specific agency, to a community, to collaborative agency partnerships, to individual providers, or to eligible clients;
  - The amount of discretion in how funding is used at the state and/or local level;
  - Whether funding is provided in the form of categorical or block grants;
  - How funding is allocated (whether as a fixed allotment or entitlement); and
  - Requirements for matching funds at the local or state level.
- How services are evaluated, including accountability for process and results.

3. What are the major problems posed by currently prevailing social policies for collaborative models of service integration and for meeting the needs of children and families?

Problems include the following:

- Crisis orientation. Social policies tend to provide for services that are primarily crisis-oriented. They are designed to address problems that have already occurred rather than promoting activities that would prevent problems from developing.
- Rigid categorization. The current social welfare system divides the problems of children and families into rigid and distinct categories that fail to reflect interrelated causes and solutions. Programs are administered by dozens of agencies, each with separate funding streams and operating with different guidelines.
- Fragmentation. The current system of social services is overly specialized and fails to plan, develop, and implement the comprehensive services that are needed to deal with the complex, multifaceted problems facing families and children today.

- Lack of communication. Communication among various social and education agencies is poor. Separate professional training, specialized vocabulary, and differences in purpose all contribute to keeping agencies that serve the same audience from working together *(Dunkle, 1993; Galvin, 1998; Melaville & Blank, 1993)*.
- Independence of the educational system. A complicating factor for collaboration between schools and other agencies is the political independence that the educational system has historically enjoyed. Whereas a state's human service administrators are accountable to the governor, chief state school officers are not, being either elected by the public or responsible to a state school board rather than to the governor *(Gardner, 1994; 1998)*.

4. What have been the major social influences on social policy and services?

Most historical accounts focus on three major categories of influence:

- Political and social ideology, including attitudes toward the poor, beliefs about the causes of poverty, and attitudes toward the respective roles of community, state, and federal government;
- Demographic factors, particularly the rate of population growth and immigration; and
- Political economy, including levels of unemployment, poverty, and prosperity; industrialization; and war and its aftermath *(Kagan with Neville, 1993; Kagan & Pritchard, 1996; Tyack, 1992)*.

5. How do these influences affect social policy and services?

There are a number of formal means through which government actions, in response to social context and societal pressures, may directly affect social policy and hence what services will be provided as well as to whom:

- Through the introduction of new legislation at the federal, state, or local level which may be directed at mandating services, funding services, or both;
- Through amendments to existing legislation;
- Through regulations that specify how the legislation is to be implemented;
- Through funding for research and demonstration projects and pilot programs; and
- Through court decisions.

6. What are the historical antecedents of the current move towards integrated services as a way of meeting the needs of children and families?

- During the Colonial Period, the English Poor Laws of 1601 set the precedent for community intervention which carried over to the American colonies. Towns and parishes provided support when family and friends could not. During this period, attitudes toward the poor were benevolent, the poor being seen as essentially virtuous but without adequate means to fully support themselves.
- As population and immigration increased, communities lacked sufficient resources to meet the growing needs and turned to the colonial governments to provide support for needy individuals and families.

- With the establishment of the republic, attitudes toward those in poverty shifted. The dependency of the poor became stigmatized. The poor themselves were seen as being responsible for their own plight, prone to vice, and destructive to society. Despite the negative attitudes toward the poor, however, their needs could not be ignored. The volunteer sector began to assume some responsibility for providing support for those in need.
- The period during and after the Civil War was a time of social service expansion. Support for human service institutions increased with the escalating needs of the population as a result of the war, emancipation, and continued immigration. This support was based in part on a sense of social obligation but also on the role that human service institutions played in effectively controlling and segregating the deviant and the dependent from the rest of society.
- The number of service providers increased during this period; and coordination, comprehensiveness, and integration became focal points of concern in state legislatures. State governments set up oversight boards to advise institutions and legislatures.
- Meanwhile, at the community level, settlement houses, which were community-based and comprehensive in orientation, assumed an important role. The first settlement house opened in New York in 1866. Soon afterward, Hull House, one of the most widely known of the settlement houses, opened in Chicago. The settlement houses both pioneered the concept of the multiple service organization and served an important role in advocating a holistic orientation to improving the environment for families *(Kagan with Neville, 1993)*. New forms of social work and counseling were pioneered by reformers working in settlement houses in urban slums.
- Charitable organization societies (COS) emerged in 1877, designed to coordinate the burgeoning number of overlapping sets of charities. The COS's were responsible for introducing two of the primary rationales behind subsequent service coordination *(Kagan & Pritchard, 1996)*:

