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The dynamics of program development: A case study in urban mental health services

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THE DYNAMICS OF PROGRAM DEVELOPMENT: A CASE STUDY IN URBAN MENTAL HEALTH SERVICES

by

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Abstract

THE DYNAMICS OF PROGRAM DEVELOPMENT:
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by

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Advisor: Professor William Kornblum

This study describes the planning, development and implementation of the on-site school mental health program, an innovative mental health services program for schoolchildren in New York City. The program, developed jointly by the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services and the New York City Board of Education in 1982, was fully implemented in 1986. This study uses data gathered via the method of participant-observation (the author was employed by the Department of Mental Health), supplemented by the review of documents and discussions with key individuals.

The study begins by providing background on the two key organizations and their relations prior to the initiation of program planning. The study then goes on to describe six discrete stages of the program's development; these stages are punctuated by "decision points."

The first three stages of the program's development

reflect macro-implementation at the Citywide level. Micro-implementation, which occurs in the individual school districts and schools, takes place in stages four, five and six (though macro-implementation does not completely end), as the program is established in seventy schools in nineteen community school districts.

Through this description and analysis of the six stages of program development, the study explores the political and organizational issues which affected the planning and implementation of the program.

The insider's view of the program also provides insight into the inner workings of public sector program development, illustrating the following: the inter-organizational and political problems raised by jointly developed programs; the ability of Budget agency officials to influence program development; and, the effectiveness of committed individuals within the educational and mental health services system to establish a program, however modified from its original conception.

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To many other people within the Department of Mental Health, the Board of Education, and the community mental health agencies involved in planning and implementing the program, I owe an enormous debt of gratitude, and hope that I have represented their efforts respectfully. I especially thank Don Holford for sharing his insights into the workings

of City government. And I wish to acknowledge the continuing efforts of mental health and education staff who work daily to ameliorate the mental health problems of the children of New York City.

Finally, I am grateful for the tremendous emotional and editorial support provided by Janice Eidus, to whom the dissertation is dedicated.

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I. INTRODUCTION

During the last two decades a great deal of attention has been focused, in New York City and other urban areas, on improving the quality of mental health services for children. Numerous reports of Federal, State and local commissions attest to this concern (Joint Commission, 1969; President's Commission, 1978; New York City Department of Mental Health, 1982; Knitzer, 1982; New York State Office of Mental Health, 1984). Along with recommendations to increase funding for programs for children have come demands that services for children be better organized, and that services which are provided under a variety of auspices be linked and coordinated. In particular, schools have been a focus of these recommendations, since nearly all children have some contact with schools. In response to recommendations for increased services, as well as for "service integration," (see Weiss, 1981 for a critical view), both public and voluntary non profit providers have responded.

NEED

The need for publicly supported and accessible mental health services for children and adolescents is particularly great in New York City, with its large concentration of poor and minority children. In 1982, the New York City Department of Mental Health (1982), using a conservative figure of 8% as a prevalence estimate for childhood mental health disorders, found that only 45,000 of an estimated 141,000 children in need of services were receiving such services. And, Knitzer (1982), wrote that, nationwide, "of the three million seriously disturbed children in this country, two thirds are not getting the services they need. Countless others get inappropriate care" (ix). A more recent report by a Committee of the Institute of Medicine (1989) used a prevalence figure of 12%, and emphasized that "childhood mental disorders are serious, persistent, and lead to suffering for the children and their families. Mental illness in childhood is also costly and a burden to society, which must care for children and deal with the results of their difficulties in school and other social systems" (33).

Delivering mental health services is often as much an organizational problem as a clinical problem. One of the virtues of addressing the need for services for children through school-based interventions is that the children are already in school; therefore, teachers and other school personnel can observe the children on an ongoing basis.

Their behavioral impressions, coupled with information on school performance (while not providing a psychiatric diagnosis) can be useful in identifying that a problem may exist (Kriechman: 1985). Based upon this information, a referral to a mental health professional can lead to the assessment of a particular problem or set of problems, which may lead to the formulation of a diagnosis and treatment plan. Often, emotional problems are linked to physical health problems. Emotional problems also are frequently exacerbated by poor housing, poverty, chaotic family situations or other stress factors. And educational problems of the sort that lead to special education placement may coexist with emotional difficulties, such as conduct disorders.

According to information provided in an evaluation report of the program I will be discussing, the sorts of behaviors exhibited by the children who received treatment in the program included physical aggression and verbal acting out, destructiveness toward property, lack of effort in the classroom, display of poor self-image, and extreme sadness. Depending on the intensity, severity, and etiology of these behaviors, they can be associated with serious emotional disorders (Garfinkel, Carlson, and Weller: 1990: passim).

A SOCIOLOGICAL CASE STUDY OF INTERORGANIZATIONAL COORDINATION

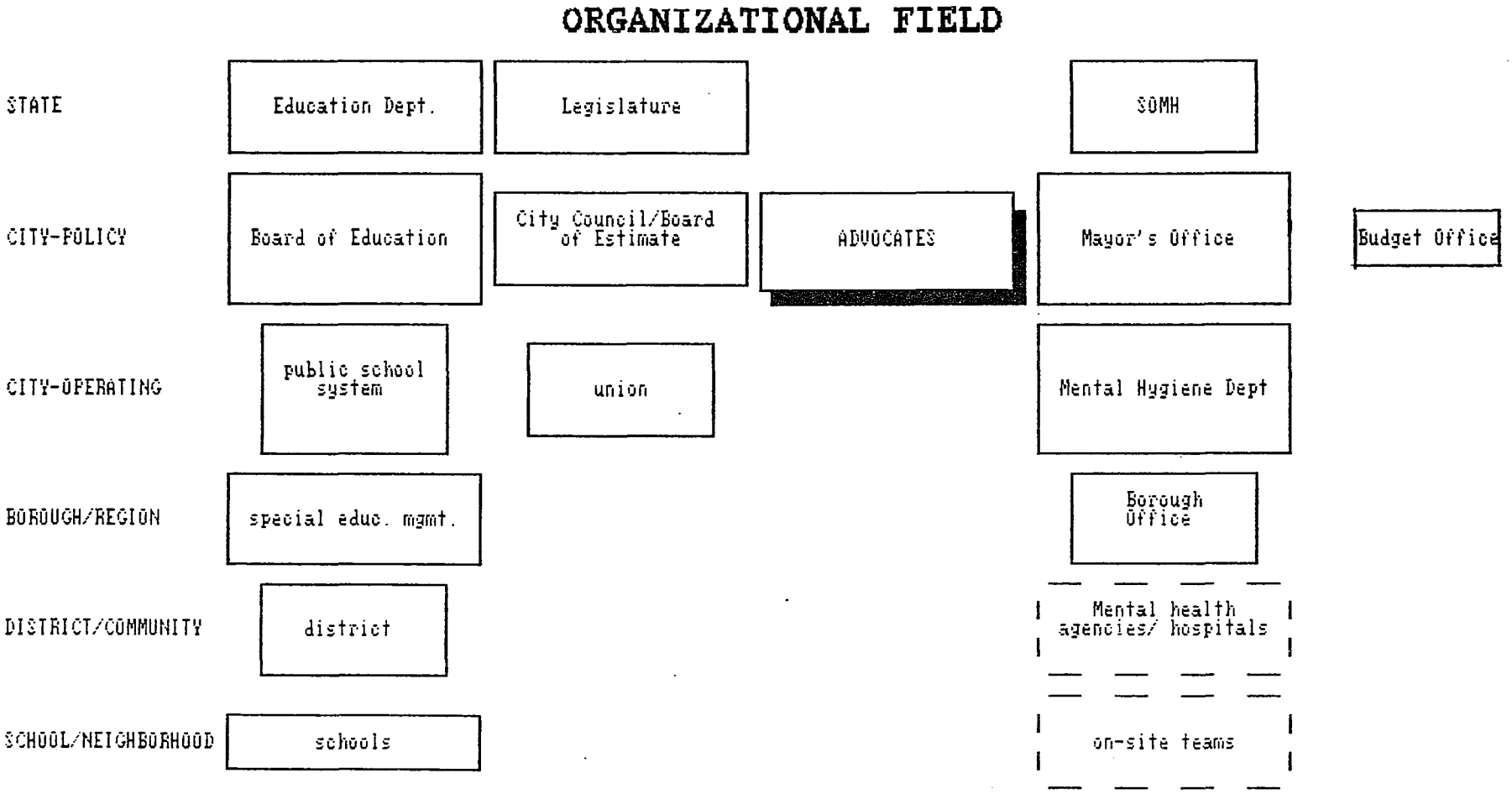
This study describes the planning, development and implementation of a mental health program for schoolchildren in New York City, the "on-site school mental health program." The program is the result of collaboration between the New York City Board of Education ("Public Schools") and the New York City Department of Mental Health, Mental Retardation and Alcoholism Services ("Mental Hygiene Department"). The program, which is currently operating in approximately 70 schools in 19 school districts throughout New York City, involves the delivery of mental health services to school children in public school buildings by the staff of voluntary non-profit mental health agencies and voluntary and municipal hospitals which are under contract with the New York City Department of Mental Health, Mental Retardation and Alcoholism Services.

Because this program was developed jointly by two municipal agencies, coordination and cooperation were significant concerns, both during the planning of the program and during its implementation in the schools. Studies of urban decision-making and program development have explored and demonstrated the difficulty of getting things done within just one organization (Yin and Yates, 1975; Yin, 1979; Nelson and Yates, 1978; Bardach, 1977); when two or more organizations are involved, the difficulty can increase significantly (Pressman and Wildavsky, 1973).

When one organization tries to collaborate with another, the standard operating procedures, vocabularies, and institutionalized patterns of each organization, normally taken for granted by those within the respective organization, are thrown into relief and often called into question. Novel problems arise which require novel responses. Also, each organization has a different stake in the program; what may be a high priority for one organization may be less significant for another. And, because organizations are not similarly structured, the units in each organization which have responsibility for the program may not be equivalent. Thus, relative power, authority, resources and responsibility may differ. All of these factors can influence the course of program development and implementation, affecting both the program's ultimate design as well as its chances for success.

This study is concerned with how the innovative on-site school mental health program came to be, how it changed as the result of the respective goals and input of members of different organizations, and how its implementation occurred within a complex multi-organizational environment. (Table 1 provides a graphic portrayal of the organizations involved.) In addition, I intend to render an in-depth portrait of the interplay of the political, organizational, and professional

TABLE 1


ORGANIZATIONAL FIELD
STATE
CITY-POLICY
CITY-OPERATING
BOROUGH/REGION
DISTRICT/COMMUNITY
SCHOOL/NEIGHBORHOOD
Education Dept.
Legislature
SOMH
Board of Education
City Council/Board of Estimate
ADVOCATES
Mayor's Office
Budget Office
public school system
union
Mental Hygiene Dept
special educ. mgmt.
Borough Office
district
Mental health agencies/ hospitals
schools
on-site teams

forces which occurred during the planning and implementation of the program. This will be done by discussing and analyzing six stages in the program's evolution, all of which are marked by major decision points (Pressman and Wildavsky, 1973). These decision points are defined as "each time an act of agreement has to be registered for (the) program to continue" (Pressman and Wildavsky, 1973: xiv). While the term "decision point" does not suggest it, this registering of agreement can be rather protracted, and the course is not necessarily a linear one with predictable movement from disagreement to agreement between parties (Berman, 1978: 167). Rather, unpredictable "urban decision games" and "game playing" (Yates, 1977:142) are more likely. Further, "... urban games are highly unstable because different players, issues, and problems combine in an unpredictable way to produce a barrage of demands that urban policy makers must constantly react to. ... I suggest that the players in urban decisions do not follow established, stable rules and rituals..."(144). Table 2 displays the major participants arrayed by stage and organizational level.

It should be noted that the decisions themselves are not the sole focus of the study; in fact, they function more as punctuation, than as nouns and verbs. Rather, it is the "action" or "process," and the social context within which they occur, which is of primary significance (Harmon, 1989).

Key: MHD=Mental Hygiene Department
PS= Public Schools (Central Offices)
SOMH=State Office of Mental Health
OMB=Budget Office
UFT=United Federation of Teachers
MHD BO=Mental Hygiene Department Borough Offices
DAS/SE=Deputy Assistant Superintendents for Special Education
MH agencies=Free-standing community mental health agencies hospitals
COH=Committee on the Handicapped
SBST=School Based Support Teams

TABLE 2

MAJOR PARTICIPANTS, BY STAGE AND ORGANIZATIONAL LEVEL

One	Two	Three	Four	Five	Six
CITY MHD PS SOMH City Council President Advocates Mayor's Office	MHD PS	OMB MHD PS Advocates	MHD PS OMB UFT Mayor's Office	MHD PS UFT OMB Mayor's Office Board of Estimate	MHD PS OMB UFT Mayor's Office Evaluator SOMH
BOROUGH			MHD BO DAS/SE	MHD BO DAS/SE	MHD BO DAS/SE
DISTRICT/ COMMUNITY			MH agency	School Dist. Supt. MH agency UFT COH	MH agency Supt. UFT COH
SCHOOL SBST MH Agency/ Hospital				principal	principal guidance counselor SBST MH agency teachers students parents

This is consistent with Harmon (1989) who writes that "decisions are not objectively real but are objectifications of the ongoing flow of social process. Informally, decisions may be thought of as "stopped processes" (p. 146).

In addition to organizing the study by using stages and decision points, I have borrowed and adapted Berman's (1978) distinction between micro and macro implementation. He uses this distinction to develop a framework for studying how federal policies -- and the programs developed from these policies -- were put into action at the local level. Macro-implementation is the execution of policies (often, but not exclusively developed at the federal level) "to influence local delivery organizations to behave in desired ways" (164). Micro-implementation is the response of local organizations, as reflected in their carrying out of these policies (164). Berman says that "essential differences between the processes of micro-implementation and macro-implementation arise from their distinct institutional settings. Whereas the institutional setting for micro-implementation is a local delivery organization, the institutional setting for macro-implementation is an entire policy sector..." (164). Berman does not define "institutional setting" precisely, indicating that it may range from "a formal organization ... or part of one" to "the complex set of interrelated organizations and actors that make up a national policy sector" (162). The important

thing is that "a policy's implementation problem derives not only from its design; it derives from the policy's relationship to its institutional setting" (159).

The impetus for this program came in 1981 from City and State mental health officials, and from the public school administration. All were dissatisfied with the way the public schools were providing mental health services to school children, and were cognizant of the need for additional services for children and adolescents. At that time, both the State and City mental health departments were providing funds to the Public Schools; these funds were provided in order to enable school personnel to refer some children with a need for mental health services to community mental health agencies, while other children would be served by clinical staff employed by the Public Schools. However, a study carried out in 1982 by the Public Schools and the Mental Hygiene Department revealed that, in fact, few children were being referred by school personnel to community mental health agencies.

In addition, the school system was faced with the problem of providing legally mandated special education services to a growing number of school children, and there was great pressure from the City's Budget Office to keep the cost of these services down. And, also, in 1982, a new schools chancellor, Frank Macchiarola, expressed his openness to the idea of outside agencies coming into the

schools to provide mental health services to children who were not necessarily enrolled in special education. While this had been suggested by the Mental Hygiene Department in the past, it had never been well-received, largely because the teacher's union, which also represented school social workers and school psychologists, had always voiced its opposition to such a proposal.

Therefore, in 1982, the two agencies began to plan a more effective program, one that would involve community mental health agencies more actively with school personnel. Two things were clear from the outset: a program had to be designed whose policies and procedures were compatible with the routines of two large, complex, and heavily regulated bureaucratic systems -- the Public Schools and the Mental Hygiene Department -- and, when this was not possible, that one or the other, or both, had to be willing to accept a change. Changes from standard operating procedure for either of the two organizations, however, often required legal or administrative approval. In addition, sometimes the approval for such changes also had to come from outside parties who often wished to maintain the status quo. Even relatively minor matters might require protracted discussion, negotiations, and justifications.

An initial proposal for the program, prepared jointly by staff of the two agencies, was completed in February 1983. Then discussions continued which resulted in a

revised proposal in September 1983. The proposal described a plan to establish mental health clinics in selected schools which would be operated by community mental health agencies in contract with the Mental Hygiene Department. Teachers and other school personnel would be expected to make referrals to the clinics of children who appeared to need mental health treatment.

Since the proposal involved resources being shifted from one municipal agency to another (the funds available for the program were at the time being expended to fund staff within the Public Schools who assessed children for special education placement), the City's Office of Management and Budget (Budget Office) had to approve the plan. The Budget Office reviewed the proposal and expressed its concern that any such plan provide a cost-effective alternative to special education services. Thus, it requested modifications to the proposal.

It was not until February 1984 that implementation of the program could begin, after the proposal was modified to gain approval from the Budget Office. Further, even after agreement on program design, policies, and procedures had been reached by central office personnel, individual school district officials had the authority to refuse the program as well as to impose their own modifications.

In spite of these obstacles a program was eventually established. the implementation took a great deal of time

and required the efforts of many deeply committed individuals. While implementation could begin once the Budget Office gave its approval in February 1984, the modifications requested by the Budget Office resulted in the Public School and Mental Hygiene Department staff having to reformulate many aspects of the program. The Budget Office wanted the program to serve as an alternative to special education placement or to serve as a way out of special education for children who could be decertified from special education. The Budget Office also demanded that an evaluation of the program be carried out to determine if the program was reducing special education referrals. The original conception of the program had been to provide mental health services to all children who might require them, without any categorical requirements. While such a program would have been difficult enough to implement and would have encountered opposition from the teachers union, one geared specifically as an alternative to special education was more complex and more likely to create friction in the schools.

The first steps to implementing the program were to identify the schools and mental health agencies which would participate. In the Spring of 1984 an initial group of five school districts were identified for implementation, in what became known as Phase One. Three or four schools in each district were chosen, with the hope that the program could

be started by the end of the school year. Meanwhile, mental health agencies were being identified to provide services in these districts. Simultaneously, fourteen more districts, Phase Two, were being identified for subsequent implementation, as were corresponding community mental health agencies. At the same time, the staff of the Public Schools and the Mental Hygiene Department were developing policies and procedures for the program's operation. These often had to be revised based upon feedback from the school district officials who were approached about the program.

It took almost two years for the program to be fully established. Each step of the way, in each school district and each individual school, there were administrative obstacles to be overcome, relationships between school and agency staff to be built, and procedures to be refined. Space had to be located for the program to operate. The search for space began anew each September in many of the schools. Also, teachers had to be reoriented to the program each year and caseloads had to be built up, since the turnover of both teachers and students in the schools is quite high.

However, in part due to persistence and commitment, the program was sustained, and was viewed by many observers as a success. For several years the Commissioner of Mental Health had to fight to keep the program in the budget,

since, at first the evaluation was delayed, and then its results were inconclusive, which led the Budget Office to challenge the program's continuation. But the program had its supporters, both in the education and mental health advocacy and provider communities, and thus its future became more secure.

ISSUES IN PROGRAM DEVELOPMENT

This study examines the development of the on-site school mental health program by looking at the different players and influences involved in its planning and implementation. I have identified six stages in the program's development during which various organizations had to reach agreements for continued development, and I have separated and marked these stages by "decision points," as follows:

Stage 1: Recognizing the Need for a New Approach

Decision Point 1: The Public Schools and Mental Hygiene Department Agree to Design a New Program

Stage 2: Planning a New Approach to School Mental Health Services

Decision Point 2: The Public Schools and Mental Hygiene Department Agree on a Program Design

Stage 3: Fiscal Constraints on Implementing A New Approach

to School Mental Health Services

Decision Point 3: The City's Budget Office agrees to the Program

Stage 4: Obstacles to Implementation: Competing Interests and Issues

Decision Point 4: Concerns Raised by The Teacher's Union are Successfully Addressed

Stage 5: Selling the Program to School District Superintendents

Decision Point 5: School District Superintendents Accept the Program

Stage 6: Micro-Implementation

The successful movement from each stage to the next was a protracted process, often resulting in program design adjustment or modification (Table 3 is a timeline of the program's development). Through the description and analysis of these events and processes, this study will provide insight into the decision-making process of the on-site school mental health program, in particular, as well as insight into urban decision-making processes, in general.

Two processes or phenomena stand out. One, which I refer to as the fiscalization of social policy, is reflected in the Budget Office staff's ability to reshape the program, based upon its own fiscal priorities. The other is the ability of individuals within the agencies, in spite of the

TABLE 3

TIMELINE OF PROGRAM DEVELOPMENT AND IMPLEMENTATION

MACRO-IMPLEMENTATION

STAGE 1	STAGE 2	STAGE 3	STAGE 4
1980 BOE Bureau of Child Guidance restructured into SBSTs	**September 1982** BOE and DMH staff begin to develop proposal for a program of mental health services in the schools	**October 1983** Budget Office reviews proposal and requests modifications; so begins a protracted series of meetings and proposal revisions; Budget office wants program to reduce special education referrals	**March 1984** Selection of agencies and school districts begins; Guidelines for program operation drafted for review; Meetings with Phase One school districts and agencies in preparation for program start-up in current school year
BOE and DMH begin effort to increase referrals from schools to community mental health agencies	BOE and DMH review previous year's effort to encourage referrals from schools to community agencies and are disappointed	Budget Office and School officials also meeting about special education budget	**April 1984** Meeting of advisory group including Central Office and district school officials; concerns about program heard from union officials

1981 State Office of Mental Health refuses to provide State fiscal aid until BOE improves accountability for mental health funds supporting SBSTs	**February 1983** First proposal presented for review by agencies' leadership	DMH carries out study of emotionally disturbed children in existing child mental health program to demonstrate similarity with special education population	**April 1984** Decision Point 4: Union officials drop opposition to program in exchange for greater input into district selections; presence of union at organizational meetings; liaison with SBST to be included in program design
City Council President Bellamy issues report critical of both Schools and DMH in regard to mental health services for children	**April 1983** School Chancellor Macchiarola resigns	**February 1984** Budget Office agrees to revised proposal and requires an evaluation of program for continued funding past 1984-85 school year	
April 1982 Decision Point 1: Schools Chancellor and Mental Health Commissioner agree in principle to establish mental health services in schools	Work continues to revise proposal; community mental health agencies would establish clinics in schools and schools would assign school liaisons to work to encourage referrals		
	September 1983 Decision Point 2: Proposal sent to Budget Office for review and approval to move funds from Schools to Mental Health Budget		

TABLE 3
(cont.)

MICRO-IMPLEMENTATION

STAGES 5 & 6

March 1984 Meetings in each school district begin; negotiations with specific mental health agencies, as well. Policies and procedures presented to local school personnel; modifications made.
June 1984 Phase One programs (five school districts) established. Space is found, in some cases, after delays. Issues such as telephone installation, security arrangements, etc. begin to addressed. Some referrals for summer programs.
September 1984 Beginning of school year provides opportunity for initiation of formal referral systems in Phase One districts; Phase Two programs begin to become established.
September 1985 After long delay, formal evaluation of program commences. Data collected both through agency databases and through questionnaires and interviews with teachers, guidance counselors, mental health workers, and others.
January 1986 Decision Point 5: Programs established in all nineteen districts and two high schools
November 1986 Draft of evaluation report completed. After review by City agency staff, changes made. Results inconclusive on question of impact on special education rates.

obstacles and organizational inertia, to persevere and establish the program, however compromised the final plan was from the original programmatic conception. And, in fact, at the level of micro-implementation within the schools, the program almost certainly was able to help many of the same children it had been initially intended for.

This study is also intended to contribute to a greater understanding of the functioning of urban educational and mental health services organizations. In addition, since this study will show how public policy development, planning, and implementation are "inevitably conjoined" (Yates, 1977:xiii), it can also serve as a guide to those who intend to develop and implement programs designed to provide services to children, especially to those designing programs requiring the involvement of more than one organization.

Because organizational prerogatives may come into conflict, organizations can be especially resistant to program changes that are proposed by other organizations or require involvement with other organizations (Miller, 1958; Gray, 1985). Sometimes, as a result of such resistance, the organizations fail to establish the programs, and, almost always, the final product is different from the policy makers' and program planners' original conception (Pressman and Wildavsky, 1973; Warren, et al., 1974; Hayes, 1982; Kelman, 1987). Not surprisingly then, in the case of the

on-site school mental health program, both the planning and implementation of the program did involve a great deal of conflict, negotiation, and compromise. And the program, which began as what Kelman calls a "policy idea," required a great deal of time and energy to become a "real world outcome" (Kelman, 1987).

