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What is This?

The Partners in Prevention Program: The Evaluation and Evolution of the Task-Centered Case Management Model

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This article reports on the further development of the task-centered model for difficulties in school performance. We used Bailey-Dempsey and Reid's (1996) application of Rothman and Thomas's (1994) design and development framework and annual evaluations of the Partners in Prevention (PIP) Program to refine the task-centered case management model. Data from four recent PIP evaluations suggests the significant improvement in academic achievement and behaviors that present as barriers to school performance.

Keywords: academic achievement; design and development; task-centered case management

Bailey-Dempsey and Reid's (1996) case study reported in the pages of *Research on Social Work Practice* described the application of the design and development framework (Rothman & Thomas, 1994) to the addition of a case management component of Reid's task-centered model. The authors conclude the 1996 article with three recommendations: First, the design and development paradigm should take into account the potential impact of contextual factors in the intervention development process; second, greater attention should be given to strategies for advanced intervention development in the absence of experimental research designs; and third, there is a need to deal with issues involved in the dissemination and adoption of interventions whose effectiveness may not be fully demonstrated or is based on tentative evidence.

The task-centered model is an empirically based approach to resolving clients' problems-in-living that has been continually refined through developmental research since its inception in 1972 (Reid & Epstein, 1972). In the 1990s, Reid and Bailey-Dempsey (1995) developed a case management component for task-centered practice with children at risk for school failure.

They taught the task-centered case management model to a group of practitioners from Liberty Resources, Inc., a large human services agency located in central New York State. The practitioners evaluated and further evolved the model as the Partners in Prevention (PIP) Program. This article reports on the evolution of the PIP Program from its task-centered origins, discusses the use of the design and development framework in the evolutionary process (Rothman & Thomas, 1994), and describes the effectiveness of the PIP Program based on the outcomes from the last 4 academic years of evaluations.

DESIGN AND DEVELOPMENT OF THE TASK-CENTERED MODEL

Testing the task-centered approach with children from a school setting began 30 years ago (Reid, 1975).

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Reid examined one part of the model: task-implementation or client–practitioner activities that contribute to a client's task accomplishment (such as enhancing commitment, planning task implementation, and analyzing obstacles to task accomplishment). Reid (1978) expanded on this with a randomized controlled experiment with children referred from a school setting. Here Reid specifically looked at how task-centered methods contributed to problem change and how effectiveness varied according to characteristics of client, problem, or practitioner.

Reid, Epstein, and their colleagues then evaluated the model's impact on academic behavior as well as peer and family relationships (Reid, Epstein, Brown, Tolson, & Rooney, 1980). One finding that would later contribute to the development of the PIP Program was the importance of the child's view, as the greatest change occurred in those problems that the students themselves considered most important.

Reid and his colleagues later added a case management innovation to the task-centered model for use with girls at risk of school failure (Reid, Bailey-Dempsey, Cain, Cook, & Burchard, 1994). Case management teams were comprised of the referred student, her parents, the teacher, and the practitioner joining together to deal with the barriers to the student's academic success. The systematic collaboration between home and school environments researched in this experiment was to become another hallmark of the PIP Program.

A year later, Reid and Bailey-Dempsey's (1995) follow-up of the experiment indicated that in the short term, the case management outcomes were superior to students being paid, but the program's effects did not carry over to the following year. This suggested to them that a more sustained intervention may be necessary to bring about enduring improvement in the student's school performance—perhaps 8 to 12 sessions was not enough.

Bailey-Dempsey and Reid (1996) concluded that a continual decline in grades is the norm for untreated at-risk students, that there was a need to redesign the model from being time-limited to a continuing service approach, that there was a need for the researcher-practitioner to watch for opportunities to further refine the intervention, that the model should be subjected to experimental tests, and that practitioners should be trained in both the intervention as well as in monitoring and evaluating its use. These principles guided the further development of the PIP model from the time Reid and Bailey-Dempsey trained the PIP staff in 1994 through the ongoing collaboration between the University at Albany and Liberty Resources.

