COLLABORATIVE SERVICES

AND THE INTEGRATION OF PRESCHOOLERS WITH SPECIAL NEEDS

By

Gary Direnfeld MSW, RSW
Interaction Consultants
20 Suter Crescent,
Dundas, Ontario L9H 6R5
905 628-4847
www.yoursocialworker.com

and

Elizabeth Shaver, ECE, SRN
Director, Early Childhood Department
Chedoke McMaster Hospitals

Unpublished Manuscript Written in 1993

INTRODUCTION

Collaborative services, as an approach to service delivery, is the present day response to the shortcomings of case management. In the 60's and 70's, case management was seen as a state of the art approach in provision of service delivery thereby reducing the fragmentation through deinstitutionalization (Direnfeld, 1990).

Collaborative services now provides an approach where participants can engage equally in the process of service delivery. This approach is found to maximize cooperation and compliance when integrating children with special needs (Davis, 1986; Peters, Templeman and Brostrom, 1987; Johnson, Bruininks and Thurlow, 1987; Scanlon, 1990; James, Smith and Mann, 1991; Idol and West, 1991; Kohl, 1991; Levy, 1991; Lourie and Katz-Leavy, 1991; Lowenthal, 1991; pascal, 1991). This paper will describe the development of collaborative services and how it is applied in the integration of special needs preschoolers at the Chedoke McMaster Hospitals, Early Childhood Department.

This paper is divided into three sections:

1) The historical development of collaborative services
2) Obstacles to overcome
3) A working model to facilitate integration of special needs preschoolers

THE HISTORICAL DEVELOPMENT OF COLLABORATIVE SERVICES

Collaborative services developed through the late 1980's and '90's. In literature it is connected with such other concepts as interagency cooperation, interagency approaches, ecological assessment, multi and trans disciplinary team services, special service partnerships, and case management (see references above). The term collaborative service is also juxtaposed with *comprehensive, coordinated, effective, flexible, and accountable*.

Collaborative services is as much a value base, with a set of underlying assumptions as it is an actual process for service delivery to persons with multiple needs (Johnson, Bruininks and Thrulow; Idol and West; Lourie and Katz-Leavy). A collaborative approach implies that all persons involved in the delivery of service and the receipt of service, share responsibility and authority for the plan of care (Stodden and Stone, 1987; Malekoff, Johnson and Klappersack, 1991). This is different than case management where the thrust of the activity is primarily in coordinating the delivery of many services. Idle and West provide a comprehensive literature review citing several definitions of collaboration from an educational perspective. Of those definitions there is one in which a distinction is made between cooperation and collaboration:

> Cooperation is a term that assumes two or more parties, each with separate and autonomous programs, where they agree to work together in making all such programs more successful. In contrast, collaboration implies that the parties involved share responsibility and authority for basic policy decision making. (Hord, 1986)

Collaborative services has its roots in the deinstitutionalization movement. Prior to this movement, agencies and programs were developed and structured to meet very specific needs of narrowly defined populations. There was an assumption that the services delivered would be housed and provided from within the sponsoring agency. This process was known as institutionalization.

From work beginning in the 1960's and then through the '70's with persons enduring psychiatric disabilities, there began a process of deinstitutionalization. The thinking was those peoples' needs and interests would be better met by providing help within their home communities. With a return to the community, there was soon a recognition that no one agency could meet the total and diverse needs of any one person and thus there was a proliferation of more specialized programs. From this was born the case management movement. Case management was to be a panacea to the developing and fragmenting service delivery system of the time (Direnfeld).

While case management brought some relief to the fragmentation of services, it too was fraught with shortcomings. Specifically there was difficulty in implementing plans of care that were developed in the absence of input from direct service providers.

Prior to deinstitutionalization, persons with psychiatric problems would have been hospitalized. People would have a limited number of needs met within the hospital. People would receive medicine, accommodation and perhaps some limited forms of social participation. There would be little or no contact with the outside world or opportunities to participate in a normalized community environment.

With the swing to deinstitutionalization, people were discharged back into the community. All of a sudden these people required service from a multitude of different helpers. People needed shelter, medical/psychiatric support, and opportunities for educational/vocational participation.

Under the case management model, persons would be assigned a case manager. It would be this person's role to facilitate and coordinate access to service as provided by the various community agencies. However, the conflicting bureaucracies of the various agencies would frequently frustrate the efforts.