The decision-making process was quite elaborate, especially in comparison to the relatively small amount of funds involved. Planning and decision-making included the two primary participating municipal organizations, the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services, and the New York City Board of Education. In addition, other organizations were involved, including New York City's Office of Management and Budget (Budget Office); the Mayor's office; the United Federation of Teachers (UFT); the community school districts; the community mental health agencies and hospitals; State regulatory and funding authorities, including the State Office of Mental Health and the State Department of Health; and other organizations with a stake in the program. Along the way, "political choices" (Kelman, 1987:6), "program production" (or implementation), (7) and "final governmental action" (7), all contributed to the outcome. Also along the way, different players contributed to the outcome, advocating for their own organizational priorities, while interpreting policies and plans through their organizational

"world view." And, over time, policy makers' views changed, so that the already planned program was modified to meet new and changing priorities.

Of much more than academic interest are the issues of how things get accomplished, and why things do or do not get accomplished, especially when the "things" are public (Williams, 1982:vii). As the public sector has grown, and as more and more is expected of it, there has been greater scrutiny of public programs. Also, during the present decade, there has been increased questioning of the efficacy of government efforts to ameliorate problems. Such efforts have been under intense scrutiny (e.g., submitted to cost benefit analyses and other exercises of accountability), from within the public sector itself, as well as from the public-at-large. This has been especially true in New York City ever since the fiscal crisis of 1975. As program development supported by public funding has increased, a number of case studies of policy-making and program implementation within the public sector have been conducted; these studies describe how policy choices are made and how these choices are translated into programs.

The case study approach is especially well-suited to research on the policy implementation process. In The Implementation Game, Bardach (1977) described the types of "games" that are likely to be played by the various players and which can strain and block the implementation of even

the most well intentioned programs, at both the State and Federal levels. Bardach, a proponent of the case study approach, writes, "the political and institutional relationships in an implementation process on any but the smallest scale are simply too numerous and diverse to admit of our asserting lawlike propositions about them. It is the fragmentary and disjunctive nature of the real world that makes a 'general theory of the implementation process' (which has been urged upon me by some readers of the draft manuscript) unattainable and, indeed, unrealistic" (57).

Other writers have also cautioned against grand theorizing and recommend the case study approach in order to understand the implementation process (Nelson and Yates, 1978; Palumbo, 1985). Palumbo (1985), for instance, points out that the sort of rationality employed in implementation is usually "retrospective," rather than prospective. That is, a sort of trial and error approach is employed in successful implementation, and it is only in retrospect that the organization involved can develop the rationale for why things turned out the way they did. Mintzberg and McHugh (1985) concluded that this retrospective understanding of the implementation process can be gained only through the case study approach because this is the only approach that provides a close enough view of the organization.

While each level of government is fraught with problems, city government tends to have particularly

distinctive ones, associated both with the structure of decision-making and the types of problems it characteristically deals with (Yates, 1977: 9). Also, municipal government, more than federal or state government, is on the front line in dealing with difficult problems. According to Yates, "...urban policy making takes place in a political and administrative system that is fragmented to the point of chaos..." He characterizes this as "street-fighting pluralism," which is a "pattern of unstructured, multilateral conflict in which many different combatants fight continuously with one another in a very great number of permutations and combinations" (34). Also, issues often take on symbolic dimensions (120), with meanings and associations beyond the issue at hand. For example, political opponents can transform a strike, a school closing, or a building project into a major confrontation along neighborhood lines, or along racial, ethnic, or class lines. Yates (125) gives the example of the New York City transit strike of 1966, in which Mayor John V. Lindsay "pushed the conflict into a symbolic plane by defining it as one between the power brokers ... and the public interest. Not to be outdone, Mike Quill [the union leader] retorted that the conflict was really between the upper class elite and the little guy." Such symbolic associations can transform an issue so much that the political battles being fought by the various players become

"zero sum games," in which victory for one side implies defeat for the other, with compromise often impossible. While tangible resources can often be divided, symbolic ones are not so divisible (Yates, 1977).

In addition, when city government attempts to carry out decisions, many service delivery issues are raised. "Reliable answers do not exist for many of the city's most pressing problems, and, seen in this light, the erratic search for solutions that has characterized urban governance is perhaps easily understood" (Yates, 1977: 79). Service delivery organizations possess different institutional histories, as well as different structures and cultures. Also, public organizations, at least, often have their own "street level bureaucracies" (Lipsky, 1980; Yin and Yates, 1975), which refers to the representatives of governmental organizations who have direct interaction with citizens, such as police and fire personnel, teachers, and caseworkers.

In addition to the political dimension which influences the course of all public programs, studies have demonstrated that there exist certain organizational factors which influence inter-organizational relations, and, therefore, the course of public programs, as well. Many of these studies have been conducted within the human services field (Morrissey, et al., 1981). Among the factors which have been shown to influence the level and quality of interaction and

cooperativeness among service organizations are the following: institutional philosophies (Miller, 1958); resource needs and requirements (Levine and White, 1961; Levine, et al., 1963; Aiken and Hage, 1968); and, the presence or absence of an "institutionalized thought structure," (Warren, et al., 1974) (i.e., a shared view of the problem to be addressed, a shared view of the strategies for solutions, and an implicit understanding of the participating organizations' turfs and boundaries).

Further, as Hall (1986) points out, human service organizations, especially, are staffed by professionals from various disciplines, each discipline with its own vocabulary, technology, professional orientation and philosophy, and turf. The relations among members of professional groups can affect the relations of the organizations within which the members of these various groups work (154). Finally, organizations have a cultural dimension, and can be characterized as systems of symbols and meanings (Smircich, 1983; 35). Some studies have explored the multi-cultural character of single large organizations, identifying subcultures, occupational communities and other cultural units (Gregory, 1983; Riley, 1983), all of which, individually, possess their own systems of symbols and meanings. Cultural differences across organizations are likely to be even more pronounced (Pettigrew, 1983; Smircich, 1983). The various pushes and

pulls among groups can contribute to the chaotic nature of urban policy games (Yates, 1977).

My case study of the development and implementation of the on-site school mental health program will (similarly to the studies described above) explore a variety of issues, including the following: inter-organizational relations; organizational culture; professional relations; political decision-making; and, implementation. Some of these issues were most significant during one particular stage in the development of the program, and others were significant throughout all of the stages. For example, during the earliest planning stages, the focus was on political decision-making at high levels of municipal government. And, during the later stages, when the program was being established in schools, the organizational culture of schools and mental health agencies became of greater concern. Finally, throughout the entire planning and implementation process, interorganizational relations was a key focus.

In the following chapter, I will describe the methodology of the study, and discuss some methodological issues raised in a study of this type. In the chapter following that one, I provide some background on the history and structure of the Public Schools and the Mental Hygiene Department, as well as on school mental health services, in particular. Then, in the six succeeding chapters I will

describe the six stages and decision points, which will trace the history of the program's development. Finally, in a concluding section, I provide further discussion and suggest areas for further study.

II. METHODOLOGY AND METHODOLOGICAL ISSUES

IDENTIFYING THE RESEARCH TOPIC

This research project emerged from my experience -- beginning in 1983 -- as one of the program planners at the Department of Mental Health working to develop and implement the on-site school mental health program. I was both a participant and observer, and as Yin (1982) points out, "the opportunity for participant observation in an implementation experience must be considered rare. [The participant can] interpret key events in a manner that extends beyond the available documentary evidence"(47). I found that, also, because of my insider knowledge, I knew which other participants could provide additional information and different perspectives, as well as which written materials could contribute to the "credibility" (Guba, 1981) of the analysis.

This research is an example of what Riemer (1977) calls

"opportunistic research," in that an occasion presented itself in the course of everyday life which was suitable for research (see also Krieger 1985, who writes of beginning research "unwittingly"). Riemer (1977) identifies three varieties of opportunistic research: taking advantage of unique circumstances or timely events; taking advantage of familiar social situations; and, taking advantage of special expertise (469-472). This study combines all three varieties, since I was in the right place at the right time, with appropriate skills and professional perspective. Rather than participation presenting merely a problem of bias, Riemer suggests that it can be a benefit to what he refers to as, acknowledging C. Wright Mills, "the sociological imagination" (468).

As part of my job, I participated in the planning and implementation of the program. This included comparing different service program models, reviewing rules, regulations and statutes, writing proposals, correspondence and requests for proposal, developing budgets, staffing patterns, and policies and procedures, and attending a tremendous number of meetings at which the content of these were discussed. At the same time that I was involved in these activities as part of my livelihood, I was trying to make sense of what I was observing and participating in. Again, I was able to draw upon both my prior employment experiences and my academic training, in order to be more

effective in carrying out these responsibilities. In addition, my intellectual curiosity about the nature of organizations and organizational change had been piqued. My academic experience at that point included a Masters degree in Anthropology and some course work for the doctorate in Sociology. Relevant work experience included applied social research and policy analysis for the New York State Council on Children and Families (a State government agency concerned with children's social welfare issues), admissions and recruitment administration in a New York City public alternative high school, and public and private secondary school teaching in New York City and Albany, New York.

As I continued working on implementing the program, I began to recognize that my vantage point provided an opportunity to document the development and implementation of the program in some detail. I also learned that this was a relatively unusual opportunity and that there was a need in the field of Sociology for greater knowledge and understanding of program implementation. In addition, there were relatively few glimpses into the political and organizational life of public administrative agencies, and there was a need for greater information in this area (Viteritti, 1990).

I found that participating in the design and implementation of the program engendered a deep level of commitment. At the same time, effective functioning in a

large and complex municipal bureaucracy involved my constant awareness of diplomacy, compromise and caution. Since the objectivity of a participant observer can be challenged, Yin (1982) advises the use of different kinds of information, which can help bolster an argument. In particular, he mentions documents as a "rich source of information" (47), and I have, in fact, utilized numerous public documents and internal documents, as well as studies of specific organizations, such as the Board of Education, the mental health system, and other organizations involved in this study. My use of these documents is intended to expand and support my narrative, as well as to provide historical information to establish a context to describe the program. Also, these documents were invaluable in enabling me to describe significant events connected to the on-site school mental health program's development which occurred prior to my employment at the Department of Mental Health. In addition, I hope, as Viteritti (1983) phrased it, regarding his own study of the New York City Public Schools, (which was based on his years as a special assistant to the Chancellor), that, "whatever objectivity [is] sacrificed by familiarity can be offset by the insights allowed through proximity" (vii).

Having recognized that I had a unique vantage point from which to observe the program, and also recognizing that this vantage point provided the basis for a potentially

interesting Ph.D. dissertation, I gradually expanded my involvement in the program from that of a participant to that of both a participant and a participant-observer. I emphasize the distinction, because, unlike in some other instances of participant-observer research where participation follows the assumption of the observer role (Jorgensen, 1989: 20-22), in my case, the research role followed the participant role. Also, in my case, the research role never predominated, since I continued to be active in the planning and implementation of the program I chose to study. And, during my tenure at the Department of Mental Health (April 1983 to June 1989), I assumed increasingly responsible positions, moving from planning analyst to senior planning analyst, then to Assistant Director of the Office of Planning and Project Management, and, finally, to Assistant Commissioner for Planning and Project Management (from 1986 to June 1989). Throughout, however, I was involved with the on-site school mental health program. When I began to consider the topic for a dissertation I informed my immediate supervisor, who approved of it.

This study is concerned mostly with the period 1981 (prior to my employment in the Department), before the program was planned, to early 1985, by which time services were being offered in almost seventy schools. (I do, however, also present information on some aspects of the

program which involved events in subsequent years.)

APPROACH

The study is concerned with the program's evolution, from the participants' initial recognition of the need for such a program, through the development of a program model, to the implementation of the program. The data include my observations and experiences as an "insider" for over three years in the planning, implementation, and management of the program. In addition, other data came from documents and recollections of others who participated in the planning and implementation of the program. Therefore, data analysis included the organizing of my own observations and experiences as a participant observer (Sanday, 1983; Lincoln, 1985), as well as the analysis and interpretation of documents pertaining to the planning and implementation of the program. The study is, for the most part, a retrospective reconstruction, in that the evnts described occurred prior to my proposing the dissertation and having the proposal approved. By that time, as part of my work, I had amassed an enormous amount of documentation about the program, including internal memoranda, reports, correspondence, and notes from meetings and other discussions. Also, there existed public documents: proposals and plans; status reports; and letters, among others. All this material gave depth and credibility to my

reconstruction. In addition, because I remained in the setting, I had first-hand evidence of the outcome of the events. In addition, through formal and informal discussions with other participants and observers, a more complete picture developed.

The conceptualization of stages and decision points provides an organizational framework for the presentation of the study. The conceptualization is the result of my initial analysis of data about the program's implementation. The study is structured so that it begins with a description of the program's evolution, followed by an analysis, (which is organized into stages and decision points in the establishment of the program) in order to illustrate the specific steps of program development in urban child mental health services, within a specific multi-organizational environment. The stages are, in part, but not fully, chronological, in order to capture the "action" of program development. And each decision point represents a point of agreement among the organizational players; these points of agreement had enabled program development to proceed.

It should be made clear from the outset that this structure -- i.e., the "stages" and "decision points" -- emerged from my analysis of the data (see also Harmon, 1989). There was not an <u>a priori</u> "course" for the development of the program which was evident to, and shared by, all the program planners and policy makers (Mintzberg

and McHugh, 1985). Program design and implementation moved, at best, incrementally. As Hauschildt puts it, "decision-makers develop their goals in a continuous dialectical process with their search for alternatives and their view of the situation" (Hauschildt, 1986: 12). Berman (1978) writes, "The particular micro-implementation path that is followed depends on the interplay of the project with the local organizational setting" (174).

In order to describe the interplay referred to by Berman above, not only a description of the project, but also a description of the organizational setting, has to be rendered. However, the "setting" is itself ever-changing. As Emery and Trist (1965) put it, "a main problem in the study of organizational change is that the environmental contexts in which organizations exist are themselves changing, at an increasing rate, and towards increasing complexity" (21). There is not a static backdrop against which to describe the changes which occur in the implementation of a new program. And, when the new program is a joint program, the "environmental contexts" multiply and the interactions increase significantly (Emery and Trist, 1965).

For example, the macro-implementation phase of the development of a new approach to school mental health services was influenced by change in leadership in the Public Schools, litigation regarding special education,

changing fiscal constraints, and the political rivalry between the Mayor and the City Council President. Each of these played a role in the progress of program development and the design of the program. At the micro-implementation phase, the unique characteristics of each school district, school and mental health agency (including structural and interpersonal dynamics) were influential.

Social service delivery organizations, in particular, are "extraordinarily 'open' to their local environments," according to Berman (1978). Thus, "their nonmarket and public nature implies an environment whose 'causal texture,' to borrow Emery and Trist's concept (1965), is an odd mixture of placidity and turbulence. Placidity reflects the captive clients and the absence of a market in public delivery situations. But turbulence sporadically arises because public organizations must respond to exogenous events (e.g., changes in government policies, trends in economic and social conditions, and in fads in technology) as well as interact with their strictly local environment. They are, in short, prone to uncontrollable and uncertain events" (1978:175-76).

These contextual elements need to be described to make descriptions of program planning and implementation "credible" (Guba, 1981). Thus, in the next chapter, I provide background on both organizational and governance structures of the two lead organizations, as well as on the

broader systems in which they operate and play key roles. Then, I give some historical background about the more specific topic of mental health services for children in the schools.

III. BACKGROUND: THE TWO PRIMARY ORGANIZATIONS INVOLVED IN THE ON-SITE SCHOOL MENTAL HEALTH PROGRAM

In this chapter, I will briefly compare and describe the two chief organizations involved in the program's planning and implementation (Berman, 1978: 168), and then I will provide some historical background on the development of the mental health services that had been provided in New York City's public schools prior to the on-site program. This information should be useful in providing a context for understanding the joint effort to bring outside mental health agencies into the schools. As Berman (1978) states, "the gestalt of local system dynamics needs to be understood before analyzing the foreground of project implementation" (174).

First of all, the relative size of the two organizations had a significant influence on their relationship. The New York City Public Schools is a much larger organization than the Mental Hygiene Department. Naturally, therefore, the magnitude of the two municipal agencies' respective budgets was quite different (as was the

place of the mental health funding in the budgets): in Fiscal Year 1981, the overall Public School budget was $2.6 billion, of which $299 million was for special education services for 91,000 children. The Mental Hygiene Department budget was much smaller; its budget was $118 million, of which the school funding was 4.5 million (New York City, Office of Operations, 1981). (Also, it should be noted that while the Public School budget accounted for just about all the public money spent on education in New York City, the Mental Hygiene Department's budget, per se, represented only a fraction of public mental health funding for New York City residents. Other major funding sources included Medicaid and other third party reimbursement sources, State funding for State-operated programs, etc. Thus, the Mental Hygiene Department could exercise much less authority over its system than could the Public Schools' leadership over its system.)

A structural correlate of the large size of the school system (Scott, 1975: 11-12) is the fact that it can be viewed as a rather complex organizational field itself (more complex than the Mental Hygiene Department). The Public School system includes the Central Office, with a large number of divisions, bureaus and units, 32 community school district boards, and, within each district, 25 or more schools. The Public School system also employs a large number of administrative, pedagogical and support personnel

to directly operate it.

The Mental Hygiene Department, on the other hand, is a smaller, more unified organization; it is a part of a large organizational field which includes State, municipal, and voluntary mental health providers, as well as other organizations. It is an administrative agency, since, rather than operating programs or delivering services directly (except in the case of evaluation services provided to the Courts), it administers contracts with providers, and oversees their activities with a relatively small staff, as compared to the Public Schools. Most of its budget is used to help fund the services of over a hundred services provider agencies. The Department relates to these agencies in a variety of ways. The Department monitored the agencies individually in regard to budget, service quality, and service quantity. The agencies themselves, however, are relatively independent, since they receive financial support from other government entities, their own fund-raising, and third-party health insurance reimbursements. Also, included among these agencies were some of the nation's leading medical and social service organizations, with powerful boards of directors, autonomous missions, and resources.

NEW YORK CITY BOARD OF EDUCATION

The New York City Board of Education has been the subject of a number of studies, both because of its

contentious history and because its problems have come to represent the problems of all large urban school systems (Ravitch, 1974; Rogers, 1968; Rogers and Chung, 1983). Those studies, however, looked at the overall school system; this study is unique because it takes an in-depth look at the establishment of one program.

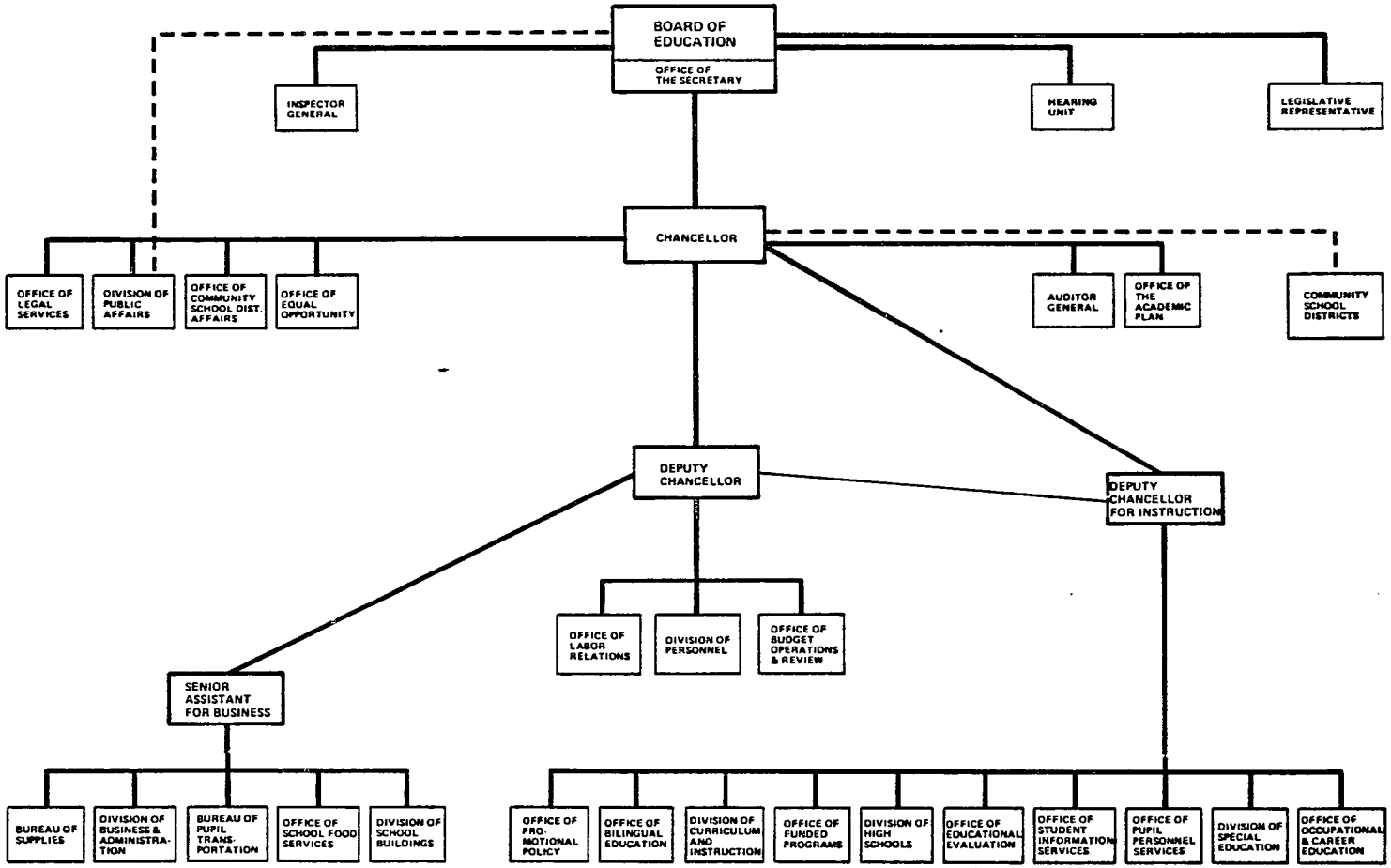
The New York City Board of Education ("Public Schools") had, in 1981, a budget of almost three billion dollars (New York City, Office of Operations, 1981). It was at that time, and still is, responsible for the education of approximately one million students annually. The seven members of the Board of Education are appointed by the Mayor and the five borough presidents. The Board, in turn, selects a chancellor, who is responsible for the day-to-day management of the school system. The system consists of a central administration and 32 local community school districts. Each of the local districts has a locally-elected school board which hires a district superintendent who is responsible for the operation of the district's twenty to thirty elementary and junior high and intermediate schools. The local district has a substantial amount of autonomy for budgeting, personnel, and curriculum, within constraints of the central administration budget controls and collective bargaining contract between the Board of Education and the United Federation of Teachers (Gittell, 1980). The central administration is responsible for the

approximately one hundred high schools through the Division of High Schools; it is responsible for delivery of special education services to over one hundred thousand children through the Division of Special Education; and, it is responsible for guidance and other support services to all school children through the Office of Student Progress (formerly the Office of Pupil Personnel Services, and, prior to that, the Bureau of Child Guidance). Table 4 is a table of organization of the central administration in 1981.

In 1968, David Rogers used the phrase "bureaucratic pathology" in characterizing the New York City Public School System (12). In 1983, Viteritti indicated that it (school system) is "widely perceived as a monument to bureaucratic inertia and ineptitude" (xii). Further, he indicated that the "schools are part of a semi-autonomous agency that has historically placed a high value on separation" (325). By most accounts the school system is a very difficult system in which to implement planned change, especially if this change involves coordination among organizational units or with outside organizations. In addition to the isolationist tendencies, lines of responsibility and communication are often vague and ill-defined. For example, in a November 3, 1986 New York Times article about two of the most well-regarded District Superintendents, the author, Larry Rohter, indicated that "superintendents ... are hired -- and can be dismissed -- by community school boards, whose members are

TABLE 4

CENTRAL ADMINISTRATION OF THE NEW YORK CITY PUBLIC SCHOOLS



*AS OF AUGUST 1981.

elected, (but) they must rely on the central Board ofEducation for everything from textbooks and supplies to the money paid to principals and teachers" (B1).

Many current and former school officials have said that this environment inhibits the development and exercise of leadership. "The politics outweighs just about everything else in the setting," said Dr. Carl Sewell, a former superintendent in Brooklyn, quoted in the article mentioned above. And he continued, "one who plans to survive has to be aware of that and willing at times to make compromises that are of political expediency and not to the benefit of the kids" (B1; B4). Also, Dr. Jerome Harris, a superintendent in Brooklyn, and one of the subjects of the same article said, "the New York system is designed for insiders. It's designed for people who come up through the system, so that when you get to this level (superintendent), you've already been a teacher and a principal. "The system purifies. When you get to a certain point, you think the same way, whether you're black, white or Hispanic" (B4). Another superintendent said, concerning the Central Board of Education, " ... generally, they don't provide you [with] anything to help you run a better school" (B4).

