The use of respite in crisis emergency services: A two year analysis

Anne D. Kuppinger
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BUILDING ON FAMILY STRENGTHS:
RESEARCH AND SERVICES IN SUPPORT OF CHILDREN AND THEIR FAMILIES

1996 CONFERENCE PROCEEDINGS

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PREFACE

We are pleased to present the proceedings for our 1996 conference, Building on Family Strengths: Research and Services in Support of Children and their Families, which took place in Portland, April 11-13.

The goal of this annual conference is to encourage the conduct and exchange of family-oriented research that is relevant, accessible and useful for family members, service providers, policy makers, and other non-researchers. As in the past, the role of family members as research partners receives particular emphasis at this meeting. Innovative programs and research efforts which address family issues in mental health and related fields are a significant part of the conference agenda.

Thank you:

We deeply appreciate the researchers, family members, administrators, policy makers, educators, and advocates who presented their work at this conference and have submitted summaries for these proceedings. We are grateful also to our speakers who have allowed us to transcribe their remarks in plenary sessions and panels.

Shad Jessen, Rae Anne Lafrenz, Anne Greenhoe, and Susan Almquist took responsibility for the preparation of this document. Kelly Blankenship and Bryan Woolcock assisted with reviewing and editing. Kaye Exo coordinated the conference itself, which was planned by committee members Barbara Friesen, Pauline Jivanjee, James Mason, and Beverly Stephens.

We offer a special thanks to Research and Training Center staff who offered their assistance and support in preparation for and during the conference.

The Editors: Kaye Exo and Lynwood J. Gordon
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- National Institute on Disability and Rehabilitation Research, U.S. Department of Education
- Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
- Federation of Families for Children’s Mental Health
- Oregon Family Support Network
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The Center’s activities focus on improving services to families whose children have mental, emotional or behavioral disorders through a set of related research and training programs. Research efforts are clustered around five themes:

1. **Family Participation in Services.** This cluster of four projects is organized to study ways that family members can contribute to the planning and implementation of the program of services for their own child. A special focus of the work of this cluster is on issues of empowerment, including ways of measuring empowerment and ways of increasing empowerment.

2. **Family Participation at the Policy Level.** Projects in this cluster will examine issues, constraints and innovative practices related to the participation of parents of children with serious emotional disabilities on decision-making bodies that plan, evaluate and coordinate services. Special emphasis is on ways of involving families of color at the policy-making level.

3. **Families and Out-of-Home Care.** In this cluster research projects are related to services that are provided to children who cannot live at home and the relationship of the family to this type of program. There are two major concentrations in this cluster. The first focus is on family support and the role family support plays in helping children stay at home. The second focus is on out-of-home treatment resources and the contribution that family members can make to the effectiveness of treatment when their child is not living at home.

4. **Evaluation of Statewide Family Networks.** This project involved an evaluation of 28 statewide family support networks funded September 1995 by the Center
for Mental Health Services. The national evaluation examined aspects of family support, system change and infrastructure development across projects.

5. **Interventions in Professional Education.** Projects in this area are designed to increase service providers’ knowledge and skills regarding state-of-the-art practice in children’s mental health.

Center staff includes faculty at the Graduate School of Social Work, research associates and assistants, students and support personnel. The Center is part of the Regional Research Institute for Human Services of the Graduate School of Social Work at Portland State University.
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SECTION I
Key and Plenary Presentations
Title: Keynote Session– The Promise Before Dawn

Presenter: Judge Glenda Hatchett

Affiliation: Juvenile Court of Fulton County
445 Capitol Ave., SW
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James Ward: On behalf of the faculty, staff and students at the Graduate School of Social Work, I welcome you to Portland. We expect about 350 persons to participate in the conference from all over the United States, Canada, and other countries as well. It is a tribute to the quality of work that has been done by the Research and Training Center under the leadership of Barbara Friesen. We have assembled here family members, researchers, service providers, and advocates. I think this is an excellent combination of people coming together to deal with the issues on the program. Here you will address needs and experiences of families whose children and adolescents have serious emotional disorders. I understand that you will address them across a variety of systems including mental health, education, child welfare, juvenile justice, alcohol, and of course, substance abuse. I think that you are taking on an excellent challenge for a group of people who are so vital to the future of our country. I want to commend you for that. But I want to say to you that you have a major challenge before you because there is a great deal to be learned about what is happening in these various systems but, more importantly, there is a great deal that needs to be done to make them work together for the good of children and families in this country. I want to salute you for your work. I want to commend you and I hope that your stay here will be a pleasant one. I hope that you will learn a great deal at this conference. I hope you will take advantage of all of it; have a good conference.

Barbara Friesen: Now it is my pleasure to introduce to you Nancy Koroloff, who is a woman who wears many hats. She serves as the Director of Research for the Research and Training Center; she also is the Interim Director of the Regional Research Institute. Welcome, Nancy.

Nancy Koroloff: Thank you. Well, you heard research in all of those titles. So I am going to talk from the research perspective for just a couple of seconds. First of all, I want to bring you greetings from the Regional Research Institute for Human Services and from all of the researchers and our colleagues there. Many of them are in the room here with us today. Also I bring you greetings from the whole research community at Portland State University. For those of you who are not from Portland, Portland State University is nearby; if you go out to Broadway and take a left and go about six blocks, you would be right in the middle of the campus. It is a very urban campus and there are a lot of very exciting kinds of research endeavors going on there. The Research and Training Center is one of them.
A couple of things I would like you to watch for over the next three days as you are attending sessions and engaging in the discussion -- first of all, you are going to have an opportunity to sample some of the best research that is available on the topics of family support, family-centered services, family involvement, in that general area. It is only recently that these topics have come to the fore in the research arena. Barbara says they are in their adolescence; I think some of them are still in their infancy. So one of the things I hope you will watch for is the struggle that is going on, and I think you will see it fairly clearly in many of the presentations, the struggle that is going on to really come to grips with some of the issues that happen when you start doing research in a new area. These are things like methodological concerns, but there are also things like the new concepts that we have never really defined and never really measured before that now we have to learn how to measure in order to do a reasonable job, a credible job of research in these areas. One of these would be the concept of empowerment, the concept of collaboration; how do you measure that? The concept of parent involvement or family-centered services. These are all very important to our families and to the kind of research we are doing, and I hope that you will watch for how the different researchers and presenters are dealing with this and also engage in the discussion of how best to address some of these very important issues that are coming out in our field.

As has already been mentioned, many of the presenters and researchers on this program are also family members. I challenge you to observe the variety of ways that family members have become involved in research and the ways in which they bring their experience and their expertise and their perspective to the research process. And furthermore, to observe and to think about the difference that makes in the research and how it is done and how it is interpreted and how the results are used.

Finally, over the next several days I hope that you will listen to the ways that family members and researchers have come together and have begun to work together, particularly to set the research agenda, to struggle with defining and shaping research designs and research topics and to work together to interpret and use the findings. I think we need to be very aware of the innovative ways that people have found to do this and to continue to think and talk about new and different ways that we can blur the boundaries between family members and researchers and to continue to work together. So again I welcome you from the Regional Research Institute, from the research community at Portland State, and I hope that you find the next several days to be productive and useful. Now I would like to introduce Barbara Huff, who is the Executive Director of the Federation of Families for Children’s Mental Health from Washington, D.C.

**Barbara Huff:** First of all on behalf of the Federation of Families for Children’s Mental Health, we would like to welcome you all here. We are pleased again to be a co-sponsor of this conference. We would like to thank Barbara, her staff, Dean Ward, and those who have made this possible for a number of years. They continue to support this notion of making sure that families are all here, gathered together with researchers and service providers and other professionals and so we thank you as usual for that commitment and
tell you that we really appreciate having the opportunity to come together. It is a
wonderful learning experience here. It is also a time to network with old friends, existing
friends and make new friends. So we encourage all of those opportunities. You know, it
is so crazy in Washington right now that I believe that we all deserve a mental health
diagnosis just by living there in that tremendously crazy environment. But there are lots
of questions continually being asked by Congress and others in Washington who want
answers to questions -- they are raising questions; they are raising issues.

Research is an opportunity to validate some of the things that we know work with our
children and families. In the last four years of living there, I’ve learned the importance of
research. So I would say, particularly to the family members in the audience, that eight
years ago I did not know what the word research meant. I was an interior designer before
I became an advocate and my being a parent got me to this place, but I did not know
anything about research. I would sit in meetings just totally feeling out of sync about
what I didn’t know about research. So I would take this opportunity to encourage you all
to ask questions, to utilize this conference as a learning experience about research. It is a
scary word to me even today because I am not comfortable with it; it is not where I feel a
level of comfort but I have gotten to know it better and I have gotten to be less frightened
of it and it is all because lots of people have spent lots of time with me over many years
educating me about it. So I would tell you that is the thing to do. There is no question
that you must feel is not worth asking. If you do not understand what people are saying,
ask those questions. That is how we all learn. Enjoy Portland, enjoy the conference, and
if the Federation can do anything to make your stay more worthwhile, please let us know.
Also, let the University folks here know as well. Thank you very much.

James Mason: Good afternoon. I am James Mason and I am Director of Training for
the Research and Training Center and I get the opportunity to introduce a very dear
colleague and friend of mine. I would like to welcome you also on behalf of the
Research and Training Center as well. This is an opportunity to hear some of the late-
breaking research efforts that are happening in the area of families and around the issues
of collaboration, empowerment, cultural competence, and what have you.

One of the things that I heard recently at a conference was that someone talked about the
power of research. I believe it was Jane Knitzer. She said that we know a whole lot more
than we did 15 or 20 years ago. We are not spreading the word to lay people, legislators,
policy makers, as well as we can, as either researchers or as family members. So one of
the neat opportunities that I think exists for us here during the next three days is to learn
what we are finding out, learn the new results of the research, and find ways to talk about
that to lay people, to professionals and for us as professionals to associate with other
professionals to make sure that word is getting out. For those of us who are family
members, making sure that we are broadening the ranks of family members because I
think that’s really going to be a powerful force for us in the future as it has been for the
last 10 or 15 years.
With that I am going to introduce Mr. Lolenzo Poe, who is the Director of the Multnomah County Community and Family Services Division. As a result of that position, he’s head of mental health, alcohol and drug, and services for developmentally disabled populations. I met Lolenzo about 15 years ago. I worked for him. It was a real neat opportunity. He was someone who had a great deal of concern for the community. This was about 15 or 20 years ago. And I haven’t seen that concern die at all or wane at all over the years. He is formerly a manager in our juvenile justice division and made great changes so that our juvenile justice division is more responsive to the needs of families and diverse populations. Please welcome a dear friend of mine and a very inspiring person, Mr. Lolenzo Poe.

**Lolenzo Poe:** Good afternoon. I had prepared an hour presentation that was both uplifting and inspirational. James told me I had about an hour to do this and then I had to introduce Judge Hatchett. But because I have worked at the juvenile department and for a chief presiding judge, she gave me an order. She said to keep it simple and make it brief because she is raring to go. So I will do that.

But first let me welcome you here on behalf of Multnomah County and on behalf of our county chair, Beverly Stein, who is truly a partner in this endeavor around building on strengths of families, children and community and the issue of diversity. I have seen her do that in times where budget constraints have been limited and most of you know that the national effort is really to put money into public safety and lock them up. She has been someone who has been steadfast and committed to putting money into communities and families. So on her behalf, let me welcome you to Portland, to the county of Multnomah.

I also want to thank you for the work that you do. Because I don’t need to stand before you and attempt to tell you how important it is to look at the issues around families, children, community, the need for research, for data. As a county official, one of the things that I have the pleasure of doing is interacting with a large number of community providers. Our department annually spends $100 million. As we continue to clamor about best practices, as we continue to clamor about evaluation, we find that in some parts of this system it is sketchy. So the work you do, the evaluation piece particularly, truly helps us move that agenda. One of the most troubling things that I am hearing as I move around the country, and this county in particular, and talk about services (whether they are juvenile justice or teen pregnancy or mental health services), is that nothing appears to be working. I think you have the ability, by using research models and data, to help us answer those critical questions about what is working. Because I truly believe that much of what we do is working. But much of what we have done has not been evaluated.

With that let me introduce our keynote speaker. It is really a unique opportunity and privilege for me, because this person’s accomplishment, irrespective of her gender and ethnicity, is amazing. But particularly because she is a person of color and an African
American, it is unique that I have this opportunity. Because one of the things that we often say is, you need to have role models, you need to have people who have achieved this. Clearly our speaker is a role model. So it is my unique opportunity and pleasure to have this opportunity to introduce her. She told me to be brief and to make sure that I mention that she is a mom, so I have done that. I will also tell you that Judge Glenda Hatchett has a list of accomplishments and honors that would be too long for me to read. Let me highlight this. She assumed the position of chief presiding judge of Fulton County Juvenile Court in Atlanta in March of 1991. She is the first African American chief presiding judge of a state court as well as a department head of one of the largest juvenile court systems in the nation, which includes Atlanta and nine other municipalities. I can tell you, as someone who has worked in the system, to wear both those hats is a tremendous job.

She has a list of firsts that goes on and on. Let me give you a few: (1) She was elected by the National Bar Association’s local affiliate as the outstanding jurist of the year for her innovative leadership in revolutionizing Fulton County’s juvenile court system with public and private partnership initiatives; (2) She envisioned an early intervention program for unruly and ungovernable children, providing services to the children and their families to prevent the children from eventually becoming delinquent. The truancy project is a collaboration amongst attorney volunteers and the court that continues to be a success today; (3) Glenda was selected in 1994 as the outstanding alumna of the year by Emory University School of Law and was specially selected as the outstanding young alum of the year; (4) The YMCA of Greater Atlanta saluted her as the woman of the year; (5) In 1990 she was highlighted by Ebony Magazine as among the 100 best and brightest women in corporate America. So in keeping with my orders, please let me introduce to you, Judge Glenda Hatchett.

Judge Glenda Hatchett: Facing the rising sun of a new day begun, let me first of all begin by saying thank you. It is a joy to be here with you today and I thank you very much, Lolenzo, for that wonderful warm introduction. I come this morning really with both a heavy but hopeful heart. Heavy because I see more than 15,000 children each and every year that come through my court system. That is just one juvenile court system in a major city and you think about what is happening to us throughout this nation. But I can honestly tell you that I stand here this morning with a very hopeful heart because I look at the content of this program of the next few days. And because I have had the wonderful opportunity of being out and mingling and talking to some of you before this session started this morning, I know and appreciate the power of the potential that is among us. As difficult and challenging as it is, regardless of where we sit in this spectrum, we are all here gathered for important work and so I am here with a heavy but a hopeful heart.

A special thank you to the people of the Research and Training Center on Family Support and Children’s Mental Health here in Portland for having invited me. Barbara in working out the logistics, but particularly to Kaye Exo who has been very supportive of my family through a very difficult time. I leave tonight for Atlanta to pick up my 15-year-old son to
make a funeral the first thing in the morning as I go to support my dear, dear friends as they bury a lovely young daughter who perished in the horrible tragedy with Ron Brown last week. Kaye, having understood the kind of hurt that we were going through, has literally been on the phone with my 15-year-old this week and just kind of checking on us. She came out to the airport in the middle of all she had to do in the rain last night, just to give me a hug and to say how glad she was that I was here. I don’t take these things for granted and so I thank you, Kaye, for just the extraordinary support that you have given me and encouragement and the special gift that she gave me to take back to my son. So she and Charles are going to be lifelong friends after this conference, I am absolutely convinced of it.

There is an old song of the church that although it is indigenous to the black Baptist church, Southern to be specific, it is a message that I think is universal, regardless of your ethnic background, regardless of what your religious predispositions may or may not be, but it simply says, “These are the times that try men’s souls.” I suggest to you that in times like these that we need men and women with vision and tenacity, with a sense of passion, a sense of hopefulness and a commitment to doing what is necessary now for our children. Because the reality is that we don’t get another chance to get it right for this generation of children while they are still our children. So the bottom line is that we have got to be prepared to put our shoulders to a common wheel. We have got to do all that is necessary, because our children are all we have to build a next generation of men and women. So I am particularly encouraged that you have chosen as the theme for this conference this whole notion of building and strengthening families. Because strong families by definition mean stronger children. Stronger children will mean stronger adults and will mean a stronger next generation of children. When I tell you it is a joy to be here I know what I am talking about. I struggle with what I talk to you about today and I know from the long list of conference panels, that you are going to have a very rich experience. You are going to hear statistics and you are going to hear about research. And so I figure that my role is not to sit here and try to capture the important research that you are going to be talking about over the next few days. My job is to fire you up and that’s what I am surely going to hope to do this morning.

I speak with a deep sense of joy and a deep appreciation, because not too long ago I sat in my chambers, and I am not ashamed to tell you that I have been on the juvenile court bench now for five years. It is one of three times that I had to leave the bench and I am not ashamed to tell you that I actually had to come into my office and I had to sit in my chambers and I sat at my desk and I cried. Because there had been a mother who had been in my courtroom who had been saying, “Judge, please, please don’t take my baby from me. She is all I’ve got. Judge, please, I’ll do anything if you just don’t take my baby from me.” But this is the deal. This child had literally been standing on the corner of Stewart Avenue, and if you don’t know anything about Atlanta, let me tell you that Stewart Avenue is an area of town in which you think twice about driving down the street with your doors unlocked late at night. And you certainly wouldn’t be standing out there on the corner. She was prostituting herself. But the real tragedy is that not only was she
prostituting herself, she was doing it as part of an initiation process to become a member of a gang. I sat there that morning and I thought, “My God, why would a child so desperately want to be a part of something that she would be willing to sell not only her body but her soul to become a part of this gang?” The next stage in the gang initiation was that she was to have sex with several members of the gang. The next stage of the gang initiation was that she was brutally raped and sodomized by members of the gang. The next stage of the gang initiation was that she was ordered to kill someone. I sat there and I cried that morning. I cried not only for that 13-year-old child, but I cried for a whole lot of 13-year-olds just like her throughout America. Fortunately, she came to her senses and she ran. She left and her mother came to us trying to get help. Because basically the gang had put out a contract on her life. They came to her mother’s home looking for her and brutally beat up her mother. Her mother came and said, “You have got to find her.” Fortunately, we found her before the gang found her. I was trying to explain to that mother and that child that if I did not take that precious child into protective custody that morning, that not only would I be signing her death warrant, I would be signing her mother’s death warrant as well.

I wonder what is going on in America. At a time when our children are out here looking for something and I am telling people and I tell you this afternoon that either our children are going to find good things and strong families or they are going to find it in places that we aren’t going to be able to stand. I am telling you now that the price is going to be too high. So when we talk about strengthening families and wrapping our arms and services around families to support children, it is time to celebrate. I cried that morning because the person that she had been ordered to kill was her own mother. We are living in some trying and difficult times. In times like these we do need men and women who are prepared to put their shoulders to a common wheel. I want to frame this discussion around two stories of two children.

The first child is one who at the time was 9 years old. He came in that morning, and I’ll never forget it. I had literally been a juvenile court judge for one week. What you may not know is that this was a radical change in my life. I hadn’t planned on being a juvenile court judge. I hadn’t planned on this. But you never know what God has in store in your life. I had been a corporate lawyer for Delta Airlines for nine years before Judge Powell, who had been in this job for probably more than 20 years, died. People came and said, “This is what we would like to see in a new judge and we think you would make a good judge.” I thought, “No, no, I was happy, I was making money, I was having a great time, I mean, you know.” But this is a job that I love more than anything I’ve ever done in my life. And you really don’t know what God has in store for you.

I give that to you as a bit of background because I was not prepared for what was going to happen in my courtroom that morning. I had literally been sworn in October 1. This is October 8, it is a gorgeous bright October morning and the door opens and in walks this precious nine-year-old child. He quickly looks around the courtroom and he stands there and he just starts to shake, to just quiver as if his whole little soul was being drained from
him. He was looking around for his mother and she wasn’t there. This is what had
happened. Here it was October 8. On July 23rd, his mother had dropped him off at a
homeless shelter. She had said, “I’ll be back to get you.” She never came back. So he
was just holding on to hope that somehow, if he could just hold on, that surely that
morning when he got to court she would be there to claim him -- and she wasn’t there.
So he just stood there shaking. I wasn’t prepared for what I should do as a judicial
response. So I instinctively stood up and did the only thing I was really clear about and I
started unzipping my robe to come down off the bench. The bailiff said, “Oh, no judge,
no, no, you are not supposed to come down here.” I said, “You get out of my way, this is
my courtroom.” Because I had been a mother a whole lot longer than I had been a judge.
If nothing else, I knew that I could come and take that precious child and just hold him in
my arms and that is what I did. But I went on to say, “I am not going to lie to you. I
don’t know where your mother is but I am going to do everything I can to try to find her.”
I turned right back around to that same bailiff, who was standing there and I said, “I am
going to go on with my calendar. I am going to recess this case until 2:00 this afternoon.
I am issuing a warrant for her arrest for failure to appear and I want you all to find her.”
“But, but, but, ah, but.” “But nothing. With all the deputy sheriffs we have in this county
we ought to be able to find a mother or we ought to make an effort to find her.”

At 1:30 they were coming in the front door with her. She was at home, kind of sobering
up from a crack hangover. She came in, she was belligerent, she was out of control, she
told me what she wasn’t going to do. Well, you know, seeing as I had taken the oath of
office about a week before, you see, you raise your hand, you put your hand on the Bible,
and you solemnly swear that you are going to uphold the Constitution, you know, all the
things that they make a judge say they are going do. Right. I took this very seriously. I
am sure somewhere in there I was expected to exercise some judicial temperament.
Right? So I did. I mean, I did it exactly by the book. I said, “You are hereby ordered
into drug treatment; I expect we are going to set this case back down for review in 45
days. You are to do X, Y, and Z and I expect you to do it and dah, dah, dah, de,
dah.” And on top of that, you know, after all, I am the judge and you order it. Right?
Wrong. I quickly learned that you can’t order someone to do something that they first
have not acknowledged as a problem. And secondly, and most importantly, aren’t willing
to do something about. So she left and I had this game plan. Here it is October, I
expected this child is going to be safely back home by December. This is a woman with
two years of training who had been a law enforcement officer who had gotten addicted to
crack. We ought to be able to fix it. We ought to be able to fix it. So I sent her out with:
“You come back and we are going to be back here for review.”

She came back on the review and she hadn’t done a damned thing. Well, I decided that
the judicial temperament approach was not cutting it. I tried it, I really did. I really did
try the first time. So she came in and I said, “I understand from the caseworker that you
did not show up for drug treatment and you didn’t do this and you didn’t do this.” She
starting telling me about how this child was too old and he couldn’t be adopted anyway
and I just decided at that point that I would just need to go off the record. There are
certain things, perhaps, that the Georgia Court of Appeals ought not hear me say. So the
court reporter kind of looked at me and we went off the record. I beckoned her to the
bench, because I wanted her right there. I wanted to look at her eye to eye. I cannot say
publicly in here this afternoon what I said to her. Largely, too, because there may be
somebody in here who knows my mother. I was raised by a wonderful Southern woman
and a fine Southern gentleman and I don’t want it to get back to my mother as to what I
said. So let me paraphrase it. “You cannot come in my courtroom messing over children.
I will not have it. Don’t come in here with this foolishness because I will recuse myself.
I will see that this case gets reassigned and I will insist that the Department move
aggressively to find this child a permanent home. So don’t come in here with this
foolishness.” She was dah, dah, dah, dah dah. I said, “Let me tell you one thing. I will
take off this robe and I will come down there and I will kick your ass.” I take this job
very seriously.