For example, the case manager goes with a person to the housing authority. The housing authority, however, cannot provide shelter until the person has welfare in place so that payments can be made. Next the case manager takes this person to an educational facility. However the educational program cannot commence until the person has a stable residence. So off the case manager goes to the welfare office. Unfortunately welfare's policies are such that welfare cannot be provided until a person has stable housing and if the person is under age sixteen, it also cannot be provided until the person is enrolled in an educational program. (Mooney (1984) provides another example of the difficulties of multi-agency involvement in children's services.)

Thus even though a case manager is available to help negotiate an unwieldy service delivery system, people still go without services, owing to the conflicts imposed by the different service systems.

Now under a collaborative services model, a person acting in the role of a case manager seeks to get all the various service providers together. The case manager develops consensus amongst the service providers in terms of an understanding of the person's needs. Then the case manager seeks to develop a working relationship between the service providers so that a comprehensive plan of care can be developed. Kohl goes so far as to suggest that given the importance of this approach, it should be a condition for receiving grants (Kohl, p.266).

Collaborative services as an approach to service delivery, acknowledges the equal importance of all service providers to developing the plan of care. As an approach it also acknowledges the importance of facilitating trust or cooperation between the various service providers.

In addition to the literature that defines collaborative services, a number of papers cited describe how well this approach works.

Even though not all the literature uses the particular term collaborative services, it is clear by definition that this is the model applied. In so far as this model is applied, the literature suggests that person's needs are being met in a more timely and beneficial fashion. The literature reviewed is also filled with examples of successful collaboration not only between professionals of different services, but also between professionals and clients directly (Idol and West; Peters, Templeman and Brostrom; Scanlon). Clients have been described as children, families, parents, and disabled persons.

The literature demonstrates a change of thinking in terms of how professionals work with people. It is marked by a shift from *working on* to *working with.* As a result of this shift in how we think about service delivery, the literature reviewed suggests increased satisfaction vis-à-vis the relationship between helpers of different settings and also between helpers and clients.

It is imperative that the decision to collaborate be a joint one, in which all individuals are committed to success. In the art of successful collaboration each side has to win something. For the parents, an appropriate placement for their child, while the community setting wins by receiving knowledge and skill development for their staff; the clinician wins by promoting a positive climate for future integrations.

As with every panacea, over time difficulties are recognized. In the musical, Mary Poppins, Mary realized that in order to get the children to take their medicine she must combine it with a spoonful of sugar. Hence we are serenaded with the song;

> Just a spoonful of sugar helps the medicine go down, the medicine go down, the medicine go down. Just a spoonful of sugar helps the medicine go down, in a most delightful way.

For collaborative services to be most effective, collaborators must have specific knowledge to manage the potential barriers to successful service delivery. The next section details the potential obstacles.

BARRIERS TO OVERCOME

Barriers can be categorized by at least three levels. These levels include the organization, the program, and the individual. (Kohl provides an argument addressing social policy as a barrier to collaboration. For this paper Kohl's issues are seen to impact on the level of the organization even though he presents them as separate.) Within each level, there are areas that must be addressed to enable successful collaboration. In the absence of an understanding of these levels and areas, collaboration can be at risk. When collaboration does break down, helpers tend to feel discouraged. This in turn can seriously undermine the probability of engaging in further collaborative activities. Therefore, knowledge of these potential barriers not only enables successful collaboration, but also in turn facilitates the likelihood of further collaborative efforts.

The Organization

This is perhaps the least appreciated or understood level when it comes to understanding its impact on successful collaboration. The organization as an entity unto itself tends to be invisible. It is like forgetting that people are actually a conglomeration of smaller and different parts housed under the skin within the body. In day-to-day interactions with other people the effectiveness or health of one's heart, spleen, kidney, lung, etc., is overlooked. So it is with organizations. Issues such as funding, mandate, goals, objectives, and organizational strategies are overlooked. Stodden and Boone (1987) discuss differences in agency philosophy and Lourie and Katz-Leavy discuss

differences in funding. Gelman and Fried (1987) discuss the economic advantages to organizational collaboration. In the absence of information about the organization, helpers can be at risk of misconstruing certain decisions as personal, when they might more correctly be an issue of funding, mandate, goals, etc.