  Efficiency and minimization of duplication; and

  Effective delivery of multiple services to clients.
- With increased professionalism and the advent of the Progressive Movement (1890-1917), the ideology surrounding the poor changed. Broader social problems rather than the personal failings of those who are poor came to be seen as the primary causes of poverty *(Kagan & Pritchard, 1996)*. Many reformers, however, worked from a deficit model, characterizing those who were poor and/or immigrants as deficient but amenable to "improvement."
- In the late nineteenth and early twentieth centuries, compulsory school attendance and child labor laws brought great numbers of poor, immigrant children into a public school system geared for wealthier classes. Predictably, the failure rates for these new children were high. The deplorable conditions of the public schools and the poor health of the children, coupled with epidemics of small pox and cholera, led to establishment of a variety of school-based health and social services, including nursing services and dental clinics in urban schools. In ghetto schools, some reformers also turned the local school into a social center for children and families in the neighborhood, providing recreation programs, job training, English classes and civic instruction as well as counseling about welfare services. In design and intent, these schools were the forerunners of community schools *(Dryfoos, 1994; Tyack, 1992)*.

- From the beginning, school officials were divided over the mission of schools, a debate that continues to this day. Some took the position that schools should provide only academic learning, while others argued that the public schools should provide supportive health services and, in some cases, social services.
- In response to the Progressive Movement, the federal government became more involved, holding the first White House Conference on Children in 1909, establishing the Children's Bureau in 1912, and increasing support through categorical grants.
- During the period from the 1930's to the 1950's, the role of the federal government continued to expand as needs increased during the Depression and World War II. Additional federal support programs were created that funneled money through the states and led to an intergovernmental partnership to provide social services. Most notably, the Social Security Act of 1935 authorized support for dependent children (Aid to Families with Dependent Children – AFDC), the aged and the blind, as well as for maternal and child health services, child welfare services, vocational rehabilitation, and public health services. Much of the maternal and child health funding was used to set up pre- and post-natal and child health clinics and subsequently became a major source of support for school-based clinics *(Dryfoos, 1994)*.
- During the Depression, the idea of the "community school," first proposed during the Progressive Era as a way to connect schools and communities, began to gain increased attention. In 1934, the Community Schools initiative was launched in Flint, Michigan, with funding from the Charles Mott Foundation, to respond to such problems as poor health, unemployment, and poverty. Community schools stressed the value of community improvement along with projects that engaged children and parents working together *(Dryfoos, 1994)*.
- The 1930's was also a decade during which organizations were greatly influenced by the work of Frederick Taylor and his School of Scientific Management. The resulting emphasis on efficiency led to the consolidation of school districts, which in turn resulted in increasing the separation of school and community and inhibited the expansion of community schools *Galvin, 1998)*.
- In 1939, the Federal Security Agency (later, in 1953, to become the Department of Health, Education and Welfare) was established to house together the Social Security Board, the National Youth Administration, the Civilian Conservation Corps, the Public Health Service, the Office of Education, and the U.S. Employment Service.
- Following World War II, the political and social climate turned conservative, with opposition to government intervention at any level. Many school-based health and social services came under attack particularly by the American Medical Association (AMA), for what they considered opening the door to socialism *(Dryfoos, 1994)*.
- In 1959, Congress established the Advisory Committee on Intergovernmental Relations. However, the federal and state governments continued to work separately with independent spheres of activity. States were largely unable to meet the expectations held for them by the federal government. States also varied in the amount of control they allocated to local government *(Kagan & Pritchard, 1996)*.