Now I am still very stern and very firm. I don’t threaten to come off the bench anymore.
I say the same things. I just don’t threaten to come down off the bench because it
occurred to me, what would I do? What am I going to do if I come off the bench? They
don’t know that I won’t come off the bench. I don’t say that I will come off the bench
anymore, right? What if I do? I come off the bench, I get my ass kicked in my own
courtroom, please. So I don’t do that anymore. But I am still very serious about this.
The parents have to be accountable in my courtroom. I don’t play with them. I don’t play
with children who are out of control and you can’t come into my courtroom with
foolishness.

After I got her attention, I went on to simply say to her that I was a parent. That my
children were the most precious gifts in my life. That if a stranger came into my house in
the middle of the night and tried to get out of my house with my children, they would
have to kill me first. I would fight that stranger with every ounce of my being. But a
stranger couldn’t come into my house and walk out with my children. I told her that she
had to look at her drug addiction in exactly the same way that you would look at a
stranger coming into your home in the middle of the night and robbing you of the most
precious gift in your life. I said to her, “You have got to be willing to kick ass in the
same way that you would to keep a stranger from walking out of your house with your
child. If you aren’t willing to do that, this child grows up knowing a stranger and never
really knowing you and you lose out on the most precious gift in your life.” It was at that
point that we really connected. She went into drug treatment. We had a lot of ups and
downs but I am here to tell you that not the Christmas Eve that I had hoped, but the
following Christmas Eve that precious child went home and he went home for good. He
was one of the lucky ones.

I pray for children who didn’t get to go home that Christmas Eve. I pray for children that
didn’t get to go home last Christmas and I pray for children that won’t get home this
Christmas. I pray for children who are trying to make unfamiliar places home. I pray for
children like the child who was a prostitute trying to get in a gang, trying to make a home

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out of something that was never intended to be home. I pray for children who live in houses that have never been homes. I don’t really have time to go into the third story. I could tell you a whole lot of stories this morning. I could tell you about a child who put a gun to the head of a homeless man who was disabled. Had him empty his pockets. The only thing he had in his pockets was a cigarette lighter, probably so he could make a fire to keep warm. Then that child put a gun to his head and blew his brains out. I can’t explain that kind of violence. I don’t understand it, but I am here to tell you that whatever went wrong didn’t just go wrong when that child pulled that trigger. Something had been going wrong for a long time. That child suffered from undiagnosed and untreated mental illness. The child that I described to you who had been prostituting herself had been suffering from an undiagnosed mental illness that had not been treated. Lord knows, I don’t know about you, but I know that I can’t imagine being left at nine-years-old at a shelter and not having anybody to turn to. Not a mother, not a father, not a sister, not a brother, not an aunt and uncle, not knowing anybody that you can turn to, to reach out to. Needless to say, that child didn’t get any mental health counseling or intervention. I pray for children.

I could tell you the story of a 15-year-old prostitute. Her father was her pimp. A 15-year-old paid assassin. A drug dealer gave him $1,000 to bump off a competing drug dealer. I could tell you about a two-and-a-half-year-old child that was beaten to death. I don’t say anymore, “It doesn’t get any worse than this.” I don’t say that anymore in this work because every time I say that I see it, something else. I’ve seen, not one, but two children starve to death, not in Somalia, but in the south side of Atlanta, Georgia. I’ve seen a five-year-old little boy prostituted, sodomized in exchange for crack cocaine for his mother’s drug habit. So as grim as this is, this really is a message of hope this morning.

So I want to talk about a critical promise that we must keep before dawn. It is awfully dark in America for too many of our children. So what I have come to tell you today is that we have got to work to illuminate the darkness and we have got to figure out what we do to guarantee safe passage from here to our children’s future. It is awfully dark in America for too many of America’s children and we have got to claim them as our children, too many of whom are living a nightmare in America. Therefore, we have got to figure out how we keep the critical promise of spanning the distance from here to their future and guarantee safe passage through the darkness until we can create a dawn of a new day. You know the stats better than I do and I am not going to dwell on them. I am concerned about where every minute of every hour of the day somewhere in America one of our children is just dropping out of school. Where every three hours a child is shot by a gun and every two hours a child is murdered. Every four hours one of our children in this nation commits suicide. I am concerned about what is happening in a nation that after the Berlin Wall is over and the Cold War is over and the Russians are coming to us for aid, that we as a nation continue to spend over $800 million a day on a military agenda. I am concerned where among industrialized nations and rankings of 140 of the top countries in the world, we as Americans rate number one in military expenditures, number one in military technology, number one in military training of foreign sources and
naval fleets and combat aircraft. I can go on and on and on and on. But we rate number 11 in public education expenditures for our children and number 11 in public health expenditures per capita. We rank number 27 in the world in the difference between the actual and expected national performance of our children. We live in a time where more than 15 million children are poor, nine million children are lacking any kind of health care, and tens of thousands of children are homeless, while Congress considers cuts that will result in 6.6 million children losing health care coverage through Medicaid. Another 1.9 million children losing remedial education through Title I. Where almost a quarter of a million blind and disabled children would lose benefits under SSI and another 200,000 children would lose federal child care assistance.

I am concerned about what is happening in this nation and so I suggest to you that those of us who care about children and who are concerned about strengthening and keeping families strong, need to ask the hard questions. Because these are not statistics -- these are America’s children, these are our children. We have got to claim them because in their eyes I see all that ails America: the homelessness, the poverty, the under-education, the lack of adequate special education for children who are most in need and vulnerable among us. The lack of prenatal care. We have to ask the hard questions of those who say they are for family values and then wimp out when it comes to supporting Head Start and special education. We have got to ask the hard questions. You can’t say you are for family values and then wimp out and won’t support legislation that gives us adequate health care for all children and people in this nation who are in need. We cannot just let them go around with the rhetoric of talking about family values and not doing what is necessary to make strong children and strong families in this nation.

I am sick and tired of politicians getting on the soap box and talking about violence in this nation and they wimp out on the issue of what we do to keep semi-automatic weapons out of the hands of children. We have to ask the hard questions. We have to ask the question: contract for which America and for whose benefit? I am tired of it. At a time when this nation says that they can’t afford nine billion dollars to give every eligible child a Head Start, they can afford to talk about another $10 billion for research in space. I am all for research in space. Before I went to Mt. Holyoke, I was on my way to MIT to be an aeronautical engineer and I am a long way from where I started to be. I believe in research and I believe in space and all of that good stuff, but I am telling you that it makes no sense to me that we can’t come up with $9 billion but we can come up with $10 billion to talk about ballistic space war.

I will tell you that I have a real problem talking about the fact that we can’t invest in programs to strengthen our children, that we can’t come up with adequate money to fund education and we seriously are deficient on the issue of special education while this government plans to spend $17.6 billion over the next five years on this ballistic star wars stuff that Reagan’s administration came up with. I am concerned that we continue to spend more than $23 billion every minute of every day, where we can only come up with $1.9 billion on the critical agenda of educating our children. Let me tell you, in all of this be reminded that the Chinese symbol for crisis is a combination of a symbol for danger
and opportunity. Don’t forget that in the middle of this enormous crisis that we face in this nation.

So as we gather to talk about building on family strengths, let me tell you that the need to collaborate has never been more acute. As you gather to share and explore new options and to strategize on what works, in order to make it work better, let me caution you. Number one, that there can be no pride of authorship. If it works, you have got to share the good news. I have never seen an idea that couldn’t get better if you sat down to brainstorm with somebody else. Children are dying in America and we cannot afford this turf war foolishness. I am going to act like I am at home and I am going to get really serious here about this. We cannot afford not to share the good news. People get caught up in saying, “But it’s my idea and I have got to make sure that I present it at this conference and so I am not going to share it so I can be the first to unfold this research.” That is absolutely, absolutely unacceptable. There can be no pride of authorship. If it works, you need to share the good news. The flip side of that is, if it doesn’t work, there is no shame in saying that it didn’t work. Figure out why it didn’t work. Pull it apart, admit that you made a mistake. There is nothing wrong in failing if you try. But don’t not step out there because you are afraid of failing. If it doesn’t work, you need to tell your colleagues why it didn’t work so they won’t make the same mistake. Too many of our children are drifting in the darkness in America for us to be sitting here and debating about where commas and semicolons ought to go in mission statements. I’m sick of it. Children are dying while we debate about what the mission statement should be. Where is the energy to move from the rhetoric to the reality of getting this mission statement in effect for children and families? We have got to stop this foolishness. We need to come to the table. We need to come to the table collectively, with the spirit of trying to find the solutions and then spreading the good news.

Secondly, let me tell you, if it doesn’t work, and it is archaic, we need to give it up. If it is a program that Aunt Emily started 50 years ago that may have been wonderful, that we continue to operate out of the memory of Aunt Emily, we need to give it up. The appropriate thing is for us to find a portrait of Aunt Emily and hang it somewhere, not to continue to pour time and resources in something that is archaic. It is not out of disrespect for her. What she was doing 50 years ago was important but it may have outgrown its usefulness. Be honest. Constantly re-evaluate what we are doing. If it is not working any more, give it up.

Thirdly, and very importantly, zero tolerance for poverty pimps. My mother would like for me to think of another way to say that. There is no other way to say that. Zero tolerance for poverty pimps. I am talking about people who come in and get on bandwagons for programs who are not committed. They do not deserve to be funded or supported. Now that is not to say that all of these programs are not important, but they were for saving the homeless last year. They were into advocating for AIDS research the year before that. They are into saving children this year. They will be into saving wells next year. The only thing that they are particularly concerned about is the budget and
overhead that pays their salary, their wife’s salary, and the two children and perhaps the
dog. I am sick of it. We have got to cut them loose. If they have not demonstrated some
commitment to the issues of mental health and children and what we do to serve children,
there should be zero tolerance for poverty pimps. We need to make it clear. I don’t care
who is related to the mayor’s cousin third removed, we have to be willing to call it as we
see it and we have got to be honest. The resources are too, too scarce for us to tolerate
any foolishness in this arena.

If you don’t remember anything I say today, what I really want to say to you from my
heart is that you really ought to stand up and take a bow. As you meet and work over
these next few days, take heart. We have seen dark times before. There are too many
people in this nation who have already written off too many of our children in this
generation. What I have come to tell you is that there cannot be a eulogy for this
generation of children and I will tell you that there can be no eulogies for this generation.
I look at my work in the juvenile court system as like an intensive care unit. So many
children get to the intensive care unit because so many other systems in their lives have
failed. They are there. The juvenile justice system in America is woefully inadequate. It
is like having children on life support that is inadequate and obsolete. Then, to boot,
there are some people who would just as soon pull the plug. We can’t let that happen.
We have got to be vigilant, we have got to stand guard and we have got to say loud and
clear to the world that there will be no eulogies for these children. But let me tell you that
the mission you have assigned yourselves to do is absolutely awesome and absolutely
necessary.

As you in your own respective ways work to strengthen families and advocate for
children’s mental health in all the ways you are involved in, whether you are a researcher
or whether you are a parent advocate, everybody is important to this. So I have come to
tell you this afternoon that you really ought to stand up and you ought to take a bow.
Walt Disney was very fond of paying people the ultimate compliment in his mind and
that was to say that a man was able to dream beyond his lifetime. Of course, Walt now
would need a little bit of fine tuning, so I will help him. He really meant a man or a
woman could dream beyond his or her lifetime. I’ve thought about that a lot and what I
have come to tell you is that you really ought to stand up and take a bow because this
work is work that will live beyond your lifetime. I want you think of it as pre-prenatal
care. It is not just this generation of children. It is their children’s children’s children and
I cannot think of more important work than to say that you have dedicated your life to
something that will live when all of us are gone. That is how you have to think of it, as
pre-prenatal care. It is not just this 13-year-old that you have been able to turn around
and get on a good track and find the resources that are needed for him to be mentally
healthy. But it is a hell of a head start for his children’s children’s children. So I have come to tell you this afternoon, you ought to stand up. You ought to take a bow
because it is important work. It is not easy work. It is heart wrenching work. But it is
work that will live on and on and on and on.
I can’t think of anything more gratifying to say other than to be able to say that you have been able to reach out and touch the future by taking hold of the hand of a child and touching and affecting his heart. Martin Luther King so eloquently taught us that the measure of a man or a woman is not where he or she stands in times of comfort and convenience, but rather where he or she is willing to stand in times of challenging controversy. That’s where we are. These are not comfortable and convenient times. You are on the battlefield and you are on the front lines. There is a battle to do what is necessary to strengthen families and it is a battle to save our children’s lives. It is not easy, but take heart. You ought to stand up and take a bow in the midst of the darkness of this crisis, take heart because we can’t linger at the pity party. Too many folk get caught up right there and can’t move beyond it. Can’t get caught up at the pity party. Our souls must be encouraged and we must journey on.

One of my favorite songs says simply, “The storm is passing over. Courage my soul and let us journey on for the night is dark and I am far from home. Thanks be to God the morning light appears. The storm is passing over. Hallelujah.” It doesn’t say the storm is here to stay. It says it is passing over. I want to tell you that it is. The thanks will not come, Kaye, in the form of a great celebration at the White House. It won’t come, Lolenzo, when the governor decides to issue a proclamation to say all is well. It will not come, Barbara, when we have a dinner celebrating all the good work of all the people who sit in this room and each of them is recognized name by name by name. That is not how the thanks is going to come, my brothers and sisters, that is not how it is going to happen. Let me tell you how it is going to happen. It is going to happen when the desperate crying of a child stops. That crying is replaced by a certain peace, and then that peace is broken by the laughter of a child. That is how it is going to come. That is how it is going to come, and it is going to come one child and one family at a time. Take heart. The storm is passing over. In conclusion, one more song. My 15-year-old is trying to drag me into the next century. I don’t understand rap. I am trying but I honestly just don’t understand it. So he says, “Mom, how can you criticize something you don’t understand?” But I don’t understand it. You have to go with what you know. Got to go with what you know. I have got to reach back to the late 60’s and early 70’s. You have got to go with what you know.

So I am going to reach back to the late 60’s and early 70’s to Nina Simone. She used to sing a song called *A New Day Dawning*. It simply says, “There is a new day dawning and it is just around the bend. There is a new day dawning because this one has got to come to an end. There is a new day dawning and it is coming in love and it is coming in peace.” There has got to be a new day dawning where we will move from the counterproductive agenda of spending over $800 million a day. Think about what you could do with $800 million just for a year to try to figure out what we do to fund what is really important in this nation. There has got to be a new day dawning because this one has got to come to an end where children are dying every three hours on the streets of America. Where every hour of every single day, somewhere a child dies in America directly because of poverty. A child ought not die because he or she was born.
poor. There has got to be a new day dawning because we cannot continue to ignore the special needs of children who are mentally disabled and who need us. There has got to be a new day dawning and it says it has got to come in love and it has got to come in joy and it has got to come in peace. I believe in this new day dawning. I believe in the research you are engaged in because you cannot cure it unless you understand it. We have got to be serious about this agenda.

So my grandmother’s favorite song was one that simply said, “Walk together, children, and don’t you get weary. Run on and see what the end will be.” That’s the message I leave with you today. Take heart. What you have assigned yourselves to do is critically important and it is work that will live on and on and on and on. But you have to take heart. Know that it is awfully dark in America but also know that the storm is passing over. Encourage your soul. So I say to you, my brothers and sisters, walk together children, walk together my brothers and sisters, and don’t you get weary. Run on and see what the end will be. My prayer for you and my prayer for me -- my prayer for us -- is that we will mount up on wings as eagles. We will run and not grow weary and walk and not faint. Walk together my brothers and sisters and don’t just get weary. Run on and see what the end will be, facing the rising sun of a new day begun. Let us march on and on and on until the victory is won, until we keep the promise before the dawn. Thank you.

Lolenzo Poe: We have some time to ask her honor, Judge Hatchett, a few questions.

Judge Glenda Hatchett: I love this part of it because I get to hear from you.

Conference Participant: This was wonderful. I mean unbelievably wonderful. I work in juvenile justice and I wish I could clone you.

Judge Glenda Hatchett: Thank you. That’s a wonderful compliment. I have to tell you a quick story. When I first went on the bench I went over to the Ebenezer Baptist Church after school program and I was introduced and there were all these kids. They said, at the time (my name was Johnson), they said, “Oh, this is Judge Johnson.” This little boy who was six-years-old was sitting right where you are sitting and sitting right in the front row, snaggle tooth, and he was just as cute as he could be. He blurted out, “You ain’t no judge.” I said, “I surely am.” He said, “You ain’t no white fat man.” I was thinking about him.

Conference Participant: Have you done any training of white fat men who work as judges? You see, when I talk to people about looking at disabilities, because that is what I do, they say, “Listen, don’t you use that ADHD stuff. This is just a bad kid.” Every system has tried very hard to excuse parents of kids with disabilities over the years. Juvenile justice is really tough because these kids have committed some offenses. How can we help parents to be more active and be more involved and not be shut out? I try to do this all the time.
Judge Glenda Hatchett: What needs to happen, I think very candidly, is that there should be almost like a 24-hour crisis triage for parents who are struggling with what to do for their children. Unfortunately, as you well know, I don’t get jurisdiction to try to intervene in a family’s life or to try to help a child until the child has done something wrong. That’s the very frustrating part of my job, but legally that is the only way I have jurisdiction. What I am advocating is that we ought not wait until a child who has been abused, who has been sexually abused and then rapes his three-year-old brother, for me then to have to deal with it when we didn’t deal with the issue of this child having been abused by his mother’s live-in boyfriend. You know the whole scenario. What I am saying is there has to be a triage system. Somehow there has to be a crisis hotline so that parents have somewhere to turn before we have to start treating children in a criminal justice system. Too many children I see, although they are committing what society would consider to be horrible crimes, have first been victims. So in Georgia, particularly, I sound like a bleeding heart liberal. I mean, you can imagine what people in Georgia must think of me. I mean, I testified before a House subcommittee yesterday and you know, they were like, “Oh, God, here comes Judge Hatchett.” I am kind of like the lone voice out here. But what I keep saying is that these children were not born like this.

We are reaping the results of what has been an inadequate system. If I had the $800 million a day for just one year, the first thing I would do is I would institute crisis hotlines that were advertised, that parents knew, that they could come and there would be some counseling and there would be a treatment plan. And if I had money in my court I would have an ISP, I would have an Individual Service Plan for every child. They would be triaged when they hit the front door, from a shoplifter to a murderer. The vast majority of children I see have some mental health issues that are underlying. And we wonder why they are acting out and why they are committing crimes. So that would be my solution. I think there has to be some place on a crisis basis that parents could go to quickly and it is responsive and they get some real help.

Conference Participant: I might mention that there are parent training centers in every state in the United States. That might be one start, find out where the parent training centers are. We get a lot of calls in Minneapolis at PACER and now I get some of those in the juvenile justice project, but our advocates work very exclusively, you know, with issues relevant to juvenile justice.

Judge Glenda Hatchett: I worry about parents who don’t have that information, parents who are so overwhelmed. It almost needs to be on the hip-hop radio stations, the number, on billboards, on flyers on the Metro/Marta buses. I mean it needs to be so visible that this is an easy number. It needs to be like a 911 number, like a 511, something that people can really call.

Conference Participant: I am a parent, but in another capacity. I also worked for four years for social services in Missouri, in child welfare. I had dealings in the court in that
regard. The one thing that I found to be the most brutal thing about that system was that not only are the children brutalized by the process, but so is everybody that works in it.

**Judge Glenda Hatchett:** Oh, absolutely.

**Conference Participant:** As a state worker, frankly the court treated us like dirt. So did the guardian ad litem. The community didn’t like us a whole lot either. Mental health and the social services fought. Everyone instead of being energized, I mean, like you say, you have darkness and also hope. But instead of having energy to go in and fight a new day, you constantly feel like you are being beaten down by colleagues, by peers. I just wonder how you would address that.

**Judge Glenda Hatchett:** That is a real problem and I think that it really does go to the issue of trying to sensitize everybody in the continuum of the system. I also think that from the judiciary viewpoint, I will be the first to tell you that there are people who sit on the juvenile court who ought not be there and who don’t want to be there. It has to be a court where people really want that assignment, not that they felt like they got rotated in and they feel like they have been sent to Siberia while they wait on a more prestigious assignment. I think there has to be better training for us who sit on the other side of this bench. I think honestly you have to be pumped everyday when you come to work. I mean, I don’t think you can do this job at half speed. At the time that I start feeling that I can’t do it really at maximum speed and be pumped, then I need not to be on the bench. There are some people who want the prestige of the robe but aren’t willing to get their hands dirty in this job. And you have got to be willing to do that. It troubles me because I do think we need to treat you with utmost respect when you come in the courtrooms because you are really where the rubber meets the road. I don’t have an easy solution other than I am hoping that in time we will get a more sensitized group of people on the bench who will be more supportive of caseworkers.

**Conference Participant:** Hi, I just have to say how inspiring I found your initial speech. I am here as a mom and an advocate. I have been a volunteer in the system. I have a special needs child. Have you ever considered running for president?

**Judge Glenda Hatchett:** I couldn’t pass the FBI check. You know, my job is an appointed job. I love the compliment, but I will tell you I don’t know that I have the political temperament, because I tend to say what I mean. I’m not so sure. Because people have asked me that locally, you know, would I run for Congress or would I run for mayor or whatever. You know, you have to be a lot more diplomatic than I tend to be. You know, if I disagree with the governor, I am going to say I disagree on issues. I don’t know how I would fare as a politician, to tell you the truth.

**Conference Participant:** Good afternoon, I am from the Kinship Care Project in Philadelphia. I, too, was very inspired.
**Judge Glenda Hatchett:** Were you part of my Amen Corner back there in the back? Alright. I told him if he sat in the back row, he could only sit back there if he promised to be the Amen Corner. Otherwise he would have to come up front.

**Conference Participant:** We are back there trying to figure how we can bottle up that enthusiasm and take it back to Phillie with us. What I would like to say is, in working with the Kinship Care Project, as bad as things are today, if it weren’t for the care givers and the grandparents that are picking up the slack at every corner, things would be even worse. What I have found is that city government and systems in general have been unresponsive to these care givers in giving them support, help, training, education. I’d just like to hear your thoughts on that.

**Judge Glenda Hatchett:** I was talking with you coworker and I really had planned to try to weave that in. There were so many things that I really wanted to say in this speech but because of time I didn’t get to. It is very interesting that you bring that up. When I testified before the House Judicial Committee yesterday, that was one of the points that I was making. We have got to find a way of being more supportive of families that are willing to then take on children who don’t have a place to go. We have to eradicate a lot of these barriers because I know there are some families that would really be willing to adopt children but for the fact that there are economic restraints. Why are we not then willing to subsidize those adoptions and so forth? Congressman Bobby Scott was on the panel yesterday from Virginia and I plan to follow up with him because I do think that we are not being nearly as supportive of that as a resource. I will tell you what bothers me is that my colleague in Oakland, who if you all ever get to meet Judge Sweeney who soon will retire but is just a phenomenal man, a juvenile court judge out in Oakland, California, said to me one day, he said, “Glenda, what are we going to do when we now have this generation of crack mothers (like the mother I described) who will then be the next generation of grandmothers?” Of course, she is rehabilitated, that is not a good example. What will we do when the next generation of grandmothers are the current crack addicts, what will we do? I think, what would I do if I didn’t have grandmothers? What would I do if I didn’t have caring aunts or uncles? We have got to figure out a way to make this much more realistic in our effort, particularly with children with special needs.