Organizations can be funded directly with tax dollars, through organized charitable donations, through a foundation, on a fee for service, or as subsidiaries to other organizations.

Depending on the funding source and structure of the organization, there may be a board of directors and possibly an advisory body. Certain obligations and standards must be met to receive the funding. Where multiple sources are involved there can be conflict. Different funders require different relationships with the organizations they fund. In organizations, while it isn't necessarily stated, the maxim, "He who pays, gets to call the tune", is an issue to be considered.

Organizations are funded to fill a particular role. That role is set out through the organization's mandate or mission statement. In the absence of a clear understanding of the organization's mandate, helpers are inadvertently at risk of asking for something that is beyond the organization's role (sometimes as specified by the funder).

Within the area of children's services, it is not uncommon to find conflict between workers who represent children's mental health and workers representing child protection. Inherent in the demands of children's mental health is the need to take risks in treatment. This stands in contrast to the inherent demands of child protection where the mandate is to minimize risk. To make this example more concrete, "How is a healthy relationship between child and abusive parent established, if at some point they are not in the same room together?" How do workers negotiate between the mandates of *taking risk* versus *minimizing risk* if the different mandates are not first acknowledged?

Arising out of the organization's mandate are goals, objectives, and strategies. In other words, organizations have structures in place for carrying out their mandate. Organizations by virtue of their structures will have varying degrees of flexibility or rigidity in how they carry out these tasks.

Knowledge in all of these areas under the level of organization cannot be understated as necessary for successful collaboration. Knowledge of these key areas of all the organizations with which one collaborates can make visible that which was otherwise invisible.

The Program

Programs are entities unto themselves. They differ markedly in terms of resources, expertise, and process. (The social compass of Desmond Conner will detail this further in a later section of this paper.) In the absence of direct knowledge and information, assumptions of what programs have and expectations of what they can do, can be amiss. The successful collaborator must possess a thorough understanding of the program with which they wish to collaborate. This is more than knowing about the organization in which they are embedded.

Programs vary markedly in their resources. Even with the same amount of money, different programs are quite likely to value different resources and will allocate their funds accordingly. Therefore money alone or funding is not necessarily an indicator of what resources a program will have.

Many daycares reflect the director's attitudes and values. One daycare could be highly resourced in terms of outdoor equipment particularly for activities involving gross motor skills. Another director may prefer or value fine motor and cognitive development. This director could resource their centre with arts and crafts that require fine manipulation and construction. If the collaborator is working with a young child that might need development in one area over another, knowledge of these differences in resources would be essential to meeting this child's needs.

Another resource that sometimes is overlooked is the level of expertise available in the persons providing service in a given program. Without assessing the level of expertise in a given program, the collaborator can be at risk of either asking more than what people are capable of providing or missing the opportunity of receiving more than what is expected.

The difference, in length of time to enter a program, between community based and a segregated one can be as significant as three to six months. This difference frequently lies in the process. Process is the means by which programs carry out their tasks. Segregated services often require a longer up front assessment process prior to the delivery of service, than many community based programs. Without a knowledge of process, collaborators can easily be frustrated by what seems like inordinate time delays. With a knowledge of process, helpers are actually in a position to facilitate the process and hopefully then minimize time delays. Again it must be understood that programs are entities unto themselves and therefore have their own "way of life".

The Individual

It is at the level of the individual that most is written. Mainly addressed are issues of culture, ego, power and authority (Frazier, 1985; Langrod and Ruiz 1985; Rothberg 1985; Smith, 1985; Maxwell, 1990). Notwithstanding, this paper includes issues of ability, self-needs, professionalization, and personal style.

Langrod and Ruize, and Maxwell both discuss values in their papers on cultural determinants to successful team/service delivery. Langrod and Ruize point out that the United States is not a "melting pot", but is rather a "conglomeration of various ethnic groups." As such, it is therefore important to have some sense of the values - standards of behaviour that each person brings.

Maxwell delineates three particular areas, or, standards of behaviour, that impact on service integration. They are: trust, status sensitivity and conflict resolution (p. 174). Maxwell claims that by virtue of different cultures people have different issues and approaches as regards these three areas. He points out in discussing Whyte (1977), there is evidence of low trust cultures as shown by different government bureaucracies such as in Peru and other third world societies as in East Africa.