- The 1960's was a period of economic prosperity coupled with the Civil Rights Movement and the emergence of a new social agenda. In this decade, federal supports were increased and the War on Poverty was launched.
- As equity issues came to be seen as a pressing national problem, the federal government greatly expanded its role in human services. Included in the legislation passed in the 1960's were:

  The Social Security Amendments of 1962;

  The Economic Opportunity Act and food stamp legislation;

  Title XII (Medicare);

  Title XIX (Medicaid, subsequently including a mandated Early and Periodic Screening, Diagnosis and Treatment Program ((EPSDT)) for all children from birth to age twenty-one in Medicaid-eligible families); and

  Head Start, which was charged in 1966 with creating preschool programs to provide "such comprehensive health, social, educational and mental health services as will aid children to attain their full potential" *(PL 89-794 cited in Zigler and Styfco, 1993)*.

  In the spirit of the times, reformers exerted pressure for inclusion of client families on service agency advisory boards and as workers in schools.
- Between 1962 and 1971, the number of federal categorical grant programs increased from 160 to 500 *(Banfield, 1971 cited in Kagan and Pritchard, 1996)*, mostly as a result of the Great Society Program. In the late 1960's and early 1970's there was also a surge in coordinative and integrative activity in response to the expansion of programs with the recognition that categorical programs were restrictive as well as difficult to coordinate.
- The Economic Opportunity Act of 1964 created Community Action Agencies (CAAs) as the prime instrument of President Johnson's War on Poverty. CAAs were charged with planning locally to cut across community agencies and sectors and implement various linkage strategies. They achieved only limited success. In part this was due to the fact that they were outside of local government, meaning that the poverty programs were disengaged from city hall. In addition, CAAs were often in competition with other established and well recognized planning agencies and organizations such as chambers of commerce, housing agencies, boards of education, churches, and the United Way *(Kagan with Neville, 1993; Kagan & Pritchard, 1996).*
- Title 1 (Chapter 1) of the Elementary and Secondary Education Act (ESEA) of 1965 provided federal financial assistance to local education agencies to improve services for "educationally deprived" low-income children.
- The term "service integration" first came into popular usage in the late 1960's. In reaction to the preceding expansion of categorical programs, the emphasis under the Nixon administration shifted to service integration. The Department of Health, Education, and Welfare (HEW), which housed a vast number of uncoordinated programs, launched a series of research and demonstration efforts at the state and local levels to expand knowledge of how to link services and move toward integrative legislation. Several attempts were made to enact legislation that would support integration across a broad range of programs, including the Model Cities program.

- In 1975, the Education for All Handicapped Children Act (PL 94-142) (now called the Individuals with Disabilities Education Act) was passed. This act guaranteed education and related services to all children from preschool to age twenty-one and set the stage for special education *(Dryfoos, 1994)*. However, attempts by education agencies at the state and local level to work collaboratively with other agencies providing services for the disabled were frustrated. The education agencies, although responsible for implementation, had no authority over these other agencies *(Kagan with Neville, 1993).*
- During the 1970's, the first modern school-based health clinic programs were established in several states but received little support at the state or federal levels. They also met with opposition from both the health professions and the education establishment *(Dryfoos, 1994)*. Declining enrollments, high inflation, and a weak economy gave rise to renewed concerns about efficiency *(Ringers, 1976 cited in Galvin, 1998)*.
- In the mid 1970's, the Special Supplemental Food Program for Women, Infants, and Children (WIC) was created to improve the health of mothers, infants, and children by providing food, nutrition, education, and counseling as well as referral for medical care. This program was to become a major source of funding for services to mothers and children.
- When President Reagan took office in 1980, funding for human service programs, including Maternal and Child Health services, was cut severely. With the 1981 Omnibus Budget Reconciliation Act (OBRA), the federal government converted 77 categorical programs into block grants, some of which allowed for blending different funding sources *(Kettl, 1997 cited in Einbinder, 1998)*. Although the block grants gave greater flexibility to states, the overall level of funding was significantly reduced.
- In the 1970's and 1980's, educational policy shifted from concerns about poverty and equality to academic standards and international economic competitiveness. In 1983, *A Nation at Risk* was published (National Commission for Excellence in Education, 1983), giving rise to a general outcry against the "rising tide of mediocrity" in the nation's public schools. As in the economic downturn in the 1930's, health and social services came to be seen as peripheral to the schools' academic mission. As school budgets were cut, support services were among the first to go *(Tyack, 1992)*.
- Although the argument over the need for and appropriateness of integrating support services at school sites continued, the late 1980's marked a resurgence of efforts to link human services at the federal, state, and local levels.
- In 1983, the federal Child and Adolescent Service System Program (CASSP) was created to assist states and communities in developing systems of care for severely emotionally impaired children and youth (later becoming the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services). The core values and principles of this program promote services that are child centered and family focused, community based, and culturally competent and that include case managers who facilitate coordination and integration of multiple services needed by the child *(Paster, 1997)*.
- In 1986, an amendment (PL 99-457, Part H) to the Education of the Handicapped Act mandated comprehensive multidisciplinary services for infants and toddlers (birth through age 2) and their families *(Kirk et al., 1993 cited in Gallagher, 1996)*.