**Conference Participant:** I have once heard that one of the reasons that the problem is ignored is that this is a gift that care givers give to government because they don’t have to acknowledge that it is a problem and they don’t have to put out money for it. A lot of times these care givers go into the middle of a crisis, they pull the children out before DHS and other systems are involved, and then those systems when they are called upon can say, “It is not a problem because the child has a safe home, so we should not be involved.”

**Judge Glenda Hatchett:** And we are discouraging what should happen naturally because we have come from a culture where extended families reached out and took in
children in need. All of us have had grandparents or aunts or somebody who took in and raised a child that wasn’t their biological child because that is what we did as a community. I know people who took in children that they weren’t even related to biologically. But the problem is that the government has got to be much more supportive. I would encourage you to write Congressman Scott who is in Virginia because we had the same conversation yesterday. He began to acknowledge that part of this is education. I think you will find him to be one that will be very receptive. I would think it would be very helpful to say that we had this conversation and you are following up with him on that. Because we are advocating for that and I really appreciate what you all are doing. I want to visit the project the next time I am in Philadelphia.

Judge Glenda Hatchett: Where are the men in this group at the microphone? Alright my sisters, just run with it, I tell you. I’m sorry.

Conference Participant: I’m from Washington, D.C. with FASA [Family Advocacy & Support Association]. I have a two-pronged comment. I also worked for the D.C. Department of Corrections. I have a problem with all systems that have failed our children, whether they are special needs or whatever. I want to know what we can do as parents or as citizens to stop the madness from coming into my system. Because once they come into my system, it costs $30,000 for each inmate. Can’t we use that $30,000 in the system that is supposed to help children before it gets to me? Stop the madness. I am tired of seeing children come into my system.

Judge Glenda Hatchett: I can’t agree with you more. There are 15,000 children that came through my court last year. As you probably have picked up, I am a very unconventional judge. What I am saying is we know two things: (1) We know that the younger the child is when he first comes into the system, the more likely he is to have a criminal record. That’s been proven by research. (2) We also know that truancy is the forerunner for drop out. Truancy is the number one predictor that a boy will have a criminal record. If we know some of these early intervention points, why aren’t we doing more then? What I said to the same panel yesterday -- it will be interesting if they ever invite me back to testify -- but what I said to them yesterday is that I am sick of discussion of three strikes and you are out. We need to figure out what the hell we do before strike one. That is exactly your point. In our own communities, I would suggest two things: we have got to advocate for the strongest educational system, absolutely, without exception. We have got to say that to elected officials, we have got to say that to business corporations. We have got to encourage corporations to partner with school systems, to adopt schools. We have got to have a strong educational system, both for children who are mainstream and children with special needs, but we have got to do a better job in this country of educating our children. And for children who are getting in trouble, we have got to intervene at much earlier stages.

Secondly, we have got to insist that our communities be responsible and open for children in that critical period from like 3 p.m. to 7 p.m.. That’s where children are really getting
into trouble in this country. So preachers don’t like to hear me say this but I don’t care, I
tell them that you cannot get in the pulpit and preach about teenage pregnancy on Sunday
morning when your doors were locked all afternoons that week and that 13-year-old
walked by four churches on her way home, then got down to the corner, saw this 19-year-
old, no good, trifling as you-know-what, who says, “Come on baby, let me rock your
world,” and then we wonder why she is pregnant. We have got to open up our churches
for after school programs. I would encourage you to look at the Beacon Program in New
York City. I would encourage you to read a book called *Fist, Stick, Knife, Gun* by
Geoffrey Canada. It is one of the best books I have read and it is short, fast reading. *Fist,
Stick, Knife, Gun*. But it talks about just the need for children to have places that they can
connect with. Beacon Center is run in the afternoon in New York for children to have
places to go. We need to revitalize things that seem corny to children like scouting and
YMCA and Boys’ Clubs and Girls’ Clubs. Our children don’t have enough positive
things going on in their lives.

Another is we have got to start knowing our neighbors’ children because, you know, I
couldn’t walk down the street without the lady down the street seeing me do something
and I would get in trouble with her and I would get in trouble with my mother when I got
home, too. We have lost that in our community. That’s a much harder thing to try to
reweave -- the school system and communities doing stronger activities for children.
Either there are going to be children who are going to be running bases, playing baseball
this summer, or for some children the choice is running bases or running drugs for drug
dealers.

**Conference Participant:** Amen, amen. We do research with deep-end kids, kids who
get into a lot of trouble. And actually have great data. One of the things that is
interestong to me and I really think it is about policy, I think it is multi-level changes that
need to occur. Because the reality is that you can send somebody for treatment and the
treatment is no good. I know that research. I can tell you about that research. But we
also know those important factors that lead a kid down the road of doom and destruction
and a life-long criminal career. One of those things is who you associate with. The
number one predictor of delinquency is deviant peer association.

**Judge Glenda Hatchett:** Everybody comes to my court and says, “Oh, Judge, I was
running with the wrong crowd.” I thought if I could find this wrong crowd, lock up this
wrong crowd, we would be straight.

**Conference Participant:** But that is the reality. You mention research, you mention
data. It just makes sense then if we have this data that suggests that by putting these
knucklehead kids together that we actually are doing more harm than good. That
literature is real clear. I wonder how the juvenile justice system deals with that given
what is happening in America today. We are locking more and more kids up and actually
returning kids to offend at higher rates. I am just real interested from your perspective
how the juvenile justice system contends with that information.
Judge Glenda Hatchett: I think we don’t very well. I am just being very honest with you. I think the system is archaic; it was designed for a different time; it is not handling well the problems that we are seeing now. I am advocating for some radical rehaul. I am trying to revolutionize my court system. I don’t have confidence in locking children up necessarily, (although there are children who need to be incarcerated), because I am not sure that they don’t come out being better grounded in how to be a criminal. You know, they go in, they get involved with gang activities in the jails, they start doing drug networking in the jails, they learn how to be better car thieves. So there is not going to be a quick fix. I think you have to start at the preventive end, and we have got to figure out how we lessen the number of children who end up being incarcerated. But for some children we don’t have a choice.

Conference Participant: Judge, my question has to do with what programs follow those children into the detention. Are there special education programs?

Judge Glenda Hatchett: It is horrible, it is horrible.

Conference Participant: Is there anything? I mean, you alluded to the fact that many of them have mental health issues. Are there any ways to bring services in at that point?

Judge Glenda Hatchett: It is horrible. There needs to be psychiatric treatment in detention centers. There need to be juvenile staff members who are specially trained in adolescent psychiatry and psychology. They are working not only with the children, but with the parents. That needs to be just as important a piece as having judges sitting on the bench. It has got to be integrated into the system. I dare say that there probably isn’t anybody in this room who is operating in that kind of system.

Conference Participant: What about education? I mean, are there teachers who come in?

Judge Glenda Hatchett: There are teachers. In Georgia we have mandated requirements that every child has to be educated up until 16. But the quality of that education is the one that I worry about. That is a constant battle. I mean, they are trying to cut funding now for my educational program and I am trying to hold the line on that. I mean, we are adding to the problem if we reduce education. Then we have a criminal who can’t read.

Conference Participant: Exactly. Then what will he do?

Judge Glenda Hatchett: What is he going to do? He is going to go out and sell some more drugs to earn some money. He is going to rob your house while you are at work. That’s what he is going to do.
Conference Participant: If we get these kids when they are first detained and give them alternatives at that point, even within the system.

Judge Glenda Hatchett: I agree, I absolutely agree with you.

Conference Participant: I volunteer with the Federation of Families for Children’s Mental Health in Colorado. I agree with just everything you have said. However, one thing that I have found, I am a parent, I am not a professional in this field. I have a special needs child, who is in a RTCF [Residential Treatment Care Facility]. There are abuse and mental health issues involved. For years and years and years I felt stigmatized myself just because I wasn’t feeling like my needs were met anywhere.

Judge Glenda Hatchett: I hear that all the time.

Conference Participant: Education, as you said, is an archaic system. It needs to be overhauled. There are lots of things that need to be overhauled. My question is -- is not really a question -- is that I didn’t feel anything. In fact, I was in a total state of crisis for many years until somebody saw my heart and somebody supported me. Until I heard those words, that “We are here to support you,” I was nowhere.

Judge Glenda Hatchett: And that you are not alone.

Conference Participant: I was nowhere. The reason I say this is because that I think that we are very nurturing people here. I think that people that aren’t so nurturing need to be reminded how to nurture.

Judge Glenda Hatchett: It is almost like the whole issue is: are we preaching to the choir? That is one of the things that I am constantly struggling with as I go to conferences. I typically don’t accept invitations to serve on panels at conferences because I always worry that we are just rehashing the problem. When Barbara and Kaye explained to me what this conference is about, I was excited about coming because it is very clear to me that you are a group of people coming together to work on solutions and figuring how we replicate good things and that is important. But I would suggest that there has to be a broader network, so that in the juvenile justice system in your own community there is like a big mother. That is not a good name for it. Big Momma certainly doesn’t sound particularly good; we need to think of something with a little bit more PR appeal on it than Big Momma. But there is someone else like you in the system who has a child in juvenile court today who, if she could have you be her kind of mentor through this process, would make her a lot stronger and the child a lot better off.

Conference Participant: Right, like a grandmother mentor.

Judge Glenda Hatchett: Yes, exactly. I would encourage people in their own communities to begin to do that because that is the way that we really begin to build a
network. Then she, in turn, will reach out to someone else. Hopefully we begin to run
the network of advocates who aren’t feeling so alone, and understand that there is some
hope and some way to feel connected in a way that we can give and draw strength from
each other.

Conference Participant: I am from the L.A. County Department of Children and Family
Services. We are the largest child welfare agency in the nation. We have over 7,000
children in our system right now. I am trying to figure out why all of this is happening
because when I was growing up, the only thing I had to worry about was maybe fighting
little Billy after school. Because I stole his candy and he stole my candy. My frustration
has turned into anger and when you mix logic and emotion, you don’t get anything. So I
am in search of answers based on why certain things are happening because I also work at
our child abuse hotline. Over 80 percent of the calls that we usually get are about
prenatally substance-exposed infants. That ranges from crack cocaine to marijuana and
so on and so forth. If you are in this you have to love it and you have to give it your all.
But sometimes, like you said, when I first started I went home and cried. I said, “Wait a
minute. I am a grown man. I am not supposed to be crying.”

Judge Glenda Hatchett: Actually that is healthy. I am glad to hear that. Because if you
hadn’t cried, I would wonder, you know.

Conference Participant: I’ll be short. It is hard to disconnect yourself from your
families because I have all my families here. You just can’t see them. I just want to
amplify what you are saying as far as trying to find answers in terms of starting at the
forefront. Because in California we have a three strikes and you’re out law. You have to
question why the legislation is going, you have to question the motivation behind why all
of this is happening. If you catch the child when they are young, you know, there is
nothing wrong with having that model family. But when you can’t, you have to have
some type of vehicle to get that child to a successful life. There is nothing wrong with a
child being successful. That is what we are all about.

Judge Glenda Hatchett: I will be very brief. Bottom line, one of the things I will share
with you from my own experience is that I had to work very hard to eliminate the word
frustration from my vocabulary when I was in this work. I will tell you when I first went
on the bench I had such a horrible case, I was telling you I left the bench three times.
This was the first time. I went in and closed the door and went in my bathroom and got
on my knees and I said, “God, please give me the strength to move the energy from
grieving to try to figure out what in the world I do for these precious children.” That is a
prayer that I pray all the time, now. I just have to constantly pray that God will give me
the strength because you can get so caught up in the grieving that you can get paralyzed.

But the other thing is that when I put the key in my front door, I am a momma. I leave it
there because that is the only way I can pick up the next day. I have to leave it. Because
it will wear you out, it will rip your heart out. I went through a ritual. It took me a little
while. But I went through a ritual because I was finding I wasn’t being able to give my best to my own children when I got home. You know, that is what you have to do. You have got to find other things in your life that will get you recharged so that you can pick it up the next day. Things like this, where you begin to reach out and you meet other people who are doing what you are doing, you network, you find other people, you get strength. And somebody with whom you can pick up the phone and say, “You know, this is a hell of a day today.”

**Conference Participant:** Well, to tell you the truth, I have already started to recharge myself. I’m going to Hawaii next month.
Title: Plenary Session:
I. Outcomes from a Study Comparing Two Case Management Approaches (Dr. Burns)
II. Implementation and Impact of a Promising Multisystemic Intervention for Youth (Dr. Cunningham)

Presenter: Barbara Burns

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Presenter: Conference Participant

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Nancy Koroloff: I am Nancy Koroloff and I am with the Research and Training Center, one of the groups sponsoring this conference.

I am going to start by introducing Dr. William Sack. He is the Director of the Division of Child and Adolescent Psychiatry at Oregon Health Sciences University which is here in Portland, Oregon. It is our medical school. We are pleased that he can be here with us this morning and he is going to introduce Barbara Burns.

William Sack: Thank you. Dr. Barbara Burns is a 1963 graduate of the University of Kentucky where she received her bachelor’s degree. She received her Ph.D. in Clinical Psychology from Boston College in 1972. She then joined the staff of the Bunker Hill Health Center in the Harvard Medical School and the Massachusetts General Hospital and worked in that program until 1978 when she moved to the National Institutes of Mental Health. Over the next nine years she rose in the ranks of the National Institutes of Mental Health to become Deputy Director for Health Services Research. She then went to the University of Maryland for two years and continued her research efforts across the life span (children, adolescents, and the aged) in various research projects. In 1989, she moved to Duke University where she is now. She is currently Professor of Medical Psychology and Co-Director of the Psychiatric Epidemiology Research Program there. Over the last 20 years she has published extensively and is a highly sought-after consultant both in this country and abroad. She has published over 80 articles in refereed scientific journals, she has written over 20 chapters in various books, and has co-authored two volumes of her own. This is what you would learn about Barbara if you were to read her CV as I have recently done. But as you know, curriculum vitae disguise as much as
they reveal and if you will, allow me a more personal reflection on Barbara the person for the next moment or two.

Barbara and I started our professional careers together at the Bunker Hill Health Center in 1969 where I had finished my training in child psychiatry at Massachusetts General and she at Boston College. We worked together for four years at the Bunker Hill Health Center. While she will tell you that I was her first clinical supervisor, within a few months it was the other way around. I was learning from Barbara, who was teaching me things about community mental health. I came out of a traditional one-to-one, individual, long-term psychotherapy modality. Within that next four years, Barbara was organizing community after-school programs, getting agencies to work together, doing a variety of things on a community basis that were exciting and wonderful. Those were the days when we had a lot of federal money and we thought we could do anything. We could cure anything. This Bunker Hill Health Center was a bold concept of putting mental health under a primary care setting so that we were working closely with pediatricians and internists and focusing on the community of Charlestown, Massachusetts. Well, soon after I left Charlestown and Boston to come to Portland in 1973, Barbara faced an enormous crisis in Charlestown in 1975 when they were going to integrate the public schools there and bus African American children into the community. That’s a very staunch, white, poor, blue collar, Irish Catholic community, and there was great fear that there would be enormous violence. Barbara worked tirelessly over almost a year to prepare for that school integration. You won’t find this on her CV, but she was successful in preventing an enormous amount of violence by organizing the community and getting people to talk to each other, rather than to slug each other or fire explosives at each other.

So if I were to characterize Barbara, some of her many talents, there are two “S” words that come to mind: one is selflessness, and the other is sweat. Barbara is the most generous person. She is a person that loves to work with other people -- she is not a prima donna. Although she has been extraordinarily productive, she doesn’t need to be the first author on papers. She loves to see other people get credit for things. She is more interested in the outcome than in any kind of self-glorification. The second characteristic is sweat. She is the hardest working person I’ve ever seen. She knows nothing about eight to five hours. She can stay up all night getting things done. She comes out of, I suppose, a Scottish Presbyterian work ethic background. But Barbara is a tireless worker and a very generous person and it is a personal pleasure for me to have Barbara in Portland. Please welcome Dr. Barbara Burns.

**Barbara Burns:** Thank you very much, Bill. I don’t think I can live up to all that you said. The question after that is: does she have anything left to say? Dr. Cunningham and I were talking this morning about what could we do for the group after yesterday afternoon’s most inspiring talk from Judge Hatchett. We won’t try to compete but what I will tell you that we will be doing is bringing you some good news because how could we do otherwise with this size audience this early in the morning?
I am pleased to be back at this family meeting in Portland. It has been four years. The last time that I was here I was talking about an agenda for research on case management. That was a point where really we didn’t have any descriptive literature on the functions, case load sizes, intensity, benefits, etc. I am pleased to at least say we are beginning to make a dent in that. I will be talking about a randomized trial of case management. Dr. Cunningham will be talking about some home-based, family-based interventions for juvenile delinquents and children with severe emotional disturbances. I tell you my true dream is to someday be able to come back to this meeting and say, “The research community finally really has solid quantitative evidence, not for two interventions, but for the whole range of interventions needed for our children.” And then to put that challenge to you, the families, the policy makers, to figure out how to convince others to get in place what we need to have in place.

So I am just going to present to you the results of one effort to try to move ahead with one intervention. We had the opportunity -- this study started around 1991 to 1994 -- we had an opportunity with the Robert Wood Johnson Foundation Program for Youth in our North Carolina Great Smoky Mountains to think about some research, to overlay that on this wonderful demonstration that would enhance in two fine service systems the service capacity that would provide resources for case management, for therapeutic foster care, to increase group homes. It was a great opportunity because there was a clear target population of children with serious emotional disorders identified.

[Recording problems for this session preclude the presentation of this address in transcript form. Dr. Burns reviewed the findings from the following article:


**Barbara Burns:** Now it is my pleasure to introduce our second presenter, Dr. Phillippe Cunningham from the Medical University of South Carolina. He is a recent Ph.D. from Virginia Polytechnic Institute and State University. But don’t let that fool you. He has been around a little longer than his Ph.D. makes him look. He has been engaged in research on child intervention for some time, enough to have a very respectable vitae in terms of his publications. He currently supervises family therapists who provide intensive family based services to substance abusing juvenile delinquents and children with serious emotional disturbances. He is particularly interested in research on services for children of color. Welcome, Dr. Cunningham.

**Phillippe Cunningham:** Good morning. It is really an honor and pleasure to be with folks who are committed to children. I think anytime I talk, prior to describing research, I really think it is good to give you a context of why I am involved in the research I am involved in. I grew up in Washington, D.C., and as you know the violence epidemic that is sweeping our nation has had untoward effects on our nation’s capital. I am real tired
and angry, by the way, that there are more black men in prison than on college campuses. I am tired of seeing kids who have been victimized. I am tired of kids telling me that they have to duck going to school. I am tired of thinking about our little brothers and sisters who have seen and witnessed members of their family murdered, raped, robbed, victimized in a host of different ways. I am a tired young man this morning. But everybody is telling us that nothing can be done. Our politicians tell us that nothing can be done.

What I am going to do today is tell you how things can be done, that we do have data, we do have literature to suggest if you want to come up with effective intervention for what I call “knucklehead kids,” that can be done. Don’t let the research throw you, though, because all the research is doing is giving us tools to unlock the secrets of how to be successful with kids with serious emotional difficulties, in the work I do, with juvenile delinquents, serious offenders, chronic offenders. The first thing I want to tell you is: Don’t believe the hype. Another thing that I want you to get today is that the way things have traditionally been done actually does more harm than good. I am going to say that again. We can have an amen corner here. I am from the South, South Carolina, right. When we are in church and the preacher says something, someone will say, “Amen.” So I will tell Newt, “Newt, don’t build more prisons. Let’s not change the welfare system so we won’t give families the resources they need to be successful with their kids.”

[Audience: “Amen!”] Alright, then we are on a roll. I work at Family Services Research Center in Charleston, South Carolina, in the Department of Psychiatry and Behavioral Sciences. Our purpose in life is to develop and validate effective family-based interventions for youth presenting serious emotional difficulties. This is our faculty: Scott Henggeler is our director, Sonja Schoenwald is our assistant director.

Now this is where we get to the audience participation part. You all did the “amen” thing very well. I liked that. Y’all could be Southerners. You notice I say, “y’all.” Y’all could be Southerners. When we deal with literature, research, I want you to be able to ask your politicians when they present these new magic bullets that are going to make a difference in the lives of our kids, I want you to ask the question, “Where is the data?” OK. Where’s the data? Where’s the data? Can you repeat that for me? The way that we can make this work is, I’ll ask you “What is the question?” You will say? [Audience: “Where’s the data?”] Now we are on a roll. I like this, I can get into this. I didn’t know Oregon was going to be this much fun, you know, with all the pine trees.

Now, in treatments for serious juvenile offenders, what we find is that there is little evidence of long-term outcome. Don’t forget the amen part, now. We also know that current mental health systems are not meeting the needs of youths with serious emotional difficulties. You also know, if you are a parent or someone providing services, that the need for services far outweighs the availability. We also know that a grossly disproportionate amount of our funds are allocated to restricted and expensive services that can only reach a small proportion of the kids who need services. Now, what’s the question? [Audience: “Where’s the data.”]. I am going to tell you where the data is.
When we look at the data on restrictive and expensive services -- and what do I mean by that? -- in-patient, RTC’s, juvenile detention facilities, boot camps. There was a rash a few years ago of, do-the-boot-camp-thing. There is no data on their effectiveness and they actually may do more harm than good. When I show you the research data, this is going to make a lot of sense. Remind me to remind you about that, OK. The unfortunate part (and this is what should concern you), is that in many of our communities we really don’t have access to more creative, more innovative community-based programs. What you end up having is what? Kids being placed in residential treatment centers or in-patient units or in the criminal justice system. By the way, let me just tell you another reason I am in this business. Because I worked in the criminal justice system and one thing I realized is that middle class kids go the mental health system route, poor black inner-city kids go what? The DJJ [juvenile justice] route.

Another thing that has happened is that many of our services are fragmented with little collaboration across services. What does that mean? That means that if your kid or kids you are working with end up going into the Department of Juvenile Justice and have special needs or emotional difficulties that haven’t been addressed, DJJ is not going to communicate with a community mental health center about this. But let’s take the case of a kid who has an emotional disturbance but is also in protective custody, or their custody has been placed in some social service or child protective service agency. What else happens? Little communication. Programs and funds are often categorical.

What about our families? What about the kids we see? They don’t meet these nice, neat packages. They have multiple needs. Now, this is the kicker for me. We put a lot of money into expensive and restrictive programs and when they don’t work, we want to blame families. [Audience: “Amen!”] It is unfortunate, though, because families are the key to making life better for any kid we work with. We may have to look long and hard, but families are the key. This is what I want to tell Newt. “Newt, wake up; you are missing the boat.” You don’t take resources from already distressed families. They need help, and more help. But I think there is a smart way about delivering services and providing resources for families. What’s the question? [Audience: “Where’s the data?”]