Status sensitivity has been defined as "Who is to call or is willing to call whom" (p. 177). This is a very utilitarian definition of status in that tracing calls a hierarchy can be revealed.

In terms of conflict resolution Maxwell again refers to Whyte and quotes "If a man cannot say no, then the word yes loses it's meaning" (p. 179). Certainly according to culture, there are many styles for dealing with conflict resolution. Some cultures would have it that conflict is simply avoided while other cultures would take on a confrontative aggressive posture towards the resolution of conflict.

In the Canadian context, culture is now given a place of prominence. This is owing to the multicultural aspects of Canadian society. However there is a culture that is predominantly Canadian. The Canadian culture tends to value issues of the society or group over those of the individual. This stands in contrast to American culture in which the freedoms and rights of the individual are enshrined in its constitution. At the level of the individual, these sometimes-subtle differences can impact dramatically on one's ability to work collaboratively.

Speaking similarly of individual issues, Rothberg (p. 1985) refers to interpersonal issues of ego, power and authority. In terms of ego, Rothberg refers to the need for satisfaction in one's performance, recognition, respect, a sense of being accepted and a sense of being valued (p. 30). While there is the assumption of interdependence for successful collaboration, issues of power and authority arise. Some people may make unreasonable demands due to dependency needs and there are those who may make unreasonable demands on the other side of the spectrum, by virtue of needs to control. Akin to these issues of power and authority is the issue of leadership. Smith when talking of leadership in team practice states,

> Leadership should be reduced from an authoritarian role to a managerial one, that is, team leadership, which might be undertaken on a rotating basis, should be confined largely to making arrangements for team meetings, satisfying report requirements, and so on, the day to day management essentials of interprofessional mental health team functioning. Substantive leadership would best be invested in the entire team membership. (p.107)

There tends to be an assumption that by virtue of professional training, everyone knows how to get along, work in teams, and perform their role at a particular level of expertise. This is simply not the case. People differ markedly in their professional abilities. This is not a function of attitude but a function of training, education and years of practice experience. Combining issues of ego with issues of ability, there are some individuals who assert more ability than is actually possessed and other individuals whose abilities are understated.

To facilitate successful collaboration, people need to perform within their given ability. Should performance that is beyond ability be required, additional dialogue and appropriate problem solving would have to take place. Solutions can be manifold. One can lower expectations, provide staff development, provide additional staff, etc.

Professionalization refers to the way in which professionals are trained to view the world. This does not necessarily refer to different professions per se as this also includes persons of the same

profession, but who were trained at different schools. For example, two youth workers can approach the issue of adolescent school phobia with radically different perspectives. One youth worker, trained in psychodynamic approaches, may wish to provide a nurturing, caring and holding environment from which the adolescent can venture forth. Another youth worker, trained in behavioural approaches, looks at the antecedent-behaviour-consequence paradigm, and suggest a system of rewards and consequences to facilitate the adolescent's attendance at school. Quite observably this is a set-up for conflict. One cannot assume that having the same title or designation provides for the same worldview with others of similar titles and designation.

More overtly, issues of professionalization occur between different disciplines. The social worker wants to see things treated systemically, the psychiatrist psychiatrically, the psychologist psychologically and so on. In the absence of knowledge of different persons professionalization, conflicts of opinion are at risk of being personalized. Without an appreciation of people's different worldviews by virtue of their education, and without valuing the contribution of such, collaboration is at risk.

Introvert / extrovert is an example of a continuum reflecting personal style. Another personal style continuum is Personality A / Personality B. Some persons are more comfortable one on one and others in small groups. Some people move with panache and others quietly and subtly. Take a gregarious person and a shy/quiet person. Each can feel uncomfortable in the company of the other. The subtleties for successful collaboration require the collaborators to make distinctions and adjustments for personal style.

Summary

The barriers to successful collaboration are manifold. In order to provide a method for distinguishing the different barriers this paper suggests looking at the levels of the organization, the program and the individual. Under each level a number of different areas have been specified. While not exhaustive, it is hoped that this overview provides a system for assessing potential barriers to successful collaboration. The next section provides a particular model for facilitating collaborative services.