THE TASK-CENTERED CASE MANAGEMENT MODEL

As currently implemented by the PIP Program, the important components of the task-centered case management model are the identification by the student of the target goals for intervention and the formation of a collaborative team with members named by the student. All team members share in the identification of goals and the tasks used to address these goals. The practitioner leads this process and is the central figure in facilitating service delivery. The practitioner assigns members of the team responsibility for specific tasks with the primary goal being to overcome the barriers to school success. The practitioner takes a leadership role in convening the case management service team, reviewing the service team's progress, and identifying barriers to task achievement.

Preliminary Phase

Any elementary students exhibiting school-related problems or behaviors that inhibit their academic performance are eligible for the task-centered case management intervention. Target problems for which students are referred range from disruptive classroom behavior or not completing homework to poor peer relationships or lack of communication between home and school. Once a referral has been made to the program, either from a parent, teacher, or school services screening process, the task-centered practitioner conducts an assessment to determine eligibility for services. Prior to initiation of services, parental permission is secured in addition to an agreement by the student's teacher to participate in services.

Initial Phase

The initial phase occurs over the first 4 to 6 weeks. This phase of service involves engagement, problem identification, and formulation of a support team. During the initial family meeting with parents, the practitioner explains the task-centered case management process and gathers the family's perspective on the referral issue. The practitioner then meets individually with the student to elicit his or her response to the concerns outlined in the referral form. If the student disagrees with the identified concerns, attempts are made to find common ground. If common ground cannot be established, then the practitioner goes with the student's perception. For example, the teacher might identify the student's classroom behavior as being disruptive and affecting her school performance. However, the student identifies

the teacher as always being angry and singling her out. In going with the student's perception, the case manager might work with the student to take a closer look at her behavior as a way to decrease being singled out by the teacher.

The first meeting with the student is also used to explain the case management support team and to ask the student to identify members of the team. Typically the members of the team include the student's parents, teacher, and practitioner. However, students can request other people whom they think might be helpful, like a grandparent, sibling, other teachers, or even another student.

Planning and Monitoring Phase

The planning and monitoring phase begins after the formation of the support team. This phase involves goal-setting and monitoring, regular team meetings, barrier identification, and problem resolution. Family counseling and individual counseling may also occur as indicated by the task plan that is developed by the team.

The first service team meeting is usually held at the school. The team members have been identified by the child, and their role is to take part in identifying solutions and working collaboratively to assist the child in making progress. They plan to meet every 2 weeks for 6 meetings. The practitioner as service provider has a primary responsibility of keeping team members focused and on track.

The goal of the first meeting is to obtain consensus on case goals and to develop a plan with all team members' input. The process begins with the practitioner summarizing the areas of concern solicited from everyone prior to the first team meeting. The team and the practitioner develop these ideas into tasks. Each member should have a task. The practitioner makes sure that the team's members are clear about the details of their tasks.

In subsequent team meetings, the practitioner reminds team members what the goal plan is and asks how they think they are doing in comparison to baseline frequency of targeted behavior. Baseline frequencies are recorded prior to the beginning of services. In addition, the practitioner asks all team members if they were able to complete the tasks. If they were able to complete their tasks, then the relationship between task completion and progress on the targeted goal is discussed. If the team member could not complete the task, then the barriers to completion are explored and the task may be modified as a result. During each case management meeting team members rate progress on goals.

Family sessions. Family meetings are used to review tasks agreed on during the case management meetings. By meeting in the home, the practitioner can address the context in which some of the problems occur. The practitioner

can intervene by encouraging the student and parent to carry out the task, modeling for the student and parent how to carry out the agreed-on task as it was planned, structuring in-session tasks to help the family identify and plan for obstacles to task completion, analyzing obstacles to tasks and reconstructing original tasks, or structuring opportunities to practice tasks.

Individual sessions. If there are individual sessions with the student, they focus on goals developed in the task plan. Specific tasks include activities like behavior chart development, skill building, or work with peer helpers. Primarily a problem-solving approach is used to address the task plan and the obstacles to completing the agreed-on tasks. If tasks have been completed, the practitioner and the student discuss the relationship between task completion and progress on goals. If tasks have not been completed, the practitioner and student discuss obstacles and develop a plan for overcoming obstacles to goal completion.