Let’s talk about child psychotherapy. Meta-analysis conducted by Weiss and Weiss down at UCLA found that you can get great results in a university-based setting but you don’t see that translated into real world outcomes with real world populations. That makes a lot of sense because researchers have a lot of control at a university setting. The kids who come in end up looking like they’ve got some problems, but they don’t look like kids in southeast D.C. where I grew up. What’s the question? [Audience: “Where’s the data?”] Let’s talk about treatment outcome with substance-abusing delinquents. No treatment has been shown to be demonstrably more effective than another. There are also innovative programs that have been on the board. Some of those are starting to show some promising outcomes, but the long-term data for serious populations isn’t available as of yet. I know my friend and colleague, Dr. Mary Evans, will definitely talk with me about some of her great data.
Now let’s talk for a second, because I really want to give an opportunity to look at our data, but let me just make this point. When we talk about service systems that don’t collaborate, don’t work together, don’t talk with one another, that really led to an initiative to really start getting service systems coordinated and developing collaborative relationships. At the Fort Bragg Project, something that was recently completed, I think it was like $74 million or $98 million that they spent. Oh, $94 million, says Dr. Burns. They spent a lot of money to develop a service system in which wherever the kid comes into the system, wherever they end up or wherever they have to go to get more services, that those agencies will be working together. What they found was great service system level outcomes, zero client outcomes. The question you have to ask, well, does it make sense? When you think about it, you would expect that. You would expect that a service systems change and collaboration wouldn’t make that much of a difference. It would make some difference. I do think service systems do need to collaborate, do need to be coordinated. But what goes into the syringe is important. The medicine that is provided wherever the kid goes in the system is very important. That’s what we need to know: not only change the systems, but what those systems actually do day-to-day with the kids and families.

I want to give you an opportunity to ask questions. By the way, that ends my Jesse Jackson portion of the presentation. [Audience: “Hallelujah!”] They learned a new word. You may ask yourself, “Well, why these dismal results? Why do things look this bad for kids that really need services?” I am going to tell you. That’s why you all asked me to come. That’s what I am thinking. There is a literature out there, we call it the causal modeling literature. I don’t want those words to throw you off. All we are asking is, if we want to predict delinquency next year, what would be those factors that we could look at that would predict delinquency next year? Just predicting something. This is like the crystal ball of research literature. If we look at some of the most sophisticated studies today about predicting delinquency, the number one predictor of delinquency is who you hang with -- association with delinquent peers. Who you hang with, our grandmothers knew that, right: “You better watch who you hang with. They are going to get you in trouble.” But my grandmother always said, “Boy.” But if we look at it real critically, we also find there are a number of reasons why kids hang out with delinquent peers. Think about kids who get expelled or suspended. Who are they going to hang with? OK, that’s the number one predictor of delinquency. So now you are creating a situation where they are going to do what? Hang out with more delinquent kids. Work with me here.

There are family factors, too, that have indirect effects on delinquency via this relationship with peer associations. What family factors would you predict? Substance abuse, child abuse, poverty. What we find is that parents sometimes don’t know what their kids are doing. If a parent doesn’t know what their kids are doing, what do you think they are doing? Who are they hanging out with? This is not some slick way of blaming families, by the way. Somebody mentioned poverty. In a lot of families that I work with, parents are working hard, damned hard -- very damned hard -- to make ends
meet. OK, Newt, wake up; smell the coffee. They may be on welfare, but they are working damned hard to make ends meet. So it makes a lot of sense that a parent wouldn’t know where their kid is. If you are spending 80 hours a week making a buck, how are you going to monitor your kid?

So if I ask you about the whole idea, across studies by the way, those factors still play themselves out. In this study what we see is that it is also the neighborhood. It is not only the kid, the family in an environment, in a school system, but also like the pot it is in. We are making the delinquency stew, right. Those ingredients, put a little association with delinquent peers in there, some family issues, some school issues, also the community. So across multiple studies we come out with the same results: who you hang with; peer influences; family influences; community influences; school influences. Across the most sophisticated studies today. This is not brain surgery. Now I am going to ask you a question: If you want to develop an intervention plan with these kids, what would you do? What would you pick? What would you do? If you want to increase the probability of being successful with a juvenile delinquent, what would you do?

[Audience: “Start with the family.”] Start with the family; that’s a good idea. Collaborate with the family; we are going to get to that because that’s a lot of what we do. But if you want to increase the probability that you are going to be successful with a specific delinquent, what you had better start thinking about is dealing with all those factors, right. You have to deal with all those factors. In a nutshell, that encapsulates multi systemic therapy.

Now our approach is grounded in family systems theory and social ecology, the work of Bronfenbrenner, which looks at kids as being nested in multiple systems of influences. Those systems of influence, again, we see are family, peers, school, community, etc. In terms of our theoretical assumptions, adolescents are embedded in multiple systems of influences and that behavior is reciprocal and bi-directional. Not only do I influence my child, but my child influences me. I know it; we know it. But this is just an indication of how complex social interactions are. When we start thinking about families and kids, we have to consider all the influences and also be prepared to deal with all those influences. The treatment implications of these assumptions are that interventions must consider the multiple causes of behavior and also should focus on those pertinent systems in which that child is embedded.

Now when I ask you the question -- what is the question? [Audience: “Where’s the data?”] We are about to present the data. But when Newt says, or your Congressmen support initiatives to create more juvenile space -- detention space -- what should you say? Where’s the data? Well, you see right here, the worst thing you want to do is lock them up with other knuckleheads -- amen -- the worst thing you want to do. That doesn’t suggest that there aren’t some kids that don’t need to be locked up. I’m not suggesting that at all. There are some kids who are very dangerous. But we just saw that the literature is saying something opposite of what our politicians are putting on the table for us to consume. There is no data to support it and actually you would predict that, locking
them up, they are going to get worse. Unfortunately what we have to realize is, these kids are coming back. If those systems in which those kids are nested have not changed, you have done more harm than good. [Audience: “Amen!”] We are rolling again. I thought you all were sleeping on me.

We use family preservation as a model of service delivery. It is not the treatment; family preservation is not a treatment. A lot of things happen in family preservation services. One of the things that Dr. Burns said is, “What do case managers do?” They probably do a number of things. That is what we have to tease apart as researchers. What are people actually providing? To make a long story short, though, family preservation is a way for us to deliver multi systemic therapy. Let me go back: This project was funded by Piedmont Center for Mental Health and the South Carolina Department of Mental Health and the National Institute of Mental Health. There were 84 serious juvenile offenders who participated in the study; 54 percent were violent offenders. They averaged 3.5 previous arrests. Think about this. It takes hard work to get arrested. Most studies, I think the highest number of (ratio to) arrests to number of crimes committed is like 100 to one. It is a lot of work to get arrested. I’m not saying that cops are Keystone Kops or anything, but it takes a lot of work to be arrested. The project goals were to reduce rates of criminal activity, reduce cost of services, reduce time in out-of-home placements, and also preserve family integrity. This is the design of the study. Kids came in meeting the criteria of serious or chronic delinquency, defined as three or more previous arrests, but also at risk of out-of-home placement. A probation officer would tell our researcher, “This kid is going before the judge, is going to be placed.” At that point, the kid is randomly assigned to MST [Multi Systemic Therapy] or usual criminal justice system services. So we’ve got the idea of the nature of the study, the design of the study.

Based on a causal model and the data we have about kids (serious delinquents), what we know is that certain things need to happen to effectively deal with serious juvenile offenders. What we need to do is: (1) increase parental discipline practices or improve them; (2) increase family cohesion or affection; and (3) decrease association with deviant peers. That is one of the things that you would have to do: increase association with pro-social peers. You don’t just extract a kid from a peer group of deviant peers; that kid still needs peer interactions. Improve school and vocational success? Why is that important? Education predicts where you end up. If you are not trained (if you don’t go to school), you are going to be in the lower echelons of our society. Engage in positive recreation activities. If you ask a parent what they want, they want structured positive activities that their kids could be involved in. Improve family-community relationships, and also empower families to solve their own problems. Empower families to solve their own problems. [Audience: “Amen!”] Right on. I am getting to the data. Now I am not going to spend time talking about what interferes with effective parenting, but you got the idea of what those factors may be: It is not just that parents don’t have skills. There are a lot of things that interfere with engaging in appropriate parental practices.
The results. Multi Systemic Therapy was more effective than usual services in meeting each of the goals that we outlined. It increased family cohesion, decreased adolescent aggression with their peers. Now let’s talk about some of the more, what we call, ultimate outcomes. What we see is that MST substantially reduced self-reported criminal offending. You are asking me, “Well, you are asking criminals to tell you whether they are criminaling or not.” That is a legitimate question, but we are randomly assigning. If these criminals are going to lie, they are going to lie equally. With random assignment, all you are doing is trying to create a situation in which the groups are equal. Theoretically, they should be more similar than dissimilar, right? So if they are lying, they are going to lie equally. But what we see is that kids are saying -- kids who received MST -- are telling us that they are committing fewer crimes. A significant number, I may add.

What about looking at arrests. At 50 weeks of follow-up, kids in usual services were twice as likely to be arrested as kids who received MST. Then what about in terms of out-of-home placements? What we see, our kids spent 5.8 weeks in out-of-home placements during treatment, compared to 16.2 weeks. Think really seriously about the data I just presented to you. Our kids are in the community longer, committing fewer crimes, and getting arrested less, but they are in the community longer. Somebody ought to say “Amen.” Like Dr. Burns said, well, “What are people interested in? What are policy makers interested in?” The bottom line: how much does it cost? For us to treat a kid with MST, it costs about eight grand. To treat a kid with usual services in this study would cost 20 grand. What do you think most of that 20 grand went to? It costs a lot of money to incarcerate kids.

This is what we call a survival analysis. On the left hand side, everybody starts off (this is a strategy taken out of the medical literature, in which you think about a cancer treatment); everybody is alive at one. At the beginning, everybody is alive. Now the question is: When will they die? In our case, when will they be rearrested? What you see is that compared to usual services, we increase -- double the survival rate -- of these kids. You may say, “But you are not perfect,” and I would say, “You are right.” There is still a lot to do, but compared to what is going on, we have doubled the survival rate. We are more effective than usual services in reducing criminal activity, considerably less expensive, and also we are more ethical in trying to maintain family integrity.

Quickly, I am going to go to another study that compared MST to individual therapy: There were 200 juvenile offenders and their families; average 4.2 previous arrests; 64 percent were incarcerated previously at least for four weeks; they were almost 15 years of age; most were male; 30 percent were African American; 70 percent Caucasian; and 47 percent lived with only one parental figure. This study allowed us to look at people who completed MST, people who dropped out of MST, and also those in individual therapy, as well as those who refused treatment altogether. Again, how long to rearrest? In this case, what we see is that people who get a whole dose of MST did significantly better than people who dropped out of MST. So in this case, a full dose is much better than a
partial dose. When we compare that to individual therapy and people got a full dose of individual therapy versus those that drop out, there is no difference between them. Why would you expect that? Go back to the causal modeling slides that I showed you. Why would you expect individual therapy with a knucklehead kid would have any effect on this kid, if you have not changed the systems in which this kid is nested or embedded? So all the sweet talking (them liking you and doing all that good stuff) in this study had nothing to do with outcome, did not increase outcome compared to kids who drop out of individual therapy, although they were better than treatment refusers – those kids who didn’t receive anything. Then why was treatment successful? (1) We target known causes of delinquency; (2) We treated these offenders in a natural environment; (3) Our therapists were well trained and supported; (4) Our therapists carry a caseload of about four families, sometimes five; (5) We give them everything they need to be successful – the same thing we do with families. Anything they need to be successful, we are going to provide it. So our therapists are doing things in the community where people live, work, play. Much attention was devoted to developing positive interagency relationships. If you think about it, you can come up with some great interventions. But if the school system is going to kick the kid out anyway, you are spitting in the wind. So we do a lot of work trying to save this particular kid.

I am going to stop at this point because I really do want you to ask questions of both Dr. Burns and me. But let me just leave you with the reality here: incarcerating kids does more harm than good; trying to change resources that our families need does more harm than good. There are ways that we can comprehensively address the needs of serious juvenile offenders, chronic juvenile offenders. We can make a difference. It is all about work: It is all about being smart in what we do. God bless you and thank you.

Nancy Koroloff: Thank you to both of our speakers for getting us off to a great start this morning. I think it is always helpful to hear from some of the researchers exactly what is known about some of the interventions that we so desperately need, to be able to go out there and advocate for. We now have time for questions.

Conference Participant: I am from Portland and the Oregon Family Support Network. I wanted to ask the last gentleman who spoke, could you enumerate a couple of the interventions that your group would do for any specific child?

Phillippe Cunningham: Actually we pride ourselves on using empirically valid data approaches, although we have nine treatment principles that are really the backbone and the grist of what we do. But if you think about it, the non-MST treatment principles really drive out use of, say, parent training. We do cognitive-behavioral interventions, but we also take into consideration the ecology that it is just not providing. Again, I didn’t have time to go over slides dealing with the factors that interfere with effective parenting, but we address those. So it is not just giving a parent a skill, but also giving them the resources they need to implement those skills, or removing the barriers that impede them from using effective parental strategies. For example, we look at substance
abuse: Right now in a study we are doing as a randomized trial, comparing MST to inpatient hospitalization, we have been seeing -- I shouldn’t say a lot, but a number of -- crack addicted mothers. Once we see that crack use is interfering with this parent being an effective parent, then we are going to have to address parental substance abuse. That can be done. People seem to think that substance abuse in and of itself is some serious behavior, but we go to great pains to address that problem. We have been very successful, by the way, in dealing with those issues. So we use empirically-based things. We don’t do the stuff that comes out of California like “Rolfing” or whatever it is called. So when there are approaches that have data, we use those approaches.

**Conference Participant:** I am a Research and Training Center staff person and this question is actually asked of either person, but Dr. Cunningham, you might want to respond to this. This is a question from a parent. I am a mother of an 11-year-old daughter. My child is at a time in her life where she is interested in other kids who are less likely to go to school. In fact, one of the youths is a fifth grade drop out. And the question is about this young man who is a friend of my daughter. My daughter does school and does all this stuff and activities and work, but she has a friend, a Hispanic child, who has effectively dropped out of the fifth grade. The school that these kids attend doesn’t appear to be concerned enough. As a professional, and as a parent who sees my daughter involved with this child, I need to bring him into the fold to advocate for him. What are some of the things that people like me, or others who see kids who may not have the supports, who may not have a case manager within the midst of their family at this point -- what do you do in order to provide them supports they may need?

**Phillippe Cunningham:** Actually, we do a lot to develop social resources for most of our families. When you think about the data on stressed families or single parent families, they are relatively isolated; they don’t have a lot of social resources. We do a lot to build those resources prior to us pulling out. I am not going to try to comment on a specific kid, because I would need a lot more data. My thing would be, “How does that kid’s behavior make sense in the context of his social ecology?”

**Conference Participant:** It makes perfect sense.

**Phillippe Cunningham:** It makes perfect sense: You are right. But another literature that we can look at outside of the treatment literature is the resiliency literature. I am really into protective factors. The number one protective factor (regardless of how horrific a kid’s living environment may be, all the trauma they may have experienced -- and this is the kind of stuff that grandmoms, we should all know, things that keep those type of kids healthy), is having some adult, not necessarily a parent, involved in their life. When you look at the data on protective factors and resiliency, the literature is quite clear: that having one adult that may or may not be related to that child, serves as one of those things that protects that child from the adverse effects of a noxious living environment.
**Conference Participant:** Creating those networks in the community is very important, and I think as a parent (and a parent of a child who could be on her way out or could be on her way into greater things), that’s the most important thing that we can do. And I see in just answering my own question, what I do is get this Hispanic child involved with perhaps another Hispanic male, and me, and again I do take him with us when we do things. I don’t tell her not to be involved with him; I involve myself with them, both of them. Thanks.

**Conference Participant:** I am from Tacoma, Washington, Catholic Community Services, Family Preservation. I commend you both for your scientific work and your willingness to share that with all of us. I have a question for Dr. Burns. Dr. Burns, you shared with us some of your scientific studies of therapeutic foster care, and my question is, have you done any studies in homes, family homes? Because our goal is to bring families back together and reunite the family and bring the child not only out of institutions, but also out of therapeutic foster care.

**Barbara Burns:** What you want to know is whether we have actually studied that transition process of return?

**Conference Participant:** No, are you planning on studying anything on in-home success, not therapeutic, but the natural environment of that child?

**Barbara Burns:** We were studying children in their natural environment, essentially, bringing them back from institutions. One of the findings was that we could keep them out of hospitals and residential treatment centers, although if they had to be placed out when they had a case manager, they went to therapeutic foster care. Then the question is, do they come back from therapeutic foster care? That’s not probably something we can answer in a one year type of study, because most of those kids were actually not placed for some time. Do we think it is really important to study what it takes to keep children at home? No doubt about it; it is critical.

**Conference Participant:** I’m with the Federation of Families for Children’s Mental Health. Maybe you said it and I didn’t get it or didn’t hear it, but I would like for you to tell me about how you define family preservation. I would like to know if you could get a little clearer with me about, first of all, what falls under that, and is there a reason you are calling it family preservation instead of family support? Is it time limited? Does it have those same kinds of restraints that normal family preservation has? Because I have some concerns about that.

**Phillippe Cunningham:** Actually we use family preservation as a vehicle to deliver services.

**Conference Participant:** Is that for funding purposes?
Conference Participant: No, it is actually for ecological validity purposes. It is going into your communities. It is time limited. We see families three or four months. We provide 24/7 coverage, so it is just really a way of delivering services, analogous to putting a kid on an in-patient unit. That the mode of delivery is the in-patient unit, but what goes on in the in-patient unit could be cognitive therapy, psychodynamic or Rogerian, or psychopharmacology. But that’s to answer how we use or how we see family preservation, as a way of delivering services. What is being talked about in that literature -- to me what family preservation is and what it does is kind of nebulous to me: People do so many different things. I mean, Homebuilders program is the one example; there are other programs. I hope I answered your question.

Conference Participant: Well, not exactly. Let me ask it a little differently.

Barbara Burns: He can’t answer it, and this may not be fair to you, because he is really talking about working with the juvenile delinquent populations, not talking about the research that is now starting on children with severe emotional disorders. That’s not to say that there are not lots of kids in that population with severe emotional disorders. Really, that needs to be addressed to Scott Henggeler and the new research. The recent conversation that I had with Scott around this very issue, which concerns me as well, and that is how firm can you be about this time-limited treatment.

Conference Participant: Even if they are not seriously emotionally disturbed, Barbara?

Barbara Burns: I’ll stay with this population anyway. What Scott is starting to find is that the intervention is requiring some adaptation with youngsters who would have been in an in-patient unit, so we are talking about that level of severity. But I think you are raising a real important issue. We want to be able to demonstrate that intensive, short-term interventions can work. On the other hand, we want some flexibility for what kids really need. When I started talking this morning, the real issue is this: How do we put together appropriate packages of different types of interventions which cover the span of these problems? Some of what we have seen, when we come up with a rich service system that, like the Fort Bragg issue, everything gets thrown at a family when they are not necessarily ready to use it. So we don’t know a whole lot about how to sequence these intensive interventions. That still might not answer what you are raising.

Nancy Koroloff: We are getting short on time, so we will take the three questions of the people who have been patiently standing up.

Conference Participant: My question is, for families who themselves are not involved in drugs and alcohol, have not been involved in corrections, and have children with brain disorders or mental illness: How then do you address and work with those families whose children (because they have not received services), fall into the juvenile justice system? What kind of parent training do you do for them? Because when you say parent training, that is blaming parents.
**Phillippe Cunningham:** Let me first be real clear. We do a host of things, not just parent training. The bottom line is, whatever a family needs to be successful. It may be parent training, but that is really a small portion of what we do. In terms of kids, you are asking a question, well, what if it makes sense that this kid needs meds? Well, we get that kid meds; we will get a psychiatric consultation; we have child psychiatrists on our staff; we will provide those services. I am not into blaming families, because we go out of our way to empower people to solve their own problems. I think the only way you can do that is to go in and collaborate with them. But the reality is that there are some terms out there that people may not like, but they are out there that describe what folks do. Parent training is just one of those things. I don’t want us to kind of get bogged with it; we do the things that you want folks to do who provide services and that is to collaborate with the family, treat them as the most important vehicle for child behavior change, and I am right there with you. I hope I answered your question.

**Conference Participant:** Yes, I would just like to address Dr. Burns around some of the outcomes. I guess basically it was like kissing your sister: there wasn’t just a whole lot there that you could get real excited about, although I do think that a decrease in substance abuse is exciting all on its own. Unfortunately, when we do these kinds of studies (and I am involved in a three year grant right now), sometimes we can’t, as researchers, measure things that we would like to do. I would like to point out a couple of things that might be outcomes of your study that you are not going to be able to publish, and that you are not going to be able to validate from a research perspective, but I believe are real important to kids and families. The first one is teaching them the life skill of using case management: having an understanding of what that kind of service level can do for a family, and teaching a child that as they go through life, if they begin to have difficulties, that a case management approach to their life may, in fact, help them. This is something that is not going to show up in your papers. But I personally believe that modeling the use of good services, whether it be case management or otherwise -- but from my perspective, case management is important, so I think that is something that is just not going to show up. But having had a positive experience with case management is a gift that is something that you really shouldn’t overlook.

I guess the other, when you start measuring costs, you are saying that isn’t a great cost savings, but as the parent of two mentally ill children who are now 19 and almost 21, I want to share that more than anything I want my children to have productive lives as taxpayers -- not as residents in a local prison. Again, if your intervention with these children has produced a child who is more likely to go on and have a productive life at whatever level they are able to do (and not continue to be a part of the welfare system or some other level of disability payment that they might be able to get from the federal government), that is a cost savings that lasts for far, far longer than whatever they might be able to save in the children’s system alone. So unfortunately, when we do our research we are just not allowed to say things like that because it is not really anything that you can say that is true within three years. I don’t think we can forget what we have really done for kids and families.

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Barbara Burns: Thanks. I think it is important to go away with a message that, although there wasn’t a huge cost savings, it was a little cost savings, but it didn’t cost a lot more. We expected that it would have cost; it would have been a high cost on just providing the service. So that helps to justify it. There are much better reasons, as you indicate, to do that. But I like your idea about, that leads us to develop a little measure of what do parents know about case management? What skills have they gotten from having that experience? I think that would be a lot of fun and important to do.

Conference Participant: This is for Dr. Cunningham. I am with the family support network in Columbia, South Carolina. We have approximately 20 parent support groups around the state and last year we attempted to get a parent support group started in the juvenile justice system. We decided to try that with a more defined population to get it started and went into what was then the Hickory Unit. There were 20 adolescents in the Hickory Unit at that time with a clinical diagnosis, and we sent out questionnaires trying to address those families. We were told that probably three quarters of the families never visited those children in the system. We only got one response from one parent. So we are trying to regroup and come up with some ideas of how we might go about doing that this time. Do you have any suggestions?