A WORKING MODEL TO FACILITATE COLLABORATIVE SERVICES

The model being described is one that is used in the Early Childhood Department of Chedoke McMaster Hospitals in Hamilton, Ontario, Canada. The Centre promotes the philosophy of integration and the inclusion of special needs preschool children into mainstream community settings. There is a strong belief that parents are the primary educators of their children and as such, must be included in all aspects of the integration and collaborative process. The model, therefore, has evolved over the years, having been originally developed within the context of integrating special needs children from a segregated clinical setting into community early childhood centres. The following is a brief description of how the model evolved.

In the beginning, a traditional consultation model was used, whereby the integrator, (referred to as the consultant) assumed the role of the expert: providing information; giving advice, opinions and directions. The belief here being that the consultant was ultimately responsible for the co-ordination, supervision, and monitoring of all aspects of the integration process. Many children were successfully integrated using this model. However, breakdowns and even failures were evident.

Experience is a significant teacher and in every situation, whether positive or negative, key elements began to emerge which required serious reflection. Gradually these key elements were incorporated into the integration process and the model changed to its current form reflecting a collaborative model. Now all individuals are equal partners in the integration process; the parents of these children, the staff of the community setting, and the clinical personnel of the segregated program.

The next section describes key elements, the use of the Social Compass and then the collaborative integration process in its current form.

KEY ELEMENTS IN DEVELOPING A POSITIVE RELATIONSHIP IN COMMUNITY EARLY CHILDHOOD CENTRES

Visibility - Individuals who promote Collaborative Services are visible at a community level. Active participation on relevant Committees task forces, or advisory boards will assist the individual become acquainted with the community and the principal individuals involved. This also allows for an opportunity to develop a positive rapport with others.

Accessibility - Making oneself available and responsive is an essential attribute. For example when a community colleague calls requesting information and you are unavailable, return the call as quickly as possible. If the information is unknown, give alternate sources. Through being accessible and responsible, trust will build.

Credibility - Actively practising professional ethics and standards is essential at all times. Individuals who portray double standards between clinical practice and social living are unlikely to gain confidence and trust from community linkages.

Recognition - Each community setting is a unique organization, each with its own goals, objectives, and history and belief system. Therefore becoming acquainted with each setting is important. A visit to the community centre should be arranged, before discussing the collaboration.

SOCIAL COMPASS APPLIED TO COMMUNITY EARLY CHILDHOOD CENTRES

Prior to engaging in any collaborative process, an essential component is to take time to collect valuable information on the centre. The Social Compass is a construct of Desmond M. Conner.

The purpose is to assess community programs. Although Connor's involvement was in determining how to change factors in larger projects, such as cities and other major communities, the list can be readily applied to smaller communities such as early childhood centres. It is applied by the Early Childhood Program staff to assess the readiness of community early childhood programs for the start of a collaborative integration process.

Questions are asked. For example, what is the set up? What resources are available? Who are the personnel? What is the philosophical perspective? And so on. This information can be obtained by reviewing sources of information external to the centre, such as other clinicians who have been previously involved, government employees who have responsibilities in upholding licensing standards or parents who have used the centre.

Of most importance, is an actual visit, spending as much time and effort in immersing oneself as unobtrusively as possible for as lengthy a period as will allow. Preferably allow one full day to observe and experience all aspects of the programme, the people and how they use their time and knowledge.

Prior to the visit, at the point when it is being arranged, request that a copy of the centre brochure and parent's handbook be made available. These often list the philosophy, goals and objectives of the centre, the hours of operation and programme content.

During the visit, talk to some key people in an informal way. Use the social profile list and explore. However, allow the discussion to be conversational and flexible rather than posed through a structured interview. Generally a conversation regarding the history of the centre will lead to many insights into leadership, norms and other factions. One rule of thumb is to refrain from writing notes during a conversation. Notes can be recorded immediately following the visit.

The social profile used in community visits is one adapted from Desmond M. Connor's Social Compass Applied to the Community - Strategies for Change, 1968. Connor listed twelve areas to explore when obtaining a sketch or social profile - see Figure 1.

1. Resources
   What resources are available in the centre including trained personnel, support staff and funding mechanisms? What equipment and materials are available for children and staff to use?

2. Technology
   List the tools, skills and techniques used to ensure administrative efficiency, as well as formal and informal means of decision-making.

3. Knowledge
   Knowledge refers to all that is known about the world and life in it. With beliefs there is an element of personal conviction. Therefore, what is the theoretical framework espoused by the centre and is it supported by the individuals within the group? Given the cultural mosaic in our society, what are the cultural systems of beliefs?