Closure Phase

The closure phase is decided on by the team. It involves the final progress rating and identification of how change has occurred. The decision to conclude services is decided with input from the student and all team members. Discharge should occur when the team assesses that sufficient progress has been made in alleviating the target problem. The team members must agree that discharge is appropriate. Most importantly, the team discusses what it was that really made a difference, so that the problem-solving skills may be applied to future situations.

PIP Evaluation

The efficacy of the PIP Program has been addressed through annual evaluations dating from the 1994–1995 academic year. The first evaluation was completed by Bailey-Dempsey and Reid (1995) after training the PIP staff in using the task-centered case management model. This report presents the last 4 years of evaluations. The data were compiled, in part, to look at the association between gender, grade level, academic improvement, and changes in behavior.

METHOD

Student Sample

The participants in the evaluation included 606 elementary students from 4 of 11 school districts in Madison County, a rural county in Central New York

State with a total population of approximately 70,000 people (Madison County Health Department, 2005). Two of the districts were large (average enrollment for K–12 is approximately 2,500 students), one medium (1,800 students), and the fourth, small (700 students; New York State Education Department, 2005). Ninety-five percent to 98.3% of the districts' students were White (not Hispanic). The second largest percentage of the population was American Indian (0.7% to 2.3%). Eligibility for reduced lunch—a socioeconomic indicator—ranged from 11% of the students enrolled in the two largest districts, with the medium-sized district at 2.9% and the smallest district at 8.6%. Only one of the four districts receiving PIP services is actually growing in student enrollment; all other districts gradually lost students over the 4 years of the evaluation. The student population loss is consistent with the population decline across Central New York State. Central New York lost an average of 2.3% of its population during the 1990s. Madison County lost 2% of its population from 1996 to 2002 (Madison County Health Department, 2005).

The 606 subjects included all elementary students who received services in the PIP Program between the academic years 2000–2001 through 2003–2004 (see Table 1). Fifty-eight percent were male ($n = 346$) and 42% were female ($n = 247$). Ages ranged from 4 to 13 years with an average age of 8.06 years ($SD = 2.01$).

Reason for referral. The students were referred for PIP services for a range of problems that included academic problems, emotional difficulties, social issues, and disruptive behaviors. Students could be referred for PIP services for more than one reason. Most frequent were academic problems, for example not completing homework or not bringing work to school. Emotional problems—also a majority of students—included grief over the loss of a parent or difficulties regulating emotions over the course of the school day. Behavior problems (31%) between the student and classmates are distinguished from disruptive behaviors (42%) for activities that occur outside of the classroom, like difficulties on the school bus or disrespectful actions that occur between adults and the student on the playground.

Outcome Measures

Report cards. Report card data were used to measure changes in academic achievement from baseline (first quarter grades) to termination (fourth quarter grades). These were used for all students regardless of when the intervention began and ended for all students. Academic

TABLE 1: Reasons for Referral to the Partners in Prevention Program

Reason	Students ($n = 606$)	Percentage
Attendance	52	8.8
Academic problems	325	54.9
Behavior	181	30.6
Disruptive behavior	246	41.6
Withdrawn behavior	125	21.2
Social	272	45.9
Emotional	295	50.0
Home-to-school communication	178	30.1
Others	281	47.7

data were gathered on reading, spelling, speaking/listening, math, social studies, science, and the overall average. Letter grades were converted to a numerical scale from 0 (F) to 40 (A).

The Behavior Rating Index for Children (BRIC). The BRIC was completed by parents at the beginning and termination of services. The BRIC is a 13-item instrument designed as a rating scale completed by persons in the children's environment to measure the degree of children's behavior problems (Stiffman, Orme, Evans, Feldman, & Keeney, 1984). The BRIC is scored on a 5-point Likert-type scale, with a high score indicating that the student is experiencing a particular behavioral problem most of the time. The BRIC is fairly stable when completed by adults, with a test–retest correlation ranging from .71 to .89.

The Teacher Report Form (TRF). Like the BRIC, the TRF measures the degree of the student's behavior problems (Bailey-Dempsey, 1993). The TRF is scored using a 5-point Likert-type scale. A high score on the TRF indicates that the student is less likely to be experiencing a particular problem in the school environment. The TRF measure has not been standardized. While there are no reliability or validity measurements for this tool, it has been used for many years in evaluating the PIP program and findings have been consistent with the findings on the BRIC.