NEW YORK CITY DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND ALCOHOLISM SERVICES

The Department of Mental Health, Mental Retardation and Alcoholism Services ("Mental Hygiene Department") has not received the same amount of attention that the much larger Board of Education has. My study will, therefore, contribute to a greater understanding of this large and important urban mental health organization.

In 1981, the Mental Hygiene Department had an annual budget of approximately 120 million dollars (New York City, Office of Operations, 1981). The Department was at that time, and still is, responsible for providing mental hygiene services to 400,000 New Yorkers annually through contracts with over one hundred voluntary non-profit service providers, as well as with the New York City Health and Hospitals Corporation. The Department also provides mental health services to the City's Criminal and Family Court systems and provides funding for the mental health services in the prisons. Also, the Department is responsible for planning and coordinating the service delivery system. This involves a variety of specific roles, including managing a community-based planning structure, advocating for mental health services at the City and State levels, and exercising a coordinative and supportive role in terms of the services system, through policy and program development and training.

The City Charter requires that the commissioner of the Mental Hygiene Department be a psychiatrist appointed by the Mayor. The Mayor also appoints a 15-member Community

Services Board to advise the Commissioner on policy matters. In addition to funding and monitoring contract agencies, the Department has legally-mandated responsibilities to plan for, and to oversee, the public mental hygiene system in New York City, in collaboration with the several State mental hygiene offices.

The Department is organized along three major dimensions. The first is functional, containing operations and management divisions, each run by a Deputy Commissioner reporting to the Commissioner. The second dimension is geographic, using the City's boroughs as units for the purposes of planning, and operating borough offices to oversee program development and contract-agency monitoring. The third dimension is operational, containing various service system and project configurations; these configurations include alcoholism services, mental retardation services and mental health services; children's services; special population- and, specially-funded services (such as community support services and services for homeless mentally ill persons). Because of the relatively small size of the Department's staff, certain functions such as contract management, fiscal services, and management information systems are centralized. Major projects require cooperation and a team approach -- often referred to as "matrix management" -- among staff from the various offices. Table 5 is a table of organization for the Department in

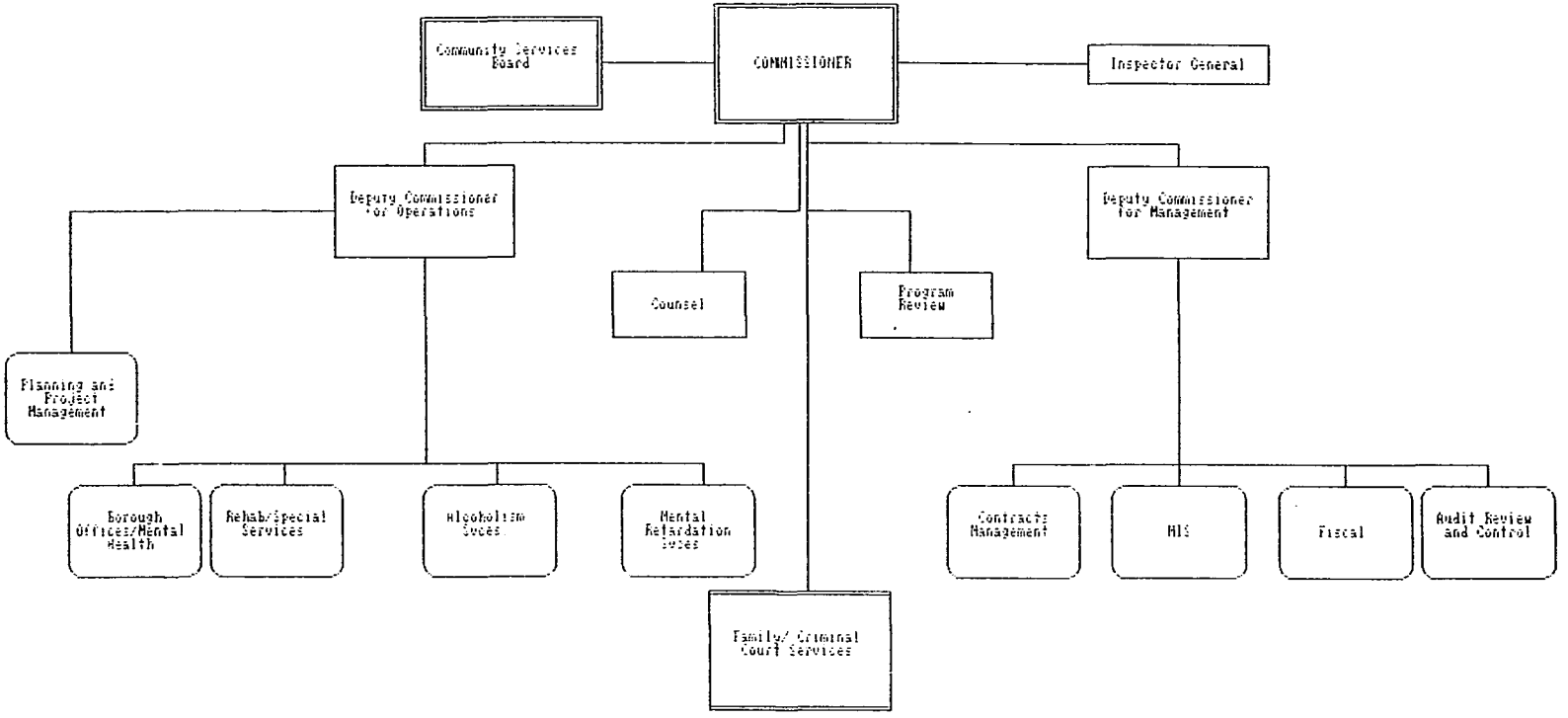
1981.

In 1957, Paul Lemkau, M.D., the first Director of the then newly-established New York City Community Mental Health Board (the precursor to the Department) wrote that, "it is safe to conclude from previous studies that the pattern of mental health services in New York City developed haphazardly and opportunistically in response to urgent need and special interests. In fact, without the factual information which well-conceived research could have obtained, it was not possible to develop a coordinated program for the City as a whole in any other way" (38). During the next twenty years, the system grew enormously as the result of several factors. The establishment of the Community Mental Health Board, following the State's Community Mental Health Act, paralleled a national trend in the growth of community mental health services, which was associated with reductions in State hospital censuses, the increased use of psychotropic medications, and, later, the growth of medicaid and Medicare funding, which increased the access of the poor to community services. The legislation governing medicaid did not allow coverage of services provided in State hospitals, which furthered the trend toward community mental health services (see e.g., Brown, 1985; Gronfein, 1985).

In 1979, the City's public mental health system consisted of various types of providers providing a wide

TABLE 5

NEW YORK CITY DEPARTMENT OF MENTAL HEALTH
MENTAL RETARDATION AND ALCOHOLISM
SERVICES



range of services. The system operated under the regulatory authority of the State Office of Mental Health and the State Health Department. The City Mental Hygiene Department had authority, derived from State statutes, to do overall planning for the system, and to coordinate service delivery. These same statutes, along with the City Charter, also gave it authority in terms of providing funding to mental health agencies to help support programs, and to monitor these agencies' performance through establishing contracts which spelled out service and fiscal requirements.

The mental health services themselves were provided by "provider" agencies, including State psychiatric centers, operated by the State Office of Mental Health; the Health and Hospitals Corporation, a public, multi-hospital system; some of the City's voluntary non-profit hospitals; and, the community-based mental health agencies of various sizes; and other public agencies which had mental health-related responsibilities, such as social services, corrections, and juvenile justice agencies. As large as the public mental health system was, it represented only a part of the City's mental health delivery organizations (Regier, et al., 1978), which includes other facilities, services, and individual practitioners. Also, the mental health system is part of, and overlaps with, the City's general health care system.

Within what appeared to me as a rather complex, often-fragmented and sometimes chaotic system, there are certain

links and alliances which contribute to cohesion. These links may result from any one -- or a combination -- of the following: proximity of agencies to each other, forming a kind of community service network; shared affiliations with medical schools or other academic and research institutions; or, common services orientation or service population, which may form links that are useful in advocacy, lobbying, promotion of innovations, etc.

Those agencies which predominantly served children maintained such an alliance, and this contributed to the eventual development and implementation of the on-site program. Those agencies had representatives who served as advisors to the Mental Hygiene Department. They also were strong advocates for more support for children's services and the leadership of the Mental Hygiene Department had identified children's services as an area in need of such support. Also, most, if not all, of the agencies serving children belonged to the Coalition of Voluntary Mental Health Agencies, which was a trade association for New york City's community mental health agencies, and advocated on their behalf with City and State officials. The executive directors of the children's agencies also had close contacts with the Mental Health Association of New York and Bronx Counties, whose Director, Carol Horn, was an outspoken advocate for children's mental health services.

It was generally believed that community based mental

health services were not reaching the children who most needed them. A review of programs with low levels of services, conducted by Department staff, indicated that a significant percentage were those whose target population were children and youth. Often, children would not receive services until their problems had already reached an acute stage, resulting, perhaps, in the need for hospitalization or other intensive service. During the City's fiscal crisis, prevention and outreach services were the first to be cut.

Because of the relatively small size of the Department itself, and because of its subsequent high degree of centralization as an administrative rather than an operating agency, the various units within the Department were able to move relatively swiftly to coordinate their efforts once a priority (in this case, children's services) was identified, and once resources became available for the service provider agencies to use. Further, the children's mental health agencies themselves provided support for these efforts, and were eager to participate in establishing new programs. However, as mentioned earlier, the mental health system did not command excess resources, nor had its advocates, in spite of their linkages and their lobbying efforts, been particularly effective at protecting children's mental health services funding from the cuts during the City's fiscal crisis.

EARLY BACKGROUND OF MENTAL HEALTH SERVICES IN THE SCHOOLS

At least as early as 1931, the need for mental health services for school children in New York City had been recognized by school and other City government officials. In that year, the Bureau of Child Guidance within the public school system was established, "for the diagnosis and treatment of maladjusted and atypical pupils" (New York City Board of Education, 1931: 294).

In December 1954, the New York City Community Mental Health Board was established, as the result of the State's Community Mental Health Act (pursuant to Article 8A of the State Mental Hygiene Law). This Act provided for State matching funds for local government mental health programs throughout New York State. The Act required that a Community Mental Health Board be established in order to administer the funding of local mental health programs, and was consistent with a national trend toward expanded outpatient mental health services (Brown, 1985). Prior to 1954, the City government did financially support mental health services provided by the Bureau of Child Guidance, as well as by the Department of Hospitals. The 1955-56 fiscal year was the first year "that it [mental health services] has emerged as a distinct and separate program" (New York City Mayor, 1955:40-41). As the result of the creation of the

Community Mental Health Board, the City moved $1,761,354 from the Public Schools budget to the Community Mental Health Board budget for 1955-56 (New York City Mayor, 1955: 25; New York City Community Mental Health Board, 1957). This gave the Community Mental Health Board responsibility to oversee the mental health services provided by the Bureau of Child Guidance, since funds were now allocated by the Community Mental Health Board to the Public Schools. This arrangement was to continue until 1983-84, when the on-site school mental health program was implemented.

In 1955, a detailed report listing a number of problems with the Bureau of Child Guidance was prepared by the Public Schools. These problems had interfered with the Bureau's successful functioning (New York City Board of Education, 1955). These problems included the lack of permanent leadership (for 13 years there were only acting directors) and a lack of clarity regarding the proper goal for mental health services provided within the schools. In particular, there was confusion about whether the goal of school mental health services should be assessment of children in the schools, with subsequent referral to certified mental health agencies in situations where it was determined that treatment services were needed, or both assessment and treatment in the schools themselves (New York City Community Mental Health Board, 1957: 115-119). These different goals had implications for the operation of the Bureau of Child

Guidance and its relationship to other child-serving systems, i.e. whether it should be a mental health service provider itself or whether it should rely on the mental health system to treat psychiatric and emotional problems in children.

Between 1955-56 and 1976, the allocation of mental health services funding to the schools grew to a high of 20 million dollars, as the result of increased awareness of the need for such services by both educators and mental health professionals. And, approximately four million of those dollars were allocated to develop programs for children in special education, including classes for emotionally handicapped children. However, as will be discussed in detail later, the Mental Hygiene Department was not able to get basic information from the Public Schools about how these funds were being spent. For example, the Public schools failed to provide a line item budget for the twenty million dollars which it had been allocated for school mental health services to be provided by the Bureau of Child Guidance. In addition, it was unwilling to develop annual service projections, or to provide the monthly statistical reports required by the City and state mental hygiene agencies of all programs. And the Public Schools did not institute the sorts of routine accountability mechanisms, both in terms of quality assurance and efficiency, that the Mental Hygiene Department demanded of its contract agencies.

Then, during the period 1976-1981, as the result of the City's fiscal crisis, the amount of funding for mental health services to the schools was progressively decreased down to 4.5 million dollars. Beginning in 1975, New York City's political life was dominated by the fiscal crisis, and, as a result, financial considerations dominated almost all policy and program decisions. Overall, the Public School system experienced large budget cuts during the fiscal crisis. According to Viteritti (43), "...the public schools were among the major victims of the fiscal crisis that struck New York in 1975. According to a report completed in 1976 by the office of the deputy chancellor, the schools took a budget reduction of $262 million during the first year of the crisis... while spending for education accounted for 21.6% of the total city budget during the three years prior to the fiscal crisis, the schools were being required to absorb 25.4% of the cutbacks the city was making in its general operating expenses in 1975."

The Mental Hygiene Department, like the Public Schools and all other city agencies, experienced funding reductions during the period, though these did not attract the kinds of political and public attention that the school system's budget cuts did. However, within the mental health services provider- and advocate- community, these cutbacks did not go unnoticed. For example, in a letter to the New York Times on February 15, 1976, the Community Council of Greater New

York criticized cuts in mental health services funds, "which would affect 80,000 people" (New York Times, Feb. 15, 1976: 61).

Accountability became a paramount issue in the public administration and public policy realms. Whereas prior to the fiscal crisis, the City's Budget Office was not able to hold the Public Schools fiscally accountable, the fiscal crisis provided an opportunity for the Budget Office to assert itself. The severe cut taken by the Bureau of Child Guidance was viewed by some Public School staff as reflecting the fact that the Mental Hygiene Department had an "ax to grind," since it had not been able to get the Bureau to provide fiscal and service utilization budgets and reports. (Some of the later resistance to the on-site school program by Public Schools employees who had been in the Bureau of Child Guidance may have reflected residual hostility from this earlier period.)

At the Mental Hygiene Department during the period 1979-1982, there was a great deal of attention given to enhancing all accountability measures, including timely and accurate reporting of expenditures and of services delivered by the Public Schools. At the same time, the concern about the low levels of service by children's mental health agencies created increased pressure to have the school personnel make referrals to mental health agencies. Especially in view of the overall fiscal austerity of the

period, it was not helpful to the Mental Hygiene Department for there to exist even the perception of underutilized services, especially in view of the publicly-acknowledged need for mental health services for children. Such a perception by the Budget Office, the Mayor's Office or the Board of Estimate members could result in funding cuts.

The expansion of mental health services for children became a high priority of the Mental Hygiene Department, as reflected in its annual local plans. This was consistent with a growing national awareness that children's mental health services were a relatively neglected area of mental health policy-making attention and that the incidence, prevalence and significance of children's mental health disorders were substantial. Because resources were scarce and many parents were unwilling to bring children to mental health clinics, the Department had determined that the schools could be an important link in getting children the services they required. Ideally, the Department believed, space in the schools should be made available to mental health agencies.

It was against this background that efforts to change school mental health services began.

IV. RECOGNIZING THE NEED FOR A NEW APPROACH

SETTING THE STAGE

There are three factors which stand out as catalysts for the eventual development of the on-site school mental health program. One is the rising cost of delivering special education in New York City and the concomitant search for less costly alternatives; the second is the long-standing difficulties the Mental Hygiene Department had in monitoring and holding accountable the Public Schools in regard to school mental health services; and the third is the call for greater collaboration and coordination in delivering, and expanding the availability of, health, education and social services to children, with specific emphasis on the link between schools and other service providers. This call came from professionals, advocates and public officials, not just in New York City but throughout the country.

Since the adoption of Public Law 94-142 in 1975, the provision of "free and appropriate" special education services had been mandated throughout the country (Chambers and Hartman, 1983). Over the years, special education

enrollment and expenses in New York City had grown dramatically. In Fiscal Year 1981 (July 1, 1980 - June 30, 1981) special education expenditures reached just under $300 million, which is over ten percent of the entire education budget (New York City, Office of Management and Budget, 1981: 41). This level of expenditure was occurring just at the time of the City's efforts to overcome the fiscal crisis which had begun in 1975. There was great pressure from the City's Budget Office to control costs. At the same time, as the result of the 1975 Law, as well as subsequent legal actions by advocacy groups unhappy with the City's implementation of the Law's requirements, the Public School's performance was constantly scrutinized. Thus, the challenge for the Public School officials in charge of special education was to make the existing special education system function efficiently and equitably. The Public Schools were also expected to develop cost-effective appropriate alternatives while dealing with an ever-growing number of children entitled to a complex range of specialized services. And, these children manifested a large variety of disabilities which interfered with their educational performance.

The second factor which led to the development of the on-site program concerned the difficulties in monitoring the school mental health services, as discussed in the previous chapter. (Briefly, the Mental Hygiene Department had

provided as much as twenty million dollars per year to the Public Schools, without being able to get in return even basic budget and service delivery information from the Public Schools.)

And the third factor, pressure for improved coordination, reflected a variety of concerns about the cost and effectiveness of social welfare and education services for children in New York City. In the City, there had long been interest among children's services providers for better linkages with the schools, since school was the one place where all children could be reached. It was often difficult for agencies to contact and engage those children most in need of services, many of whose families were not aware of services or did not find them accessible. Also, on the policy level, the perceived lack of coordination among agencies and different systems, which could result in duplication of services and wasted efforts, contributed to a sense of disorganization in the City's social welfare system for children, and provided ammunition to those who opposed social welfare programs in general.

The convergence of these three factors provided an opportunity for the development of a new approach to school mental health services in New York City, and the various pressures on the Public Schools and Mental Hygiene Department provided the motivation. These three factors are sufficiently distinct and important to be treated

separately, beginning with the enormous problems faced by the Public Schools in implementing Federal and State policies in the area of special education.

The Rising Cost of Special Education:

In 1980, the Public Schools restructured the Bureau of Child Guidance into School Based Support Teams under the auspice of the Division of Special Education. The funds provided by the Mental Hygiene Department were to be used to help support the activities of School Based Support Teams (SBSTs). The transferring of these funds was part of a plan, entitled Special Education in Transition, developed by a new Chancellor, Frank Macchiarola (New York City Board of Education, 1979). Though the Plan described the move as part of the incorporation of the Bureau of Child Guidance into the Division of Special Education, this reorganization eliminated the Bureau of Child Guidance. Also, the plan specified how mental health funds would be used and accounted for in the context of the overall reorganization of the special education system. The plan had input from the Mental Hygiene Department. The Department was particularly concerned that the Plan would identify specific activities that it would fund and be able to monitor. Also, the Plan emphasized collaboration between schools and community mental health agencies, which reflected the interest of the Mental Hygiene Department.

It should be noted that an earlier plan to reorganize school mental health services had been proposed in May 1979; in addition, there had been discussions at least as far back as 1974 about the issue of reorganization. The May 1979 Plan had called for the elimination of the Bureau of Child Guidance and the establishment of a Bureau of School Mental Health Services in the Office of Pupil Personnel Services. This would have integrated the administration of mental health services delivery to both special education and non-special education students. However, this Plan was "found unacceptable" by the Mental Hygiene Department, according to the Mayor's Management Report (New York City, Office of Operations, 1979: 182). Further, according to the Mayor's Management Report, the Mental Hygiene Department had indicated to the public schools that "any such plan should carefully address the effects of a major funding cut in BCG (Bureau of Child Guidance), and should indicate the administrative steps the Board can take to minimize the impact of any reduction" (182). The May 1979 plan, however, had been very general and did not address these issues.

The revised Plan, offered in November 1979, was far more detailed, both in terms of the program itself and its financial aspects. The School Based Support Teams (SBSTs), were "comprised of (a) school principal, a psychologist, a social worker, and a special educator" (New York City, Office of Operations, 1981: 349). These teams were formed

to screen school children to determine if they required placement in special education. The teams were established as part of a "comprehensive plan to reorganize and improve delivery of services," by the new leadership in the Division of Special Education, under the Chancellor's direction (New York City, Office of Operations, 1980: 215-216).

The Public Schools were then under mandates from the Federal Court to "reduce the existing backlog in evaluation and placement of children with handicapping conditions..." according to the Mayor's Management Report (New York City, Office of Operations, 1979: 236). The legal pressures on the Public Schools had to do with problems of compliance with Federal Public Law 94-142, enacted in 1975. Public Law 94-142 guarantees "a free appropriate public school education to school children with handicapping conditions" (David and Greene, 1983: 117). The law also included stipulations regarding proper assessment and placement of these children, and due process for parents regarding the decisions made by school officials which affect their children. At that point, the New York City Public Schools had been the target of a number of legal suits because of alleged failures to follow the regulations regarding the timeliness of assessment and placement of children, as well as because of alleged bias in the placement of children, due to ethnic, linguistic or cultural differences. The result of many of these suits was that the Division of Special

Education was forced to operate under the close supervision of the courts, with strict timetables governing its efforts. In 1985, the Mayor's Commission on Special Education (in its report referred to as the Beatty Report) commented on the significance of these cases on the Public Schools by indicating that, since 1979, these suits "spawned federal court judgments, stipulations, and implementation plans that now govern (in over 200 separate detailed provisions) virtually every facet of the New York City special education system..." (New York City, Mayor's Commission on Special Education, 1985: 3).

For example, one of the stipulations of the Federal Courts required the Public Schools to act within 60 days to evaluate and place handicapped children in appropriate programs. In 1980, funding for mental health services was provided to give the SBSTs an opportunity to provide consultative services to other school personnel, to make referrals to community-based agencies, and to provide short-term assessment and treatment services. As a result of the Federal legal requirements, however, the SBSTs devoted all their time to screening, assessing and placing children in special education, and, therefore, did not have the time (nor was it considered a priority) to make referrals to community mental health agencies. Also, there was strong speculation among the Mental Hygiene Department staff that SBST members saw community mental health agencies

as competitors, in that the community agency provided the treatment services that the SBSTs wanted to provide. The Federal legal requirements which governed the entire special education system carried much greater weight than did the Mental Hygiene Department in the use of resources within the Public Schools, even though the $4.5 million had been allocated to the Public Schools to provide mental health services.

Management Information Reporting Problems:

One of the ways that the State and City mental hygiene departments monitored certified mental health agencies was through extensive data-reporting requirements. The State and City mental hygiene departments expected the Public Schools to meet these same requirements. The schools, historically, had not fulfilled these requirements, and school officials had at times expressed the view that they should not be required to submit reports detailing the use of the mental health services funding. In their view, these mental health services were a small part of a large service system and thus it was difficult to separately identify and report on the specific services supported by the Mental Hygiene Department. However, the Mental Hygiene Department was particularly concerned that its funds be used to provide mental health services, and not be used to fund educational services. And, in the Mayor's Management Report

for September 1981, the Mental Hygiene Department's section states, "The primary focus during Fiscal Year 1981 was to strengthen its planning, monitoring and evaluation capabilities to ensure the delivery of high quality services. Initiatives included ... negotiation of policy and guidelines for monitoring mental health services in the Board of Education" (New York City, Office of Operations, 1981: 323).

Extensive discussions took place between the Mental Hygiene Department and the Public Schools regarding problems with the promptness of submissions and the accuracy of routine administrative reports concerning the mental health services funded by the Mental Hygiene Department and provided by SBST staff. These reports were intended to provide a detailed accounting of the services provided to school children by staff paid with Mental Hygiene Department funds. These reports were required by the State in order for the City to claim approximately $2.25 million in State financial assistance. For example, the Mayor's Management Report for 1979 (New York City, Office of Operations, 1979: 233) referred to "the primitive" state of management reporting throughout the Public Schools. Terms such as "unreliable, inaccurate or invalid," were used in regard to data (234).