- The Family Support Act of 1988 created Jobs Opportunities and Basic Skills (JPBS), the success of which depended on the availability of child care *(Zigler & Styfco, 1993)*. Implicit in the act was the recognition that families needed more than just housing or job training to achieve self sufficiency *(Wolch & Walsh, 1998)*.
- In 1988, the Annie E. Casey Foundation provided funding for a "New Futures" initiative, an ambitious program which "sought to encourage a fundamental restructuring of the way communities planned, financed, and delivered educational, health, and other services to at-risk youth" through deep systemic reform *(Annie E. Casey Foundation, 1995)*. This was followed in 1991 by another systems change initiative from the Annie E. Casey Foundation, "Rebuilding Communities," designed to help "transform troubled neighborhoods into safe and supportive environments for children and their families" *(OMG Center for Collaborative Learning, 1997)*.
- During the 1990's, as the economy grew, poverty levels reached record heights and increasing numbers of children were being raised in single parent families or in families in which both parents worked outside the home. The need for child care, affordable health care, and reform in the child welfare system gave rise to a renewed surge of interest in providing services more efficiently and effectively, including expansion of efforts to integrate services.
- By 1991 there were 557 federal grant programs, including 77 for children and families, funded at over $100 million per year. In 1998, the US Department of Education had 90 separate grant programs (most for less than $15 million). On a local level, the Los Angeles Unified School District had 238 separate programs for "at risk" students.
- In 1991, a National Center for Service Integration (NCSI) was established, with grants from the U.S. Department of Health and Human Services and private foundations, to serve as a technical assistance resource and information clearinghouse on service coordination. When federal funding for NCSI ended in 1995, the Child and Family Policy Center, one of the original organizational participants, assumed responsibility for producing and disseminating relevant publications on issues that communities and states face in developing comprehensive, community-based service systems.
- During the 1990's, at least 28 state governments established some type of governance body designed to give greater priority to children and family issues and to promote better coordination among government programs that serve children and families *(Hutchins, 1997)*. Prominent among initiatives currently operating are the Oregon Commission on Children and Families, Missouri's Caring Communities, Kentucky's Family Resource and Youth Service Centers, and California's Healthy Start program.
- In 1993, the Centers for Disease Control and Prevention, the Maternal and Child Health Bureau, the Ewing Marion Kauffman Foundation and the Stuart Foundation sponsored a National Consensus Building Conference on School-Linked Integrated Service Systems, attended by more than 50 national organizations. The report that came out of this conference presents a set of principles for unprecedented collaboration among essential services at the local, state, and federal levels *(Ad Hoc Working Group on Integrated Services, 1994; Kagan & Pritchard, 1996)*.
- In 1994 the Elementary and Secondary Education Act was reauthorized. It allowed schools which receive Title 1 funding when at least 50 percent of the students are low income to merge both funds and programs school-wide. By 1997-98, 17,000 of the 22,000 eligible schools were exercising this option *(Sherman, 1999)*.

7. What are current major initiatives in approaches for integrated services to meet the needs of children and families?

Current initiatives concern welfare, child safety, education and after-school activities:

- In 1996, the U. S. Congress passed The Personal Responsibility and Work Opportunity Reconciliation Act (PL 104-193), also known as the Welfare Reform Act. This act abolished federal guarantees of welfare benefits, establishing in their place a system for Temporary Assistance for Needy Families (TANF). Welfare moved from a focus on child protection to employment and "moral reconstruction" of those in poverty (Finkelstein et al., 1998). States are provided funding through block grants. Eligibility requirements are allowed to vary from state to state, but several conditions were mandated:

  The new law established work requirements for most of those seeking assistance. Those receiving benefits must find employment within two years.