Research Design

The question of whether the PIP Program was a successful approach to address barriers to academic achievement has been addressed through evaluations completed by the University at Albany beginning with the 1994–1995 school year. The initial report was completed by Bailey-Dempsey and Reid (1995). Subsequent reports were completed by Reid and his doctoral students. Each evaluation was based on a one-group

TABLE 2:   Grade Change From Baseline to Termination of Partners in Prevention Services (*n* = 606)

Subject	Baseline (1st Quarter)		Termination (4th Quarter)		
	M	*SD*	*M*	*SD*	Difference
Reading	24.19	9.38	27.09	9.18	2.90***
Spelling	24.75	9.08	26.48	9.44	1.73***
Speaking/listening	25.00	8.21	26.81	8.95	1.81***
Math	26.08	9.90	26.40	10.58	0.32
Social studies	26.74	10.36	27.65	10.10	0.91*
Science	27.20	9.96	28.28	9.86	1.08*
Overall	25.66	7.78	26.95	8.02	1.28***

NOTE: Paired *t* test between baseline and termination. Letter grades were assigned numerical scores with F = 0 and A = 40.
*$p < .05$. ***$p < .001$.

pretest–posttest design. The data here focuses on the results of 2000–2004 school years. The four sets of data were aggregated to look at the impact of the PIP intervention and the effects of gender and grade level.

Results

Grades. PIP students' grades increased from baseline to termination in all course subjects, with all but math grades having statistically significant changes (paired *t* test, $p < .05$; see Table 2).

Boys improved in all subjects, with statistically significant change in 6 of 7 subjects (paired *t* test, $p < .05$). Girls improved in six subjects (four significantly) but actually lost points in their math scores (see Table 3). This is the only subject area where students did not improve.

Students in the lower grades—kindergarten, first, second, and third grades—had significant improvements in their overall grade averages (paired *t* test, $p < .01$; see Table 4). Fourth and fifth graders improved, but not significantly. Sixth graders did improve significantly. Students in lower

grades generally started with better grades than older students.

Behavior. The evaluation of the PIP model shows positive behavioral and emotional changes for students from baseline to termination of the intervention (paired *t* test, $p < .05$; see Table 5). The results of the TRF completed by classroom teachers reported positive changes in most areas, including both externalizing (e.g. hyperactivity, disruptive) and internalizing (e.g. lack of participation) behaviors. Although males demonstrated more changes that were significant (10 of 14 behaviors on the TRF, vs. six for females; see Table 6), females generally had fewer problems in their behaviors at baseline.

The results of the BRIC completed by the students' parents from pre- to postintervention are shown in Table 7. Parents indicated significant improvement in all 13 behavior areas (paired *t* test, $p < .05$).

DISCUSSION AND APPLICATIONS TO PRACTICE

While the results of the evaluations did demonstrate that students improved on grades and behavior while in the PIP Program, lack of control group information leaves questions about whether the elementary students would naturally improve their grades and behavior as the school year progresses. We know that at-risk students are likely to continue to show a downward trend over time (Reid & Bailey-Dempsey, 1994). However, the students referred for PIP services were not all at-risk in the same ways or with the same level of intensity. Clearly, control information would strengthen the evaluation findings. It is also important to note that there was another trend that indicated that the PIP intervention may have greater impact in the earlier grade levels and that female students showed

TABLE 3:   Grade Change by Gender

Subject	Males (*n* = 346)					Females (*n* = 247)				
	Baseline		Termination			Baseline		Termination		
	M	*SD*	*M*	*SD*	Difference	*M*	*SD*	*M*	*SD*	Difference
Reading	23.94	9.77	26.85	9.25	2.91***	24.55	8.79	27.44	9.13	2.89***
Spelling	23.97	9.36	26.07	9.52	2.10***	25.78	8.63	27.07	9.28	1.29*
Speaking/listening	24.19	8.55	25.99	9.14	1.81**	26.28	7.54	29.04	8.65	1.77**
Math	26.71	10.01	27.98	10.30	1.27*	25.06	10.30	24.03	11.04	−1.03
Social studies	26.89	10.30	27.74	10.32	0.86	26.43	10.58	27.56	9.84	1.13
Science	27.46	9.83	28.76	10.10	1.30*	26.78	10.15	27.58	9.48	0.80
Overall	25.57	7.90	27.14	8.08	1.57***	25.76	7.66	26.67	7.76	0.92*