4. Values and Sentiments

Values are the ideals that people have, their concepts of good true and beautiful; sentiments are pervading feelings about core issues. Both are at a subconscious level, therefore, few people can identify and discuss their sentiments and values even although they are the heart of human motivation, so important and yet so elusive. Attempt to determine the attitudes of individuals in terms of their ideals and the reality of putting them into practise.

5. Goals and Felt Needs

These are targets that individuals set for themselves and wish to achieve. Some may be unique to the individual while others may be shared by their colleagues and the centre. What are the goals of the centre? How will they be achieved?

6. Norms

These are the accepted standards of conduct for given situations; they form the rules of the game. Some norms may have originated from traditions set during the origins of the centre and although may not be deemed as relevant today are highly valued by the centre.

7. Positions and Roles

Positions range from official job titles to informal ones of friendships. Associated with each position are a set of expected behaviours which constitute the role of the one occupying that position. Usually a person occupies a number of positions at a time and thus has many roles. At times some of these will be in conflict with each other. Official job titles can be listed in an organizational chart, while informal positions can often be viewed through observing the interactions of the staffing.

8. Powers, Leadership and Influence

Power is the ability of one person to control another; leadership is the ability to help a group make decisions and act upon them; influence is the capacity to affect human behaviour, often without being aware of it. Determine who is in control and how the control is applied. What is the background? Often the least expected individual yields the greatest power. Many cooks in early childhood centres wield the greatest power.

9. Social Rank

This indicates the standing a person has in the centre or who rates and why. Explore the social structure internal and external of the centre personnel. What is the rationale for this?

10. Sanctions

These are the rewards and punishments that a group uses to induce an individual to adhere to its values, norms and goals. What are the rewards? Are they tangible or social? What punishments are used?

11. History

This refers to the selective recording and interpretation of past events. What is the history of the childcare centre? How long has it been in operation? Who were the founders? Are there political issues?

12. Space Relations

These are the internal and external boundaries of the centre. Internally, what is the set up? Is there adequate space? Is the space shared? Is the space accessible to accommodate special needs? In terms of external boundaries, who are the neighbouring early childhood centres? What is the relationship?

In a questionnaire format, list the above points with sufficient space to add your comments. Following the visit complete the questionnaire. Together with the organizational chart, a useful centre profile can be assembled which will provide information on the main features of the centre, its personnel and how they view and manage their world. The profile data will assist the clinician in judging the appropriateness of continuing further at this time. In the future, the information can readily be updated and expanded upon more fully and in greater depth as may be needed.

KEY ELEMENTS FOR SUCCESSFUL COLLABORATIVE INTEGRATION

The collaborative process must be practical and easily incorporated into the regular curriculum of the centre.

Other children and parents using the centre need to be in support of the process. The process requires to be cost efficient with the ability to use existing or borrowed materials. Centres are not able to provide costly building adaptations or to buy expensive materials.

There must be a clear understanding and recognition of the importance of the role for the community setting and the role of the parents.

Collaborative team members need to ensure there is:

- Good communication, respect for all members and a willingness to learn and take risks.
- Work towards eliminating the fear of diagnostic labels supporting the belief that a child is a child first and a special needs child next.
- Belief in collaborative integration and that to support it, will make a difference.

The writer will now describe the model as it relates to integrating children with special needs into community childcare settings. However, it must be stressed that this is only an example of how the model can be applied. It is sufficiently generic for use in multiple situations where collaborative services apply.

THE INTEGRATION PROCESS

It is highly recommended that the integration process be a gradual one. The well-known phrase "haste makes waste" should be kept in mind at all times. The object is not to determine how fast the process can occur, *but rather how successful it can be*. The goal of the process is to ensure the child and family have a successful experience during the integration and the receiving centre is gradually guided through the experience, thereby providing ample opportunity for readiness and acceptance.

In addition, sufficient time is granted for each of the parties to reflect, consider the long-range commitment and determine all other possibilities and options prior to being fully committed. The following is a list of steps that can be used as a guideline. It should be noted that the process could cease at any step in one centre and begin at Step 1 in a new location.

Step 1: Space Availability - Make contact with the centres in the desired location to determine whether space is available for special needs children.

Step 2: Arrange Visit - If the programme is unknown to you, ensure that a visit is made to the centre. Complete the social compass and determine suitability.