These problems of timeliness and accuracy were particularly pronounced within the Division of Special

Education. In 1978, a Touche Ross and Co. study drew "... a dismal portrait of the organization and management practices of the Division of Special Education and Pupil Personnel Services," (New York Times, March 3, 1978: II, 2, 5). The lack of accountability within the Division of Special Education regarding these services eventually became so significant that the City Mental Hygiene Department brought the issue to the attention of the State Office of Mental Health. The State Office of Mental Health, which provided funding to the City to help support a variety of public mental health programs, (including funding for services in the schools) wrote to the Mental Hygiene Department in 1981 that it would refuse to grant State Aid for the period January 1, 1982 through June 30, 1982 unless the reports of expenditures and services activities from the Public Schools were improved and made available on a more timely basis. This action by the State provided the Mental Hygiene Department with some leverage with which to try to effect some change in the administration of the mental health services in the Public Schools, by attracting the attention of the Budget Office. Thus, the City Mental Hygiene Department wrote to the Public Schools that the funding for school mental health services was jeopardized.

When the Mental Hygiene Department still did not receive a satisfactory response from the Division of Special Education, the State took action, officially holding in

reserve the funds which it provided to the Public Schools via the City Department; it was not prepared to make those funds available again to the public schools until some improvements in documenting service delivery activity and expenditures were demonstrated. The Mental Hygiene Commissioner made the Mayor and his staff aware of the problem. Naturally, the Mayor was quite concerned about any loss of State funds to the City. This resulted in added pressure on the Public Schools to comply with the data-reporting requirements. Subsequently, the Public Schools did begin sending the Mental Hygiene Department administrative reports which were acceptable. The State then released the funds to support the SBSTs services in the schools for the coming year. However, the Mental Hygiene Department still found it difficult to oversee the mental health services in the schools. And, Department staff believed that a more effective way to deliver mental health services in the schools could be developed.

Services Coordination:

In addition to the data-reporting and fiscal-accountability issues, there was another concern about mental health services in the schools. This concern was that there was little linkage or coordination between the schools and those community-based mental health agencies which were in contract with the Mental Hygiene Department to

provide mental health services to children and adolescents.

Concerns about a lack of services coordination were not new. In 1953, for instance, prior to the creation of the Community Mental Health Board, a study by New York University graduate students which reported that "most mental health activities are directed toward the children of New York City," went on to say, however, that, in spite of the scope of these activities, "... no city-wide mental health program for children exists. Duplication and lack of coordination prevail" (New York University Graduate Division of Public Service, 1953: 74). In the 1970s, the provision of mental health services to children had become a significant issue, both nationally and in New York City. In particular, the attention given to the issue had to do with the lack of available and financially accessible outpatient services to children and their families, and the resultant reliance on more intensive and restrictive inpatient services, especially for Black, Hispanic and other ethnic minority children (Knitzer, 1982). There also was concern about the overall lack of services for children and youth, the lack of coordination among various child-serving systems, and the inadequacies of traditional treatment approaches in reaching some of the most seriously disturbed and underprivileged children and youth.

Amidst this atmosphere in New York City, mental health

program planners began to view the establishment of programs in the schools as an effective way to reach children who required mental health services. There existed ample documentation regarding the inadequate supply of children's mental health services (e.g. President's Commission, 1978). In previous years, however, school officials had not welcomed outside agencies coming into the schools to provide services. According to the 1976 report of The Task Force on the New York City Crisis (in mental health services), the unwillingness to allow outside agencies into the schools was a concession to the teachers union. It also may have reflected the rigidity of the school system, as described by Rogers (1968). The Task Force report recommended that the responsibility for the mental health services provided by the Public School Bureau of Child Guidance be turned over to the Mental Hygiene Department (New York Times, October 10, 1976: 68).

In 1981-82, the lack of coordination between the schools and community mental health agencies became a political issue, linked to under-utilization of children's mental health services funded by the Department (New York City, Office of Operations, 1981: 325). Carol Bellamy, the City Council President, issued a report in February 1981 which stated that "it is inexcusable that the Board of Education (Public Schools) has demonstrated a reluctance to use community mental health agencies" (New York City, City

Council President, 1981: 3).

In addition to criticizing the Public Schools, the report criticized the Mental Hygiene Department and its contract agencies. The Mental Hygiene Department was criticized because it offered "... no effective financial incentives for agencies under contract with the City to provide all the services they are paid to furnish" (4). In regard to the agencies themselves, the report stated that "underutilized contract agencies often do not pursue rigorous outreach and public education activities to improve contract performance" (4). (In fact, Ms. Bellamy had expressed these same concerns a year earlier, during the Board of Estimate contract approval process. In May 1980, Ms. Bellamy sent a letter to her Board of Estimate colleagues asking that a large number of the mental health contracts pending approval at that time be approved for only a three month period, rather than for the usual full year. This letter was sent shortly before the vote on the contracts, giving the Mental Hygiene Department little time either to respond to Ms. Bellamy or to try to persuade the Board of Estimate to give the contracts full year approvals. However, through the last-minute assistance of the Mayor's representative on the Board of Estimate, the contracts were approved for a full year.)

The problems in children's mental health services provided an opportunity for Ms. Bellamy to embarrass her

political rival, Mayor Koch, as well as to criticize the Public Schools (which had long been a target of criticism by politicians). She was also able to demonstrate her concern for children to the electorate. At that time, the Commissioner of Mental Health, Dr. Sara L. Kellermann was only in an acting capacity, so the Mental Hygiene Department was in a weak position.

In the year or so prior to Ms. Bellamy's 1981 report, The Mental Hygiene Department and the Public Schools already were designing new procedures to increase referrals from the schools to community-based agencies. A committee composed of representatives from the boards of both the Public Schools (Board of Education) and the Mental Hygiene Department (Community Services Board) had developed a written agreement which outlined specific steps to be taken in order to increase these referrals. The agreement also contained an overall policy statement intended to foster cooperation between the mental health agencies and the schools. In a June 10, 1981 press release, the Community Services Board of the Mental Hygiene Department announced details of the agreement. These included the following: "dissemination of a statement" regarding increased interagency collaboration; issuance of guidelines for referrals and cooperative services; forms for referrals and follow-up efforts; and, the dissemination of a directory of available services in the community, designed to be used by

school personnel to assist them in making referrals. Finally, training was also to be provided in order to "insure the successful implementation of these measures."

During the Fall of 1981, the two agencies began to implement the agreement (New York City, Office of Operations, 1981: 325). Staff from the two agencies designed an elaborate multi-part referral form to enable school personnel to refer children with a need for mental health services to community-based agencies. The multi-part form allowed both the Mental Hygiene Department and the Public Schools to keep track of the referrals. The training sessions that were held involved supervisory staff from both agencies, direct services personnel from the schools, and mental health providers. Discussions at these sessions focused upon the most effective use of the forms, as well as upon ways of fostering better communication between school and mental health agency staff.

The training was delivered in two stages, called Levels One and Two. Level One training sessions, which were held in each borough, were attended by Public School supervisory personnel and Mental Hygiene Department staff. The Public School personnel included Regional Supervisors, Committee on the Handicapped Chairpersons, and clinical supervisors. The Mental Hygiene Department staff included borough coordinators and central office personnel. This training was designed both to introduce the procedures and goals of

the agreement to these personnel and to prepare them to carry out the Level Two training.

Level Two was designed for school district personnel, such as SBST members, community mental health agency representatives, and staff from the Mental Hygiene Department. It was delivered by the staff trained during Level One training. Once the training was completed, the mental health agency staff and the SBST members were expected to be able to use the forms and procedures. The staff from the Mental Hygiene Department would monitor and provide technical assistance to the community mental health agencies under contract to the Department, while the Regional Supervisors would supervise the SBSTs.

The goal of these efforts, according to guidelines for the program, was to refer "children in need of mental health services which do not reflect an educational need...to appropriate community agencies." The guidelines went on to state that "there are two groups of children in need of such mental and social services." The first of these two groups was composed of children who were candidates for referral to community agencies alone. This group included: "all children requiring long-term therapy; families requiring family therapy; all cases of habitual law offenders (e.g., known repeatedly to family court, on probation); child abuse cases; cases of alcoholism and/or drug addiction." The second group was composed of those children who required

both mental health services and specialized educational services. This group included: "children in classes or schools for the emotionally handicapped; children in classes for the neurologically impaired-emotionally handicapped; children with minimum brain disfunction; retarded children with emotional handicaps; all children attending special schools for the severely emotionally handicapped; school-phobic children; truants who need extensive mental health services; and pregnant students."

In addition to procedures for referral from the schools to community agencies, the guidelines also included instructions for making referrals from a community agency to the School Based Support Teams in the schools. "This is indicated when the treatment plan requires auxiliary, on-site services at the school for special placement or to support school adjustment."

In December 1981, the joint committee met to review the progress that had been made in carrying out the terms of the agreement. All of the training -- both Level One and Level Two -- had been completed by that time. The training was viewed as a success: approximately 1,200 school based support team personnel and guidance counselors were trained, as well as 600 staff from mental health agencies. In addition, 30 superintendents of guidance and 100 assistant principals were trained, as well as 50 staff from the Mental Hygiene Department.

While the training sessions were successful, certain problems with the programs' design had been identified during the training sessions. One of these problems was how to determine which information about the children referred for mental health services could be shared between school and mental health agency personnel and which had to be kept confidential. A second problem was that the role of school guidance counselors in carrying out the new procedures was not yet clear. And a third problem was that, according to rumor, some school personnel were circumventing the process of gaining parental consent for referrals by avoiding use of the parental consent forms. In fact, whether the rumor was true or not, some school staff felt that parents would resist having children identified as needing mental health services. Naturally, this raised issues about the pros and cons of parental involvement in decisions which would have an effect on their children, and it also confounded the efforts of the Mental Hygiene Department and the Public Schools to improve program accountability. During the following year, when the use of this referral process was being evaluated, monthly meetings between school and mental health agency personnel were held in each borough to try to resolve these problems and to assure that proper procedures were being followed.

Throughout this period of evaluation, however, the Mental Hygiene Department and the mental health services

advocacy community maintained a strong and continued desire to institute on-site services in the schools, to be provided by staff of the community mental health agencies. Nevertheless, those involved recognized that it would be very difficult to implement such a program, even if agreement could be reached to try to do so. A New York Times editorial of January 5, 1980 stated that "pilot projects (to improve schools) historically have been disappointing" (20). This, I think, reflected general public and professional sentiments. In general, many of those who were advocating for mental health services in the schools also felt that "it couldn't be done."

DECISION POINT ONE: THE PUBLIC SCHOOLS AND MENTAL HYGIENE DEPARTMENT AGREE TO DESIGN A NEW PROGRAM

In a Spring 1982 meeting that took place between the Schools Chancellor, Frank Macchiarola, and the Mental Hygiene Commissioner, Sara L. Kellermann, M.D. (in which the Chancellor participated as co-chair, along with Marian Schwartz of the Mayor's Office, of the mayoral Task Force on Youth) the Chancellor "made a commitment that agencies would be given physical space for the provision of mental health services on site in selected school districts" (New York City Department of Mental Health, Mental Retardation and Alcoholism Services, 1982: 61). According to Viteritti, the Mayor "recognized (the) coordination problem in early 1982,

when he created a Mayor's Task Force on Youth, the purpose of which was to bring about better cooperation among the various service agencies. By appointing the chancellor of schools as chairman of the task force, (Mayor) Koch hoped to lessen the gap that has traditionally existed between the schools and municipal agencies" (1983: 325), in coordinating the provision of education, health, and social services.

A few months after this meeting, the Mental Hygiene Department, in a study of children's mental health services needs, documented what they had believed informally all along: significant numbers of children were in need of mental health services in New York City and not getting them (New York City Department of Mental Health, 1982). Further, the study indicated that there were certain agencies which were providing mental health services in the schools on their own, without either Mental Hygiene Department or Central Public School office involvement. And these agencies, the report went on to say, "... believe that direct access to children and youth in the schools improves the quantity and quality of treatment" (DMH, 1982: 61). Although the Mental Hygiene Department was impressed with the results that these agencies achieved on their own, its priority was to develop and implement a more systematic citywide approach.

The verbal commitment by the schools chancellor to make space available to mental health agencies in the schools

provided impetus for further collaboration between the Public Schools and the Mental Hygiene Department. It did not, however, in and of itself, create a program.

V. PLANNING A NEW APPROACH TO SCHOOL MENTAL HEALTH SERVICES

> "The restructuring of school mental health services will greatly increase access to mental health treatment for the general public school population." (from the Preliminary Proposal for Restructuring School Mental Health Services, February 1983)

In this chapter, I will describe the initial steps taken by the Public Schools and the Mental Hygiene Department, following the commitment by the Schools Chancellor to support the presence of mental health agencies in the schools. These steps were intended to make space available in the schools for the delivery of mental health services to school children. This was occurring at the same time that the Mental Hygiene Department and the Public Schools were still implementing and evaluating the program begun in 1981 to encourage school personnel, including SBSTs, to make referrals from the schools to mental health agencies in the community. As it turned out, this effort was not deemed successful, and this fact aided the cause of those trying to bring mental health services agencies into the schools.

BACKGROUND

In the Spring 1982 meeting (mentioned in the last chapter), between Chancellor Macchiarolla and Mental Hygiene Department Commissioner Sara L. Kellermann, M.D., the Chancellor had said that space in the schools would be made available for mental health services. This offer, however, was just a starting point, and a myriad of major and minor issues would have to be addressed before mental health services would be delivered to school children in school buildings. Thus, while the first decision point had set the stage, it did not, by any means, mark the beginning of a program. And, although one might make the assumption that, once the leaders of these two organizations had agreed to do something, it would just happen, the complex organizational arrangements of the Public Schools and the Mental Hygiene Department assured that nearly all decision-making concerning the program would be slow, incremental, and provisional. In general, for both lead agencies, the implementation of decisions made at the top of the organizational structure is contingent on a variety of factors which come into play throughout the systems at a number of different organizational levels. In fact, sometimes, decisions are made which do not result in any action whatsoever. As goals become more specific (i.e., the decision process is made more explicit and decisions involve allocation of concrete resources) the potential for conflict

increases (see also Benson, 1973; Mathews, 1987). This is true in all complex organizations and institutional settings; in the public sector, it may be more likely because the authority for decisions may not lie in one place, and oversight agencies, other branches of government, and the vagaries of politics all may affect the ability of individual organizational leaders to make decisions that have force. Also, the decision-making process itself often has multiple functions in the public sector, including ideological and symbolic ones, which further complicate the making of decisions and the studying of decision-making.

So, several things stood between intention and implementation. First, regardless of the authority of the Commissioner and the Chancellor within their respective systems, there existed innumerable constraints, including statutes and regulations governing their systems, as well as limits on financial resources and the authority over them. In addition, space in the schools was itself a limited and highly coveted commodity. Within individual schools, principals had control of space. Principals were answerable to Superintendents, who were themselves responsible, under the City's school decentralization plan, to both the community school boards and the Chancellor. Thus, making space available to mental health agencies required decisions that would likely affect other programs.

If the Chancellor were to have waited to make a

commitment to the Mental Hygiene Department Commissioner until after every single detail had been worked out within the Public Schools, it is likely that nothing ever would have gotten done, since it is possible (and perhaps likely) that such planning would easily have gotten bogged down in all sorts of internal administrative, policy and legal concerns. Rather, the meeting of the Task Force on Youth Services gave the Chancellor an opportunity to send a message to those within his system that this was a priority; also, since the Task Force was co-chaired by Marian Schwartz of the Deputy Mayor's staff, it made the Mayor's office a party to the agreement. (Her involvement in later discussions between the City and the teachers union, during the period when the union was placing obstacles in the way of implementation of the program, was significant.) The agreement between the Chancellor and the Commissioner also was a signal to those opposed to such a program that it was time to start paying attention.

In part, due to the political and practical complexity of the two major systems, and, in part, due to the complex, often fragmented and discoordinated nature of both systems (which is characteristic of many service delivery systems [Berman, 1978; Lipsky, 1976]), bringing the mental health agencies into the schools was not just a matter of opening the doors to their staff. The reflexive opposition of many within the school system needed to be counter-balanced by an

effort which drew its legitimacy from a broader agenda. This broader agenda included the following: the coordinating of youth services; the recognition of the need for more comprehensive mental health services in the schools; and, the pressure to find cost-effective alternatives to special education. This effort also required the commitment of leadership in several key agencies; and, as will be described, the enormous patience and commitment by the staff involved to a rather protracted and often frustrating process of development and implementation.

My own involvement in the program's development began during this stage. I joined the Department in April 1983, as a member of the Office of Planning and Project Management.

EVALUATION OF A REFERRAL SYSTEM

Several months after that key meeting between the Public Schools Chancellor and the Mental Hygiene Commissioner, a report was issued evaluating the referral mechanism which had been established in the Fall of 1981. The report was an evaluation of the success of the referral mechanism between January 1982 and June 1982, and it showed that relatively few referrals had been made by school personnel to the community mental health agencies. In fact, the forms and procedures designed for this purpose were rarely used. Overall, citywide, 520 referrals had been made

during that period, and only half of those had been made by SBSTs. And, in view of the total number of children projected to be in need of such services -- approximately 45,000 (New York City Department of Mental Health, 1982) -- this seemed a very low number. Even if, as is likely, some referrals were made to agencies without the use of the forms, based on an analysis of the agencies' service delivery reports to the Mental Hygiene Department, this was a small number, since the total amount of services delivered by the agencies did not increase substantially.

There may have been several reasons for the low number of referrals. As discussed earlier, SBSTs were under pressure to evaluate as many of the children as possible who had been referred to special education. This was their highest priority, and referrals to community mental health agencies took time and involved completing additional forms. Also, there appeared to be some jealousy on the part of some SBST psychologists and SBST social workers toward mental health agency staff. Some complained that mental health agency clinicians performed what they viewed as the more professionally rewarding and attractive work of psychotherapy, while the SBST members performed large numbers of assessments, without being given the opportunity to engage in clinical practice. In a letter to the New York Times in 1980, the former chief school psychologist, Rachel Lauer, referred to the "assembly line manner in which school

psychologists examine children." (New York Times, March 15, 1980: 18).

In addition to SBST staff, guidance counselors could make referrals. However, their ranks had been diminished severely during the City's fiscal crisis, leaving many schools with, at best, part time guidance counselors. Again, school-mandated activities took up much of their time, and reaching out to community mental health agencies was time-consuming, though in a few areas of the City, individual schools and local mental health agencies and hospitals had developed ongoing referral and consultation relationships.

PROPOSAL

Based upon the Spring 1982 meeting, Mental Hygiene Department staff were prepared to begin working with the Public Schools staff to bring mental health agencies into schools. As mentioned earlier, the children's mental health agencies were anxious to establish a presence in schools, and, in fact, some had been able to do so on their own in certain areas. And with the commitment of the Chancellor, it was hoped that a large-scale effort could be mounted.

The Mental Hygiene Department staff followed up with their counterparts at the Public Schools, in order to begin making arrangements for mental health agencies to establish programs in the schools. Meetings began with the staff of

the Division of Special Education, many of whom had been involved over the years in the discussions between the Mental Hygiene Department and the Public Schools regarding accountability and, more recently, regarding the SBST referral effort. However, there was resistance on the part of the Division of Special Education staff, largely because of ongoing pressure from the union to keep contract agency personnel out of the schools. Also, reflective of the communication problems between units in a large organization like the Public Schools, it appeared that there was not a consistent understanding among the school staff about what the Chancellor had intended by his agreement with the Mental Hygiene Commissioner.

Since the impetus for changing the way school mental health services were organized was a response to the shortcomings of school mental health services under the auspices of the public school system, there may have been defensiveness on the part of some school officials to the suggestion of change. These shortcomings concerned not just the services themselves, but the administrative monitoring of the services, and the timely reporting of information to the Mental Hygiene Department, which provided funds for school mental health services. Over the years, the origin of the mental health funds and the specific purpose for which they had been made available may have become obscured within the overall budget, as well as because of changing

educational priorities and fiscal pressures. Also, as mentioned, there was an ongoing conflict between the municipal government and the school system regarding budgetary control of the schools and the amount of City funding available (Viteritti, 1983).

In general, the Public Schools and the municipal government were used to an embattled relationship, and over the years school officials had tried to defend their autonomy and rebuff efforts at external accountability (Viteritti, 1983). Also, the teacher's union had effectively lobbied the Public Schools administration not to have contract agency personnel come into the schools to provide services. However, when the City's mental health services State Aid was threatened, the Mayor's Office and the Budget Office supported the Mental Hygiene Department's efforts. Also, Frank Macchiarola, unlike previous Chancellors, was open to the idea of outside service providers coming into the schools, and was strong enough, independent enough, and popular enough to be willing to risk angering Union officials.

The Mental Hygiene Commissioner contacted the Chancellor's office with the intent to reaffirm and clarify their agreement so that staff could begin planning. This resulted in work beginning during the Fall and Winter of 1982 on a proposal outlining a school mental health services plan. Apparently as the result of the resignation of the

chief of the Division of Special Education, the Public Schools Chancellor gave responsibility for working on the proposal with the Mental Hygiene Department to the Director of the Office of Pupil Personnel Services, Angelo Aponte, who was responsible for guidance, attendance and other services for the general school population. Many of the Mental Hygiene Department staff involved in the planning were those who had been involved in the effort during 1981 to establish relations between mental health agency staff and Public Schools staff.

In a series of meetings, the program planners for the two agencies laid out the program; in February 1983, the Mental Hygiene Department staff took responsibility for completing the proposal. The proposal was very general, focusing on the overall distribution of the funds and staff; the proposal did not suggest the many implementation issues that finally would have to be addressed in order to realize a program. The proposal, entitled, "Preliminary Proposal for Restructuring School Mental Health Services," described two major program components: one component was intended to improve the coordination of mental health services delivery in the schools, with a particular emphasis on increasing referrals of school children to community-based mental health agencies. This was to occur through reallocating some of the funds that were currently in the Division of Special Education to the Office of Pupil Personnel Services

within the Public Schools. The Office of Pupil Personnel Services was to create a new position, called "school liaison worker." These workers, one in each school, would coordinate referrals to agencies in the community. This component preserved some of the funds in the Public Schools, and reflected the belief that under the right conditions school personnel would refer children to community mental health agencies.

The second component of the program was designed to make mental health services more accessible to schoolchildren by bringing agencies into the school building to provide mental health treatment services. It was important to the Mental Hygiene Department that a new program reach those children who most needed services and whose families did not seek out services in the community, or, if they did seek them out, would not continue using them because they did not find these services easily accessible. By having mental health specialists in the school building, it was believed that it would be easier to get the children to begin using services and then to continue to use them; for one thing, the services would be more accessible, and, for another, valuable information about the children could be shared between school staff and mental health staff. It was believed by many children's mental health professionals that this sort of open communication would definitely contribute to the improvement of the treatment of many

children's mental health problems. This component -- making the services more accessible -- involved removing the balance of the funds in the Division of Special Education entirely from the Public Schools and returning them to the Mental Hygiene Department budget. The Mental Hygiene Department would then use these funds, plus anticipated Medicaid revenues, to develop contracts with certified mental health agencies.

The case for this restructuring was based on several things. First, as previously mentioned, the evaluation of the referral mechanism used by SBSTs to refer children to community agencies showed that there were relatively few such referrals, especially as compared with the amount of money provided by the Mental Hygiene Department. The proposal indicated that each of these referrals had "cost" $5,625. By creating school liaison workers who would have the ability to refer all schoolchildren with a need for the services, the planners believed that a far better and more cost-effective program could be created. The proposal included the projection that 4,500 referrals would result from the school liaison workers described in component one (as opposed to the small number -- 520 -- that had occurred during the evaluation period).

Second, while the SBST program was funded at $4.5 million, in the proposal only $1.5 million was budgeted for school liaison workers. This was because it was believed

that far fewer workers whose full-time job it was to refer children could be more effective than the 200 SBST staff who were part of a system with other priorities.

Third, if the services were provided by mental health agencies, the funding from the Mental Hygiene Department would be supplemented by reimbursements from third party payers, including medicaid. The schools, which were not licensed health care providers, could not bill third party payers. Also, the not-for-profit mental health agencies contributed some of their own funds, gained through fund-raising, to the operation of the programs in contract with the City. Thus, overall, more services could be provided since the program would attract these additional resources. In addition, the children's mental health agencies had some excess capacity, so that they would most likely be able to serve some children without additional funding from the City. In fact, the City Council President's report (described in the previous chapter) criticized the City for "the waste of dollars and the neglect of children" (New York City, City Council President, 1981: 3). It was hoped that this proposed program could be started in September 1983.