NOTE: Paired *t* test between baseline and termination. Letter grades were assigned numerical scores with F = 0 and A = 40.
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 4: Overall Change in Grades by Grade Level

Grade	n	Baseline M	Baseline SD	Termination M	Termination SD	Difference
Kindergarten	46	29.52	6.10	32.68	5.65	3.16***
1	56	26.52	6.98	28.09	6.37	1.57**
2	72	25.41	6.88	27.46	7.30	2.05***
3	87	26.63	7.05	27.67	7.96	1.04*
4	87	25.37	7.41	26.14	7.39	0.77
5	53	23.08	8.41	23.20	9.27	0.12
6	33	21.67	12.04	23.47	9.86	1.80*

NOTE: Paired t test between baseline and termination. Letter grades were assigned numerical scores with F = 0 and A = 40.
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 5: Classroom Behavior (Teacher Report Form)

Behavior Item	Baseline (1st Quarter) M	Baseline (1st Quarter) SD	Termination (4th Quarter) M	Termination (4th Quarter) SD	Change
Swears during class	4.74	0.61	4.72	0.58	−.02
Disrupts other students	2.91	1.22	3.22	1.06	.30***
Does not pay attention	2.81	1.08	3.01	0.93	.20***
Hyperactive	3.41	1.25	3.68	1.14	.27***
Asks for passes	3.64	1.25	3.74	1.13	.10
Talks back to teacher	3.98	1.16	4.06	1.05	.08
Shows off	3.65	1.22	3.79	1.12	.14**
Requires help with work	2.57	1.22	2.91	1.21	.24***
Quiet or no participation	3.27	1.23	3.37	1.11	.10*
Talks out of turn	3.06	1.29	3.29	1.16	.23***
Attends minus books or supplies	3.39	1.19	3.50	1.13	.11*
Aggressive toward others	3.82	1.17	3.89	1.05	.07
Unhappy for no reason	3.29	1.11	3.56	1.05	.27***
Other	2.02	0.79	2.44	0.89	.42*

NOTE: Paired t test between baseline and termination. Classroom behavior rating: 1 = *always*, 2 = *often*, 3 = *sometimes*, 4 = *seldom*, 5 = *never*.
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 6: Classroom Behavior by Gender (Teacher Report Form)

Behavior	Males Baseline M	Males Baseline SD	Males Termination M	Males Termination SD	Change	Females Baseline M	Females Baseline SD	Females Termination M	Females Termination SD	Change
Swears during class	4.66	0.67	4.64	0.65	−.02	4.85	0.47	4.85	0.43	.00
Disrupts other students	2.71	1.13	3.07	0.99	.36***	3.23	1.29	3.44	1.13	.21**
Does not pay attention	2.73	1.05	2.96	0.92	.23***	2.92	1.12	3.07	0.93	.15
Hyperactive	3.18	1.18	3.54	1.07	.36***	3.79	1.26	3.90	1.22	.11
Asks for passes	3.67	1.24	3.83	1.03	.16*	3.60	1.26	3.60	1.23	.00
Talks back to teacher	3.83	1.17	3.98	1.03	.15*	4.23	1.09	4.21	1.07	−.02
Shows off	3.41	1.20	3.63	1.11	.22***	4.04	1.14	4.04	1.09	.00
Requires help with work	2.67	1.21	2.93	1.25	.26***	2.65	1.22	2.86	1.14	.21**
Quiet or no participation	3.38	1.21	3.46	1.11	.07	3.06	1.23	3.22	1.09	.16*
Talks out of turn	2.85	1.21	3.08	1.11	.24***	3.40	1.33	3.62	1.16	.22**
Attends minus books or supplies	3.26	1.24	3.43	1.19	.17*	3.58	1.11	3.60	1.05	.02
Aggressive to others	3.63	1.17	3.72	1.03	.09	4.11	1.11	4.13	1.02	.03
Unhappy for no reason	3.28	1.12	3.50	1.03	.22**	3.30	1.08	3.65	1.07	.35***
Other	2.15	0.83	2.42	0.75	.27	1.80	0.67	2.47	1.12	.67*

NOTE: Paired t test between baseline and termination. Classroom behavior rating: 1 = *always*, 2 = *often*, 3 = *sometimes*, 4 = *seldom*, 5 = *never*.
*$p < .05$. **$p < .01$. ***$p < .001$.

diminished scores in math. Control data might be able to help us understand what is happening for students in the earlier grades levels and if the declines in math for our female students happens with all female elementary students.