Phillippe Cunningham: I have a whole bunch of suggestions. I think the question really is, for us and with the work we do, is what is keeping the parents away. I am going to give you a quick example because I do some work in a school setting with teachers and they had the same question. I asked them the question, “What do you think keeps parents away from the programs at school?” They listed things like transportation, child care, a work schedule that is interfering with them getting there, etc. Those things. That was the list of what we call barriers to parents coming. Then I asked the question, “Well, what do you do -- actually do -- to get parents to come in?” They listed things like, “We provide food.” “What else do you do?” “We have snacks.” I am thinking, when we looked at the barriers and what people were actually doing, what they were actually doing had no relationship to the barriers that parents were facing. So what we do is to identify what is the barrier, and then come up with strategies to overcome the barrier. Not trying to force a parent to do something that they can’t do. I don’t know about your organization, but I think that is a way to think about it and coming up with some viable solutions that will increase the probability that you will get parental participation. Something like transportation is a big deal for families. Something like child care for other kids in the family is also important. Considering the parents’ work schedule, everybody doesn’t work nine to five. Some parents I know, they work 3 to 11 or midnight, or 11 to 7. They work these odd hours and you ask that parent who has just worked 11 to seven to come into your office and you are wondering: they are not invested; they are resistant; they are tired. I hope that helps. That is how we think about it; that’s what we do to overcome those barriers.
Title: Plenary Panel: Positive Examples of Partnerships Between Families and/or Family Organizations and the Child Welfare, Juvenile Justice and Education Systems

Moderator: Barbara Huff

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Barbara Huff: It is truly my pleasure to facilitate this distinguished panel. We are really excited to talk about positive partnerships between family members and professionals. I thought it would be helpful to set the stage. I will make some introductions here in a moment about the people to my right and to my left, and also share with you some of the questions that we have asked them to answer. Over the years of my involvement, whether it be in Kansas or in the Washington, D.C. area, I’ve had the opportunity to have a lot of partnerships in my life with professional service providers and government people. I don’t know that I have the answers to exactly what it takes. Barbara Friesen once put together what the elements of collaboration were; they included trust and sharing information and all the different adjectives that describe what it takes to have a partnership with one another. I think we are now beyond those descriptive words and into what does collaboration really mean. When you trust one another, what does that really mean? How does that play out every day in your lives as you are trying to work together? As we have many more family members employed by the systems that serve our kids, I think that now we are at a point where we really can begin to ask the more difficult questions.

Today we are going to focus more on the positive side of things, but also, if the panel has barriers to this to share, I think that is helpful and useful as well, because this is not an easy thing. I think what we have learned since Barbara put together those elements of collaboration, is that it is not as easy as those elements might appear to be. What I do know, though, is the most success I’ve had with things has been because I’ve understood where my weak areas were or the Federation’s weak areas were or the weaker areas of Keys for Networking, and kind of wrapped around me, in a wraparound fashion, professionals who had lots of knowledge in different areas that I didn’t have. I know that I could not do the work that I do today, and I don’t think our staff could, if it weren’t for some really committed professionals who help. So I am still into creating, developing, and maintaining partnerships, no matter where I live or what I do.

With that in mind, let me first of all share with you the questions that we will answer this morning. First of all I asked them, “Why are you serving on this panel?” The more I thought about that one, the more I thought, “Because I told them they had to.” One of the questions, “What are you hoping to accomplish through your collaboration?” Another one, “How are your experiences unique and worth sharing with others interested in collaboration?” Another one is, “What is your greatest accomplishment together and how did you achieve it?” And the last one, “What advice would you give others about developing and maintaining partnerships?” We are hoping to get past why did you do this and what are the barriers to doing it, to what is really happening within these partnerships and what are they accomplishing and what are their goals to accomplish together? We are trying to elicit questions and discussion that gets a little deeper into the framework of partnership. You will notice that the conference committee at Portland State University was wise enough, I think, to look at partnerships across the different agencies and bureaucracies. I think that is wise, because we are newer to partnerships in the child welfare and the juvenile justice side of things. We have been thinking and
doing partnerships more in mental health and education, partly because education has had more of a mandate to involve families. And mental health has been doing this since some of the early CASSP initiatives, where they had to involve family members at some level. So it is newer to think about child welfare doing it. Since the family preservation initiatives and family preservation and family support legislation, there has been more impetus to form partnerships. And to think about families not in just a child saving mind set, but instead in a real partnership mind set.

This morning our first panelists are going to be our mental health education partnership. Carol Redditt, on my far right, is the professional on this team, along with Cheryl Anderson -- actually they are both professionals on this team. Carol is the clinical administrator of the Wraparound Initiative. This is a school-based wraparound project located in Illinois, right outside of Chicago. Her partner is Cheryl Anderson. I have had the opportunity to meet CarolAnne and Cheryl through the Federation’s technical assistance that we offer family organizations and service sites. When I say service sites, I mean that the federal government, in the last two or three years, has allotted some service dollars to 22 programs, or service sites across the country. Two of the panelists this morning are actually from those service sites where they have extra money to spend on actually developing a coordinated system of care with tremendous involvement of families. Cheryl is employed by the site as well.

Carol is responsible for clinical consultation and training for the wraparound facilitators and the coordination of family advocacy efforts. So they really do have a partnership in many ways when you talk about the coordination of advocacy efforts. CarolAnne has extensive experience with family advocacy, systems change, and implementing the wraparound approach for children who have serious emotional disturbances and their families. Cheryl is employed at the same service site in the Community Wraparound Initiative. She facilitates parent support networks and resource development for families. Cheryl has experienced first hand the benefits of the wraparound approach for her son through the LaGrange Area Department of Special Education. We are happy to have both of you here. I have had the opportunity to utilize their expertise around partnerships in the past and they have helped me on many occasions do everything from practically teach a class to doing workshops. I appreciate that.

Our second presenters are representing the child welfare system. Arlene Belfield is the clinical supervisor of the family preservation staff at the Annie E. Casey site in East Richmond, Virginia. She also supervises other clinical staff for the city of Richmond and the clinical staff who work with children who have more long-term needs than short-term family preservation. Her partner, Cynthia Loney, has a special spot in my heart because she has been around for a long time with the Casey Initiative. She has done tremendous things in her community. East Richmond is one of the four Annie E. Casey Urban Children’s Mental Health Initiative sites. Many of you may have met Mary Telesford, our staff person who works with families and the staff at the sites related to family involvement and family organizing.
Cynthia is one of seven community members employed in the East Richmond site. I remember that it was a whole new thing for East Richmond to actually employ these seven parents and family members. Cynthia stuck with us all the way in convincing the site that it was OK to hire family members. She is a person who has come a long, long way with the Federation on that and has been right by our side and has truly been partners with the Federation for a long time. She has received awards from the community, and is intimately involved in trying to improve her East Richmond community. We thank the both of you for being here. Cynthia has also been of personal support to me once or twice in my lifetime, which I have also appreciated.

Our next team, representing the juvenile justice system, is Jane Adams and Dr. Leo Herman. Jane Adams is one of my dearest friends and colleagues, lives in Topeka, Kansas, and is the Executive Director of Keys for Networking. I could probably go on and on because since I used to have that job, I intimately know what Jane does. Jane is my late night phone call. She and I are wonderful support systems for one another and our work. The most recent accomplishment Jane has had is in really maneuvering the system to get a parent to be the chair of the Mental Health Planning Council in Kansas, of which Jane is a member. I think that is one of her most important recent accomplishments.

Keys for Networking is a statewide family organization in Kansas; they also are the state organization for the Federation of Families for Children’s Mental Health. Jane has taken on the task of partnering with juvenile justice and has much to share. So we are really happy to have this team here. It is one of the newest kinds of partnerships, I think, with juvenile justice. Their experience is going to be most interesting for us to hear. Southeast Kansas is a rural service site and Jane is the contractor for the family piece of that site. That site hires seven family members in a rural part of Kansas and Jane supervises them and provides ongoing support and supervision.

Next to her is Dr. Leo Herman. He is the Program Director at the Youth Center in Topeka, Kansas. The Youth Center houses approximately 220 young boys in the juvenile justice system. I’ve had the opportunity a number of years ago when I was still living in Kansas to work with Dr. Herman in our very beginning efforts to think about what it would look like to have a partnership with a youth center. In the very beginning stages we had some early meetings with family members in which the Youth Center supported and helped us and has been very supportive over time. But Jane and Leo have taken this to two and three and four higher levels. So I give them all the credit for that. But I think it is very extraordinary for a program director who is working at a youth center behind huge walls and who is thinking about what family collaboration with that youth center could look like. That is not the mind set of most people in the juvenile justice system. So we appreciate Dr. Herman having flown in late last night to do this with us today. Thanks, Leo, for being here; it is really good to see you.

CarolAnne Redditt: When I pondered the first question of why I was on this panel, I thought about personal motivation. I thought: Well, I had been asked by someone I
really respect. But then I shifted into other thinking about this, and I thought: Why me instead of any one of you? Because I know there are really solid professional/parent partnerships out there because I can just feel it and I’ve seen it in the workshops. So the answer to the question of why I am here is because someone knew and had seen Cheryl and me speak before and had asked us to be here. So I know that, to make a partnership, there is a willingness and a value system that allows you to develop these partnerships. I would like to invite you to just turn inward and if you are part of a positive parent/professional partnership, I would like for you just to stand up. You don’t have to be with your partner; they don’t have to be in the room. They can be states away. I would like for you just to stand up and be acknowledged. This is kind of like the Academy Awards. We will make our comments on your behalf. Thank you.

The second question is about what do we hope to accomplish. Through the Community Wraparound Initiative, we want to provide opportunities for parents to support other parents. We also want to provide opportunities for parents to have their needs met, become informed, and figure out together how we can impact the system so that significant and long-lasting changes are made and the needs of families are met in a more responsive way. Another question we were asked is what is the unique aspect of our relationship. That one really puzzles me a bit. I had to think about that. What I came up with is that Cheryl is the age of my children. Her children are the age of my grandchildren. From the very first time that I was exposed to Cheryl, I felt this wisdom in her. I have learned from her from that basis constantly since then.

Our greatest accomplishment? I don’t think we have done this yet. We are just getting warmed up. We haven’t hit our greatest accomplishment yet. Then I thought about some of the things that we had done together. One of the more recent, more significant things, I think, was that we were allowed to present at the Illinois Association of Community Mental Health Centers. This is a conference of executive directors and administrators, those far removed from family folks, usually. We talked about the Community Wraparound Initiative and especially about wraparound, because it is a term that is used loosely and often and doesn’t have a lot of clarity as to what it actually is. So we were talking about that. But then when Cheryl got up to speak, she had those administrators spellbound. They were attending; they weren’t writing or fiddling or reading or looking at other papers. I think that exposure probably will do more for families in Illinois than any other. Now we need to get into child welfare and juvenile justice, definitely. And don’t leave out education; that’s one of our big challenges, too.

Advice in developing and maintaining partnerships? I don’t know that you all need advice. I think the fact that you are here speaks to the fact. But the thing about partnerships, especially maintaining partnerships, is allowing each other just to be who they are. One of our things is, if you make a mistake, you ask forgiveness and forgive and you move on. Also there is a thing about humor in partnerships. Yesterday we were told that examples really help, so I am going to give you an example of humor. This isn’t about Cheryl and I. It is about some other colleagues of ours. Yesterday JoBeth Antos,
in her partnership with Mary Lou, was talking about one event when her son wigged out, (that’s a clinical term), and she needed to call in her reinforcements. She called Mary Lou in and they did some interventions. But then the next day I happened to be in another colleague’s office when JoBeth called to tell her about what had happened. She was saying how her brother-in-law had come in and taken her son to the lake, which is Lake Michigan for people that aren’t familiar with Chicago. My colleague, who is Lucille Eber, said, “Well, did he throw him in?” So I am sure JoBeth’s mouth fell open at first, but then everybody started laughing. So that is an example of humor. Just a good laugh is very therapeutic. So if you laugh together, you have got a solid partnership.

I would also recommend that you go back to this 1988 *Focal Point* and the Professional Checklist and Family Checklist; it is very appropriate today. And be encouraging and accepting. So my partnership with Cheryl is easy. She is a high caliber individual, so it is not hard to have a partnership with her. I don’t have anything to offer as far as barriers with Cheryl. When we get into discussion, maybe I can tell you about some others.

**Cheryl Anderson:** Good morning my friends. Because of who I am, I don’t follow directions. So I didn’t bring my list of questions because I couldn’t remember what they were. But one of the things I do remember is we were supposed to talk about how we build a relationship, a positive relationship with one another. CarolAnne is easy to talk about, just because of who she is. I don’t know if I thought two or three times about her being a professional after I got a chance to talk to her for about 15 minutes. She listened to me talk about some of my issues with my son. That made me want to get closer to her. I would like to take some time to talk about how difficult it is to partner up with professionals. You need to forgive me on some words that I say, like “the system.” When I am talking about “the system,” I am talking about the school system, I am talking about juvenile, I am talking about child welfare, and I am talking about people outside my family. So I just kind of put everything in one ball and call them the system. I was brought up where you don’t let the system in. And I didn’t. When I needed the system, I had a hard time accepting them. So that made my life kind of difficult. I needed to go back into my room and think about how I am going to make it through tomorrow without the system. Because my family was there, but they didn’t have the right answers. My church was there, and they didn’t have the right answers. My friends were there, and they didn’t have the right answers. That meant that I needed to take some time out and figure out where I needed to go to get some help for me and my son. And I had to go to the system. And the system had dogged me out real bad. I had kind of dogged them out, too. So we had a problem there that we needed to work out. Because crises in my life started to get worse, I needed to really think about where I was going to go and who I was going to go to, to get help. So I took some time out and I said, “Well, I don’t think these people are willing to change, so, Cheryl, you may need to change.” So I had to change. I had to start thinking about what I want from other people, not what I wanted from the system, but what I wanted from other people. I wanted other people to trust me for who I was. I wanted other people to trust me for what I knew. I wanted people to respect me. I
wanted people to encourage me because I am an encourager, but I didn’t encourage them. So I did that.

When I opened up, the first place I went was to a support group called Illinois Federation of Families. That is the Illinois branch of the Federation of Families. That is where I met CarolAnne. I watched her, I listened to her, and I always wondered why she was there. She didn’t have children. But one of the things I found out about CarolAnne was she was a person that cared and a person that kind of felt the same way that I felt about change. I hurried up and latched onto that person. To make a long story short, you need to know something else about me: that I jump from one story to another. That is just how I am, but I hope you get the point. The point is that it wasn’t easy to build a relationship with professionals. It started being easy for me when I looked at CarolAnne as a person and not a person from the system. I looked at her as a person. And that makes a difference when we look at one another as who we are: just people that don’t really know what to say to families. As a family member, I didn’t know what to say to CarolAnne, but we just moved on. I don’t know how we got to this point, but I am at a point in my life where I love her as a friend, I respect her as a partner, and it is something special. One of the things that I realized is that we can’t make a difference until we can get to that point with one another. Because it makes us stop thinking who we are, but what we are here for, and that is to make a difference in our children’s lives. I hope you understand what I just said because I don’t. It is hard, but it can work. I don’t know if you will ever get to the level that me and CarolAnne are as partners -- as friends -- but if you can, it is a good thing.

CarolAnne brought me to another level in our relationship a couple of days ago when we sat in the office and we were talking. It was after we talked to Barbara about what we were going to do today, and it would kind of go in one ear and go out the other. But she was concerned about some of the issues that are going on in my life. I asked her why. She kind of looked at me real funny and she said, “Just because.” I said, “But why?” She said, “Because, you know” -- she didn’t know what to say. So I had to jump in and say, “You don’t have to worry about that. That’s my issue. That is something that I, as Cheryl, have to deal with, but I respect you for caring enough about me that you want to do that for me.” There was nothing that she could do, but I was just happy that she had moved to another level in my life to where I can trust her, even if I wanted to go and talk to her about something real personal and something real close to my life.

Once again, I would like to challenge the professionals to partner up with parents, go back to your homes, go back to your communities, go back to your agencies, and challenge them to get a family member on board, because we have something to offer. We are not all bad. I would like to challenge family members (and I do this often) that the system can work for you. But you have to give a little to get anything back. It is a good thing. I just want to tell CarolAnne that I appreciate our relationship; I appreciate her patience; I appreciate her butt-kicking every once in awhile. I appreciate that about her. I want to let all of you know that this can work, if our goal is to make a difference for our children. Thank you.
Arlene Belfield: I am proud to be here today. I am especially proud that I was asked to come. I have for many years (for about three years now), been working with staff of the Annie E. Casey Family Preservation Project in the east end of Richmond, Virginia, my home town. So for any of you who have not visited Richmond, please come. The Casey Project is kind of unique because the philosophy is parent and community, working together. The purpose of the family preservation piece that I am working with is to maintain those children with special emotional or behavioral needs in their homes and in their communities, and that takes a lot of creativity. And not necessarily creativity on my part or on my staff’s part, but creativity on the part of the parents who are helping us to help their children. We don’t do it ourselves and we don’t profess to be able to do it, because the parents are the experts and the parents know their children and live with them everyday when we are not there.

I work primarily with the mental health system, but we do have projects that deal with child welfare and therapeutic foster care. Also a part of the family preservation project is working with those children who are in the child welfare system and trying to transition them back into their homes. So we provide intensive, in-home, home-based services to help the families get ready for the kids to come back and help the kids to get ready to go back home. We provide supportive services through the assistance of the interagency team network for funding, sometimes, and also from the child welfare system for funding to get the kinds of services that they need. We have had a lot of challenges in working with the East District Project. As you know, with any system that gets caught up with part city and part grant funding, there is a lot of politicking that goes on. So we have had to struggle with some of those barriers, but they have not stopped us from doing what we have to do.

Cynthia Loney is one of the representatives of the Fairfield area of the East End. She has been very active and been very supportive as we have struggled and worked through trying to create different kinds of partnership in the community, between parents, the East District Initiative, and the systems as they exist. One of the first times that I became involved or acquainted with Cynthia was when we were hiring the staff to work in the East District. Cynthia was on the interview panel and as a parent and a community leader, she had a great deal of input into who was going to be hired to provide services to the East End. That is when I really began to know how involved and how committed she was to the community that she lives in, and have learned a lot more about some of the things that she has done.

She has also been instrumental in referring other families to us who are in need of services. She knows her community; she knows the residents in her community. She knows what they will and will not accept. When she tells you that this person wants services, you’d better believe that she already has asked the question and she knows that. She has developed the kind of relationship with us that she can come to us or we can go to her to get help for the community and for the residents, whatever they need.
The uniqueness about the relationship with Cynthia and with the East District families is that they are more involved than in any other part of the city. They are involved in the questioning, you know, “What kind of services are you providing? Why are you providing those services? How many families are you seeing? What are you doing about this?” And they question what’s happening, which is kind of different because we usually go on and provide services as we design them. But in this instance and in many other instances, we are trying to be more creative about the way that we deliver services to the community. The program committee had me there recently where I had to talk about what we were doing, why some things were not in place, and why we were proceeding in certain other ways. We had to describe what we meant by saying a child had a serious emotional disorder or a serious behavioral disorder. For many people, that is very confusing and very disconcerting.

The advantage of our program, and some of the benefits, has been that the community parents have become comfortable enough to request services from us. We have taken on responsibility for not only forming partnership with the families, but also playing an advocacy role. So that the parent, as a partner with us, can become their own advocate and move into other areas like schools, like knowing how to interact with the schools and the courts. We discourage them from attending IEP meetings alone. We want to go with them because we know how confusing it is for us so we know that sometimes parents don’t understand what is being discussed. We are there to sort of say, this is the kind of question you need to ask so that you can get the answer. We already know what the answer is, but many times the parent doesn’t know. So we need to help them -- help parents to help themselves. Our overall goal is so that the family becomes self sufficient. The community’s goal, Cynthia’s goal, is so that she becomes (and all the families become) self sufficient. They can take on the responsibility of making change in their communities, whether it is through the mental health system, the child welfare system, through the schools, or through the courts. Thank you.

Cynthia Loney: I am Cynthia. Why I am serving on the panel? For a long time I worked with mental health, with the kids that have disabilities, long before Casey came into the picture. One of my supervisors, who is Harlen Carter, came to me and told me, “Cynthia, you need to get on this board with Casey so we can get this money so we can have some more kids.” So I got involved. I became one of the board members. It is the Youth and Family Committee. So I served on the board for a couple of years and I fought hard to get parents and the professionals together. We argued and we argued and we argued until we were where we are now. We also got the grant.

So, through that strife, they decided, since the East End of Richmond was a large part of Richmond, that we needed more people to serve. So they decided to get seven coordinators; we call ourselves the neighborhood coordinators. I was picked as one of the coordinators because of the activities that I was doing in the community. My job as a coordinator is to bring out resources and to refer people to the different agencies as
needed. My big concern is the kids in the community. So I am going to get into something that I did that was very successful. The kids started shooting at each other. They were 13, 12 years old, shooting at each other. I didn’t like it. The community decided that they weren’t going to get in there because they were scared that they was going to get harmed in some kind of way. So I ran around and talked to the captain of the police, the chief of the police, the mayor, city manager, and got all of those people together and I said, “You all have to do something.” So we came up with a strategy that we would go into the community and we get both courts together, we call them courts. We will get both courts together and we will talk to them, find out some kind of way that we can stop all this shooting and kind of calm down the crime in the area, because the crime had got really bad. What we came up with, both communities and all the agencies, we came up with tenant patrol. We have been patrolling for about a year. I am one of the captains, you know, I had to get in it. Crime in the East End of Richmond has dropped 50 percent. My accomplishment is to watch things grow and see kids grow. I am going to strive for that.

I also have been fighting with the school. I also am referring to Arlene a whole lot of people that I think that need help. Their children need help. They need help. I refer them to the right agencies. I have been really working hard. We always have a lot of barriers. But I manage. I sit down and think about it, and I manage to get through all those barriers to get what we need to be done and to accomplish all of it. And I have accomplished a lot. The East District Commission said that we had to do things within the community. I feel like if you don’t have a proper facility to bring services in the community and it is not safe for the people to come, then there is no need of having them. So I got all the agencies, together with the residents, to come up with commitments to make it a little bit better for our community and make it better for our people to come out. Maybe get family counseling or come out to other programs. I have got all the agencies to remodel our recreation center -- all the recreation centers. There are four in the East End of Richmond and all of them have been remodeled. Playgrounds have been fixed and our playground has been remodeled. Thank you.

Leo Herman: To talk about a partnership between a family advocacy group and a juvenile corrections agency, is to talk about what our differences are first. To many people it would appear to be, I think, a very unholy alliance until you really begin to look at what both of us are all about. The last really big or formal conference that I attended was the American Corrections Association (ACA) in Cincinnati, Ohio. As I looked at the agenda and the program of this conference, I was struck with how philosophically apart this group and the ACA was -- geographically about as far apart as Portland and Cincinnati. In that conference that I attended in Cincinnati, Janet Reno was the keynote speaker. As Janet spoke, I think the differences between this group and the American Corrections Association began to come together, because Janet talked about community programming and she talked about wraparound services and she talked about families. If you really think about it, no matter what agency or institution or who you represent in our society, the foundation of our society or our culture is still the family. It is something that
has to be recognized and it is something that has to be dealt with. It would be a very foolish person in any agency or institution who wouldn’t recognize the strengths that lie in families as they try to make changes in their clients.

Here’s a little bit about the Youth Center in Topeka so you will understand where I am coming from. The Youth Center in Topeka is the most secure, the maximum security facility in the state of Kansas. All of the students (we call them students), all the juvenile offenders that we get, are Court adjudicated for either chronic delinquent behavior or for one or two serious acts. I have been at that agency for approximately 22 years. Kansas has enjoyed, I think, the luxury of being richly staffed with clinicians, especially as we look at ourselves and compare ourselves to other youth centers throughout the nation. But it was this maximum security facility which is probably most deeply entrenched in what many of us would call the system that started this work with this parent advocacy group.