  In addition, a five-year lifetime limit was placed on cash benefits, with the exception of those recipients who are disabled or experience hardships that make it impossible for them to work.

  Teen parents under the age of 18 must be enrolled in school or a GED program.

  Teen parents are also required to live with a parent or guardian until they reach age 18, unless the state deems the home situation is dangerous or inadequate.

  Food stamp funding was reduced. Individuals deemed able to work may only receive food stamps for three months in any three-year period unless they are employed only part-time. If laid off from work, individuals are eligible for another three months.

- Because of a strong economy, many former welfare recipients have been successful in obtaining employment. The jobs they have filled, however, are predominantly low-paying, with the result that family earnings remain below the federal poverty level. A scarcity of quality child care poses other significant problems for many parents.

- The Adoption and Safe Families Act of 1997 (PL 105-89) was enacted to improve the safety of children, promote adoption, and support families going through separation and adoption. In addition to providing funding to prevent child abuse and neglect and to assist families in crisis, the program includes funding for time-limited services such as counseling, substance abuse treatment services, mental health services, and temporary child care as well as transportation to and from these services *(Child Welfare League of America, n.d.)*.

- Within the field of education, several other developments during the 1990s have implications for the future of collaboration and of integrated services. Both nationally and at the state levels there are movements for school choice, including magnet schools and charter schools within the public school system and voucher initiatives which provide public funding for parents to enroll their children in private schools. These alternatives to the traditional neighborhood school may increase (or even require) parent involvement and collaboration with the school, but they may also further remove the school from the neighborhood. As schools become more independent, collaboration between the state and local levels of education may become even more difficult.

- Increasingly, states have put more focus on standards and accountability, moving toward high stakes standardized testing with associated rewards and penalties. As a result, schools feel pressured to focus all their energies on their academic program.
- Although there are numerous models for comprehensive school reform, most focus on curriculum and instruction. However, there are exceptions to this narrow curricular focus in programs that specifically provide school-linked or school-based health and social services, including collaborations between schools and Family Resource Centers that are promoted by a number of states (e.g., Kentucky, Connecticut and Washington). In addition:

    In 1997, the U.S. Department of Education convinced Congress to appropriate funds to create after school programs (21st Century Community Learning Centers) in schools across the country. Funding has increased each year through 2001. These programs provide a variety of school-based or school-linked educational and enrichment programs, and, in some cases, health and social services. Although funding is extended for only three years to any one school, this funding has led to a resurgence of interest in developing Community Schools that offer extended services to children and families.

    The School of the 21st Century developed by Edward Zigler, one of the architects of the Head Start program, transforms a traditional school into a year-round multi-service center open from early morning to early evening to parents and their school age and younger children. In conjunction with the School Development Program developed by James Comer which emphasizes staff support and family involvement, some of the Schools of the 21st Century have become CoZi schools (for Comer/Zigler), combining the two models.

    Many communities are working collaboratively to create new service systems through the development of local governance structures and partnerships among the various organizations and agencies that serve children and families. The goal of this activity is usually to develop a "seamless web" of high quality, comprehensive, continuous services for families and children.

    The drive to improve services to families and children has been joined by community efforts. Attempts to develop more effective interprofessional and agency collaboration are being joined with efforts to increase neighborhood and consumer participation in constructing services and supports within communities.

    Collaborative community endeavors are increasingly being encouraged to gather information and data about communities and to develop measurable outcome indicators and performance measures. Such information can be used to inform and guide community efforts and to hold communities accountable for achieving improved outcomes.

8. How do categorical funding policies affect the integration of services?

Categorical funding restricts the flexibility of agencies. They hamper the ability to engage effectively in integrating services because of differences in eligibility requirements, narrowly defined allowable services, and barriers to blending funding streams across programs and agencies.

9. What are categorical services?

Categorical Services are those with rules specifying such things as:

- Who is eligible to receive services;
- What services may be provided, including who may provide them;
- The amount of services that may be received; and
- For how long people are eligible to receive services.