Step 3: Observation of Child - Arrange for appropriate personnel from the community centre to visit the segregated site for the purpose of observing the child to be integrated. Preferably the director/supervisor and teacher expected to eventually work with the child should be encouraged to attend. Invite the parents to attend the observations. During the observation, the unique needs of the child can be addressed and whether special equipment is required. This should demystify the needs of the child and eliminate any concerns.

Step 4: Visit to Community Facility - The parent, child and clinician visit the community centre during a period when an activity that holds the child's interest will be offered. This opportunity allows the parent to view the set up and see the staff in action with other children, thereby giving an understanding of group interaction between peers and staff relationships with the children and each other. The centres equipment can be seen and whether there requires to be additional equipment brought to accommodate the special needs child. In general terms, such a visit can reduce fears and anxieties by assisting the child to relax and enjoy the attention of new friends.

Step 5: Contract for Involvement - A meeting is arranged to include personnel from the community centre, the parents and the clinical staff. Full information is provided regarding the child's specific needs and what special requirements are anticipated. Expectations for the integration are clearly defined. Responsibilities are negotiated and role definitions made. The centre and parental roles may reflect the desired level of responsibility. If equipment or other resources are an issue, problem solving occurs. Skill development opportunities for staff are determined. When agreement has been reached, a written contract is completed with copies given to each participant of the collaborative team. Contracts include the task and the individual responsible for each task. Generally a start date is agreed upon at this time to include a probationary period of time. The idea here is, *"If it ain't been written, it ain't been done"*.

Step 6: Gradual to Full Integration - Integrating children into the mainstream should only be attempted at a time of readiness for the child and the centre. The experience must be viewed as a positive one for all concerned. Initially short period of times should be made available, especially at known times when success can be achieved.

Choosing a time when there are familiar activities for the child and when centre staff can devote time to spend with the child is an ideal time to commence. Gradually the time spent in the centre can increase until full integration is accomplished. (see Direnfeld, 1987, for case example of gradual integration of special needs adolescent.) There is no magical time span. Some children will fully integrate after one or two weeks while others require a longer period.

Step 7: Continued Collaboration - Ongoing contact through regular expected visits by the clinician follows. During these times and in accordance with the contract, hands on facilitation may occur or educational opportunities and skill development for staff, eg., learning signed English. The collaborative team meets regularly to develop and review individual program plans, set new goals, and write reports.

CONCLUSION

This paper illustrates the developmental changes in service delivery and the extensive knowledge base required for a collaborative services approach to the integration of special needs preschoolers.

Collaborative services was shown to be the current form of service delivery with its history traced through the deinstitutionalization movement of the 1960's and next the case management movement. The distinquishing features of collaborative services are the emphasis on equality of input from multiple service providers and the shared responsibility for implementing and seeing through the service plan. Obstacles to effective collaboration were shown to occur at the level of the organization, the program and individual. Understanding of these potential obstacles enables the collaborators to appropriately account and therefore plan for difficulties as they arise.

An adaptation of Desmond Connor's Social Compass was described as a system for collecting data about programs targeted for possible collaborative work. This enables persons to determine the suitability of particular programs prior to initiating agreements for service. If a program is deemed appropriate the data next facilitates overcoming potential obstacles to collaboration by virtue of early identification.

Based on the above, this paper next demonstrates the process and elements for collaborative integration of special needs preschoolers. A graduated step-by-step process is recommended. The process includes:

Initial assessment of program to determine overall design and resources as required to meet the child's needs and then the potential obstacles if program determined suitable.

Observations.

Contract for involvement.

Planned integration.

Continued collaboration.

While this paper is specific in its application of a collaborative service model for the integration of special needs preschoolers, it should finally be noted that this model develops with inputs from mental health, social work, special education and physical rehabilitation. This model is not specific to the needs of a particular target population, but to helping processes that require input and cooperation from multiple service providers. As such, it is these authors' belief that the model of collaborative services described herein is appropriate to the delivery of service to any targeted population where input and cooperation from multiple service provides are required. It is hoped that this paper encourages other persons to adopt similar thinking for service delivery.

References

Davies, F.: Inter-Agency Cooperation: Health and Social Services - An Occupational Therapy Perspective. The British Journal of Occupational Therapy, 49(5), May 1986, 151-153.