I want to talk a little bit about how that got started. Barbara Huff was one of the pioneers of that, as I recall. It was I and several people from the institution, Barbara and some key players with our Social and Rehabilitation Services which started the first, what we call, Parent Advisory Group. As we looked at this Parent Advisory Group or our partnership with families, on the surface many people would say that these are two groups that are so philosophically and dichotomously different. The reality is, we were working for the same things. We were working for the success of our students or the families’ children. We shared this common bond which I think forced us into this partnership, forced us to work together. We also learned as things went on, much to our surprise, that although we were a large institution (we have approximately 220 beds), families shared many of the same internal or institutional concerns that we had, primarily around the safety and security of our students and staff.

You know, I feel like a pair of brown penny loafers with a black tuxedo with this group. When I looked at this I said, “What is a person with juvenile corrections doing here?” At any rate, as we developed this partnership, we really had to do some soul searching about what it is that we wanted to accomplish and what we were all about. Why should we, as an entrenched part of the system, why should we get involved with this thing? I guess my answer to that is, very simply, “It is the morally correct thing to do.” That families are the ones that have the biggest investment in their children and you simply can’t ignore that, if for no other reason, then because it is morally right.

The second thing is, we recognize that families have a wealth of information about their child and if you really want to make some changes in their child’s life or this young person’s life, you need to tap that information. And they have information that isn’t always on all those formal reports you get from about 15 different agencies, all of whom describe the kid or the family differently. We found that the first thing you have to do is start listening to families.
You have to recognize the value of the families and what they have to offer and look at each family as a system that has some strengths. How are you going to use those strengths in this partnership? Now it wasn’t easy for families to deal with the Youth Center either, I think. Since we were so deep into the system, they had years and years of frustration in trying to get help for their child, and trying to deal with the system. A lot of times I think that frustration was vented on us for a lot of things that we really didn’t have control over: things that belonged in the community, in the courts, and local law enforcement. But we had to lay that on the table and had to talk about it. I think families had to recognize that some of these things weren’t our fault. And maybe there are some good people in the system as well as bad people. It was developing that trust and that partnership which really made our relationship take off.

As far as some of the things that we have accomplished with Keys for Networking with families, probably the biggest thing that we tried to do (and something that I have been doing with my staff), is to empower families and to try to instill in my staff that families are one of the team members or treatment team members. Every student that comes to the Youth Center in Topeka is assigned a psychologist and a social worker and a youth service specialist. Those are the people that traditionally would make decisions about the child and his program there and what he was to get or what his accomplishments were. I have been working very hard over the last several years to try to change their mind set, to say: “No, there is one more key member of this treatment team, and that is the family.” They know the kid better than you, they have got more investment in him, and frankly they are going to have more impact on him, not only while he is at the Youth Center, but certainly when you do any kind of reintegration programming. So that is something that you really need to bring into the loop. To do that we had to change a lot of the way our system operates. One thing we started to do was send our program planning and review conference summaries to the families. We didn’t always do that. You know, like a lot of mental health people, we used to just put those in files and stamp “confidential” and then lock the drawer and then shut the door and lock that door, too. And only let those who had a legitimate interest in the child see those. That usually wasn’t families. One of the first things we did was to start sharing information. Then to solicit feedback from families, not only in the conference but what the report said.

Another thing that we tried to do was give our families a formal voice in the institution and the program. We did that through what we call a monthly meeting of our Parent Advisory Council. We send letters to every family member of every student that we have at the Youth Center at Topeka letting them know when the meeting is. Keys for Networking develops the letters and then we put them in envelopes, put postage on them and send them out, soliciting people to come to our meetings. We have them involved in policy development. We developed some policies around family visits, around telephone calls, around safety and security issues on campus as it related to people coming in. We worked with our Parent Advisory Group to try and get the families’ perspective about what their interests were, what their issues were, what they saw this institution needed to do. We tried to develop what I called a “PTA,” for those of you who are familiar with
your school system, which is basically just a family support. It seems like a minor thing, but it really made what could be a very oppressive and dreary institution around the holidays a lot brighter.

We try to do a Christmas reception every year for all of our students and we find one of our largest staff and put him in a Santa Claus outfit and we have several social workers who go out and solicit gifts from the communities like pizzas and hamburgers and various kind of trinkets, things that companies want to give away: pens, papers, that sort of thing. But our families got involved with that as well, these last two Christmases; we had family members baking cookies and going to their communities and soliciting things from their corporations like comic books, magazines, model cars, helping to wrap gifts. And the institution and the families worked together to make this Christmas a little better for the kids that were there.

Another thing that we have done with our families: We have developed a consumer evaluation form, and every student who leaves the Youth Center at Topeka, we mail a consumer evaluation form to the families and solicit feedback about our program and what we could do differently, or those things that they felt were good about our program as we tried to get feedback from probably one of the most important consumers that we have.

Now, as Jane will probably attest, things haven’t always been rosy between the Youth Center at Topeka and the Keys for Networking. I don’t know if there has been a problem so much with our two agencies, but we have faced a lot of issues and concerns as we have tried to continue on. Our membership in our Parent Advisory Group has gone to kind of a lull where there hasn’t been a very good turnout. In fact, at one meeting there were more Youth Center staff there than there were families. Part of it is we need to maybe stand back and say, “How can we better accommodate families’ involvement?” When we first started out, we used to have meetings Saturday afternoons in a conference room, where Keys’ offices were downtown. We really found that wasn’t working, so we got with our families and said, “How could it work better?” Well, it didn’t take a rocket scientist to figure out that families were coming up on weekends to visit their children at one o’clock in the afternoon, so why not have your Parent Advisory meetings an hour or two hours before then? So we started doing that. That kind of enhanced some of the participation. Now we are looking to maybe traveling to communities and meeting with families there, because we understand that a lot of families have to work on weekends. We’re trying to make ourselves more available. Kansas is a big state. The Youth Center at Topeka covers the whole state, or at least gets students from throughout the state. So, that is something else we want to look at.

Some of the main concerns of families usually center around, number one, medical care for their children. I was surprised to learn (in fact, I would have predicted when we started this thing), that most families’ concerns were going to be, “How quickly can I get my son out of there?” But that really hasn’t been the case at all. The concerns have been
primarily around medical treatment, visitation, and letting other family members visit, and probably the last one is their programming and how they are doing in the program. The other concern is families getting there to visit, since it is geographically distant for a lot of people. One thing we learned to do was when families would take kids off campus for visits in the community, if they didn’t have a lot of money they had no place to go. So we contracted or made an arrangement with one of our sister institutions in the City of Topeka which was the Kansas Neurological Institute, to set up a visiting room with a microwave and a TV and some soft furniture where families could go off the Youth Center at Topeka campus and go some place in the community to just sit around and visit with their son. But it was those sorts of innovative things that we began to develop just by listening to families and giving them some kind of a formal voice. That pretty well describes, I think, where we came from and some of the things we have done. I am going to turn the microphone over to Jane: She can talk about where we are going.

Jane Adams: First of all, let me tell you how really hard it is to take over an agency that was Barbara Huff’s. They expect big things in Kansas. I want to tell you three stories. I think they will illustrate, better than any other way I know, to tell you why we are here, why we came here together, why we believe in the partnership between families and the Youth Center at Topeka. I have a friend who this month has been in prison 26 years. His name is Bill. He is at the largest adult prison in Kansas. Years ago, he was the last person in Kansas assigned to death row. The laws changed or he would be dead. Some 30 years ago when he was 14 or 15, he was in juvenile corrections in Georgia. He was released. His mother was single. His mother was poor. She never was able to visit him when he was in the juvenile offender facility. He left there. She was afraid of him. His community was afraid of him. Five years later, he was re-convicted of murder and has spent the rest of his life in prison. As he looks now to parole, and as he talks to where he might go, he talks -- 26 years later -- about going back to his family. His family doesn’t know him. That’s one story.

Let me tell you another. Leo will remember this kid. One hundred years ago when I was tall and thin, I worked at the Youth Center and there was a kid there, a little tiny African American kid. His name was Cory. Remember him? We couldn’t get him to do anything. I had just gotten my degrees and after I tried all of the stuff that was in those classes and those books, one Saturday afternoon I decided to do something really brilliant, so I called his mother. I said, “We’ve tried everything and we are not getting anywhere. We can’t even get him out of his cell. He was in trouble all of the time. Will you tell us what to do? Will you tell me what to do?” She said, “Honey, I’m just going to come down there.” She got on a bus and she came to the Youth Center and when she got there she said, “I’m going to have to have some time with my son. Find me a place where we can talk.” Two hours later she came out and she said, “All right, here’s what you need to do.” She said, “He wants and he is willing to work for a degree. He wants to graduate. But he doesn’t want one of your institution diplomas.” I am wishing I hadn’t invited her. So we talked about that. She said, “I’ll even go to his principal back home and see what we can work out.” I thought if she could do that I could do my part. She talked to his
principal who is now superintendent at Junction City, Kansas. They agreed that if Cory would do the work and we would do it together, that they would give him a diploma from Junction City. Then his mom said, “Now he won’t remember all this for too long, so you might need to have him call me every now and then.” So every time Cory would forget what we had all agreed to, we would bring him in and say, “Get your mother on the phone.” A year and a half later that principal brought Cory’s mother and Cory’s grandmother and they came to the Youth Center and they even brought a cap and gown from Junction City. We gave that kid that diploma. Getting ready to come here today, I called Larry Dixon at Junction City who was the principal and I said, “Do you know how Cory is doing?” He said, “Jane, he hasn’t been in trouble.” And that’s been 20 years ago. He made it. Cory made it because I called his mother. I do believe that.

Now let me tell you about another kid. About five years ago I was working in an institution and this was a premier place in Colorado, in Denver. It was one of the first places where we had a mental health facility for kids who were adjudicated. There were 45 kids and we were told we could do whatever it took to help these kids. So we did all of our education stuff and we counseled those kids. One day, we let our very first kid go. His name was Danny. Three days after Danny left, they came and got me because it was late; it was like nine o’clock at night and I was the only one there who could go up front and talk to a parent. Danny’s mother was out front. Danny’s mother had been drinking. Danny’s mother had said she would not leave until she talked to someone in charge. Danny’s mother took hold of me and she said to me, “What am I supposed to do? He has been gone from you three days and I can’t get him up. I can’t get him to go to the school that you planned for. If you don’t do something, lady, I will lose my child.” Six months later Danny was dead.

That day I quit and that same day Barbara Huff called and said, “Would you consider taking my old job? Would you help families?” That was bigger than I was and I said, “I don’t know, but I will do it if you will help me.” So then I started in Kansas with people like Leo Herman, saying, “How about families? What can we do?” We have spent many years. Barbara started working with the Youth Center in ‘88, so we have been at this for a long time. We have a history of “sometimes we are pretty good and sometimes the word partnership may be too rich for what we are doing together.” When Leo joked and said, “Too close and too far,” that may well describe our whole relationship.

I think because our families who deal with the Youth Center, who cope when their children are incarcerated, when judges own their children – I think what keeps us from doing more is not what the institution does, what the institution tolerates: It is what families feel, the fear they feel, the tension, the anger, and the pain in even trying one last time to claim their children. When I am asked to talk to you about what makes us unique, I believe that the only common ground between Dr. Herman, his boss, and myself is that we all three have children who we really love. And we are, in the end, parents together. I believe that collaboration with parents is the most natural act that we can engage in. In fact, there is no other act to change the lives of children.
I was asked to talk to you about things that we are doing. About a month ago, when this conference was planned, we had a real hard time deciding whether we should come and talk to you about our partnership or not. Because staff had changed, and so oftentimes the very partnership itself depends on the relationship one or two people have made. The staff person who worked for Keys had left. Different people at the Youth Center. So when they asked us to be on this panel, I said, “We can’t. We are not in a place to do that.” Almost a week later, Leo’s boss called me and said, “Could we talk about this?” So Leo and his boss came to Keys, and said, “What about families?” Is that like good or what?

We have been to a place where both Leo and I have met and we have met with families and both of us have read grants and agreements from years past (starting with Barbara) because we didn’t trust each other very much and we didn’t know who was supposed to do what. Then we went through a spell where they decided if we wanted to do families, they would say “hands off” and we could do it. That did not work. So as of about three weeks ago, we are recommitted and we are here today to recommit to working better, more seriously, closer with each other and with families. We have made some new agreements. We are going to re-establish, reaffirm, and push that monthly meeting with families. We are going to re-advertise it; we are going to do this the first Saturday in May, an orientation for all families and do tours and do the whole thing and let families see where their children are. We haven’t done that. We are also aiming to do a family conference this summer where we bring families to the Youth Center. We are beginning to talk about putting a family person on site to attend those training meetings, to help with orientation when the kids first come. We are also planning to do some audio conferences so that families can have an hour with the program director, Leo, or the superintendent to talk about visiting, what about telephone calls. Anyway, we are here because we have made a new commitment to do this in more depth than we have done before. I think your invitation to us to do that, in part, is responsible for helping us look at what are we doing and what are we doing it for. Thank you.

Barbara Huff: Thank you. We have seen a broad range of different kinds of partnerships. I think none of them are probably without some struggles. I appreciate the honesty of everybody to be able to say that, because this is not easy work. I think at this point we would like to turn it over to you and I’ll just kind of facilitate and allow people to come to the microphone and ask questions of any of our panelists this morning.

Conference Participant: I am from here, about 65 miles down the road. I think it is really great that the judicial system is starting to work with parents. As a recipient of services that I’ve heard talked about so much in the last few days, I can’t emphasize enough the impact it has on the collaboration piece. Right down to when my son was first coming home for visits, I could take him out of the facility and have him for two or three hours. It wasn’t really fun sitting in the car in the rain but we were together. When it got to where they gave us passes to go to the show as a family, we needed to learn as a
family how to do things differently than we had done in the past. When here is a family in recovery, and so many times people don’t understand that parents don’t know how to do their families different. So when we are able to work together we can all learn, we can learn how to do things not to get arrested, how to get off the system, how to be functioning and self sufficient. It is just a really great piece. I am sorry it has taken our country so long to get this piece together, but it just works so well. In financial terms, I’ve had people say, “Well, it is really expensive for the treatment and the wraparound services,” but hey, it costs a lot less to have some help for my family for a year or two than it would keep them in prison for years, and your cars are all safe now from the car thief. So I commend you all and thank you.

**Conference Participant:** One of the problems when a child is placed in detention is that they oftentimes get behind in their studies or kids aren’t graduating, from what I understand. I know what we are doing in our area. I was curious what you are doing in yours?

**Leo Herman:** That is a problem and maybe Jane could talk about it more than I could since she was the principal of the high school. But ours is more of a long-term program and every student or kid that we get at the Youth Center in Topeka is involved in six hours of schooling during the day. We graduate with high school diplomas approximately 45 kids a year, and we put out about another 100 kids a year with GEDs. But you have just got to very quickly get on with their education. Most of the kids that we get I think are about three years behind academically because of problems adjusting to the school. So we see a lot of growth very quickly because they are finally in a very structured kind of situation where they can focus more on their studies. The beauty of it is with a lot of the kids that we see, that it is the first time in their lives that they have succeeded academically. That really does help with their self esteem to be able to learn how to read, to be able to get high school credits, or to get the GED. We have a formal graduation ceremony about three times a year in which we put our students in caps and gowns and we give them formal diplomas and we invite their families in to take pictures and they bring them graduation cakes. We try to have a special day for them. Jane, is there something you wanted to add?

**Jane Adams:** The institution schools in Kansas are sound. It is the schools that kids end up in between beginning court holding and those detention facilities. This is going to be a new initiative for us this year. We need to look at those kids who can spend 45 days in one program, move to another program, and do 50 days or 10 days; those kids are in school but they are earning no credits because those credits don’t transfer. They are twice, three times defeated because what they do in school they don’t like much anyway, and it is then good for nothing. So an initiative for our agency is going to be to look at the accumulation of credits. They are forced to go to school but they don’t get credits from those short-term detention facilities. So I hear you, I really agree with you.
Conference Participant: One of the things that our special ed department did is that in every school, the computer is basically available to special ed kids. They took a program and networked it, so that no matter where the children are, the studies go with them, so there is a continuum to it.

Jane Adams: Where are you from?

Conference Participant: I am from Moorhead, Minnesota. It costs the school system a lot of money, but it is well worth it if we get our kids graduating.

Jane Adams: I would like to talk to you.

Conference Participant: I am from the Lake County, Illinois area and I am a parent who is a family facilitator for wraparound. This is a statement, or a story, or a question, directed to the judicial system. I just had an experience that was such a true collaboration of the family, the school, and the judicial system that I just feel I’d like to share it. We have a principal of a high school that will go to court with the child. What happened was, we met, with me as a facilitator, the parent, and the school principal. We came up with a plan to ask for in the court system. We went to court with this child -- juvenile court -- and the principal asked for many things, including even that the court order this kid to undergo a psychiatric evaluation. All of the things that the principal asked for, I have a feeling that the kid would have gotten off a lot easier if the principal hadn’t come and asked for these things. “Be in school every day,” number one, “Be there on time,” a bunch of different things. But I just wanted to share that as such a wonderful example of collaboration. I am wondering if this is the only principal in the world that does this, or have you heard of this going on, this type of collaboration?

Leo Herman: I think the answer to that is no.

Conference Participant: Is he the only one? At any rate, if he is the only one, I think I am glad that I shared this because it was wonderful. The mother in this family actually was able to ask the court system for what types of probation she wanted for the kid through the help of the school and wraparound. I just thought that was so exciting and wonderful.

Conference Participant: I would just like to make a very brief comment that emphasizes a comment that was made by Leo Herman on the panel. That he was doing what he was doing because it was morally the right thing to do. I am personally getting real tired of people who follow the letter of the law. I think that I just wanted to put that out there and say that I really appreciate you using that language.

Leo Herman: Thank you.
Conference Participant: I am Cheryl Honey with the Family Support Network of Washington and I thank every one of you for sharing today. I learned so much from you. I can’t emphasize enough the importance of the coming together of the judicial system, the law enforcement system, mental health, especially. I run into families on a regular basis that are so stuck and feeling so victimized and so isolated that they don’t know where to turn or what to do. A couple of points that you made are so important. It is obvious you were able to listen through the ears of a collaborative partner that you had and able to get connected to a partner with the school. But as funding begins to decrease, we lose the legal services to help families with their youth. The schools are at capacity and they don’t know what to do with these kids. I see the money transferring over to build bigger detention centers, more prisons. I see mental health rolls dropping clients and consumers off. My fear and my hope is that we can build conferences around these issues so that we can begin to build solutions that will empower families and communities to build and support families.

I have a family with me today in which the son has just recently been let go, two days ago, from a second charge. He was in jail for three weeks. They were concerned about letting him out for the same reasons you said. These families are not so concerned about when are you letting my child out, but how can we get him the help that he needs in order to be able to live a productive life. If anyone in here shares that, I would recommend and encourage them to contact the Family Support Network. There is information out in the table in the foyer. Give us a call. I would start compiling -- or -- Barbara Huff, do you have a location where families can start connecting, especially around this issue with their children in jail or juvenile justice that we can begin to start talking?

Barbara Huff: We don’t have that formalized, but we have three things that are happening for us. We have our first steps into the door of OJJDP [Office of Juvenile Justice and Delinquency Program] in Washington and then we have our first newsletter coming out that is solely devoted to the issues of juvenile justice. That will be out in the next month. We have a diversity committee that is a board appointed committee for the Federation. They have a sub-committee called the Juvenile Justice Committee. These are family members who have an interest in the juvenile justice system mostly because their kids have been in it or they are advocates for whatever. That committee has overseen the newsletter. It is also a committee that I think would be looking for a bigger role within the Federation. But we are just new enough at the juvenile justice arena, I’m not sure they know, they haven’t really decided on what they will do.

Conference Participant: I know the diversity in the room geographically is very broad and there have been innovative programs or trials going on, and to have a place to share that information and get connected to one another is going to be very exciting.

Barbara Huff: We would be happy to share it, at least through our chapters who then get information out. If someone sends us information that is useful, we have the ability to get it out. Between the two us maybe we can come up with something.
Conference Participant: I wanted to go back for a second to the question that came from Illinois about “are there other places?” There are other places. They are few and far between, but there are other places. The reason why there are other places is really important. In those school systems where people really feel some ownership and commitment to kids, and where they don’t see pushing kids out or getting kids arrested or getting kids institutionalized as ways of getting rid of them, there have been places that will go with kids and families. At the same time, what Jane was talking about in terms of Kansas, which is the issue of what happens to kids in detention, my own sense both as a parent as well as what I have seen in other detention facilities is that’s what goes on across the country. When people complain that kids are truant and then they arrest them, and what do they do? They don’t teach them or if they do teach them, what they don’t do is they don’t let the kids accumulate the credit. That in part reflects, I think, a lack of commitment, both within educational systems that still have an obligation to these kids, as well as within the juvenile justice system to do anything. All people want to do, in large part, is manage the kids rather than see what the mother that Jane talked about understood about with her kid, which is the fact that her kid did have some goals. I think what we need to do is really think and build within our own communities, within our own school systems, and within other systems, that commitment that does not see the fact that a kid is leaving temporarily as bailing out on the kid, but rather just a different level of obligation.

Barbara Huff: Thank you, David. I appreciate that. David’s wife Trina works in the Federation office and they have a tremendous commitment between the two of them to helping to change the juvenile justice system in a coordinated effort across all systems. So Trina is sort of our in-house expert on juvenile justice. If anybody wants to make contact with her, that might be an opportunity as well. Yes?

Conference Participant: Thank you. I have a couple of different things that I would like to ask and then share. Just recently Mary Evans was at our Child and Adolescent Mental Health Conference held in Colorado Springs. I took on the role there of interviewer for our newsletter as to what people wanted. Regardless, I had asked her as a final question in the interview, “What do you see as the most important step that we can take to decrease the stigma around mental health issues?” I believe that we are, as a nation, beginning to see what it is and that is getting our stories out. And what she had said was if the people, actors, actresses that have names around this were to share their own stories, that would be a big help. I encourage that type of effort. We are already seeing commercials late at night on these issues. But I was wondering about the technological aspects of networking and how we can increase that. I know that we have vast resources with our computers now and I don’t see any reason why we can’t network and share among each other. Do you know of a way to put that point out?

Barbara Huff: I totally agree with you. We have a tremendous amount of technology and I would like to visit with you about that later. I also want to make a commitment to
people that don’t have access to it as well. I think that sometimes it can be fairly exclusive instead of inclusive.

**Conference Participant:** I am a parent, and I didn’t realize this was such a wealth of professional folk and parents. I am with the Family Support Network of Washington and my son has just gotten out of jail. When I spoke to the prosecutor she said, “It is not a mental health issue, Mrs. G.; it is about the fact that he committed a crime.” I just wish I didn’t have to be here right now, doing this. That’s the reason I started. But I guess everybody has a purpose, right, and my son’s illness and our situation has been my purpose. So I really do want to say thank you; thank you very much for the work you are doing, all of you, and I am very, very happy to be here, although I didn’t know it was going to benefit me in such a way.