10. What are the advantages of categorical services?

There are several reasons for defining service program provision along categorical lines:

- Categorical services allow for resources to be targeted to people most in need;
- They give the funder more control over how resources are utilized;
- They enable politicians to demonstrate their commitment to certain needy populations or services (gaining "political credit");
- Interest groups find lobbying for separate programs more effective than generating support for broad-based programs; and
- The importance of certain professional disciplines is often reinforced through a categorical approach.

11. What are the disadvantages of categorical services?

- The bureaucratic structures involved are not well designed to offer human services in responsive ways;
- The unique characteristics and needs of local communities and local populations are not adequately considered;
- The system of services invariably becomes fragmented *(Gardner, 1990):*

  There is little communication among differing provider organizations;

  People are required to go to different locations for each specific service;

  Enrollment criteria are often conflicting; and

  Service delivery is often duplicative in confusing, wasteful ways.

- The resulting services are often not provided:
  - To the right people;
  - In a timely fashion;
  - In the right amounts; or
  - In the most effective manner.
- This often results in:
  - Services being inefficient and/or ineffective;
  - A focus on remediation rather than prevention;
  - A focus on specific problems, rather than on the whole individual;
  - A failure to empower individuals/families to solve their own problems; and
  - Minimal lasting improvements in the lives of children and families in need.

12. What is decategorization?

Decategorization includes the following components:

- It involves removing certain requirements that govern the financing, delivery, and evaluation of publicly-funded health and human services;
- It is usually pursued to organize an intergovernmental initiative or an integrated service program for children and families; and
- It is generally characterized as a "policy option" or a tool for achieving either:
  - Service delivery improvements; or
  - An alternative to a service-based system.

13. How are decategorization and integrated services related?

They are related in several ways:

- Decategorization is not necessary before any level of service integration can occur. Innovative service integration can be achieved without decategorization. However, where categorical services are a significant barrier, decategorization becomes a very helpful tool for advancing service integration.
- Effective service integration does not automatically follow decategorization, which may only open the door for the development of more effective service integration. Thoughtful collaborative efforts are also needed to effectively redefine and integrate services, especially if (as usually happens) other barriers to establishing collaborative, integrated services exist in addition to those created by categorically defined services.

14. How does practice in the field affect the development of governmental social policies?

Health and human service practices affect the development of governmental social policies in a number of ways, including:

- The provision of standards through which social problems and issues are viewed, addressed, and evaluated;
- The highlighting of social issues and problems bringing them into specific relief;
- Identification of possible solutions and courses of action to address social issues and problems; and
- Mobilization of community responses to social issues and problems. The initiation of collaborative community approaches can help produce changes in governmental policies. Political processes sometimes respond more to community-wide manifestations of concern than to the appeals of more narrowly focused individuals and groups.

15. How can practitioners most effectively influence the policy process?

There are a number of suggested approaches, including the following:

- Recognize that politicians have a self-interest in being able to show results within a short time frame (i.e., before the next election), and they want to attribute results to program activities. Anticipate the information they will need to present a persuasive case to their constituents;
- Be sensitive to the current political climate, considering both supportive factors and barriers to policy change and implementation;
- Develop a clear, understandable proposal for addressing the issue. Make clear what the objectives are, how the proposal will meet these objectives, how these objectives will be measured, what are interim benchmarks for evaluating progress, the timeline of activities, and procedures for outcomes measurement. It is critical that definitions are clear and that the logic linking proposed activities with desired outcomes is easy to follow;
- Make clear how your proposal fits with existing research on effective strategies and outcomes;
- Use the media to your advantage in demonstrating needs and successes and to build public interest and support;
- Network with influential members of the community to enlist their support;
- Mobilize community members and recognized experts to support your proposal;
- Work with advocacy organizations to enlist their support in lobbying efforts;
- Work with professional organizations, particularly those that serve as accrediting bodies for their members, to make accreditation standards more clearly supportive of collaboration across professions and organizations; and
- Be patient, but persistent *(adapted from Zervigon-Hakes, 1998; see also Kagan & Pritchard, 1996)*.

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