A REVISED PROPOSAL

In February 1983, in the midst of this planning, Schools Chancellor Macchiarola resigned. Soon thereafter, Robert Wagner, Jr., the son of former New York City Mayor

Robert Wagner, Sr. and an influential Deputy Mayor (who, in fact, had been given the responsibility in 1979 by Mayor Edward I. Koch to "serve as liaison between OMB [Budget Office] and BOE budget officials" [Viteritti, 1983, 52]), was selected to be Chancellor. However, before he had assumed the position, he was found to lack certain educational credentials, according to the State Education Commissioner. Therefore, he was not allowed to assume his position. Then, Anthony Alvarado, the Superintendent of Community School District Four in East Harlem, was chosen to be Chancellor. During this period of time, while there was this confusion and lack of leadership within the Public Schools, efforts on behalf of implementing the on-site program were delayed. It became clear to the planners that the program would not begin in September 1983, as had been hoped. Also, since it had been Chancellor Macchiarola who had made the commitment to the Mental Hygiene Commissioner, and since the program was not yet off the ground, the fate of the program was no longer clear.

It was at this point, in late April 1983, that I joined the staff of the Department's planning office, as a planning analyst. One of my assignments was to participate in the planning of the new program. The Director of the Office, Barbara Bengen, and the Assistant Director, Cynthia Dames, had been given the responsibility by Commissioner Kellermann and Deputy Commissioner Bruce Gantt to lead the Department's

effort, which involved other offices as well. Because of my previous work experiences, which included applied research and policy development at the New York State Council on Children and Families, as well as secondary school administration and teaching, it was a most appropriate assignment. I became immediately engaged by it, although I certainly had no idea that, a number of years later, I would be writing my Ph.D. dissertation about it.

In spite of the turmoil and changes at the top of the Public Schools' administration, staff of the Public Schools were able to review the proposal submitted in February, and to make significant changes. It should be noted that during periods of transition in large municipal agencies it is often difficult to predict which activities will be affected and which will continue as normal. Obviously, day to day school operations continued; central office functions were the ones most often affected, because of the change in personnel that accompanied the transition, and because there was a great deal of reviewing and recasting of policies and priorities. In this instance, the work of the Office of Pupil Personnel Services, which had been reviewing the proposal, went on.

I am not able to determine to what extent the changes proposed were the result of the changes in leadership at the Public Schools. In general, changes in the environment account for a good deal of why it is so difficult for public

organizations, especially, to set directions and move toward established goals in a linear, predictable fashion (Cohen, March and Olsen, 1972). These organizations find themselves constrained by the activities and domains of other organizations, as well as by their own internal limits. Therefore, they often find themselves changing directions in response to changing priorities, policies, and resources. And, of course, goals do shift over time, and different goals "compete" for attention (Tuite, et al., 255).

The most significant change in the revised version of the proposal was that component one, deploying school liaison workers to refer children to mental health agencies, was dropped at the suggestion of the Public Schools; this change was, in some ways, surprising, since the Public Schools have generally been loathe to give up any resources. It is most likely that the component was dropped because the Public Schools, under budgetary pressure, did not want to increase its personnel. Also, in view of the uncertain future of the program and its potentially controversial nature, the Public Schools might not have wished to create a new job title and to hire new staff should the program be terminated at some point.

Instead, the plan was revised so that all the funding was to be for the establishment by community mental health agencies of on-site mental health programs. The program would be implemented in three or four schools in each of 15

districts out of the total of 32 community school districts in New York City. The 15 districts were selected based on need, as measured by the number of requests for assistance for the SBSTs received in the district. These districts corresponded to areas of the city most in need of children's mental health services, as determined by the Mental Hygiene Department. It was reviewed again by the Public Schools staff during August. The plan was made final in September 1983.

DECISION POINT TWO: THE PUBLIC SCHOOLS AND MENTAL HYGIENE DEPARTMENT AGREE ON A PROGRAM DESIGN

In September 1983, the Public Schools and the Mental Hygiene Department agreed to implement the program described in the proposal. They then forwarded the plan to the Budget Office, since funds were to be shifted from the Public Schools' budget to the Mental Hygiene Department's budget.

It is noteworthy how long it took to move from the initial meeting in Spring 1982, to a proposal that had the agreement of the two agencies, in September 1983. As should be clear, although there was a great deal of writing, editing, and rewriting going on, the time was not taken up merely by the writing of the proposal. Rather, the time involved may be indicative of the decision process at work, especially within the Public Schools, which at this point, had more at stake in the restructuring. As mentioned

earlier, the Public Schools had a long tradition of maintaining autonomy. Thus, there was a great deal of resistance to 1) giving greater control to the Mental Hygiene Department; 2) giving up resources, even if the resources had originally come from the mental health system; 3) causing any conflict with the Teacher's Union (UFT), if the potential gain was not viewed as necessarily worth it. Also, within the Public Schools (as in many bureaucracies), historically there has been a larger price paid for making a mistake than for not acting or waiting. Therefore, even though there was a verbal agreement between the Mental Hygiene Department Commissioner and the Schools Chancellor, there existed an inertia, which was not easy to overcome.

VI. FISCAL CONSTRAINTS ON IMPLEMENTING A NEW APPROACH TO SCHOOL MENTAL HEALTH SERVICES

Reflecting its enormous power during and since the City's fiscal crisis, the Budget Office partially "coopted" (Selznick, 1966) the on-site school mental health program, shaping the program's goals toward its own ends (ends neither envisioned nor desired by the program's designers). More specifically, the power of the Budget Office to "coopt" the initial program design is an example of Selznick's (1966) notion of "informal cooptation," wherein "...individuals upon whom the group is dependent for funds or other resources may insist upon and receive a share in the determination of policy" (14).

BACKGROUND

The Budget Office had exercised tremendous power and influence in the City ever since the City's fiscal crisis in 1975-76. The Director of the Budget Office reported directly to the Mayor. The Budget Office's role was to plan the City's budget, monitor expenditures, forecast revenues, and anticipate and plan for changes in the City's economy

that would affect municipal finances. The Budget Office also had the authority to recommend management improvements throughout City government.

All budget requests from City agencies (that is, requests to make expenditures), had to be approved by the Budget Office. This included even those requests that were funded entirely -- or in part -- by non-City funds. Also, the Budget Office, in exercising its budgetary discretion, often made program policy decisions that the Commissioners and other leaders of City agencies believed should have been left to their discretion. Viteritti (1983) quotes a budget office official as saying, "OMB has an inordinate amount of authority. We know the Mayor's priorities. It's our job to put them into policy" (52).

The relationship of the Budget Office to the Public Schools was somewhat different (both in law and in fact), than its relationship to the other City agencies. The other City agencies, including the mental Hygiene Department, reported directly to the Mayor. The Public Schools, however, were not a mayoral agency, and did not report directly to the Mayor (although the Mayor did appoint some members of the Board). Rather, the Public Schools had been created by State Charter, and it was supposed to exercise educational policy autonomously. According to Viteritti, however, "the City school district is also fiscally dependent (on the City), and that arrangement sometimes

forces school officials to compromise their autonomy when they solicit funds from the municipal government. School officials have come to realize that it is easier to extract money from the local budget when they can be specific about what they want to do with it, why it is important, and who will benefit. However, jealous of their own autonomy, they do not like to be told to do these things" (60). In general, the Public Schools had been unwilling to capitulate to Budget Office directives for improved accountability, and, because of their size, governance structure, and a relatively relaxed attitude to fiscal accountability in the City prior to the fiscal crisis, they had been successful at getting City funds prior to the fiscal crisis, without such accountability.

Because of this refusal on the part of the Public Schools, relations between the Budget Office and the Public Schools were particularly strained in the late 1970s and early 1980s. Since the schools received State Aid in addition to local funds, and since the City was under much fiscal pressure, the Budget Office used any additional State funding to reduce the amount of City funds being spent. Viteritti refers to this as "disinvestment" in education, on the part of the City (47-49). In 1980, for example, both Mayor Edward I. Koch and Comptroller Harrison J. Goldin decried the huge size of the special education budget, and Koch criticized the federal government for mandating

expenses while not providing funds (New York Times, May 16, 1980: II, 3; July 9, 1980, II, 3; September 6, 1980, 23).

The Budget Office's assumption and exercise of greater authority illustrates a more general phenomenon of the late 1970s and 1980s, called the "fiscalization of social policy." The term refers to the fact that social policy considerations had been subsumed by fiscal policy, and that budgetary considerations became paramount in the development and evaluation of policy, as compared with other values, such as resource redistribution, access to services, and equity. (Block et al. (1987) critique the "realist" view of social welfare spending held by many conservatives; the realist view provides some of the ideological support for this fiscalization of social policy, and blames social welfare programs for the nation's fiscal problems.)

The organization of certain sectors further contributed to this policy situation, and is described in the organizational environment literature, in particular by Scott and Meyer (1983). They point out that "within public sectors in the United States, funding decisions are more highly centralized than are programmatic decisions" (144). At the same time, "the medical care and educational sectors provide good examples of institutional sectors that are characterized by high levels of fragmentation" (145). And, they point out, "when funding is centralized, but programmatic authority is not, control is exercised by

financial officers and accountants" (145).

PROPOSAL SUBMISSION

In the Fall of 1983, the proposal for school mental health services was submitted to the Budget Office. There followed several months of negotiation, mostly between the Mental Hygiene Department and the Budget Office. The Budget Office staff's interest in the proposal stemmed solely from their view that the program had the potential to reduce special education expenses. Cost-savings would result if children in special education could be removed from special education and returned to the regular classroom, where they would then receive specialized services through the on-site school mental health program. Thus, the Budget Office did not approve the proposal as submitted, but requested that the program be geared toward removing children from special education.

The text of the Fiscal Year 1984 City Executive Budget (New York City, Office of Management and Budget, 1984), which was prepared in the Spring of 1983 (before the Budget Office had seen the on-site school mental health program proposal), discussed cost-saving efforts to control the Special Education budget, including "mainstreaming" students in special education into regular education. At that time, the special education budget was over one half billion dollars, and serving over 110,000 students; this growth

represented a 2.5 times increase since 1978. Every three years, children in special education received what is called a "triennial evaluation" to assess their need for continued special education services. The budget officials saw this triennial review as an opportunity to "decertify" some special education students. They hoped that these decertified students would then be placed in regular education classes, and provided, at the same time, with the mental health services of the on-site program. Since special education cost approximately $8,000 per pupil, as compared with $3,000 for regular education (New York City, Office of Operations, 1981), substantial savings would be realized through this strategy.

This goal, however, of decertifying special education students, was not the goal of the program, as stated in the proposal submitted to the Budget Office. Rather, the goal of the program's planners had been to make services accessible to <u>all</u> schoolchildren with emotional problems, although within this group, there certainly would have been children who would have been diverted from special education.

In addition to the fact that the on-site program had been planned with a very different set of goals, the Mental Hygiene Department was not at all anxious to become involved with the special education system for the following reasons, as well:

-- It had been the problems of accountability and monitoring in the Division of Special Education which had prompted efforts to move mental health funding out of the Public Schools in the first place.

-- The special education system was operating under intensive federal court scrutiny, including monitoring by a Federal judge, as the result of litigation against the Public Schools from various plaintiffs. Naturally, the Mental Hygiene Department and its contract agencies were not anxious to become linked to this system, and to face possible legal scrutiny, as well.

-- It was by no means certain that the triennial review process would yield referrals for the program. Very few children, proportionally, were decertified from special education annually, and it was not known how many could be decertified even if mental health services were made available.

-- Even if a triennial evaluation showed that a child could be decertified, parents could block such a move, which happened often. The conventional wisdom offered by educators about why parents often prefer their children to remain in special education classes is that because the size

of those classes is much smaller than the size of regular education classes, students often receive greater individual attention in special education classes, and can be perceived as being higher achievers. If the students are returned to larger regular education classes, parents fear that their children will achieve less and receive an insufficient amount of attention, while, at the same time, be stigmatized for having once been in special education classes.

-- The Mental Hygiene Department feared that the SBSTs, who performed the triennial evaluations, might not wish to cooperate with mental health agency staff. This was a concern since, as mentioned before, some members of the SBSTs had stated that they were just as qualified to do the work of the mental health agency staff, and that they saw no reason why they shouldn't, in fact, be doing it.

The compromise reached at that time, concerning the issue of mainstreaming special education students was that the Mental Hygiene Department, which was taking the leading role in negotiating with the Budget Office, agreed to revise the proposal, incorporating the goal of removing children from special education, which was stated by the Budget Office. It did not however, agree to gear the program

totally toward removing children from special education.

It is ironic that a program proposal which had as a major impetus the removal of the delivery of mental health services in the schools from under the special education aegis should be viewed fiscally as a potential solution to special education budget problems. This resulted from the combination of the fragmentation of authority and decision-making (Edwards, 1980; Scott and Meyer, 1983), and the separation of programmatic and fiscal authority in municipal government, with the Budget Office exercising great influence. That is, although the Mental Hygiene Department and the Public Schools had, with some difficulty, agreed to implement a mental health program in the schools with specific programmatic objectives, the Budget Office, through its fiscal authority, was able to change the orientation of the program's stated goals. However, when viewed in the context of the overall relationship between the Budget Office and the Public Schools, as described above, this is not altogether surprising. The Budget Office could use its influence on this program to exercise control that it normally did not have over the Public Schools, especially over Special Education. In view of the relatively small amount of City money (out of the $4.5 million, half was City funds) actually involved in the proposed transfer of the school mental health funds from the Division of Special Education to mental health agencies, one is tempted to look

for a potential symbolic role for the Budget Office's scrutiny of this proposal. Considering the history of contention between the Budget Office and the Public Schools, it may be that this provided the Budget Office staff with the sense that they were exercising greater control over the Public Schools' budget.

As discussed at the beginning of the chapter, the Budget Office's actions are an example of what Selznick (1966) calls "informal cooptation" (14). Selznick then goes on to make the distinction between the "substance of power," (14) in this instance assumed by the Budget Office, and "formal authority," (15) which was maintained by the lead agencies. As he puts it, "an open acknowledgement of capitulation to specific interests may itself undermine the sense of legitimacy of the formal authority in the community" (15). Thus, for the Mental Hygiene Department, especially, which had placed great significance on this initiative, it was important for its legitimacy that the final program bear some resemblance to the proposed program. Its constituency, which included the mental health agencies and advocacy groups, had made the program a focus of attention, and had lobbied hard for the program. Thus, if the outcome of the negotiations with the Budget Office had been entirely unsuccessful, the credibility of the Mental Hygiene Department might have come into question.

A countervailing force which provided impetus for

maintaining as much of the program's original design and intent as possible was the input of the children's mental health advocates, (which included representatives of the community mental health agencies). These advocates of children's mental health services wrote letters to the Mayor's Office, the Budget Office, and local political figures. It is quite likely, too, that some of the more influential members of the advocacy community may also have had informal discussions, behind the scenes, with City officials. Some may also have been prepared to put pressure on the Mayor, if necessary, by pointing out that it was during meetings of the Task Force on Youth Services (which he had established) that the Mental Hygiene Department and Public Schools had first agreed to bring mental health services into the schools.

PROPOSAL REVISIONS AGAIN

The Mental Hygiene Department then went ahead and revised the proposal, maintaining elements of the original program design, while addressing the Budget Office's concerns. The Mental Hygiene Department argued that by making mental health services available to all school children, placements to special education could be prevented. However, the Budget Office was not usually very receptive to arguments for preventive services of any sort; the Budget Office tended to believe that it was not possible

to demonstrate conclusively that any problem had ever been "prevented," and, thus, that savings could be realized. Also, the Budget Office staff expressed the concern that the program would end up resulting in identifying large numbers of children for whom additional services would be required, thus further escalating costs. Also, the Budget Office was concerned that, since the Public Schools did not have data on the number of children referred to special education as the result of emotional problems (as opposed to learning disabilities, physical problems, etc.), it was not a simple matter to estimate the potential impact of the program.

In order to help bolster its case for the program, the Mental Hygiene Department tried to use data on the special education system to help estimate the potential impact of a prevention-oriented program. However, because of the above-mentioned lack of data and the fact that the process for referral and placement into special education involved several steps, it was really impossible to trace the relationship between an initial decision to refer a child for an assessment and the ultimate placement decision. (Since the Public Schools was an educational system and not a health system, its method of classifying problems was not comparable with the mental health system's, and it was difficult to estimate the current or future demand from the special education population for the specific services to be offered by the proposed mental health program.)

Thus, a study was undertaken by the Mental Hygiene Department to demonstrate to the Budget Office that the children whom the agencies were planning to serve in the on-site program would, indeed, have as serious emotional problems as those children who were being placed in special education. The Budget Office wanted to be assured that the program would, in fact, be treating children who would otherwise be placed in special education. The staff at the Budget Office still felt very strongly that the on-site program should have a large impact on reducing special education costs.

The informal study was carried out by reviewing the clinical records of a random sample of one hundred school children receiving mental health services through a program run by Brookdale Hospital CMHC in District 23 in Brooklyn. The program was similar to the one proposed by the Mental Hygiene Department, and had, in many ways, served as a model for it. It had been operating since the mid 1970s through a local agreement between the community school board and the CMHC.

The study collected data about diagnoses and reasons for referral to the program, gleaned from medical charts. This data was reviewed by the Mental Hygiene Department's Special Assistant to the Commissioner for Children's Services, who was a child psychiatrist. In his opinion, the profiles of these children reflected a level of disability

so severe that it was almost impossible for such children to function in a regular classroom. While it is difficult to determine the impact of specific individual factors on complex policy and program decisions, the results of this study, informal as it was, may have been fairly influential. First of all, it was quantitative, which appealed to the Budget Office staff, who were themselves quantitatively oriented. Second, the Budget Office was not likely to challenge the clinical judgment of the City's Mental Hygiene Commissioner, Sara L. Kellermann, M.D., a psychiatrist, further supported by a child psychiatrist. (If the Budget Office had challenged the clinical determinations, it would have had to get its own outside clinical consultant. This would have been perceived as a serious incursion into Dr. Kellermann's domain, and the issue would have been brought to the First Deputy Mayor or Mayor for resolution. As much power as the Budget Office had, it is unlikely that a confrontation on this issue would have been to its benefit.)

Meetings between the staff of the Budget Office and the staff of the Mental Hygiene Department continued throughout the fall of 1983, and into the winter of 1984. Information was exchanged, data was analyzed, and the program model was continually revised. These revisions involved mostly reworking the numbers of children to be served and the impact on special education. Since there was very little hard data, much of this was quite speculative,

involving various assumptions about preventing special education placement. The Department staff became focused on getting approval to establish programs in the schools, no matter what. While the Budget Office did make requirements and modifications which seemed unreasonable and unrealistic to the Department staff (such as numerical commitments about the number of children to be removed from special education), that did not deter the Department from its goal. It was, of course, frustrating for Mental Hygiene Department staff to constantly have to revise the proposal in order to project potential cost savings. The staff were anxious to implement the program rather than to keep performing what seemed to them unnecessary and rather speculative exercises.

Among those of us who were actively working on this effort, there was a certain frustration and cynicism, as well as excitement, as we attempted to fashion arguments that would convince the Budget officials. The Mental Hygiene Department was very eager to begin implementing the program, while the Budget Office was very determined to be assured, before implementation began, that the program would help reduce special education costs. In addition to many meetings and written exchanges at all levels, there was a lobbying effort by child mental health services advocates to pressure the Budget Office, and, ultimately, the Mayor's office, to approve the program.

Independently, there were meetings between Public

School officials and the Budget Office about the overall Public School budget, as well as about the particular concerns over special education. Although many school officials expressed skepticism to the Budget Office about the program being able to remove children from special education (because of the administrative and legal barriers to decertification), there was some affirmation about the preventive elements of the program.

This process illustrates what is so often noted about attempts to make changes in large systems, which is that change tends to be slow and incremental. Relatively ambitious plans for change face opposition, cooptation, fiscal realities, slow-moving regulatory processes and other decision-making processes, as well.

DECISION POINT THREE: THE CITY'S BUDGET OFFICE AGREES TO THE PROGRAM

In early 1984, after many meetings and exchanges of memoranda, agreement on a proposal was reached between the Budget Office, the Mental Hygiene Department, and the Public Schools. The new proposal stated that the program would serve two groups of children: children who might otherwise be placed in special education as the result of an emotional problem; and children who could be decertified from special education. The first group of children were to be referred to the program by teachers and guidance counselors, and a

system for making these referrals was to be worked out. It was intended that the second group of children, those already in special education, would be considered for the program during the triennial review of their special education placement. In addition, if more frequent reviews of special education status took place, that would provide an opportunity, as well, for school personnel to consult with the mental health agency staff to determine if supportive mental health services provided to the child would allow the child to be decertified from special education and placed in a regular classroom. Then, the mental health agency staff would provide services to the child.

The program was to be implemented in 15 districts; the Mental Hygiene Department would contract with community mental health agencies to provide the services. Further reflecting the program's special education focus, the administrative responsibility for the program within the Public Schools was switched from the Office of Pupil Personnel Services to the Division of Special Education. Although this switch occurred at a time when the Pupil Personnel Office was, in fact, being reorganized, I believe that the switch really had to do with the enormous pressure the Public Schools continued to be under to reduce the size and expense of special education.

As part of the agreement, the Budget Office requested

that the program be formally evaluated during the first year of operation to measure if the program was achieving the goal that the Budget Office had set for it, namely that of reducing referrals to special education. After further discussions, funds for such an evaluation were made available by the Budget Office. Then the Public School and Mental Hygiene Department staff began meeting to discuss terms for an evaluation, including who would carry it out and what its scope would be, as will be discussed in the next chapter.

VII. OBSTACLES TO IMPLEMENTATION: COMPETING ISSUES AND INTERESTS

The approval of the program by the Budget Office provided a cause for celebration within the Mental Hygiene Department, and also among the children's mental health services advocates who for so long had been trying to get mental health services funding for school based-programs. In fact, however, there was very little time for celebration, since there still were so many details to be worked out on the Citywide level.

At the same time, the Mental Hygiene Department needed to begin dealing with the operational-level, day-to-day details of the program, which would concern all of the schools and mental health agencies that would be involved in implementing the program. During the period when all efforts had been directed toward getting the program approved, such details as the precise mechanism for children to be referred to the program, had not been a focus. Suddenly, there was a whole new set of complex issues to attend to before the program could be fully implemented.

As a result of these new considerations, the number of

organizations with an active interest in the program had increased. Naturally, these new stakeholders did not all see things the same way, and the issues raised by the ensuing conflicts also added a level of complexity to the entire effort.

Finally, further adding to the complexities was the fact that new staff members within the two lead agencies -- the Mental Hygiene Department and the Public Schools -- were now going to become involved. Initially, a small cadre of staff within the Mental Hygiene Department, and a few staff of the Public School's Office of Pupil Personnel Services, had worked on the original program proposal and the revisions of that proposal. However, at this stage of the game, as the program was going to be introduced to individual districts and mental health agencies, a new level of staff within both systems was about to become involved. In the Public Schools, this included Regional staff, who had responsibilities for several districts (as part of the special education system), and district and school-level staff. Within the mental health system, the staff with Citywide responsibilities were joined by Mental Hygiene Department borough office staff, as well as by representatives of the mental health services agencies which would be serving the districts.

BACKGROUND

Ironically, after what had seemed to the Mental Hygiene Department staff to be an eternity of waiting for approval by the Budget Office (which finally came in February 1984), the Budget Office began exerting pressure on the Mental Hygiene Department and the Public Schools to have some of the schools and agencies begin their individual programs before the end of the 1983-84 school year, even though there were many details of the program design and its implementation still to be worked out. And these details were no small things; they included the selection of agencies and schools, the drawing up and negotiating of contracts with the agencies, the subsequent hiring of staff by the agencies, and the establishment of policies and procedures to govern the program's operation in the schools, (including determining how to secure Medicaid funding for the services).

However, to the Budget Office staff, the fact that the program had been approved meant that certain service and financial commitments regarding the program's impact on the special education budget had been incorporated into the City's 1983-1984 Financial Plan, and thus, there was no time to lose in meeting those commitments. The Budget Office staff had no patience for the views of program planners about the need for attention to the details of the process of program implementation. Berman states (1978): "The

article of faith that unites implementation analysts is a belief that the carrying out of a policy, the installation of a technology, the realization of a plan, or the enforcement of a law is neither automatic nor assured" (160). Clearly, the Budget Office staff were not "implementation analysts."

The ability of the Budget Office to exert this influence is another manifestation of the "fiscalization of social policy." Within City government, the influence of the Budget Office made it difficult for the leadership of agencies like the Mental Hygiene Department to raise program implementation concerns, because the raising of these issues likely would have resulted in the Budget Office saying that the agencies did not know how to run programs, and then challenging their legitimacy.