**Barbara Huff:** Thanks for sharing. And you are right about the signs. I mean, if there are probably two people that know about that, it is this collaborative team here; all of them probably do, but I’m sure that you see it in your communities and neighborhoods like never before, noticing those early signs, don’t you?

**Conference Participant:** Two things, very quickly. In November I was at the national CHADD [Children and Adults with Attention Deficit Disorder] conference in Washington and for the first time they are addressing the juvenile justice issue for children with attention deficit who make up a large proportion of the kids in the system. They did a half day professional workshop with juvenile judges and lawyers from around the country. It was so popular and well attended that then the parents demanded it be repeated in a regular session for the parents that was well attended. They have just set up a juvenile justice sub-committee also as you have. Is it possible -- do you collaborate at all with other national support groups?

**Barbara Huff:** Yes, we are on the Consortium for Citizens with Disabilities which is 148 organizations representing disabilities. Those are two of the really active ones as well, so we sit side by side in meetings weekly.

**Conference Participant:** My other thing is my son is 21 now; he has Attention Deficit Disorder (ADD), and he went through problems with the law too, and he was convicted of a felony when he turned 18. That put him in prison for a year and a half with people 20, 30 years older, lifers. Nothing therapeutic came out of it at all. You know, for these kids with ADD, the national researchers say that they are like an average of 30 percent below their chronological age in maturity, you know, they are functioning like a 14-year-old and then they are put in prison at 18. It is too bad there can’t be somewhere in the interim between 17 and 21 to put them where they could get some sort of rehabilitative help that they are not getting in the adult prison.

**Barbara Huff:** That’s right.
Conference Participant: My son came out of prison before he even turned 21.

Barbara Huff: I think we all agree with that because we all know the maturity level of kids is low. That is very problematic, isn’t it? Thank for your comments. I would just like to end this by thanking these wonderful teams of people. I want to finish it with a very quick story about my colleagues to my far left from Kansas. A little bit about one situation that happened back in my days with Leo, to tell you just how committed I am and how unusual this is and how committed I think they are. When we first started this collaborative process, his boss was the most scared human being you have ever seen, wasn’t he, Leo? He shook.

Leo Herman: He wasn’t the only one.

Barbara Huff: They both shook. I wasn’t going to say it, but they had never met, I don’t think, with an advocacy organization like Keys for Networking and they weren’t sure what to expect. It was very scary. His boss called me every single day for weeks as we were kind of putting together this first meeting. So the family members met with me and then we set up a meeting with our staff. We set up a meeting to begin to lay out what the difficulties were with the Youth Center, after having three or four meetings of discussion. One of the family members, (after trying to build all the trust level with Leo and his boss, saying that this all was going to be fine, there was nothing to be scared of, this was all going to be fine), one of the family members called the press. You remember that, Leo?

Leo Herman: Yes, I do.

Barbara Huff: The whole collaborative relationship stalled all over again. They started all over again. These relationships don’t just falter a bit once. You know, we have to be ready, especially in juvenile justice who have never done this with us as a partner, that it is going to falter and falter and falter. But somebody decided we could get over the deal with the press coming. This was all over TV that night. All the problems that we had identified were on public television. So for them to even think they were willing to start over when Jane got there, because that was about the time I left, I thought, “I think I will leave town now.” So I give them much credit for having the stamina to start this again and again.

As Jane described, this has not been without problems and issues. So as people deal with this, I mean juvenile justice is the newest, so they are kind of getting it today, but as people deal with it, with community partnerships like these two have, there will be problems. And the one thing I have noticed in knowing Cheryl and CarolAnne is that these two people accommodate one another all the time. I just love watching what that looks like between parents and professionals. I also like what it looks like when family members are so committed to their communities that they find, when they are not there,
parents go out and find the police department; they make those partnerships. Thank you all for being here. Thanks for your attention through all of this and thank you, partners.
SECTION II

Summaries of Paper and Panel Presentations
The creation of the Child and Adolescent Service System Program (CASSP) in 1984 represented a new policy initiative by the federal government aimed at improving children's mental health services. Recognizing that many of the needs of children with emotional and behavioral disabilities and their families were not being met, CASSP initiated a family-centered approach to mental health service delivery. Knitzer (1993) described the resulting changes in the children's mental health field as a ‘paradigm shift.’ Involving parents as partners in the process and delivery of mental health services for their children is one dimension of this shift. Moreover, when services are family-centered, the role of consumer satisfaction with services provides an important component of program evaluation (McNaughton, 1994).

Assessment of consumer satisfaction with children's mental health services, as a component of service evaluation, has been described as being in its infancy (McNaughton, 1994). Young et al. (1995) point out that “there are no extensive discussions in the literature about the ideal role of children's mental health services consumer satisfaction data, nor are there any accounts of consumer satisfaction data being used to make practical changes in programs or services systems” (p. 235).

Like many constructs in the human services field, consumer satisfaction with service delivery is difficult to assess. Satisfaction measurement has been criticized for a number of reasons, including lack of construct specificity and extensive socially desirable responding (Stüntzner-Gibson et al., 1995). Moreover, the relationship of satisfaction to other components, such as treatment effectiveness, and the sensitivity of satisfaction instruments, as well as the lack of psychometric properties of satisfaction scales, may confound the role and measurement of consumer satisfaction. Additionally, issues specific to measuring children's perceptions of satisfaction can also confound their assessment of satisfaction with services.
Service providers should understand the various kinds of problems that can encumber satisfaction measurement and that, historically, these problems have skewed consumer satisfaction distributions, possibly making consumers appear more satisfied than they actually may have been with programs and services. Further, overall positive findings may limit the desire of program managers to probe into the consumers' actual experiences with the program's services. However, it is important to recognize that information from the consumer can provide valuable insight about the perceptions of children and families utilizing mental health services -- information that may not be uncovered otherwise.

A number of measures of service satisfaction are evident in the children’s mental health services literature (see Nicholson and Robinson, [1996] for a review of some of these instruments). However, because no standardized measure of satisfaction with children’s mental health services exist, there has been a tendency for researchers and service providers to develop their own questionnaires (Heflinger, 1992) and, to date, the majority of studies are based on instruments whose psychometric properties are unknown (Young et al., 1995).

While acceptance of the role of consumer satisfaction has gained momentum, the parallel activities of developing models, instruments, and methods for measuring satisfaction have not kept pace. Adoption of the construct has outstripped the research realities for how best to assess the level of satisfaction with services and its role in providing feedback to program staff as well as external audiences. In a review by Nicholson & Robinson (1996) of 12 instruments to measure satisfaction of mental health services used in the children's mental health field, only two scales reported psychometric properties available for inspection. Additionally, many scales are adaptations of the scale developed by Larsen et al. (1979) that measures adult perspectives of satisfaction with mental health services, and have not been tested in the children's area.

There have, however, been some notable exceptions in the measurement of satisfaction of services for children and families involved in children's mental health services. Among these is the work conducted as part of the Ft. Bragg Child and Adolescent Mental Health Demonstration (Brannan et al., in press; Heflinger et al., 1996; and Bickman et al., 1995), where a model of satisfaction was theorized as being determined by factors both internal and external to the services received. The scales developed for this project acknowledged that both global and service-specific factors of satisfaction should be assessed.

Today, families are getting more involved in their children's mental health services. They are also becoming increasingly vocal in expressing their needs to service providers (Northrup et al., 1994). Developing and utilizing effective methods for including and valuing the family's perspective can provide insight for practitioners into the nature of the services they deliver. Consumer satisfaction is only one type of program outcome, but is a necessary component of program evaluation. Service providers must understand that there are many components of, and purposes for, service and program evaluation.
Measuring consumer satisfaction with services is one of several developing service assessment strategies playing a vital role in the ongoing development of the children's mental health field.

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Respite care is one of the most popular support services for children and families caring for a challenging child or adolescent. However, there exists little research to document its impact on children and families in general, and no longitudinal research studies investigating outcomes for children experiencing emotional and behavioral disturbance (EBD) and their families.

The Vermont Family Services Study (VFSS) represents the first controlled, longitudinal research study to investigate the impact of respite care on children experiencing EBD and their families. Conducted out of the University of Vermont Department of Psychology, the Vermont Family Services Study (VFSS) interviewed 45 families who received an average of 102 hours of respite during the six-month study period (the Respite group) and 28 families assigned to waiting lists (the Comparison group). Parents and children in both groups participated in two interviews: a baseline interview when they applied for services, and a follow-up interview six months later. In each interview, parents were administered standardized measures of family functioning [the Family Assessment Device (Epstein, Baldwin, & Bishop, 1992)], caregiver stress [the Impact on Family Scale (Stein & Reissman, 1980)], general life stress [the Hassles & Uplifts Scale (DeLongis, Folkman, & Lazarus, 1988)], and child behavior [QAIC: the Quarterly Adjustment Indicator Checklist (Bruns, Burchard, & Froelich, 1998)]. In each interview, children were administered a scale of life satisfaction [the Perceived Life Satisfaction Scale (Adelman, Taylor, & Nelson, 1989)]. Finally, both parents and children in the respite
care group were administered respite satisfaction measures and provided feedback to open-ended questions about respite.

Families with children experiencing emotional and behavioral disturbance who were referred to respite care services were found to be among the most challenged of those served by Vermont's system of mental health care. About half the families had a total family income of less than $15,000, half were headed by single mothers, and 23% had required an out-of-home placement for their child in the past year. Yet, those who applied for the service were likely to receive no additional or very few additional mental health services. In addition, despite the fact that over two-thirds of the sample's families cared for a child with EBD under 12 years old, 57% received no child care or day care services because of their child's degree of behavioral challenge, their low family income, or both.

Parents and children receiving respite services generally rated themselves as being “satisfied” or “very satisfied” with the service. Seventy percent of families stated they thought respite helped their family “very much” (the highest rating possible). Ninety-three stated that, in comparison with other mental health services, respite care was “very important” (again, the highest rating). However, both parents and children reported less satisfaction with the flexibility of scheduling and number of hours of respite they receive than with other aspects of the service. These findings are in line with previous research that has documented that respite care is the most often-sought mental health service for this population. Finally, results showed that parents' overall satisfaction with respite was best predicted by (1) the perception they were involved with the service, followed by (2) high satisfaction with the flexibility of the service, and (3) high satisfaction with the training and skill level of workers. Children's satisfaction was best predicted by (1) the perception they could talk openly with their workers, followed by (2) the feeling that the worker would “stick with them no matter what” (unconditional care), and (3) high satisfaction with how well they got along with their workers.

There existed several positive outcomes for families who received respite care compared to families who were placed on the wait list. First, Respite families were forced to place their child in costly out-of-home placement significantly less often than wait-listed Comparison group families during the study period. Second, Respite group families rated their chances of needing placement in the future as significantly lower than wait-list families. In other words, parents who received respite were more optimistic than Comparison group families, even after controlling for their previous use of out-of-home placements. Third, parents who received respite experienced a significant decline in personal strain as measured by the Impact on Family Scale, in comparison to parents who did not receive respite care. Finally, parents who received respite reported lowered incidence of one subscale of negative behaviors -- “Community Externalizing Behaviors” (e.g., Truancy, Substance Use, Police Contact) -- on the QAIC, in comparison to Comparison group families.
Analysis for the areas of family functioning, parents' perceived general life stress, overall child behavior, and child-reported life satisfaction demonstrated no statistically significant differences between the Respite group and the Comparison group. Such null results may have been obtained because the respite intervention was not intensive enough at its current allotment per family to impact on these areas, or because respite services should not be expected to impact on these difficult-to-influence outcomes. However, such findings also may have resulted because the sample size of the study was too low to detect differences between the groups, or because the measures used were not sensitive enough to change over a six-month period.

Analysis of family and service variables revealed interesting relationships between service characteristics, parents' satisfaction, and outcomes. Most interestingly, a consistent association between the number of hours of respite received and outcomes was found, in which more hours per month, and more total respite hours over time was associated with better outcomes in areas such as parents' stress and parents' optimism about future out-of-home placement. In addition, parents' ratings of satisfaction with the flexibility and availability of respite care was found to correlate positively with better outcomes over time, even after controlling statistically for the number of actual hours of respite a family received. Interestingly, other domains of parents' satisfaction, such as the implementation of respite (e.g., workers' training and skills), were found to not be associated with outcomes. These results suggest that the impact of respite care may be linked most closely to both the intensity of the service and the degree to which the service meets the family's reported service needs.

Overall, the major outcomes of the Vermont Family Services Study are encouraging in an area of research where encouraging results are difficult to obtain. There is evidence that parents who receive respite care are very satisfied with the service, and that their increased confidence around caring for a challenging child may allow them to continue to care for that child at home. There is also evidence that respite may result in significant reduction in the perceived personal strain of caregiving for a challenging child. Yet, if other goals for the service are to be met (such as improved family functioning or reduction in child negative behaviors), a more intensive services experience may be required for the family. Increased intensity of respite services may include more respite hours, concurrent additional services, such as parent coping skills groups or support groups, or both. In support of this conclusion are four pieces of evidence: (1) When surveyed, Vermont parents and children continue to report that more respite hours would make a bigger difference for their families; (2) Analyses from the present study suggest that better clinical outcomes may be associated with increased respite hours per family; (3) Families' satisfaction with the availability of respite was positively associated with better outcomes in several areas; and (4) Previous research has shown that increasing the number of respite hours per family plus adding additional support services has resulted in significantly better clinical outcomes for families than respite care services alone (e.g., Singer, Irvin, L. K., Irvin, B., Hawkins, & Cooley, 1989).
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Title: Respite Care for Families Adopting Children: Public Policy Challenges and Solutions

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What is Project AFIRM? Project AFIRM (Adoptive Families Individualized Respite Model) is a three-year federally funded project to support families that adopt children with special needs. Our purpose is to develop a model to assist families to plan for respite, to assist respite providers and families to work better together, and to identify public policies and agency practices that support families. Our activities include: (1) policy and advocacy for respite care and special needs adoptions, (2) collaboration with families, (3) developing a model for individualized family respite planning, (4) developing curriculum for respite providers, (5) training of individual respite providers, and (6) training of trainers.

Project AFIRM begins with core values:
· We believe that families want and need very different kinds and amounts of support.
· We believe that these needs change over time.
· We believe that families are the best judge of the supports that they need at any given point in time.
· We believe that for many families, part of the support needed at any time is respite care.

What is respite care? We define respite care as any temporary, short-term care to persons with disabilities or other special care needs, or someone who is at risk of problems such as abuse, neglect, or residential placement. The primary purpose of respite care is to provide relief to the family.

Depending on family need, respite care can take on many forms, but it must always reflect three ideals: (1) Respite care is family focused; (2) respite care is planned and proactive; and (3) respite care involves an array of options. That is to say, the entire family may benefit (not just the individual with an identified disability), and the family can best identify needs. Respite must not be limited to or take the place of crisis intervention; it should be a planned, coordinated, on-going activity. Different families will want different types of respite at different times. There is no “one” type of respite.
What do adoptive families say about respite?  In our conversations with families who have adopted children with special needs, in focus groups we have conducted, and in the literature, the messages from families about the role of respite are clear and consistent:
“Did we need it? You bet we did!”
“The respite program is a tremendous asset.”
“Respite gave me and my child a break.”
“What a difference respite makes!”

What are the challenges we face nationally?  At the national level, we have found it very difficult to review the current status of respite care, especially as it applies to adopted children with identified special needs.  We have identified seven barriers to conducting a national analysis of public policy in this area:  (1) lack of good national data, (2) no uniform definition of “special needs,” (3) vagaries of public/private partnerships, (4) cultural differences, (5) short-term successes of pilot/demonstration projects, (6) isolated islands of excellence with little or no national literature, and (7) state to state differences create inequity and problems for mobile families.

What about the Adoption Assistance Program?  The Adoption Assistance Program helps, but still presents challenges.  Adoption subsidies are designed to find good homes for challenging children in foster care, but there is little “infrastructure” for respite and other types of family support.  For example, families may take on the task of parenting a child with significant problems without adequate access to trained respite care providers.  For children with serious behavioral problems, almost every community has a severe shortage of affordable, appropriate respite.

The current Adoption Assistance Program faces four challenges: (1) Workers are inadequately trained to understand the issues and available resources, (2) there is insufficient quantity and variety of families, (3) there is a heavy reliance on Medicaid, and (4) access is restricted for private agencies.

Recommended Policy Changes:  Based on our analysis of the current challenges facing the system, we propose the following policy changes as steps toward a social solution:
1) More flexible boundaries between agencies.
2) State-wide family support services across age and disability type.
3) Broader access to Adoption Assistance subsidies.
4) Requirements for front-line staff and supervisors to have a working knowledge of family support values and practices and of community resources.
   · Federal incentives for family support services to decrease the inconsistency across state lines.
   · Balance reliance on Medicaid with other payment options.

Children are caught in broader, over-arching social problems.  Ultimately, the fate of adoption respite is inseparable from larger societal pressures including the federal budget,
current efforts at welfare reform, the present tax code, and the debate over federalism vs states’ rights. The final resolution of these issues may affect adopted children and their families more than any narrow changes in the Adoption Assistance Program.
When our parent questionnaire was developed, it was anticipated that families would check off responses on the structured response questions and that a few parents might elect to provide some narrative feedback. When the completed parent questionnaires were returned to the Department, the time and effort that parents made to freely and comfortably write about their experiences with the Family Support Program were impressive. Families provided a wealth of qualitative data on which to evaluate the experiences of families with this program. Part of the surprise was due to the fact that the complaint people frequently make in this era is that they are too busy. The families we surveyed not only are as busy as any other family, but also must include in their daily schedule the support and caring for children with serious disabilities, and in some cases must cope with the reality that their child is terminally ill. As stated by Linda Brown, parent of a child with developmental disabilities, in her address to the Wisconsin Family Support Conference in June, 1984, “...we families deal with things most families never even have to consider: occupational, physical and speech therapy; special feeding techniques, utensils and foods; special equipment like wheelchairs, bolsters, wedges, seats, splints, braces and hearing aids; life support equipment like oxygen, apnea monitors, ventilators, nebulizers and compressors, various tubing, trachs, trach masks and suctioning equipment.” These are families who experience stress factors far greater than the “average” family.

Based on the comments and experiences that families have shared through their surveys, those elements and qualities that define what constitutes a high quality, successful program have been defined. One outcome families desire is to maintain as “normal” a lifestyle as possible. Their interpretation of normalcy includes having the capacity to keep the family intact and to be able to participate in jobs and community activities and events just as any other parent might and for their child to have the opportunities and experiences of non-disabled children to the greatest degree possible.
Parents of children with disabilities need help and support to care for their children. They need the items or services that the program can purchase that they otherwise could not afford. But in addition to that, they need information about where and how to access services, supplies, resources, and providers, and information about the special needs of their children; emotional support and empathy; respite and opportunities to refresh themselves, revitalize their marriages, and spend quality time with their non-disabled children and others. The intensity of care required for children with serious disabilities necessitates greater need for respite care and “breaks” for parents to refresh themselves from the time-consuming and at times arduous efforts needed to provide the necessary care for children. While these tasks may be undertaken with the greatest love and patience, they still require much greater effort and add greater stress than most other parents usually experience. The frequently expressed concern about a shortage of qualified, capable respite providers is an issue worthy of exploring for viable solutions.

The support needed by families requires service coordinators who are available to families as needed, who achieve effective results, listen and understand, and display compassion and concern to families. The program that can provide this support to families will be responsive to the needs of the family as a whole; flexible in determining, arranging, and providing services; respectful to the wishes of the family; and supportive to the staff who work with families so they can provide the best assistance of which they are capable.

This evaluation has clearly shown that, overall, the Wisconsin Family Support Program has been highly successful at providing services and supports to families who have children with disabilities. While this success can and should be applauded, there were a number of issues identified through this evaluation where quality improvements are possible in striving for the greatest degree of excellence in serving these families.

Data indicates that the number of children living in the state Centers for the Developmentally Disabled has dropped dramatically (almost 83%) in the last 10 years. This clearly speaks to the need to provide support to families, as they assume the role of caring for these children who in earlier years had been relegated to state institutions and other paid professional providers. In 1994, 2,575 children were served through the Family Support Program within a statewide budgeted allocation of $4,339,773. While this is not a totally accurate indicator of cost or need since some families were only partially served, were this budget to be averaged over the children served, the average cost per child in 1994 was $1,685. The trend toward caring for these children in their homes and the need for family support is further supported by the fact that there were 2,445 families waiting for service from the Family Support Program at the end of calendar year 1994.

Families have stated that this program has enabled them to continue to care for their children with serious disabilities. It is hoped that information gained regarding the
essential elements of program success, staff qualities, areas for quality improvement, and coordinator training can be used to further develop and fine tune this program to continue its mission of serving families who strive to function well as a family unit to and provide the best care possible for their children with serious disabilities.
Increasingly, schools are being recognized as a logical place for identifying and planning services and supports for children with -- or at risk of -- emotional and behavioral disorders and their families. In Hillsborough County, Florida, school-based wraparound services were implemented in six elementary schools. These services feature Family Support Coordinator-Family Advocate teams, a multidisciplinary team planning process for family support plan development, and access to flexible service dollars to support implementation of family support plans. Preliminary outcomes and costs for this program were presented.

Method: The Family and School Support Team (FASST) has contractual obligations to provide a description of the children and families served, the services provided, and to assess outcomes. While these data serve an important accountability function to the funders, program managers and staff were interested in selecting measures that would support program development and clinical practice. A participatory approach, involving FASST program staff, managers, and doctoral students, was employed to clarify ways in which data could support program development. Efforts of the FASST program staff and university consultants led to the incorporation of standardized measures into intake and case review processes to inform clinical decision making, as well as to serve the evaluation needs of the program. In the future, standardized measures for all children will be collected at the time of enrollment, six months later, and at discharge. These procedures were not fully in place at the end of the second year of program operation, hence, the smaller number of children for whom data are reported. While 103 children received services in the 1995-96 fiscal year, the present report is limited to discussion of those children who received at least six months of services (N=51).
Child and family characteristics: The majority of these children were white, non-Hispanic (55%) males (78%). At the time of the initial staffing, the largest group of children served was in the first grade (21.6%), although children may be staffed at any grade level. Most of the children (79%) received free or reduced lunch in school, an indication of economic need. Although many of the children in FASST are enrolled in special education, only 20% are in settings for those identified as having emotional handicaps.

The children presented some very challenging behaviors and functional impairments at home and in school. Parents (64%) most commonly identified externalizing behaviors as being an impetus for referral. Similarly, school personnel identified non-compliant behavior (62%) as the most frequent reason for referral, but academic risk factors such as being below grade level (42%), were also common referral reasons. Attendance was also a concern, with the average student missing over three weeks of school (16.2 days, range 0-55 days) in the year before enrollment in FASST.

To obtain an idea of problem behaviors exhibited at home and in school, caregivers completed the Child Behavior Checklist (CBCL) (Achenbach, 1991), and teachers reported on school behavior with the Teacher Report Form (TRF) (Achenbach, 1991). Both parents and teachers identified approximately two-thirds as falling in the clinical range on the Total Problem T-Score, an indication of need for mental health intervention (See Figure 1). Consistent with the concerns noted by referral sources, the majority of children displayed externalizing behaviors both at home and in school. Substantial proportions, however, also scored in the clinical range on the Internalizing T-scores (See Figure 1).