Given what we learned from the annual evaluation outcomes, we asked how the PIP Program might have the potential to impact children before they find themselves on the path to school failure, and how this intervention might be particularly potent for those who come to the learning environment with risk factors right from the time they enter kindergarten. This question leads us back to where we started: the design and development framework. The framework has directed our attention to look more closely at the identification of mediating factors that might explain the success at the primary grades. According to Fraser (2004), translating mediating processes into action should take place early in the design and development framework. As the model has evolved into the PIP Program, we believe the most important mediating factors may be how the model is applied to each case.

Evolution of the PIP Program

In the initial evaluation report (Bailey-Dempsey & Reid, 1995), children receiving PIP services improved significantly in behavior and academic grades. Results were impressive considering earlier studies (Bailey-Dempsey, 1993; Reid & Bailey-Dempsey, 1995; Reid, Bailey-Dempsey, Cain, et al., 1994) that showed a

TABLE 7: Behavior Change (Behavior Rating Index for Children [BRIC] Ratings by Parents)

Behavior Item	Baseline (1st Quarter)		Termination (4th Quarter)		Change
	M	SD	M	SD	
Feel happy or relaxed	3.52	0.95	3.91	.82	.39***
Hide thoughts from other people	2.93	1.20	2.55	1.08	.38***
Say or do really strange things	2.05	1.06	1.85	.95	.20***
Not pay attention when should	3.44	1.00	3.01	.93	.43***
Quit a job or task without finishing	3.13	1.12	2.69	1.01	.44***
Get along well with other people	3.82	0.99	4.02	.88	.21***
Hit, push, or hurt someone	2.08	1.10	1.76	.90	.32***
Get along poorly with other people	2.12	1.01	1.87	.93	.25***
Get very upset	3.11	0.98	2.56	.91	.55***
Compliment or help someone	3.40	1.02	3.51	.97	.11*
Feel sick	1.87	1.08	1.69	.96	.18**
Cheat	1.57	0.86	1.44	.77	.13**
Lose temper	2.90	1.08	2.52	.98	.39***

NOTE: Paired *t* test between baseline and termination. BRIC rating: 1 = *rarely or never*, 2 = *a little of the time*, 3 = *some of the time*, 4 = *a good part of the time*, 5 = *most or all of the time*.
*$p < .05$. **$p < .01$. ***$p < .001$.

statistically significant decline in the grade point averages of students who did not receive services. At that time, the evaluator concluded "through PIP, the seemingly inevitable downward trend in the school performance of at-risk students was not only halted, but reversed" (Bailey-Dempsey & Reid, 1995, p. 6).

This study, 6 to 10 years later, also demonstrates that children receiving PIP services improve their grades and school behavior. In addition it suggests differences between boys and girls and between lower- and upper-grade students. Between the two sets of evaluations, the PIP task-centered case management model evolved using the design and development framework of Rothman and Thomas (1994). This section discusses some of the steps in the evolution of the model. The next step in the design and development framework—a quasi-experiment comparing the PIP model to a school counseling approach—is reported in another article (Colvin et al., in press).

Thomas (1990) asks the researcher to consider the ways in which conventional practice is carried out in the context of the design and development framework. We would differ, and instead considered design and development as they are carried out in the context of practice. By this, we mean we paid particular attention to how the practitioner researcher balanced the needs of teachers, students and

parents, administrators, and funders as the task-centered case management model evolved into the PIP Program. As the evaluations provided feedback to the practitioners, supervisors, schools, and funders, further development took place. The supervisors and practitioners asked themselves what parts of the task-centered case management approach required a high level of fidelity to the model and what parts needed to be adapted to the context of the different school environments. They reviewed the evaluation outcomes; the feedback from students, parents, teachers, and principals; and the experiences of the practitioners of the model. Over time, three answers emerged.