This chapter will further explore the effort to get the program off the ground -- or, in Berman's terms -- to move from macro- to micro-implementation (Berman, 1983); that is, from a focus on "high-level management decisions" to a focus on "the delivery or technical task" (164). And, this move was occurring amidst what was still a great deal of uncertainty regarding how the program would operate, including the following: the details of the contracts between the Mental Hygiene Department and each community mental health agency selected for the program; the establishment of policies and procedures for operating the

program; the evaluation of the program, including some events which take us further ahead chronologically than the rest of the chapter, but which belong, structurally, in this chapter; and, perhaps most crucially, the involvement, which was unanticipated, of the United Federation of Teachers (the teachers union), in decisions about the program's design and implementation.

MENTAL HEALTH AGENCY SELECTION

In order to solicit agencies to participate in the program, the Mental Hygiene Department circulated a Request for Information (RFI) to all State-licensed mental health agencies in New York City, including both those that received funding from the Mental Hygiene Department and those that did not. The public mental health system in New York City consists of over 100 agencies throughout the City, as well as State and municipal (Health and Hospitals Corporation) facilities. Within each borough, the Mental Hygiene Department has a manager and staff who are responsible for overseeing the service system in that borough. The manager is familiar with all the agencies in that borough and, through a variety of planning and informational committees which meet on a regular basis, is well-known to the agency directors and senior staff. Also, the Mental Hygiene Department staff perform site visits to audit the programs. Thus, these RFI forms were intended to supplement an already rich formal and informal knowledge

base. In these forms the Mental Hygiene Department requested information about the agencies, including a brief description of their current programs for children, prior experience working with schools, and the location and service area of the agencies. Most of the responses came from agencies well-known to the Department, since these agencies already had contracts with the Department to support other mental health programs.

Once the RFI responses were received, the agencies that responded were matched with the school districts that had been identified as priorities for the program, based upon the Public Schools' criterion of numbers of requests for assistance for SBST services. In many cases, there was only one agency appropriate for the district, based on location and service area. In those districts in which more than one agency was available, the individual agency's experience with schools, and its fiscal, administrative, and clinical performances were considered, before a decision was made.

While the Mental Hygiene Department was making these decisions about the agencies, there were, however, (as will be discussed below in greater detail) changes being made in the selection of which school districts the program would serve. Since one of the criteria for the agencies was that they be able to serve specific areas of the city, changes in the district selections had an impact on the choice of agencies. Thus, during this period of Spring 1984, there

was intense activity, as well as a feeling of uncertainty, as Department staff were trying to work out choices of agencies, and also to get contract documents written, approved, and forwarded to the Board of Estimate for approval. The Department staff wanted the programs to start as soon as possible; and, at the same time, they were trying to adjust to the changes in districts being made as the result of simultaneous discussions with Public School officials, representatives of the Teacher's Union, and the Mayor's Office of Youth Services.

In order to contract with voluntary non-profit agencies and hospitals, the Mental Hygiene Department had to bring the proposed contracts before the City's Board of Estimate. The Board of Estimate met monthly, and contract documents were to be submitted to the Board of Estimate membership sufficiently prior to the meeting to allow time for review. The Board consisted of the Mayor, Comptroller, City Council President, and the five borough presidents, all elected officials. Prior to submission to the Board, the contracts had to be reviewed by the City's Budget Office, as well. Thus, it was clear to those involved that, from the time contract negotiations began, through contract preparation and the various approvals necessary, several months would have to pass.

The proposed contracts between the Mental Hygiene Department and the agencies required that the agencies

specify in detail the anticipated costs of providing services. The contracts also required that the agencies make specific projections of how much service would be provided, as measured by the total numbers of visits. These projections were to be made annually, as well as broken down on a monthly basis. And, while various guidelines were made up regarding these projections, sufficient differences existed among the agencies, themselves, as well as among the programs they operated, to make each contract unique. (As part of its negotiation with the Budget Office, the Mental Hygiene Department already had projected the amount of service the program would provide; this projection, however, had been worked out in the aggregate, for the program as a whole. In order to complete the contracts, projections had to be worked out for each agency. And these projections had to take into account differences in costs for each agency, reimbursement income, and other factors.)

To assist the agencies in contract preparation, and to attempt to standardize the program as much as possible, the Mental Hygiene Department developed a model for the agencies to use in staffing the program. A staffing pattern specifies the combination of staff of each mental health discipline required to provide a certain quantity of service, taking into consideration the type of setting the services are provided in, the types of clients, the goals of the program, etc. The staffing pattern was developed

keeping in mind the available funding, as well. In addition to providing a staffing model, the Department lowered its requirement for the number of direct treatment visits that each staff member had to perform, since it anticipated that starting up the program in the schools (which would require meetings with teachers, guidance counselors, parents, and other interested parties), would take up staff time that might otherwise have gone to actual direct service to the children. The Mental Hygiene Department wanted to be sure that staff had time to work with teachers and other school officials to develop referrals and to follow up on cases. The reduced service commitment, however, affected the projection of revenues, which had an impact on the overall budget for the program. A change in any one assumption had a ripple effect, not just for the individual agency's contract in question, but for the entire program, since the total amount of funding available, citywide, was fixed. As discussed earlier, the Mental Hygiene Department and Public Schools had made certain commitments to the Budget Office about the overall impact of the program, as measured by the numbers of children served, and also by the numbers of children kept out of special education and/or removed from special education. The contracts required projections of this as well.

Also, the Mental Hygiene Department still was negotiating with the Budget Office as late as March 1984

about the precise outcomes for the program. These negotiations concerned the number of children to be removed from the special education system and the number of children whose entrance into that system was to be prevented. These numerical targets had an impact both upon the contracts with community mental health agencies and upon the design of the evaluation of the overall program. The City's Executive Budget for Fiscal Year 1985 (July 1, 1984-June 30, 1985), which was prepared in April 1984, makes reference to a savings of $4.5 million in the Board of Education budget, as well as to the budgeting of money for an outside evaluation (New York City, Office of Management and Budget, 1984: 192). In order to gain Budget Office approval, the Mental Hygiene Department developed projections of the impact of the program: "1,700 children will be mainstreamed (i.e. removed from special education and placed in regular education) and referrals for evaluation will be reduced by 2,940 students" (192).

For the most part, the agencies accepted the model staffing pattern developed by the Mental Hygiene Department, and thus were willing to enter into contract. However, in one case, a municipal hospital that had been selected to participate in the program wanted to make a significant change in its staffing pattern. This change was to add a full-time administrator for the program, although such a position had not been included in the Department's model.

In addition, the hospital wanted to include substantially more time of a psychiatrist than the staffing pattern anticipated. Psychiatrists were considerably more expensive than other mental health professionals. These two enhancements would increase the budget of the proposed program considerably, without any offsetting revenues; thus, the Mental Hygiene Department could not approve this, and so another agency had to be found in order to serve the district.

In order to begin to meet the targets set for the program, at the same time that the above mentioned negotiations were taking place, the Mental Hygiene Department and Public Schools were trying to get the program started in an initial group of five districts (referred to as the Phase One districts) by June 1984. By June 1984, the Five Phase One agencies had contracts which had been approved by the Board of Estimate, and the districts had identified schools for the program to begin. Since it would take some time for the agencies to get new staff hired for the program, program directors or other members of the agencies' senior clinical staff would begin working with school officials to set things up. By mid-July, seventeen agencies for fifteen districts (two districts were divided so that two agencies would serve them) had been identified, and nine contracts had been approved. Twelve superintendents had approved the program, and another three

had given provisional approval, while they awaited community school board approval.

DEVELOPING POLICIES AND PROCEDURES

At the same time that these agencies were being selected, and at the same time that contract negotiations were beginning with the agencies that were to participate in Phase One, Public School and Mental Hygiene Department staff began meeting to discuss the program with a greater attention to detail. An initial meeting of high-level Mental Hygiene Department and Public School staff was held in February 1984. At that meeting, both the Division of Special Education and the Office of Pupil Personnel Services were represented, though this was the last time the Office of Pupil Personnel Services was to be involved.

Since the program had taken on a special education prevention focus, the leadership of the Public Schools had placed responsibility for the program within the Division of Special Education; this move by the leadership reinforced the direction in which the program's focus had been moving. Also, as discussed earlier, the fact that the program was going in that direction -- which had not been the initial intent of either the Mental Hygiene Department or the Public Schools -- reflected the desire of the Budget Office to find less expensive alternatives to growing special education system. And, as mentioned earlier, Special Education is a

heavily regulated area. There had been court cases brought against the Public Schools regarding access to services. Thus, now that the program had a focus on special education prevention, extra care needed to be taken so that the program not be viewed as preventing access to special education in those instances in which special education placement was, in fact, most appropriate for the children.

In April 1984, a meeting was held between Mental Hygiene Department staff and representatives of the Public Schools. One purpose of the meeting was for the Mental Hygiene Department staff to be introduced to the Division of Special Education's newly-selected liaison for the program, Irma Godlin, who was in charge of the Division's Office of Alternative Programs. This choice was consistent with the view by the Public Schools, and the Budget Office, that the program be a part of the overall effort to develop alternatives to special education. This view, although consistent with the expectations held by the Budget Office, was quite different from the initial conception of the program held by the Mental Hygiene Department, which had been to make mental health services more accessible to all schoolchildren. And, while the program still involved placing mental health workers in the schools (thus increasing accessibility for the children), it now seemed to the Mental Hygiene Department that the program's focus on preventing special education placement, on the one hand, and

helping to remove children from special education, on the other, would leave many children whom the Mental Hygiene Department wanted to serve with no greater access to mental health services.

The Mental Hygiene Department did not want the program to become a part of the special education system. The original conception of the program was that it would be an extension of the community mental health agencies which could reach into the schools. However, once the Budget Office attached special education-related outcomes to the program's funding, and once the Division of Special Education became the program's sponsor within the Public Schools, this conception was held only by those within the mental health system. Yet, it had been problems between the Bureau of Child Guidance, the Division of Special Education's predecessor, and the Mental Hygiene Department, that had been a major catalyst for the program's development.

Thus, in order to counter the perception that the program was designed to provide counseling services in the schools merely as an alternative to special education, the Mental Hygiene Department began to emphasize to the Public Schools Central Office and school district personnel the fact that the programs in the schools would be linked to the larger agencies which sponsored them, and thus would be able to offer services not just to the children but also to other

family members, including family therapy, if it would help address the problems of the children referred to the program. In addition, they emphasized that the agencies could provide comprehensive psychological and psychiatric services beyond what could be provided by either the SBSTs or the on-site programs alone.

Subsequent to the meeting at which the Public Schools' liaison was introduced, a Program Advisory Committee was formed, chaired by the Executive Director of the Division of Special Education, and including senior Mental Hygiene Department staff, the Public School program liaison, and a number of District and regional level administrators and supervisors in both the regular education and special education system. One of the purposes of this advisory committee was to provide advice on the best way to implement the program, reducing conflict and assuring appropriate referrals. In addition, the Program Advisory Committee provided information, based upon their experience, on the likelihood of the program being successfully established in the various school districts. This information was used in revising the list of selected districts.

PLANNING THE EVALUATION

The agreement with the Budget Office had included that a formal evaluation of the program be carried out. The intention of the evaluation would be to determine the

program's effectiveness during its initial year. The continued funding of the program would hinge on the evaluation, which would seek to determine if the program was reducing referrals to special education. One hundred and twenty-five thousand dollars was made available for the evaluation by the Budget Office.

In the late Spring of 1984, the Public Schools staff proposed to the Mental Hygiene Department that the Office of Educational Evaluation, a quasi-independent unit within the Public Schools, administer the evaluation. This was acceptable to the Mental Hygiene Department. Then, the Office of Educational Evaluation was asked to prepare a preliminary evaluation plan, and a few meetings were held with the Director of that Office to discuss the evaluation.

The Office of Educational Evaluation shortly thereafter submitted its preliminary evaluation plan. Naturally, the plan proposed to determine if the program was having an impact on special education referrals. In addition, the evaluation would provide some descriptive information on the children receiving services. It would also describe the manner in which the program was functioning within the schools, so that future modifications could be made. And, finally, the plan proposed the evaluation of the behavioral and educational impacts of the program.

While the Office of Educational Evaluation was willing to evaluate the program, certain difficulties in evaluating

the impact of the program on special education referrals began to be identified and discussed at these preliminary meetings. The problem had several dimensions:

-- The special education system was in flux. There were changes being implemented in the classification system used in categorizing and placing children in specific programs. This would make it difficult, if not impossible, to compare one year's performance to the next.

-- In some areas there was a backlog in the referral process, so that if some children were, in fact, diverted, their places would have been taken up by other children. This would make it difficult if not impossible to show the impact of the program.

-- At the initial referral stage in special education, the referring teacher does not specify the type of service required by the child, since that is determined further along in the process by the Committees on the Handicapped. Since the on-site school program could only be expected to reduce referrals for emotional problems, and not for other sorts of problems such as physical disabilities, hearing and speech difficulties, etc., there appeared to be no way to make a one-to-one comparison between the on-site program and

the reduction in referrals.

However, the Mental Hygiene Department staff and the Public Schools staff felt that the Office of Educational Evaluation would be in the best position to devise solutions to these evaluation problems, since it was familiar with the various data bases in the schools and had experience with working on similar problems in other school evaluations.

The plan proposed by the Office of Educational Evaluation was then reviewed by the Budget Office and the Mayor's Office. While no one challenged the merits of the plan, it was decided by these staff that the evaluation results would never be accepted as independent and impartial, if the evaluation were carried out by the Office of Educational Evaluation, even though the office had evaluated highly visible and sensitive programs in the past. At that point, the Director of the Office of Educational Evaluation did agree to be a technical advisor to the staff who would have to develop a Request For Proposals (RFP) for an outside evaluator. A Steering Committee was formed, consisting of representatives of the Mental Hygiene Department, the Public Schools, the Budget Office, and the Mayor's Office of Youth Services. This group would be responsible for reviewing the proposals, choosing a contractor, and overseeing the conduct of the evaluation.

It was not until the early Spring of 1985 that an RFP was completed that was satisfactory to all parties. Some of

the issues that arose in developing the RFP had to do with defining the scope of the evaluation, and being precise about what would be expected as far as data gathering, versus what could be provided to an evaluator in the form of already collected data. It was the staff of the Mental Hygiene Department and the Public Schools who wrote and rewrote the RFP. As they tried to make it as clear and precise as possible, a major difference in the views of the representatives of the two systems emerged. To put it somewhat more starkly than may be fair, the difference was that the education system is geared toward relatively short-term behavioral changes. The mental health system, in general, is geared toward changes in internal emotional states, which would then drive behavioral changes. These happen relatively slowly. For teachers who want relief from children who often are disruptive, the prospect of referral to a mental health program which would not offer some short-term results would be relatively unattractive. Also, basic educational indicators, such as reading and math scores were not likely to change significantly over the course of a single school year because a child was receiving an hour of psychotherapy a week.

Since the evaluation was not a research project, but rather a highly politicized evaluation, the Mental Hygiene Department staff were concerned that the variables to be measured, and the outcomes to be expected, be reasonable. On

the other hand, neither party wanted to do the work of the evaluator, so the RFP was kept fairly brief and schematic, leaving it up to potential evaluators to propose strategies.

The Budget Office had hoped that the evaluation of the program would be completed in December 1985, so that the decision about continued funding for the program could be made in time for the 1985-1986 school year. However, with the delay in developing the RFP, it became clear that the evaluation would most likely not be completed until December 1986. In the spring of 1985, the RFP was sent out to a list of twenty or so university and corporate evaluators; only two responses were received, perhaps because prospective evaluators were aware of both the difficulties in measuring what was expected to be measured, and the political context within which the evaluation would be conducted. After reviewing the proposals and meeting with the evaluators, the Steering Committee chose Dr. Sheldon Kastner of NYU to carry out the evaluation. By this time, the program had been in operation for more than an entire school year.

I have gotten way ahead chronologically in this story, but, from a structural point of view, the events described above fit into Stage Four. This disjuncture between strict chronology and the structure of events often occurring simultaneously reflects what I discussed in the first two chapters about things not necessarily being linear nor the

structure a priori. We now return to the Spring of 1984.

THE UNION ENTERS

In New York City, the teacher's union -- the United Federation of Teachers (UFT) -- is an important and influential participant in educational politics. Although the UFT does not get involved in decision-making regarding every single program the Public Schools develops, once it appeared that the on-site school mental health program was going to be implemented, the union expressed its concerns about the program to the Public Schools' leadership. Its major concern was that the mental health agency staff coming into the schools would pose a threat to the jobs of school social workers and school psychologists. Further, the school social workers and school psychologists believed that they themselves could perform the work being asked of the mental health agencies, if they would be relieved of their responsibilities to assess children for special education placement. Thus, the union membership wanted the outside mental health staff eliminated and the money used to hire additional school social workers and psychologists.

A series of meetings was held with the Division of Special Education, the Mayor's office, the Mental Hygiene Department and the union leadership. The union's top leadership seemed to understand the value of the program and the additional resources which were being brought to bear on

a serious problem, but wanted assurances that its members' jobs were not jeopardized. And, the union received agreement that its representatives could attend various district level meetings at which the program was presented, to assure that the interests of union members were protected. Once these assurances were provided, the union officials, did, in fact, provide information which was useful to the Public Schools' officials in selecting districts for the program. Among other things, this information included the union officials' perceptions about the likelihood of successfully implementing the program in various districts, and conversely, identifying some in which, as the result of an uncooperative or unreceptive superintendent or lack of guidance counselors, implementation would be difficult. This advice, was, in fact, heeded, and did result in four districts being dropped from the list of districts which had been created in 1983, and additional districts being added. The total of community school districts selected was now nineteen. In addition, the Public Schools requested that the Mental Hygiene Department contract with an agency to serve two high schools in Manhattan. The Mental Hygiene Department agreed to do this.

It should be noted that the Deputy Assistant Superintendents for Special Education were also brought into this decision-making process about the choice of districts.

The DAS's, as they are referred, have Regional responsibilities for supervising special education within the Public School system. The regions correspond to Boroughs, except in the case of Brooklyn, in which one Region is part of Brooklyn and another is the balance of Brooklyn plus Staten Island.

Also, separate from the above meetings, the union received a promise from the Division of Special Education that the program would not be expanded beyond its originally planned numbers of schools and staff, at least until the program evaluation was completed. The Mental Hygiene Department was not a party to this agreement; this was to be a source of tension, periodically, since the Mental Hygiene Department and mental health advocates were to lobby to expand the program during subsequent years.

While the top union leadership agreed to support the program, the union chapter representing the school psychologists and social workers did continue to try to have the program stopped. An issue of the chapter newsletter ran an item stating that the chapter leadership was continuing to attempt to remove the mental health agency staff from the schools, and to have the funds returned to the Public School budget. School psychologists and social workers continued to perceive the program as an intrusion by outside mental health agency staff. Since the school psychologists and school social workers' salaries were paid by the Public

Schools, from a budget which had grown over the years (in part as the result of the increase in special education), they were concerned that the Public Schools might try to replace them with the mental health agencies' staff, whose salaries were paid by the Mental Hygiene Department (and in part by medicaid and other insurance reimbursement).

Also, there was some resentment by the school psychologists and social workers against the mental health agency staff. Some of them stated that they viewed their own work (assessing children for placement in special education) as less professionally satisfying and interesting than providing ongoing clinical treatment to children.

DECISION POINT FOUR: CONCERNS RAISED BY THE TEACHER"S UNION ARE SUCCESSFULLY ADDRESSED

As the result of the agreement by the Teacher's Union to support the program's implementation in exchange for involvement in decision-making about the program's development, the program planners could begin to contact school superintendents about the superintendents' interest in the program.

VIII. SELLING THE PROGRAM TO SCHOOL SUPERINTENDENTS

BACKGROUND

For the program to be implemented, individual school districts had to agree to participate in the program. As discussed previously, a list of potential districts had been drawn up, based upon the criterion of numbers of requests for assistance from teachers and guidance counselors to SBSTs during a six month period. These requests were taken as an indication of a need for mental health services. Subsequently, changes to that list had been made, based upon input from the Union and from the Deputy Assistant Superintendents for Special Education, who had borough-wide responsibility for special education services. This input included assessments of the anticipated reception the program would receive from the superintendents, the sufficiency of guidance counselors in districts, and an assessment of the ability of the Superintendents to manage the program and to work cooperatively with Central Public Schools officials, mental health agencies and other interested parties.

Until this point, all of the meetings and other

discussions between the Mental Hygiene Department and the Public Schools had involved the Central Office and these few Borough-level personnel. Individual district officials had not participated in the planning of the program, nor had they been contacted about their interest in the program, at least not formally. (It is likely that there may have been informal discussions within the Public Schools with District Superintendents regarding the intent to implement the program).

In this stage in the program's development, a significant change in the path from plan to program outcome occurred. As discussed earlier, in his discussion, Berman (1978) distinguishes between macro-implementation and micro-implementation. While there is no precise point at which things move from macro to micro implementation, certainly at this point micro-implementation is underway. In the present case this is highlighted by two related factors: changes and an increase in the number of settings in which program activities occurred, as activity within the separate school districts and communities began in earnest. What had been conceptualized as one, single program, was now becoming five programs, one for each of the initial five school districts. And it would then become fifteen programs for the three schools apiece in those districts. And then it would become an increasing number -- approaching seventy -- as districts, and schools within these districts, become the sites of

activity. Also, at the same time, the number of interested parties became enormous, and, as will be discussed in the next chapter, implementation involved an increasing number of issues (many unanticipated) with unforeseen problems arising.

Berman states that "the literature agrees that the implemented program [what Berman calls the missing link between policy and outcome] depends on the complex interplay between the policy choice [i.e. the policy itself] and the policy's institutional setting, which consists of one and often many formal and informal organizations" (164). Berman adds, "the faithful execution of government programs typically requires changes in the standard operating procedures that define delivery organizations. Such change never comes easily. Indeed, organizational members may adapt to demands for change in unanticipated ways, which is the crux of the micro-implementation problem" (172). The unpredictability suggested in the above quote was exacerbated in establishing the on-site school mental health program for two reasons: first, two different systems were involved, and, second, although the program was being coordinated at one level it was being implemented at another level (the local level) in a number of different sites, and by a number of different organizations. There were both vertical and horizontal connections that had to be made, and translations between systems.

Also, because of the prior history behind the program's development, there were old rivalries between members of the two systems, as well as different goals implicit in the implementation. The school personnel who were approached about implementing the program, for instance, were only familiar with the final program that had been approved by the Budget Office (and then subsequently made even more specific in written materials developed by the staff of the Public Schools and Mental Hygiene Department). On the other hand, many of the leadership and staff of the children's mental health agencies, as well as the Mental Hygiene Department staff, still carried with them the memory of the earlier program plans, which had had nothing to do with reducing costs for special education. Added to these different goals was the fact that the conditions in each district, school, and mental health agency would be different enough to make it impossible to implement the programs as carbon copies of each other (Lipsky, 1980; Berman, 1978).

In each district, and in each school, the program model and the resources being offered were interpreted by superintendents according to the current district politics, their view of the schools' needs, and their prior experiences with mental health services, among other things. Thus, regardless of the central office staffs' intentions to manage the program on a citywide basis, each district and

school had, to some extent, a distinct and separate program. And, each mental health agency also had its particular view on things, reflecting different structures, size, orientation, and other factors.

PHASE ONE DISTRICTS

Soon after the approval of the program was received from the Budget Office, five district superintendents -- one from each borough -- were approached about their potential interest in having the program in their district. Then, a presentation was scheduled at which both Public School and Mental Hygiene Department staff introduced the proposed program to the superintendents. Naturally, after these presentations had been made, the district superintendents raised their own specific concerns about program implementation and policy. These ranged from concerns about finding appropriate space for the program, to skepticism about whether the program would be successful in helping to remove children from special education. The superintendents also raised questions about the process by which children were referred to the program, and whether parents would consent to having their children receive mental health services in the schools.

For the most part, the choices of districts and mental health agencies for Phase One of the program, were unproblematic. In one case, however, there was a problem.

The superintendent of one district in the Bronx rejected the choice of mental health agency, indicating that another agency was preferred. The rejection of the agency created a bit of a crisis, and brought to a head issues of program control, because, in its haste to move ahead in Phase One, the Mental Hygiene Department already had completed a contract with the agency it had chosen. A compromise had to be reached, therefore, and so the originally-chosen agency agreed to serve some schools in part of an adjacent district. (And the program was not established in the district that had rejected the agency.)