Direnfeld, G. : Traumatic Brain Injury And Case Management. Cognitive Rehabilitation, NeuroScience Publishers, 8(5), Sept.-Oct. 1990, 20-24.

Erickson, A.; Moynihan, F.; Williams, B.: A Family Practice Model For The 1990's. Families In Society: The Journal Of Contemporary Human Services, Family Services of America, May 1991, 286-293.

Frazier, S.: Mental Health Team Practice. in Interdisciplinary Team Practice: Issues and Trends, Lecca, P. and McNeil, J. Editors, Praeger Special Studies, New York, 1985, 42-56.

Gelman, S. and Fried, B.: Multi-Institutional Arrangements and the Canadian Health System, Publications Canadian Hospital Association, Ottawa, Canada, 1987, 1-6.

Idol, L. and West, J.: Educational Collaboration: A Catalyst for Effective Schooling. Intervention In School And Clinic, 27(2), Nov. 1991, 70-78.

James, W., Albert, J. and Mann, R.: Educating Homeless Children: Interprofessional Case Management. Journal Of The Association For Childhood Education International, "Childhood Education: Infancy Through early Adolescence", Annual Theme Issue, 67(5), 1991, 305-308.

Johnson, D., Bruininks, R. and Thurlow, M.: Meeting The Challenge Of Transition Service Planning Through Improved Interagency Cooperation. Exceptional Children, The Council for Exceptional Children, 53(6), 1987, 522-530.

Kohl, H.: A Renewed Effort On Behalf of American Families: Coordination and Partnership. Families In Society: The Journal Of Contemporary Human Services, Family Service America, May 1991, 262-267.

Langrod, J. and Ruiz, P.: Cultural Aspects In Team Practice. in Interdisciplinary Team Practice: Issues and Trends, Lecca, P. and McNeil, J. Editors, Praeger Special Studies, New York, 1985, 155-175.

Levy, J.: Essay: Schools and Social Services: A Nascent Partnership. Families In Society: The Journal Of Contemporary Human Services, Family Service America, May 1991, 310-313.

Lourie, I. and Katz-Leavy, J.: New Directions For Mental Health Services For Families And Children. Families In Society: The Journal Of Contemporary Human Services, Family Service America, May 1991, 277-285

Lowenthal, B.: Ecological Assessment: Adding A New Dimension For Preschool Children. Intervention In School And Clinic, 26(3), Jan. 1991, 148-151.

Malekoff, A., Johnson, H. and Klappersack, B.: Parent-Professional Collaboration On Behalf Of Children With Learning Disabilities. Families In Society: The Journal Of Contemporary Human Services, Family Service America, May 1991, 416-424.

Maxwell, J.: Cultural Values As Determinants Of Service Integration: Some Examples In International Perspective. International Social Work, Sage, London, 33, 1990, 175-184.

Mooney, S.: Coordination Among The Residential Treatment Centre, Guardian Ad Litem, And The Department Of Social Services, The Hawthorn Press, Inc., Chap. 4, 1984, 47-57.

Pascal, C.: So You Want To Be My Partner: Some Notes On Partnership and Democratic Administration. (Working Draft), Premier's Council On Health, Well-being, And Social Justice, Aug. 1991.

Peters, J., Templeman, T. and Brostrom, G.: The School And Community Partnership: Planning Transition For Students With Severe Handicaps. Exceptional Children, The Council For Exceptional Children, 53(6) 1987, 531-536.

Rothberg, J.: Rehabilitation Team Practice. in Interdisciplinary Team Practice: Issues and Trends, Lecca, P. and McNeil, J. Editors, Praeger Special Studies, New York, 1985, 19-41.

Scanlon, J.: A Study Of Team Approach To Planned Change: Cooperation and Coordination Among Individuals Serving Special Needs Preschool Children. Dissertation Abstracts International, 51(6), Dec. 1990, 2173-A.

Smith, N.: Social Work In Team Practice. in Interdisciplinary Team Practice: Issues and Trends, Lecca, P. and McNeil, J. Editors, Praeger Special Studies, New York, 1985, 97-123.

Stodden, R. and Boone, R.: Assessing Transition Services For Handicapped Youth: A Cooperative Interagency Approach. Exceptional Children, The Council For Exceptional Children, 53(6) 1987, 537-545.