First, PIP service providers were convinced that they could not be successful in changing behavior without the student, parents, and teachers working together. Meeting with just the student, or with just the parent, or with just the teacher was insufficient: All of them together made the difference. So, while the case managers followed the model very strictly about building service teams around the student and developing task plans with the service team, they began to think about their role in this process differently. How they applied the model individually with the student and parents became more flexible. Sometimes PIP case managers would utilize only case management team meetings to work on and review tasks, rather than meeting with the student or family individually. This was particularly true when the referral problem was related to communication problems occurring between school and home. In these cases, the case management team meetings actually served to bring parents and the teacher together on behalf of the student, thus increasing school and home communication and eliminating the need for separate meetings with the family or individual student.

Second, the work in the schools needed to go beyond collaboration. PIP practitioners and schools had to share the same goal. As Lawson (2004) points out, collaboration has to penetrate the core technologies of what school social workers do and what teachers do. This means that teachers were asked to pay attention to the emotional, social, or psychological needs of a student, and the PIP practitioners were asked to pay attention to the academic performance of a student. These ideas are related. Academic success is tied to the emotional, social, and psychological experiences of children in their school and home environment. So, the core technology of the PIP Program has to incorporate and understand both the needs of the child and the needs of the school. Both the practitioners and the schools could agree on removing barriers to academic achievement as the goal of the program. As the PIP staff came to understand the needs of the school environments, they realized that there were many students

who were having problems that did not meet the referral criteria for task-centered case management intervention. So, the PIP team expanded their repertoire of services to include after-school parenting groups, short-term crisis intervention, lunch groups, and interventions with an entire class.

Finally, after being trained in the task-centered case management approach, the PIP supervisor interfaced with program staff and school personnel to monitor adherence to the model. After observing case management meetings, the supervisor would provide feedback to staff and teachers. The supervisor would also consult with Dr. Bailey-Dempsey, who would talk through specific cases and meet with the staff periodically. Over time, Liberty Resources developed its own method of supervision for the development of clinical programs. This method was a layered approach with a direct supervisor having responsibility for the daily direction of staff and relationships with school personnel at the intervention sites and a second clinical supervisor who acted in a similar way as the consultant. The clinical supervisor provided group supervision and as-needed case consultation using a Self-Based Systems (SBS) approach developed by Schur (2002) who worked directly with the PIP Program clinical supervisor as he was developing the SBS model of supervision (Schur & Burton, 2002).

As the PIP team's understanding of the model developed, the clinical supervisor guided them in maintaining a focus on self within the context of the larger client system. This required that the service providers pay attention to their own anxiety and make sure that decisions in the case management meetings were purposeful rather than led by the practitioners' anxiety. In the commitment to using the model, both the supervisor who oversaw day-to-day operations of the program and the clinical supervisor were faithful to using the task-centered case management model for developing a contract with the case management support team about how services would be delivered. The practitioner then used the contract as a means of staying focused on the goals that were agreed to by everyone on the case management team. When practitioners experienced anxiety with what they saw as constraints—dealing with only the barrier to academic achievement and not every aspect of a student's life—the clinical supervisor reminded them they were working within a systems model, and that they needed to focus on the case management team's agreement while looking specifically at what was driving their anxiety as they strayed from the task plan. They were also reminded that change in one part of the system could lead to extraordinary change in other parts of the system with which they might not be directly involved.

Of primary importance in design and development is the expansion of ideas, taking feedback, and evolving the intervention. Question the model: Does it work? As the development of the intervention model occurs, so does the type of methods applied to test the model. For the researchers, the evaluations indicated that the PIP Program did, in fact, have an impact on grades and behavior. Does this still hold up in comparison to another model? Does it have greater impact on grades; behavior; and how student, parent, teacher, and practitioner view their progress on target goals when compared with other school-based approaches to school failure? These questions led to a quasi-experiment reported elsewhere (Colvin et al., in press). The key characteristic of developmental research is that answers lead to more questions and further research.

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