MEETING WITH SUPERINTENDENTS

It was planned that the remainder of the fifteen district programs would start during the following school year, beginning in September 1984. But it was not until the Spring of 1985 that the program was fully implemented. By that time, nineteen community school districts and two high schools were being served by twenty-two mental health agencies. Of the original fifteen districts, five were not included in the nineteen which were ultimately to participate in the program; of the final nineteen, nine had not been in the original list. The meetings with the school superintendents (during which the initial presentations were made) had provided the first opportunity to bring the program from being a well-elaborated idea to being poised

for implementation. While up to this point the locus of the program planner's activities centered around the City Hall area of lower Manhattan and the Public Schools central offices on Livingston Street in Brooklyn, now the "orbit" extended to school district offices in five boroughs.

The typical initial meeting with the District Superintendent occurred at the School District office, either in the Superintendent's office or in a conference room. Most often the District Offices were in schools, or in buildings adjacent to schools. The meetings were usually attended by some members of the superintendent's staff, and the director of guidance services. Also, representatives of the school social worker and school psychologist chapter of the Union attended, as had been agreed to at meetings mentioned in the previous chapter. If, by that point, the mental health agency to provide services had been selected, it often had a representative in attendance. Also, in addition to the Mental Hygiene Department planner who had made the presentation about the program in conjunction with the Public School liaison, staff from the Borough Office of the Mental Hygiene Department was included. In general, it became clear during these initial meetings that the Superintendents were pleased that additional mental health resources were being made available for children in their district. They recognized the need for mental health services for school children, and many of the

Superintendents expressed strong and enthusiastic interest in the program. They also appeared to recognize that implementation of the program would not be easy.

It was widely believed by the staff of the Mental Hygiene Department that the program would not have been accepted by the Superintendents and the principals without the efforts of the Director of the Division of Special Education's Office of Alternative Programs, who was the liaison for the on-site program. Her ability to steer the implementation effort through some often tense and conflict-laden meetings and incidents was unusual. She had an understanding of the mental health system, and such understanding had appeared to be missing in earlier contacts between Mental Hygiene Department staff and Public Schools staff. She also dealt very effectively with District officials, who at times felt that the program's implementation would be too much trouble, or would create friction, within the districts.

The circumstances in each district were different. Sometimes, for instance, there was a lack of space in the schools. Also, some schools lacked guidance counselors, and, this was viewed as a major problem since it was believed that their presence was essential. The program planners expected the guidance counselors to insure referrals to the program, as well as to provide a link between the teachers, school administrators, the special

education system, and the mental health agencies. In districts where there were guidance counselors, the superintendents were concerned that often already beleaguered guidance counselors would perceive the program as an additional burden. Also, some superintendents were hesitant to commit to the program without community school board approval.

These and related concerns influenced the willingness of the superintendents to receive the program, as well as the selection of specific schools. The superintendents also selected schools based upon the following: the quality of individual school management; the need for services in the specific schools; the nature of the student bodies; and, the likely acceptance on the part of parents in each school.

Also, relations with the SBSTs was a critical issue. The SBST school psychologists and school social workers were not part of the community school district hierarchy. Rather, the Division of Special Education had its own structure, which divided the city into five regions, with a Deputy Assistant Superintendent in charge of each region. The social workers and psychologists reported up through a structure that included clinical supervisors who oversaw the work of these professionals. On the other hand, within each district there was a Committee on the Handicapped, which was the body that made the placement decisions into special education (based upon the information provided by SBST

evaluations). In some districts, good management, mutual respect, and informal professional and personal relations contributed to relatively smooth relations among all of these players. In other districts, it was reported that this was not the case.

After that initial meeting with the superintendents had been held, the Public School's liaison worked tirelessly to encourage the superintendents to accept the program and to begin selecting specific schools. Sometimes this required behind-the-scenes discussions so that assurances could be provided to equivocal superintendents that the program would definitely receive enough resources to operate, and that it would not become an administrative or political headache for them.

In addition to their joint effort to recruit school district superintendents to select schools to participate in the program, the planners were working together on other aspects of the program, such as designing and getting approval for printed forms for use in the program. Also, as planning started in each district, different sorts of issues arose, such as who would be responsible for telephone-related expenses, and assuring that locks would be placed on the doors of rooms where mental health agency staff would work. Because of the different organizational perspectives that the staff brought to their work together, there were some differences of opinion concerning the degree and type

of flexibility which could be incorporated into the program's design, and how much local discretion could be exercised by the various parties in attempting to solve problems, and to adapt the plan to unique conditions and requests in the districts.

As the program moved closer to becoming a reality, the differences between the two systems -- education and mental health care -- became even more relevant. Both the community mental health agency staff and the Mental Hygiene Department staff were unfamiliar with the inner workings of the schools and the "world view" of those inside. Similarly, the mental health system was unfamiliar to the Public School personnel. The two systems operate under very different models -- health care and education -- and the structure and culture of the systems are very different.

For example, in terms of structure, the Public School system encompasses a vast system of schools, districts, and Central Office bureaus, units and Divisions, under a single Board of Education. Within that system, the Central Office has certain responsibilities and authority, while other rights and responsibilities are held by the districts and the schools. But all ultimately are part of the single system.

On the other hand, the mental health system consists of relatively autonomous mental health agencies and even more autonomous hospitals, with specific, and well defined,

contractual obligations to the Mental Hygiene Department. But these obligations do not in any case encompass the full scope of the agencies' responsibilities. They all have their own boards of directors, and they tend to have contact with lots of outside organizations, including other City and State agencies, each other, and their professional organizations. Their nomenclature, ideologies of treatment, etc. are different than those of the school personnel.

Also, what Meyer (1986) says regarding the mental health system in general is true in New York City regarding organizational forces at work within the mental health system. He writes that "the system lacks integration and structure. This is apparent on both classic dimensions of structure in an organizational system. Vertical differentiation is unclear, with anarchic networks of partial control or sovereignty. Horizontal differentiation is also unclear, with any given organizational unit handling multiple problems, and any given mental health problem being dealt with simultaneously by many different and unintegrated organizations" (25).

In terms of culture, many of the Public Schools employees have been in the system for a long while, and have moved among the various units, adopting a shared organizational "world view." They take for granted the model of authority and the division of responsibility, and expect those they come into contact with outside the system

to know it too. In general, they do not have a great deal of contact, on a professional level, with outside organizations. The system is relatively monolithic and all-encompassing. Nevertheless, significant tensions do exist within the system. In particular, there are tensions between the community school districts and the Central Offices. For example, some of the cynicism expressed initially by the superintendents about the program, was because they perceived it as something cooked up in the Central Offices, without their input, that they would then have to make work.

It is more difficult to characterize the mental health system's culture, since the system is more differentiated, with different types of organizations and settings, ranging from small, community-based agencies, to departments of psychiatry in large medical centers. Also, various professional disciplines are represented, including psychiatrists, psychologists, social workers, and counselors of various types, all of whom have different treatment ideologies. Also, services are delivered in private, under norms of confidentiality and with the pressures, often, of societal stigma. Further, individual professionals in the system may move from one agency to another throughout their careers. Also, practitioners may move into policy and program development positions in either City and State government, and vice versa. As Meyer (1986) writes about

the mental health system, "the different organizations reflect different collectivities, professions, ideologies, definitions of the problems, technologies, and funding systems" (25). And he continues, "the system reflects continual and direct crises of legitimacy. It is highly funded but left open in every respect to fundamental cultural attacks" (27). While in New York City mental health services possess greater legitimacy perhaps than elsewhere in the nation, mental health services are not taken-for-granted and normative, like school services, for which, on the other hand, according to Meyer, "there is a national institutionalized definition of education, broadly shared and used in every arena, from which school organizations can draw clarity, support and legitimacy" (27).

The Division of Special Education liaison who had been given responsibility for coordinating the program's implementation was then assigned to implement the program. She had had no particular involvement with, or interest in, the earlier conception of the program that the Mental Hygiene Department had held (establishing mental health clinics in schools to serve any, and every, child who might be in need of mental health services). This earlier, and broader, conception, of course, was at variance with the specific focus the program had taken on as the result of the agreement with the Budget Office.

One of the concerns the liaison voiced was that, in her view, while the program provided additional resources to the mental health agencies, the schools were being given no additional resources to support the administrative burdens the program placed on them. Thus, she was protective of the school staff.

Also, in the same vein, since the programs were to be located in school buildings, the liaison promoted the view that the programs be seen as "part of the school." She expressed the view that the schools were the "hosts" of the programs, and believed that the agencies should adapt fully to school norms. Her perspective was that teachers would be more likely to refer some children with problems to the program, rather than just to special education (as was most often the case) if the mental health staff were viewed as part of the school. Thus, the message from the Public School liaison, and from others within the schools, as well, was that mental health agency personnel were to consider themselves as school personnel and, therefore, to acknowledge both formal and informal authority structures within the schools. This would sometimes create a dilemma for the mental health agency workers, who viewed themselves as independent and autonomous workers providing the schools with their psychiatric expertise, and also with diagnostic and treatment services that would not be available to schools otherwise. And, therefore, they sometimes perceived

the school personnel as inflexible. As it turned out, however, in many cases, as the programs were implemented, the mental health agency staff did find that they were able to be most effective by becoming identified as part of the school (albeit, with a special role to play). The independent evaluator of the program described this as "quasi integration" into the school.

DECISION POINT FIVE: SCHOOL DISTRICT SUPERINTENDENTS ACCEPT THE PROGRAM

In each district, the superintendents made their decisions under different conditions, and with different priorities in mind. Decision Point Five is really the aggregation of the decisions made by nineteen school district superintendents, between Spring 1984 and mid-1985.

The fact that the superintendents agreed to participate in the program did not, by any means, eliminate the ambivalence that many had about the program. They expressed concern that the program would require a great deal of attention and commitment from guidance counselors, who were in short supply. Some of the superintendents did not wish to become involved in a program that would be so scrutinized by the Central Public Schools. They envisioned paperwork and other demands made upon them.
Also, some superintendents must have been concerned about the potential conflict with the SBSTs that could result from implementing the program. Nevertheless, there appeared to

be a general consensus about the need for mental health services for children. Some of the superintendents and their staff had had positive relations with some of the mental health agencies, which contributed to their affirmative response.

IX. MICRO-IMPLEMENTATION

In this chapter I will discuss the micro-implementation of the program, which involved establishing and maintaining the program in each of seventy schools. As discussed earlier, the concept of micro-implementation is borrowed from Berman (1978) who distinguishes between macro- and micro-implementation. While the overall Citywide planning of the program corresponds to macro-implementation, micro-implementation is a more local process, occurring in each district and school, leading to the establishment of the programs in each school.

Thus, Stage 6 -- micro-implementation -- unlike the preceding five stages, is not punctuated by a decision point. Rather, instead of a decision point, I discuss the transition toward the institutionalization of the on-site program, since, according to Berman (1978), institutionalization is the last phase of micro-implementation (177). Institutionalization is often said to have occurred when a program's continuation is taken for granted by those responsible for funding, operating and otherwise supporting it, or when a program becomes part of

"standard operating procedure" (Berman, 1978). Institutionalization frequently results in the practices associated with a once new or innovative program being absorbed into the overall functioning of the sponsoring organization. In this type of situation, while the discrete program may lose its identity, the practices associated with it endure.

BACKGROUND

The fact that micro-implementation was occurring in each school did not mean that macro-implementation ceased. While micro-implementation went forward, there continued to be ongoing discussions at the Citywide level about the following: overall management of the program; the continued funding of the program; the evaluation, which had bearing on the continued funding; and, other issues. Issues overlapped, and often the line between program planning, macro-implementation, and micro-implementation was difficult to draw (see, for example, Pressman and Wildavsky (1983) for an extended discussion of the notion of the overlap of planning and implementation). Palumbo (1985) has made the observation that, "program implementation and program design are highly interrelated activities" (10). Certainly this was true in regard to the on-site program, in which planning and macro-implementation continued well after micro-implementation had begun, since so many unforeseen issues

had to be addressed.

A great many adaptations and adjustments had to be made in order for the micro-implementation process to be successful. As discussed in previous chapters, the staff of the Mental Hygiene Department and its agencies, and the staff of the Public Schools, had to learn to adapt and adjust to one another as part of macro-implementation. Also, there needed to be mutual adaptation between the overseers of the program (the Mental Hygiene Department and the Public Schools) and the individual schools and agencies participating in the program. The Mental Hygiene Department and the Public Schools wished to maintain an over-arching identity for the program for reasons of accountability and prestige. On the other hand, they did recognize that, in order for the program to be effective, it had to be adapted to local realities. Of course, the staff of the Mental Hygiene Department and the staff of the Public Schools frequently perceived these local realities in different ways. Also, within both the Mental Hygiene Department and the Public Schools, staff frequently perceived these local realities differently. Naturally, as these various adaptations and adjustments were made, the course of micro-implementation was affected.

PROGRAM OPERATIONS

Operations Context:

The development of detailed guidelines on how to operate the program had been made complicated by several factors: the differences between the mental health system and the educational system; the complexity of both systems; the fact that the program was being implemented in so many different school districts and schools, by so many different mental health agencies (Lipsky, 1976; 1980); and, the different expectations for the program held by various stakeholders, as well as their differing views about the importance of the program.

Especially at the beginning of the program's micro-implementation, unanticipated problems and issues arose. Each time a problem arose, the first decision that had to be made by those involved was whether the problem was something to be handled locally within the school, or whether it should be brought to the attention of the representatives of either the Public Schools or the Mental Hygiene Department.

The Staff in the Schools:

Before proceeding to discuss the specific micro-implementation issues, some background on the types of individuals involved in the micro-implementation, as well as some background on their organizational and professional

affiliations, may help to provide a context for greater understanding of the discussion. At the individual school level, each school had a school liaison, appointed by the principal. Often this was a guidance counselor, though in some cases it was an assistant principal. The school liaison's job was to represent the school in discussions with the mental health agency staff, and also with the district liaison (who had been appointed by the superintendent to coordinate the program district-wide). In addition, the school liaison represented the school in discussions with all other interested parties. The liaison also was involved in helping to set up and manage the school's referral process, and in helping to establish cooperative relations with the SBSTs, whose members evaluated children for special education, and the Committees on the Handicapped, which were responsible for making the determination of which special education program a child would be placed into.

The district liaison worked closely with the school liaisons in each school and also with the Public School's overall coordinator for the program, as well as with the staff person from the mental health agency who was in charge of the on-site program in the district. In addition, the district liaison worked with the Mental Hygiene Department's respective borough office in resolving problems with the mental health agency or in organizing borough-wide

activities, such as training sessions for mental health agency staff and Public School staff.

Within the schools, the predominant mental health agency workers were social workers (M.S.W.s); there also were some psychologists, as well. Each agency also had at least one part-time psychiatrist assigned to the program, in order to supervise treatment and provide medically-oriented assessments. The mental health agencies had program directors who coordinated and managed the program across school sites; their responsibilities included providing clinical and administrative supervision, working with the school and district liaisons to monitor program operations, and providing a link to the Mental Hygiene Department staff. All of these people contributed to the ongoing operation of the program, and their collective efforts represent both successes and problems of the program.

Entering the Schools:

Once the individual schools had been selected for the program, mental health agency staff needed to be given a place to work inside the schools. Finding an unoccupied office in many of the City's schools for full-time use was difficult, because in many areas the schools were overcrowded. Most often, an office or classroom might be found on a part-time basis. However, in some cases, mental health agency staff worked in storage areas, closets or

other spaces not intended for providing services of any sort to children. Sometimes these spaces were not entirely satisfactory because, in addition to safety and comfort, the mental health agency staff wanted to be able to insure privacy for the children (and their parent or guardian) during treatment sessions. Thus, mental health agency staff wanted to be sure the door of the room locked securely, which was not always an easy thing to obtain. Also, if mental health agency staff kept records or other materials in the school for any length of time, they required a cabinet with doors that locked securely. These, too, were often a challenge to find in the sorts of spaces that were available; many of these rooms were small, and, most of the time, the space was shared. In selecting space for the program, principals were sensitive to the fact that many educational programs did not have adequate space. The principals did not want to create a morale problem with educational staff by giving the mental health program staff space that would be coveted by the staff of educational programs. In order to address all this, there was quite a bit of shuffling of space in the schools.

Once space was identified, it was not always easy for the mental health agency staff to obtain maintenance and custodial services in the schools; there was some conflict about who should pay for repairs and for additional locks, and similar items. The Mental Hygiene Department and the

contract agencies felt that, within the school buildings, the school system should absorb minor costs associated with establishing the program. They felt that this was appropriate for two reasons: each school had a custodial staff; and, within the school building the principal was responsible for all that went on in their schools, regardless of whether school employees were involved. (A few years later, there was widespread political and media attention in New York City to the "discovery" that principals did not, in fact control the custodians, as the result of various contractual arrangements.) The Public Schools, however, did not want to assume any additional expenses for the program. The Public Schools staff believed that, since the funds for the program had been moved to the Mental Hygiene Department's budget, the Mental Hygiene Department should pay for everything, even though space-related expenses within the schools had never been anticipated nor budgeted.

Even when appropriate space was found, the mental health staff felt they needed certain things, like telephones, which were not routinely available throughout a school. Again, it had been assumed by the Mental Hygiene Department that the mental health agency staff in the schools would have access to telephones. However, many of the agencies quickly discovered that many of the principals could not provide spaces with phones in them. Therefore, the

agencies had to arrange for telephones themselves, bearing all the costs. After some discussions between agencies and the Mental Hygiene Department, these costs were able to be applied to the contracts, but the contract funding was not limitless, and the danger existed that too many of these unanticipated administrative costs would exhaust the funds available for the program.

Once space was identified by the principal, the mental health agency staff expected to be able to begin to work immediately. These individuals did not view themselves as school employees, and did not expect to have to adhere to the timekeeping, security, and public health requirements for school employees. They did not want to be held to the same regimen as the teachers and other school staff. However, when the mental health agency staff began to show up in the schools, most of the principals insisted that the mental health staff follow the same procedures as the teachers, including sign-in or punch-in for daily attendance.

Also, school officials insisted that the mental health agency staff receive fingerprint checks and TB tests before they did any work in the schools. This requirement had not been previously discussed, nor had it been anticipated by the Mental Hygiene department. This issue was brought up only in the midst of micro-implementation, as staff were set to begin working in specific schools. The mental health

agencies were not pleased about the fingerprint checks and TB tests, since they had their own personnel policies. They viewed this as an incursion by the Public Schools on their authority. The schools, however, were insistent. Also, there was concern about who would pay for the TB tests and fingerprint checks, since the Public Schools normally charged prospective employees for these tests. The Mental Hygiene Department found itself, in the interest of the program's continued implementation, having to approve this as an allowable expense in its contracts with the agencies, though the expense had not been budgeted initially. Once this was resolved, the mental health agency staff traveled to Public Schools headquarters, where the Personnel Office administered the fingerprint checks and TB tests.

Professional Relations:

As noted earlier, the school principals, administrative staff, and guidance counselors brought different expectations to the micro-implementation of the program than did the mental health agency staff. These differing expectations reflected a number of things, including the following: the history of the program's development, which meant different things to individuals in the two systems; the structure and culture of the two systems; the different roles the representatives of the two systems had vis-a-vis the program; and, the differing expectations held by the

representatives of the two systems for the outcomes of the program.

Hall (1986) has made the point that what may appear to be inter-organizational conflicts (having to do with the organizations' operating philosophies or power) are really interprofessional conflicts, due to differences in the views of occupations or professions which, in this instance, deal with children. In settings where more than one profession operate together, "order and dominance must be negotiated" (152). He also points out that professionals attempt to differentiate themselves from each other in order to establish professional identity and to assert professional power. In the case of the micro-implementation of the on-site program, the mental health staff encountered teachers who had different ideas about how the schoolchildren should be treated from the ideas of the mental health staff. Teachers also had different ideas about how treatment should affect children participating in the program. In general, teachers were concerned about immediately reducing the incidence of disruptive behaviors by students in their classroom, and assuring that emotional problems were not interfering with educational performance. On the other hand, the mental health agency staff viewed disruptive behaviors as symptoms of underlying problems, including family problems and more serious mental illness, and approached treatment with a longer perspective in terms of

results. Many of the workers in the mental health agencies also had private therapy practices, and many of them had a psychodynamic (if not psychoanalytic) orientation, which looks beyond observable behavior to underlying motivations and to exploring unconscious factors. Therefore, treatment tended not to result in immediate reduction of negative behaviors, much to the chagrin of teachers.

While the distinction between the inter-organizational and interprofessional is useful, it can be very difficult to differentiate the inter-organizational from the interprofessional in a specific setting, because these factors interact. For example, teachers had found referral to special education an expedient route to remove children who were highly disruptive from their classrooms. If a teacher were to choose, instead, to make a referral of such a child to the on-site program, and the child was accepted, then the teacher would be agreeing to keep the child in the classroom, while the mental health workers attempted to address the underlying problems at the root of the child's disruptive behaviors. A substantial amount of time might pass before there was any significant change in the child's behavior in the classroom. Thus, the choice of whether to refer children to special education or to the on-site program could cause a conflict for the teacher. Therefore, in order to address teachers' conflicts about referral to the on-site program, the staff of the on-site program took

several actions, including the following: the mental health staff made efforts to educate and inform the teachers about mental health treatment; the mental health staff began setting shorter-term, more behavior-oriented goals in their treatment with the children; and, in some schools, a committee (consisting of guidance counselors and other staff) was formed to make decisions about referrals, so that teachers no longer had to make those decisions.

As mentioned before, the principals and other school personnel believed that the on-site program would function best if the mental health agency staff became part of the school. For the mental health staff, this would involve de-emphasizing their own professional identities as social workers, psychologists or psychiatrists. To a certain extent, though, the integration of the mental health staff into the schools was consistent with the community mental health philosophy. The community mental health movement, begun in the 1960s, encouraged mental health services agencies "to reach out to children in their normal family and neighborhood setting and to provide innovative approaches for both the coordination and integration ... [of services]" (Wagenfeld and Jacobs, 1982: 60). So, some of the mental health staff did endeavor to develop informal relations with teachers and guidance counselors. In addition, nearly all of the mental health staff began to eat in the school cafeteria, spend time in the teacher's lounge,

and chat with teachers in the school hallways between school periods. Some of the mental health professionals, however, were not comfortable with this integration into the schools; these individuals felt strongly that their distinct professional identities should be emphasized, and that part of the rationale for the program was that expertise and services not traditionally available in the schools was being made available. (Meanwhile, some of the mental health staff had been requested to provide consultation and training to teachers about classroom management, child abuse, drug abuse and similar issues. Although this was viewed as a service by the school staff, in some cases, it reinforced for the mental health staff that they should be viewed as expert consultants to the schools.) These mental health staff who wanted to keep their professional identities as distinct and separate were viewed as elitist by the school staff. Naturally, both the Mental Hygiene Department program managers and the Public School liaison were concerned that this divisiveness over the day-to-day role of the mental health workers in the schools would undermine their efforts to encourage referrals to the on-site program. As a result, they held joint training and information sessions to provide opportunities for the teachers and mental health professionals to become more familiar with one another's values and viewpoints, and to attempt to foster mutual respect.

Both informally and formally, some of the teachers and guidance counselors said they felt discouraged from making referrals because some of the mental health staff did not provide feedback about the children after referrals were made to the mental health staff. (The teachers and guidance counselors also said that this lack of feedback contributed to their feeling that mental health agency staff were frequently arrogant and elitist.) Since these teachers were making referrals based upon problems which manifested themselves in the classroom -- usually in the form of disruptive behavior -- they wanted immediate relief. When this was not forthcoming (when the behaviors did not change quickly), they felt entitled to hear from the mental health agency staff what was going on and what to expect. Some of the mental health agency staff, however, concerned about protecting confidentiality, were reticent about saying anything too specific about the children to the teachers. The Mental Hygiene Department staff, however, believed that the teachers had a legitimate need to receive ongoing information about the referred children, and so they encouraged the mental health agency staff to provide more feedback. The Mental Hygiene Department staff believed that such feedback could be provided without violating the regulations regarding confidentiality. Over time, many of the mental health agency staff did develop communication strategies which seemed to address the teachers' concerns

for information, while leaving the mental health staff feeling that they were still safeguarding confidentiality. For example, in some districts, the mental health agency staff set up group meetings with teachers, during which they discussed, in a general way, the progress of cases. These discussions provided the teachers with a sense about what to expect regarding changes in the children's behavior, as well as a better understanding of what occurred during the children's treatment sessions. (At the same time, as mentioned earlier, the mental health staff in some of the programs decided to set short-term, behaviorally-oriented goals for the treatment, which were consistent with the school staffs' expectations.)

The way in which these program adaptations unfolded varied from school to school, although the Mental Hygiene Department staff and Public Schools liaison did try to encourage these efforts at mutual adaptation across the board. However, much of the micro-implementation depended on personal relations, timing, and serendipitous occurrences (Lipsky, 1980). (Also, because of the turnover of school and mental health staff, as well as the turnover of children, a great deal of the orientation and developmental work had to be repeated at least annually. While I have no systematic data on this, the fact that need for ongoing orientations kept being brought up in a large variety of settings and forums, over the years, makes me believe that

the extent to which they actually occurred in each school or district had an enormous impact on the success of the program.)

The orientations that were held consisted of training sessions, which were then followed by meetings within the boroughs, to create a bond among the participants from the mental health agencies and schools, and to provide an opportunity for in-service training and professional exchange. These events were unique, especially for the school staff involved, since, as mentioned earlier, the school system has been, traditionally, quite insular, and the school day schedule does not provide much flexibility for such activities. The fact that the program did provide an opportunity for school and district liaisons to participate in these special events with their own colleagues (as well as with the mental health staff) may have contributed to the school staff's feelings of being invested in the program.

In addition, among the mental health agencies, there were periodic meetings arranged by the respective Mental Hygiene Department borough offices to provide an opportunity for information-sharing and problem-solving. These meetings fostered an esprit de corps among the agencies, and may have been helpful in alleviating some of the isolation that the staff felt at first while working in the schools, before they had developed relationships with school liaisons and

other staff.

Naturally, in addition to the above-mentioned organized events, other things also contributed to the successful micro-implementation of the program at the local level. Sometimes, a serendipitous event or a personal relationship that had developed among staff members went far toward breaking down institutional or professional barriers. The following is a dramatic example of breaking barriers; it also serves as an example of the independence and discretion that can be exercised by staff working in schools, in spite of the regimentation of many aspects of school life (Lipsky, 1980). Very early in the establishment of one of the Phase One programs, when the mental health agency staff were just getting set up in the school, a crisis occurred. A child had come to school distraught, depressed, and frightened, as the result of some family problems. Although the guidelines for the program require a fairly formal referral process (described in the next section), the principal asked the social worker to speak with the child on the spot, in order to help resolve the situation. The social worker agreed, and, in fact, took command of the situation, proceeding to intervene with the child. Subsequently, the social worker met with one of the child's parents, who came to the school. Through these efforts, the child's crisis was resolved, and the principal made it clear that he was delighted that the mental health agency staffperson had been available and

responsive. From then on, the staff were viewed as an integral part of that school, and their services were always well-regarded there.

Referrals:

Prior to the program receiving final approval from the Budget Office in February 1984, staff from the two lead agencies had begun meeting to develop policies and procedures to govern the program. A major issue which surfaced at these meetings was what criteria would be used to select children for referral to the program. To address this issue, a fairly detailed checklist was developed, which listed behaviors and symptoms which teachers might observe in children having emotional problems. However, after this checklist was reviewed by the Public Schools staff, it was rejected as being too detailed and clinical in approach. Then, as a compromise, after several discussions among the planners, a form requesting a brief narrative description of the reason for referral was developed and adopted for use. The mental health agency staff, did, however, request that a companion form also be developed, which would allow them to request additional information from the teachers, once a referral had been made. After some back and forth about the specific information to be requested, such a form was devised. It took a great deal of time and effort to develop and finalize these two forms, as well as others that were

developed. This was because the central office program staff of both lead agencies, as well as the legal office staff of both agencies, had to review them. Also, many of the forms were reviewed by individuals in the school districts and community mental health agencies, to ascertain if they would be both practical and useful. This all added to the time it took to establish the program in the schools.

Another major issue in terms of the referral of children concerned the referral process itself, which turned out to be rather complicated. First, the school personnel would not pass along any information about the children to the mental health agency without the consent of parents. As a result, parents were asked to come into the school to provide written consent, as required by law. As the program developed, it was the guidance counselors, in most instances, who met with parents and explained the program and the nature of the consent for referral and assessment. Thus, first the referrals went from the teacher to the guidance counselor, not to the mental health staff (as the mental health staff had originally assumed would be the case). The guidance counselors then reviewed the referral form. Sometimes, the guidance counselor would decide that the child should not, after all, be sent to the mental health staff but rather to the School Based Support Team for evaluation to determine whether special education was required, or to some other program which might be available

in the school. And, sometimes, the guidance counselor would decide that no outside program was needed by the child at all; in such an instance, the guidance counselor might discuss alternative classroom management strategies with the teacher, or other ways to address the problems. Of course, in many instances, the guidance counselor did, in fact, send the referred child to mental health staff of the on-site program.

Over time, some districts and schools formalized this referral process. By formalizing the process, some of the districts also broadened participation; on a regular basis, in these districts and schools, representatives of all the various programs in the school which received referrals from teachers and guidance counselors would meet to discuss the referrals. (These other programs included remedial education programs and other counseling programs.) At these meetings, participants would determine, on a preliminary basis, the most appropriate program for the child. In addition to this being an efficient way to match up children with the most appropriate program, it also helped the on-site school mental health program to become an integral part of the school. The adoption of this coordinated referral process tended to occur in those schools in which the school administration had consistently been most receptive to the program. This referral process further cemented the link between the mental health agency staff and school staff.

In those cases where parental consent for referral and assessment was obtained, the child was then referred to the mental health staff for an interview (called a "screening and assessment"). At this point, the mental health agency staff also might ask for additional information about the child from parents or school personnel. If the mental health staff believed that mental health treatment was appropriate, the mental health agency was itself required by State Mental Hygiene Law to get written consent from a parent to treat the child. At first, this required that the parent return to school once again. Some referrals only got this far, since it sometimes was difficult to get parents to return to the school a second time. As time went on, mental health staff and school staff coordinated this process so that parents could provide both consents at one time. This usually entailed the parent having a meeting with representatives of the mental health agency at the same time, or immediately following, the meeting with the guidance counselor.

Payment:

The issue of payment for the services highlights the differences between the mental health and education systems. The public mental health system, as previously discussed, is supported by a combination of the following: Medicaid and other third-party insurance; patient fees which often are

paid on a sliding fee scale; City and state tax dollars; and, contributions by the mental health agencies themselves. Although some kind of payment is always requested of patients by the public mental health system agencies, services are not denied if no payment is possible.

The first time a mental health agency described its payment policy to a school district superintendent, the superintendent indicated, categorically, that no parent could be requested to pay anything, since all services in public schools traditionally were free. This response surprised the representatives of the Mental Hygiene Department and the agencies, since the central office Public School staff had never indicated that the agencies would not be able to request Medicaid or other insurance information. In fact, one of the attractions of the program for the municipal government was that these other, non-City sources of support, existed.

After some discussion with school officials it was agreed that parents could be asked to provide insurance information, but that it would be made clear that services were available regardless of their having such coverage or their willingness to provide insurance information, and that no patient fees could be requested. This had to be well-documented by mental health agency staff, since the various insurers have strict guidelines about co-payments and co-insurance. On the other hand, since one of the purposes of

the program was to reach children whose families would not generally seek needed treatment, it was important that there be no financial or administrative obstacles to their receiving services.

Mainstreaming:

Throughout the negotiations to establish the program there had been a great deal of skepticism expressed by both the Public Schools and the Mental Hygiene Department about the program's ability to remove children from special education. This was because very few children were decertified at all from special education, and because there were legal and administrative barriers to mental health agencies participating in the process of decertification. However, based on the commitments made to the Budget Office, the contracts that were negotiated with mental health agencies included funds for staff who were expected to work both with SBSTs and Committees on the Handicapped to identify those children who could be decertified from special education if mental health services could be provided to them.

The more, though, that was learned by the Mental Hygiene Department staff about the decertification process, the more difficult working with that process appeared to be. For instance, at least every three years -- hence the term "triennial review," -- children in special education were

required to receive a formal review of their need for continued placement in special education from the Committee on the Handicapped. The rules governing special education included stipulations that outside consultants (which would include the mental health agency staff), could participate in this triennial review process only with the consent of parents and by invitation of the Committee on the Handicapped. Also, special education regulations required that decisions to decertify a child had to be made independent of the expectation that other specialized services would be available once the child was decertified. That is, unless the child could function in a regular classroom with no other help, the child was expected to be kept in special education.

The central office staff of both the Public Schools and the Mental Hygiene Department who were coordinating the on-site program would have been pleased to have the mainstreaming component of the program eliminated, so that they could focus all efforts on reaching children before special education placement was necessary. However, the Budget Office staff insisted that the Mental Hygiene Department and the Public Schools find some way, despite the legal and administrative barriers, to make the mainstreaming component work, perhaps through an "informal arrangement," although this was viewed by Public School and Mental Hygiene Department staff as an uninformed suggestion, since special

education was under extensive judicial scrutiny.

In a highly unusual move, to try to resolve this issue, the Deputy Director of the Budget Office agreed to meet with selected school district and mental health agency staff, as well as with Mental Hygiene Department staff and Public School staff, to discuss the obstacles to making the mainstreaming component work, as well as to receive information on the components of the program that were working. Even after this meeting, however, at which a litany of obstacles to the success of mainstreaming were presented, the Budget Office was not willing to remove this requirement for the program.

THE EVALUATION

As discussed earlier, the evaluation of the program did not get underway until the Fall of 1985. As previously discussed, the evaluation was being carried out by Dr. Sheldon Kastner, a professor of psychology at New York University. By the time the evaluation commenced, the program was fully operational in all but one of the chosen nineteen districts. An initial draft of the evaluation results was reviewed by staff of the Budget Office, the Public Schools, the Mental Hygiene Department, and the Mayor's Office of Youth Services in 1986. Then, some additional data from the 1985-1986 school year was made available, and the evaluator did further analyses at that

time. Thus, it was not until 1986-1987 that a complete draft was shared with the steering committee. This draft was reviewed, and changes were requested by the steering committee. Further, there were meetings held to discuss the report and the implications of the findings, especially in regard to the program's effect on special education referral rates. (A final evaluation report was never made available, since the finding about the program's effect on reducing referral rates was so equivocal.) By that time, the program was well-situated in most of the districts, and yet, to the Budget Office, its future hinged completely on the impact of the program on reducing referral rates and accomplishing the mainstreaming of school children; in fact, in the absence of evaluation results during the previous year's Budget preparation, the Mental Hygiene Commissioner was called upon to defend continued funding for the program.

As mentioned, the evaluation had several components, including the following: a description of the characteristics of the children and the services they received; a measurement of the impact of the program on individual children; an assessment of whether the program was meeting the goal of reducing referrals to special education; and, a description of the way in which the programs functioned within the schools, with recommendations for future modifications of the program.

Initially, Dr. Kastner, the evaluator, had proposed

observing a sample of children in the classroom on a pre-test/post-test basis, to determine if the services were having any impact on classroom behavior, which was often a reason for a referral. However, when he began to go about the process of implementing this (which included getting parental consent) there was an uproar from some parents who felt that this would violate the privacy of their children. The mental health agencies also contributed to this uproar, since (in addition to the privacy issue) they did not want parents to become discouraged about the program.

The findings of the evaluation (which looked at 1034 participating students in fourteen districts), as reported in the most up-to-date draft report included the following:

-- The average age of the children was 9.9 years, with most (80%) of the children in grades one through five. Two-thirds of the students were male. Data on race/ethnicity was not available to the evaluator.

-- Most of the children were receiving individual therapy, and many were also receiving family therapy. In addition, other services of the mental health agencies were being used, including visits to psychiatrists.

-- The evaluator had developed a questionnaire to measure improvement in the children's behavior, as judged by both the teachers and the therapists. According to the findings, the therapists observed

large improvement. The teachers, on the other hand, saw little or no improvement, with some indicating a worsening of troublesome behaviors.

-- When asked to appraise the program as a whole, the school liaisons and guidance counselors indicated that they were pleased with it, and wanted it to continue in the schools. They expressed the belief that the program made needed services available, including services to family members, whom school staff could not treat.

-- The evaluation was inconclusive on the issue of the effect of the program on special education referral rates, as the result of the methodological and practical problems. The executive summary of the draft report indicated that "... the evaluation team questioned the utility of reduction of referral rate as an indication of the effectiveness of the program due to the small percentage of students referred to special education, and the very small decline in the referral rate that could be reasonably expected." By the time the evaluation results were made available to the steering committee (including the Budget Office) it was the 1986-1987 school year, and the program was well-established in most schools.

-- The evaluator recommended that greater communication between teachers and therapists be facilitated, and

that more information about the program be made available within the schools. He also noted that some of the intended clinical effects would not likely be captured in such a short-term evaluation, and that, not surprisingly, further evaluation needed to be carried out.

THE FINAL PHASE: TOWARD INSTITUTION BUILDING

The local implementation, or micro-implementation, of the program extended from Phase One, in May of 1984, through the 1984-85 school year, and into the 1985-86 year, since there were a few delays in identifying agencies and districts. Between July 1, 1984 and June 30, 1985, the program's initial school year, 1,877 referrals were made to the program. Of those referrals, 1,434 (76%) resulted in treatment services being provided for some period of time. During the following school year, by which time all but one of the district programs were fully operational, approximately 3,000 children were receiving ongoing services.

Once the program was in the schools, the balance of power between the Budget Office and the Mental Hygiene Department shifted, although the Budget Office continued to raise the possibility of eliminating the program during each year's budget preparation. Initially, the Budget Office did this because the evaluation had been delayed. Then, later,

it did this based on the inconclusive evaluation results concerning the effect of the program on special education referral rates. However, the City's Mental Hygiene Commissioner, Dr. Sara L. Kellermann, was able to appeal to the Mayor's Office to preserve the program, based upon its successful implementation, and upon the program reviews carried out by the Mental Hygiene Department's Office of Program Review and Evaluation. This sometimes created conflict with the Division of Special Education, which was sensitive to the teachers union's concerns that, were the program to be expanded, it might result in some Union member's jobs being eliminated. For example, at the April 1985 meeting of the American Orthopsychiatric Association, the Director of the Division of Special Education, Edward Sermier, was invited to speak about the program's implementation. In his remarks, he said:

> ...The next question is, are the right children being identified. I was over at the City Mayor's office about a week ago and the Department of Mental Health was trying to get this program expanded, and I said no way, until we have the outside evaluation. They said no, no, we have all the evaluation you need. We know we are serving the right kids, and they are emotionally troubled. I said, hey wait a second, I can say the exact opposite because I'm at the Board of Ed. I said

> this is too important, I said you can't ask me to sit here with the information you have, given the vested interest that you have, and agree with you that you are serving all the right kids. I said I have an obligation to my own professionals out there and we agreed that we would have an outside evaluation before any expansion occurred... (Sermier, 1985).

The program was not, in fact, expanded, but the program gained the support of most of the principals and superintendents in the participating districts. (In one district, however, the program was terminated, since the mental health agency was receiving very few referrals, and efforts to remedy the situation were not effective.) Also, interest in the program model was expressed by superintendents in other districts. This suggests that the program was popular within the school system, and had developed a positive reputation. By many indications, the program was becoming a fixture in those districts in which it had been implemented, and the process of institutionalization was occurring.

At the same time that the program was becoming institutionalized, there continued to be micro-implementation issues that arose, that had an impact on the program's functioning. Each September, some Superintendents

made changes in their choice of schools. Also, there were changes in mental health agency staff, since many social workers and other mental health professionals found it difficult and unsatisfying to work in some of the schools, especially those in which space was poor or school staff were uncooperative or hostile. (Fortunately, over time, most school and agency staff developed good working relationships, and the programs began to be viewed as essential parts of the schools.) This helped the agencies hold on to staff for the program, although maintaining staff continued to be an issue for the agencies. Also, there was a great deal of turnover among teachers in the schools, so that each September the programs had to start over, to some extent, as far as orienting school staff.

Nevertheless, the program was becoming institutionalized. As time went on, the Budget Office concentrated less energy on the program, and the particular Budget Office officials who had resisted the program, and who had then continued to scrutinize it, had left the Budget Office, while the program persisted (Goodman and Dean Jr., 1982: 229). By the time, in early 1990, that a Five Year celebration of the program was held (sponsored by the Mental Hygiene Department, the Public Schools, and the community mental health agencies) the new staff at the Budget Office did not give the program the attention that their predecessors had, and it appeared as though their priorities

had changed.

CONCLUSION

In this study, I have described the planning and implementation of the on-site school mental health program, with particular concern for the organizational and political dimensions of program development and implementation. I have traced the development of the program, situating it in an organizational and historical context, and discussing the process through which program proposals were developed, written, and revised, as well as the process through which meetings and negotiations were held to plan various aspects of the program. Then, I looked at the manner in which, once the program had been approved, the process of implementing the program in the schools (micro-implementation) took place. This process led to a point at which mental health services were being provided to schoolchildren in each of the seventy individual schools participating in the program.

The study utilized several organizing principles. First, six stages in the program's evolution -- from idea to implemented program -- were identified. These stages were marked by "decision points" corresponding to specific key events which were essential to the progress of planning and implementing the program. Over-arching the six stages was the use of Berman's distinction between macro- and micro-

implementation, as the locus of activity and decision-making moved from the citywide level and the central offices of municipal government agencies (macro-implementation) to the individual school districts, schools and community mental health agencies (micro-implementation).

As part of the description and analysis of the program's evolution, attention was given to the following: the political context within which events were occurring; the organizational structure of the two main organizational players; and the inter-organizational relations among the participants. Also, as events proceeded, the number of participants increased. And, each of the participants had, to some extent, different concerns and perspectives. "And so it is in the world of organizations. The meaningfulness of any change may well vary with the perspective taken" (Woodman, 1989).

Two of the noteworthy characteristics of the planning and implementation of the program were the incremental nature of the process, and the numerous changes that were made during the process. These two characteristics reveal how, to some extent, program implementation is not a linear, predictable activity. At any number of points during the planning stage, for instance, the program could have taken a direction which would have resulted in a very differently-shaped program than the one which finally emerged, with different goals. If, for example, during the early stages,

the experience of referring children from the SBSTs to the community agencies had been more successful (or, at least, had been viewed as more successful or desirable) it is conceivable that much of the energy that ultimately went into the on-site program might have gone into the enhancement of these referral procedures. Most likely, had that scenario occurred, the mental health agencies would never have been brought into the schools. Or, later, if the on-site program had not been tied to special education goals, both the program's implementation course and final design would have been different.

The study illustrates that individuals can make some difference even within large complex organizational settings, which often seem totally impersonal and immune to the effects of individual leaders. At several points throughout this program's development, the impact of individuals can be discerned. The two chief executives who were responsible for setting program development in motion, Chancellor Macchiarola and Commissioner Kellermann, deserve some credit for having overcome some of the unmitigated uncooperativeness that had existed between their two agencies. While the time may have been right for certain changes, and some of the impetus came from outside, the importance of the leadership they provided should not be lost.

The recognition of individual leadership can be easily

lost because of the distance in time between the setting in motion of a program idea and its realization. And because of the difficulties and delays in implementing programs, they do not often meet the expectations made for them. Claims made for proposed programs during the approval process are often exaggerated, in order to get them approved. This is understandable, since supporters of a particular program will try to present it in the best possible light, in order to compete for scarce resources. Implementation delays and the problems of delivering and evaluating services are down-played at this point. However, once program proposals are approved, they become the center of attention. By this time, the attention of the leaders has moved on to other priorities.

The behavior of the Budget Office officials illustrates, in part, the importance of individuals, particularly in the fact that it was their growing inattention to the program, in spite of the inconclusive evaluation, that allowed it to become institutionalized. This was in contrast to their earlier stated position that the onus was on the program to prove itself. If public agencies functioned entirely bureaucratically, the program should have been eliminated.

The school mental health program was very much shaped by a variety of forces which affected it along the way from initial plan to implemented program. One such force was the

interorganizational politics of the two organizations. In order for treatment services to be provided to children, staff of the two organizations involved in planning and implementation had to be able to communicate as effectively as possible on all issues, such as how to select schools and mental health agencies, how to find space for the program, and how to structure the process of making referrals for children in need of services. Another powerful force which shaped the program was the influence of the Budget Office, whose expectations (as discussed) were at variance with the original conception of the program held by the Mental Hygiene Department and its contract agencies. The Budget Office's influence in changing the goals of the program (turning it into an alternative to special education) also shaped the implementation process, because it exacerbated the conflict between the mental health agency staff and the SBSTs. Although, once the program was established in the schools, the Budget Office's influence was diminished, and the program appeared to function much like it had initially been envisioned by the Mental Hygiene Department, though the link with the special education system continued to be a source of constraints and an invitation to scrutiny by the Budget Office and the teacher's union for several years.

Historically, neither organizational and inter-professional context nor program implementation have been adequately attended to by policy makers and budget

officials. Therefore, although policy makers and budget officials may be anxious for program activities to commence, the actual implementers of the program may be grappling with unforeseen practical problems. In the case of the on-site school mental health program, the macro-implementation stages were taken up largely with fiscal issues and broad program design issues. It was only when the program plan had been approved by the Budget Office that attention was given to how the program would operate day-to-day. Thus, when the program plan was first presented to school and mental health agency personnel, there was a fair amount of criticism, as well as requests for modification. The school superintendents, in particular, complained that they had not been involved in the program's initial planning, and that too many practical issues had not been adequately dealt with by the program planners. However, the program planners, and the policy makers they worked for, continued to believe that progress would have been too slow if each step of the way they had brought the various practical issues to the superintendents and other individuals in the schools for review. They believed this to be especially true since macro-level agreement among the Mental Hygiene Department, the Public Schools, and the Budget Office had been so slow and difficult to achieve, in the first place.

While agreement at the macro-level between the Mental Hygiene Department and the Public Schools (followed by the

approval of the Budget Office) was a necessary condition of program development, much of the success of the program was due to the individuals within the schools and mental health agencies who operated the program on a day-to-day basis. These individuals were able to recognize their common goals, and to forge cooperative relations among themselves. They were able to create a network of mutual interest, which was supported by their knowledge that such networks were being forged in all the other schools that were implementing the program, as well, and that, even during times of crisis, there was a broad base of support for the program on all levels. While I was not in a position to systematically observe the individuals who operated the program, I do believe that they were instrumental to the program's staying power, and to its becoming institutionalized to the large extent that it did.

However, there continued to exist tension as a result of the conflict between the educator's desire for immediate behavioral change in the students and the mental health staff's approach which was based on the identification and treatment of underlying psychological factors which affected behavior and which changed relatively slowly, as well as their desire, in some cases, to treat the problems in the context of the entire family. This conflict is reflected in other ways. For example, while teachers use test scores, attendance, and behavior to measure educational outcomes,

the mental health system often relies on evaluation of the organization of treatment as a proxy, since outcome measurement is not well-developed in clinical settings. Adherence to clinical standards, adequate treatment documentation, and other process factors are used to determine if good care is being provided. Of course, when behavioral change data is available to the therapist, it is utilized, but the subjective nature of much of clinical practice makes it difficult to systematically measure outcomes, especially in the typical community mental health setting, where resources for evaluation and research are lacking.

This study demonstrates the enormous energy, effort and attention to detail that was needed to sustain the implementation of the program. It also illustrates the intermingling of organizational, political, and professional issues in services delivery, and the ways these act as obstacles and constraints. It suggests that a number of major obstacles exist toward improving both the access and integration of mental health services for children, which are goals of many children's mental health services providers and advocates. Conversely, it also demonstrates that a network of committed individuals can successfully make changes and accomplish things within the City's education and mental health services systems, despite all of the political, fiscal and organizational constraints.

The study illustrates the greater effort it takes to have an even marginal impact on the problems of childhood emotional problems. In the first chapter, I mentioned the fact that one reason the program was initiated was to address the gap between the estimated need of mental health services for 141,000 children and the served population of 45,000 children. Once it reached its full capacity in the seventy schools in which it was located, the program could serve 5,000 children annually. These seventy schools represent less than ten percent of the public elementary and junior high schools in New York City. The 5,000 children is, however, ten times the number of children who had been referred to community mental health agencies by school staff, citywide, in 1981, prior to the on-site school mental health program.

While this study has been concerned with the planning and implementation of a mental health services program in the schools, it has relevance for other areas as well. For example, the phenomenon referred to in Chapter 6 above as "the fiscalization of social policy" affects more than just mental health and education, and has become more pervasive since the early 1980s, as part of the changes in social policy associated with the Reagan administration. While most students of public policy recognize, and almost take for granted, that budget officials will exercise great power, there exist few studies which look at this closely,

to explore its concrete results. Also, these days, many other areas of social welfare are facing the task of coordinating delivery of their services, and of developing joint programs (especially with the growing recognition that social and health problems interrelate). These agencies face planning and implementation problems not unlike those faced by the planners and implementors of the on-site school mental health program. Greater attention to the organizational, inter-professional and political contexts within which programs are developed would be extremely beneficial to both practitioners and researchers, and could help establish more effective and efficient programs.

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