Figure 1
To ensure multiple perspectives of the children, FASST Family Support Coordinators completed the Child and Adolescent Functional Assessment Scales (CAFAS) (Hodges, 1995). Family Support Coordinators were more positive about the child’s functioning than parents and teachers but did indicate that at least 30% of the children experienced moderate to serious impairment in age-appropriate role performance (48%), behaviors towards others (29%), and in moods/self-harm (30%). FASST staff also reported that many of the caregivers were able to provide materially for the children, with 70% evidencing no or mild impairment in this area. Providing a nurturing home environment with adequate family and social supports appeared to be more challenging, with 50% of parents experiencing moderate to serious impairment in this area.

**Service utilization and costs:** The two mental health agencies that deliver FASST services provide most services (50%) in the home or at school. Services provided included case management and family support (42%), in-home therapy and respite (39%), clinic-based therapy (18%), and psychiatric services (1%). In addition to understanding the types of services provided and the locus of services, program and evaluation staff were interested in understanding to whom and in what proportions services are provided.

Patterns of utilization revealed that 66% of case management, clinical, and supportive staff hours were devoted to 26% of children and families. This pattern was remarkably consistent across the six schools. This analysis included only services provided directly by the FASST program and it is likely that this analysis underestimates total service utilization across child-serving systems to which the child and family may have been referred. The annual program cost per referred child was $5,300. However, this figure overestimated the cost of services since the program is family-focused and family members derive benefit, though they are not necessarily ‘billable’. When caregivers and siblings were accounted for in deriving costs, an estimated 220 persons were served, and the cost fell to $1,281 per year.

**Child and family outcomes:** Changes in functioning at home and in school were assessed using the Parent and Teacher Rating Forms (FMHI, 1995). The results suggested parents felt that their child’s behavior had improved at least slightly since the onset of FASST services. Rated on a six-point scale from ‘no improvement’ to ‘greatly improved,’ the majority of parents reported that their child had made at least modest gains in behavior at home, in the child’s ability to get along with other family members, and in increased self-esteem. Teachers also noted improvements with the child’s behavior at school, academic performance, self-esteem, and interactions with peers (See Figure 2.)

Changes in attendance, suspensions, grades, and out of home placements were other measures used to assess the impact of the FASST services. Examination of changes in attendance (N=14) between the year prior to enrollment in FASST and the first year of enrollment, show a decrease from an average of 18.1 days absent to 14.9 days, a positive trend. Suspension data were more difficult to interpret, because differences may be a
function of children getting older. In the year prior to enrollment, there were no documented incidents of in-school or out-of-school suspension. The following year, when children were first enrolled, four children were given in-school suspensions, and 18 children were suspended out-of-school with an average of 2.8 days for each event. Grade data, while difficult to standardize, show promise as well. Between the year prior to enrollment in FASST, the year first enrolled, and the following year (n=21), 91% of children improved in math and/or reading.

Importantly, children enrolled in FASST were maintained in their homes. At the end of the 1995-96 school year, most children (92%) still lived at home with their natural or extended families. Though 13% had been placed out of home into either foster care or other residential placement, some had returned to their homes by the end of the reporting period.

Parents (N=48) were asked to evaluate the extent to which their family’s strengths were considered in the planning process, whether they had adequate information to make decisions about working with the FASST team, the degree of participation in developing and implementing the family support plan, and whether their opinions were valued,
respected, and incorporated in the plans. Figure 3 shows the high level of satisfaction in these particular areas (See Figure 3).

**Summary and discussion:** There are obvious shortcomings to measuring the outcomes, primarily the relatively small numbers and the lack of standardized measures of functioning and achievement. These issues have been addressed through implementing standardized measures of achievement, symptoms and problem behaviors, as well as home, school, and community functioning which will allow for more precise reporting in the future. Nevertheless, the preliminary attempts to document outcomes show promising trends.

The participatory process of developing the evaluation plan, collecting the data, and preparing the evaluation report, highlighted several issues that affect continued program improvement. The ‘heavy users’ analysis which revealed that one-quarter of children and families accounted for two-thirds of staff time led to two issues which are now a focus of program planning. A focus of current discussion includes determining the optimal caseload mix, perhaps through a weighting scheme that balances ‘heavy’ versus ‘regular’ users of services, so that all children and families receive an appropriate degree of service intensity and staff availability. The second issue revisits the issue of whether the program is intended to be child or family centered service. In examining costs per child and per family member, the issue of ‘who is the client,’ that is, the unit of service question, was raised. While philosophically the program is intended to meet the family’s needs, funding streams still operate on an ‘identified child’ model which underestimates staff efforts with family members.

Finally, data and evaluation issues were raised. Specifically, it was important to program and evaluation staff that data elements be useful at the individual and program level, that they be reasonably easy to access, and that they be uniformly collected across the two agencies that provide services. The identified need for a broad utility of measures led to the selection of the CBCL, TRF, and CAFAS. For clinicians, these measures produce profiles that can inform the family support planning process. For managers, these measures provide description of children served that can be compared to similar programs elsewhere and are well documented psychometrically. The partnership of evaluation and program staff engaged in a continuous data review process and introduction of standardized measures has established a continuous feedback loop that informs planning for program improvement and service and support delivery for children and families.
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There has been little or no information published about the partnering of parents and researchers, although this partnering is no less important than the partnering of parents and providers. Parent-researcher partnering can be expected to improve the relevance of research by impacting the areas selected for research, the design and conduct of research projects, the interpretation of outcomes, and the dissemination and usefulness of the results.

Since 1990, researchers and program staff at the New York State Office of Mental Health have been establishing working relationships with parents. Some of what we have learned follows. The discussion focused on two federally-funded projects, an emergency services research demonstration, and FRIENDS, a services demonstration. Both projects are being conducted in the Bronx, New York. The former is a four-year study, examining the outcomes of three models of intensive, short-term, in-home crisis intervention services as an alternative to hospitalization for children experiencing a psychiatric crisis. FRIENDS is a project to ensure the provision of family-directed, integrated, community-based services for children and youth with serious emotional disturbance and their families residing in the Mott Haven community.
Following a description of both projects, evaluators presented a list of some commonly heard reasons why researchers may resist collaboration with parents. Common reasons include:

- It will mean more work to coordinate with parents;
- We don’t have any way of paying parents;
- We are afraid of confidentiality problems;
- We will have to train parents for this work;
- Parents are most concerned about the results; we can inform them at the end of the project;
- Parents seem to have a lot of complaints about professionals. We feel like we’ll always be under attack;
- Parents have too many other commitments and they won’t get anything out of this;
- Parents cannot be objective -- they are too involved;
- Parents don’t have evaluation skills; what role can they play?; and,
- We don’t know any parents.

Parent advocates then presented commonly heard attitudes or beliefs why families hesitate to collaborate with evaluators. These reasons include:

- We don’t understand the terminology evaluators use;
- We don’t feel like real partners;
- The evaluation team is pretty high-powered. We feel out of place;
- We don’t know how to ask researchers/evaluators to collaborate;
- There is a lack of compensation or the compensation is disproportionately low compared to others;
- We don't understand what’s in it for us?;
- We don’t have the right education;
- We believe that there must be a parent out there who knows more about this than we do;
- We have never had a job other than parenting and we are afraid;
- We are not experts;
- No one has ever asked us to work with them on an evaluation;
- There is a lack of or insufficient training and preparation for parents;
- We don’t have the time;
- Our priority should be providing advocacy to families;
- We know what works. Why do we need research and evaluation?;
- We are advocates; how can we work for the system?;
- Our families still go through tough times and we are afraid we won’t be able to fulfill responsibilities;
- Most evaluations don’t look at the things we think are important;
- There isn’t any job-security;
- We believe that this should be the role of statewide parent organizations;
- We need more money for services; why spend it on research and evaluation?
Given the hesitation on both sides, case studies were presented to illustrate how the collaboration developed and expanded over time.

In the emergency services project, parents were collaborators in a number of areas. These included participating in program development and grant preparation, assisting in project oversight as members of the project management team, helping to design and select measures, providing services as parent advocates, assisting in data collection, providing the data through interviews and focus groups, providing outreach and logistical support to facilitate data collection, and helping to disseminate information about the project. An example of a specific contribution was the Parent Resource Center's role in organizing focus groups to discuss the use or non-use of respite care by parents enrolled in the study. A parent was very helpful in this project through her partnering with data collection staff. This partnership increased access to families and improved the comprehensiveness and quality of the data collected. Now that the project is in its final year, parents will be collaborating with researchers in the interpretation of the project's results.

In the FRIENDS project, which is in an early stage of development, parents have recently begun to collaborate with evaluators. Examples of this collaboration are participation in the development of a spirituality questionnaire and a cultural assessment instrument. It was parents who advised the evaluators that spirituality was an important aspect of their lives that has an impact on how they cope with life stressors. Working together with parents, the evaluator was able to develop an instrument to assess this aspect of their lives. Parents will also be actively involved in data collection and have a lead role in project management.

Like many good things in life, parent-evaluator/researcher collaboration takes time to develop. Our experience, however, is that collaboration with family members enriches the capacity of research and evaluation to make a contribution to knowledge about the effectiveness of services for children with serious emotional disturbance and their families. Parents have unique perspectives that can and should influence the questions posed in research, how data are collected, the interpretation of data, and the dissemination and use of findings.

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Over 10 years ago Congress took action to address the problems faced by children with serious emotional disorders and their families: not enough services, especially community-based ones; inappropriate services even when available; and disproportionate allocation of resources to costly residential and in-patient care. The approval and funding of the Child and Adolescent Service System Program (CASSP) in 1984, with the aim of promoting system reform in children's mental health, was part of the federal response to these problems.

State and community-level reforms stimulated by CASSP are often organized according to the principles for a system of care proposed by Stroul and Friedman (1988). Despite the wide acceptance of these principles, and their importance as a value base for system reform, there have been few attempts to measure how they are put into practice and the effects of their implementation. This presentation described an attempt to operationalize and measure CASSP principles, focusing on the key principle of "comprehensiveness."

This attempt, and the research reported in this presentation, occurred within an evaluation of the Oregon Partners Project (or "Partners") one of eight projects funded by the Robert Wood Johnson Foundation's Mental Health Services Program for Youth in 1990 (Beachler, 1990). Partners featured specialized case management, used flexible funds and community-based services, and brought together mental health, child welfare, and public school systems in Multnomah County, Oregon, for interagency planning and fiscal partnerships. Partners aimed to build a children's mental health system of care according to CASSP principles.

Because Partners case managers focused on developing a comprehensive plan of care for individual children and families, and arranging, paying for and monitoring services (most of which were provided through contracts with community agencies), the evaluation research team was concerned about what reasonable outcomes of this approach would be.

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1 The evaluation of the Oregon Partners Project was funded by the National Institute of Mental Health, through the Oregon Mental Health and Developmental Disabilities Services Division; see Friesen et al. (1996) for overall findings from the evaluation.
Thus, the focus of the research was on the overall impact of the Partners intervention, measured by the extent to which Partners was successful in implementing CASSP
principles. Included in this evaluative approach was investigation of what the team called
*service fit*, i.e., how well children's needs were addressed by the services provided.

These needs are not unidimensional, and thus "comprehensiveness" refers to the
assessment, planning, and provision of services around a broad range of children's needs,
not just their mental health needs. Comprehensiveness was defined as consisting of
multiple domains that are building blocks for children's social, physical and emotional
development. The research team devised a spectrum of eight need areas shared by all
children: *leisure*, defined as time to relax, play, or engage in enjoyable activities;
*education*, knowledge and/or training provided in a school setting; *social*, developing and
maintaining healthy relationships; *health*, health care services to promote or maintain
children's physical well-being; *mental health*, services to promote healthy emotional
development and to relieve emotional or behavioral problems; *primary/basic*, good
housing, nutrition, clothing and safety; *facilitation*, things that help caregivers or children
use services, like transportation, coordination of services, advocacy or child care; and
*support*, services that provide relief and support. A general category (*other*) for other
potential needs identified by caregivers, such as legal or spiritual needs, was also
included.

The evaluation of the Oregon Partners Project was based almost solely on data provided
by the caregivers of children with serious emotional or behavioral disorders, in hopes of
reflecting the rich--and direct--experiences of families. In gathering information about
the services children received, research interviewers also asked about the more informal
activities children were involved in, such as hobbies, sports, clubs, church groups, and
art, music or language classes. These activities were considered as valuable in meeting
children's mental health needs as the more traditional services like therapy and
medication.

Two parts of the *Service Fit Questionnaire*, an instrument used in the evaluation, were
reviewed in the presentation: (1) a Services and Activities Matrix, and (2) a
Comprehensiveness Rating Table. Using the Services and Activities Matrix, caregivers
were first asked to list all activities and services their child had been involved in over the
prior six months. They were then provided with definitions of the eight need areas and
asked to indicate which needs were addressed by each activity or service in turn. Using a
four-point scale (from "not at all" to "a lot"), caregivers rated both how well each service
met the needs addressed by that service and their satisfaction with that specific service.
This idea for rating individual services came from parents in rural Idaho who worked
with researchers to recommend the best way to reflect their satisfaction. Finally, the
research team felt it was important to investigate the substantial family role in arranging
and providing services and activities for their child; therefore, caregivers were also asked
to indicate "who arranged" and "who provided" each activity or service.
Using the Comprehensiveness Rating Table, caregivers rated how well each of the need areas making up the full spectrum of their child's needs was met. The same four-point rating scale described above was used. Respondents were asked to think about the need areas one domain at a time, and to make their judgement in relation to the child's overall circumstances regardless of the services received. The table included space for interviewers to record (verbatim or paraphrased) caregivers' descriptions of the obstacles or barriers that kept their child's needs from being completely met for that domain. Thus, both quantitative and qualitative data regarding comprehensiveness were generated by completion of the table. To arrive at what the research team called "Comprehensiveness of Needs Met," or simply the "Comprehensiveness Score," ratings were first dichotomized (any rating less than "a lot" = 0; "a lot" = 1) within each domain and then summed into a single score, with a range of "0" (no needs met very well) to "8" (all needs met very well).

The presentation featured illustrative data generated from both the Services and Activities matrix and the Comprehensiveness Table, drawn from responses of a pooled, pre-intervention sample of research participants (n = 294). The selection of findings reflected the values inherent in this measurement approach, and included:

- **Percentages of children receiving formal and informal services, by type of service.** Informal services included family activities (28%), recreational activities (21%), church-related activities (19%) and clubs (16%). The highest percentages of formal services received included counseling (78%), special education (52%) and organized recreation (44%).

- **The average proportion of informal services addressing each need area.** Across the eight need areas, the proportions ranged from a high of 62% (checked as addressing leisure needs) to a low of 22% (mental health needs addressed by informal services).

- **The average proportion of services arranged by family members.** Leisure activities were the service/activity most frequently arranged by family members (68%), while facilitation services were the least (41%).

- **The distribution of caregivers' satisfaction scores, based on average ratings of individual services.** Keeping in mind the rating scale (1 = "not at all" to 4 = "a lot"), 75% of the respondents gave satisfaction ratings of 3.0 or higher.

- **Caregivers' average ratings of how well their child's needs were met across each life domain.** Not surprisingly, ratings were highest for the domains of primary/basic and health; social, mental health and support were the lowest-rated domains.
The distribution of caregivers' ratings of Comprehensiveness.

5.5% of the family members surveyed indicated no needs were met "very well," while an identical percentage indicated that all eight needs were met "very well." The bulk of the ratings were in the two to five needs met "very well" range, reflected in the overall mean of 3.8.

A sampling of caregivers' responses to open-ended questions regarding barriers to their children's needs being met completely in four specific life domains was also presented. In each case, interviewers categorized caregivers' comments into service system barriers or family situational barriers. The four domains reviewed for this presentation were:

- **Barriers to social needs being met completely.**
  Service system barriers included issues of appropriate assessment, planning and referral to services as well as issues raised by the service setting or quality itself. Comments about family situational barriers fell into categories of issues related to the child's behavior, choices or disability; to other family member's needs or family circumstances; and to the child's neighborhood.

- **Barriers to leisure needs being met completely.**
  Issues of accessibility and availability of appropriate activities and services, along with issues of characteristics of the services provided, were the primary perceived service system barriers. Family situational barriers again included issues of the child's behavior or disability, along with difficulties involving family finances and logistical arrangements, and problems or difficult circumstances within the family.

- **Barriers to facilitation needs being met completely.**
  The cost, availability and reliability of transportation; lack of knowledge of resources or inability to access them; and scheduling conflicts and time constraints were all family situational barriers identified by caregivers. Issues of availability of services and problems in service coordination were mentioned as key service system barriers.

- **Barriers to support needs being met completely.**
  The availability and adequacy of respite care, coupled with problems with lack of timely information about and referral to services, stood out as service system barriers in this life domain. Family situational barriers centered around the severity of the child's disability and the lack of support resources and/or the energy to use them.

The concept of comprehensiveness of needs met, the method of assessing it from a parent/family member perspective, and the Comprehensiveness score itself can have practical value to parents, service providers, program evaluators and policy makers alike. If parents can quickly assess how well their child's needs are being met in an overall sense, it can be a useful tool in advocating and planning for "whatever it takes" to meet those needs more completely. Identification of barriers, too, is a practical prelude to
eliminating them. Finally, changes in Comprehensiveness can be monitored over time as one measure of effectiveness, of a good "fit" between services and needs.

REFERENCES


Title: A Study of Satisfaction Ratings of Interagency Collaboration Among Parents, Youths, and Case Managers

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The study was designed to examine selected factors in interagency collaboration. Satisfaction rates among the participants were calculated to distinguish the reasons for their satisfaction or dissatisfaction. The research study’s design replicated previous studies of interagency collaboration (Burchard & Schaefer, 1992).** The study built upon Burchard and Schaefers' (1992) research into evaluating systems of care and interagency collaboration by expanding the sample to include children who have been referred for interagency collaboration through more than one source.

The present study surveyed 35 youths and 108 adults involved in interagency collaboration about their satisfaction and the reasons behind their satisfaction rating. The study was a designed replication of previous research on interagency collaboration to extend that research in two ways. Rather than focusing on a sample of subjects receiving one or two treatment modalities, the present study examined youths receiving an array of interagency collaboration. The present study sought to provide further information about the relationship between satisfaction of participation and reasons behind the satisfaction ratings.

The results suggest several conclusions: (1) In general, the participants in this study who were involved in interagency collaboration appear to be satisfied with services and process; (2) the relationship between youths’ and adults’ satisfaction appears to be independent of the restrictiveness of out of home placements; and (3) as a predictor of behavioral outcomes, satisfaction ratings seem to be of limited value, while other related variables may be more important.

The findings suggest that most of the subjects who participated in this study were satisfied with interagency collaboration services. However, this conclusion must be made with caution. Although subjects gave high ratings to almost all of their services, these data were not compared to responses from a control group. Moreover, such findings are common in the satisfaction literature and may be a function of demand characteristics or social desirability (Lebow, 1983; Sabourin et al., 1989). While high satisfaction ratings are encouraging, they cannot be said to be definite markers of successful interagency collaborations.

One other noteworthy finding emerged from the participants’ satisfaction ratings. As a group, subjects gave higher ratings to case managers than to state case workers. Upon
closer examination of ranges and pockets of respondents, there were higher ratings for case managers than for state case workers. Many parents that were involved in interagency collaboration gave markedly higher ratings for conflicts and their direct case managers when asked to rate the effectiveness of interagency collaboration.

Case managers coordinate and implement interagency collaboration services and they typically have small case loads. In West Virginia, case workers are the representatives of the state Department of Health and Human Resources and average much larger case loads. Consequently, case workers have substantially less contact with their cases, and interactions with youths and families tend to be more crisis-oriented, often revolving around changes in services and placements. Case workers also serve as youths’ legal guardians, thus adding another dimension of power to their relationships with the children and families in their case work. Case managers, in contrast, have frequent contact with their cases and tend to have daily involvement in the youth and family’s life. It may come as no surprise, therefore, that youths and families are more satisfied with case managers.

The importance of satisfaction is highlighted by other findings of the present study. The results suggest that case managers rated themselves higher in interagency collaboration and tended to report relatively high satisfaction with their services. Moreover, even with high rates of conflict, case managers tend to be more satisfied with their services. These findings provide some evidence for the utilization of interagency collaboration and suggest ways to increase satisfaction with services that do not involve interagency collaboration. Yet the question remains: What is the success rate of the interagency collaboration?

This is not to say that satisfaction will guarantee positive interagency collaboration procedures. Indeed, the results of the present study indicate that overall satisfaction was non-related to the level of participation of the subjects and the youths’ reasons for referral for interagency collaboration. While it is difficult to draw firm conclusions from null findings, this result is consistent with several previous studies (e.g., Burchard & Schaefer, 1992; Distefano, Pryer, & Garrison, 1980) and inconsistent with others (Kazdin, French, & Sherrick, 1981; Baumheir, Welch, & Mohr, 1978). Though it is possible that the present study used inadequate measures of satisfaction, it seems equally plausible that behaviors and levels of participation are determined by factors unrelated to satisfaction. In particular, factors such as the severity of the presenting problems, familial problems, and professional developmental issues may influence interagency collaboration processes independently of participants’ satisfaction with interagency collaboration and services.

Interpretations of these data must take into consideration several limitations. Though case managers were used as a subset of the group, only two teachers participated in the study and did not adequately reflect the educational component of interagency collaboration. Of all problems identified in the youths’ treatments, it was identified by
parents and youths that school played a major role in the development and identification of problems in behaviors and services for the targeted children of the study.

In order to identify the predicator of interagency collaboration and satisfaction, future research should attempt to distinguish between behavioral adjustment during treatment and post-treatment outcomes. In addition, it would be useful for future studies to compare interagency collaboration services with more traditional forms of delivery systems, with particular regard for school involvement and satisfaction with educational components of interagency collaboration.

For those designing and implementing services for exceptional children, such research can provide useful information about improving the likelihood of successful collaborations and outcomes for children. Moreover, listening to young people's opinions about their care seems inherently positive, furthering the goal of providing services for youths and families which are respectful, productive, and beneficial.

* Affiliation at time of presentation.
** Complete references not available from presenter.
In the fall of 1990, a grant was made by the Hogg Foundation for Mental Health to four independent school districts (Austin, Dallas, Houston, and San Antonio) to develop a school-based service project in one or two elementary schools and their “feeder” middle school. The strategy of this demonstration project, called the School of the Future (SoF), is to provide an integrated array of health and human services, both treatment and prevention, using the school as the locus for their delivery. The major goal of the project is to improve the mental and physical health of children and their families in these schools and the surrounding community.

One of the many data collection efforts of the project evaluation was an intensive interview conducted with a sample of parents of children in three of the School of the Future sites – approximately 100 parents in each site. The family survey instrument developed for this study contains approximately 180 questions and was conducted by a trained interviewer. The interviewer contacted the respondent by phone, scheduled a date and time for the interview to take place, and then conducted the interview in the respondent's home. Each interview took approximately one and a half hours to complete.

Most of the interviewers trained to administer this survey were residents of the communities. Interviewers were trained by Hogg Foundation staff on general interviewing skills and the use of this particular survey instrument. Interviewers were paid $30 for each interview completed. Families were paid $15 in food store gift certificates for participating in the survey.

Each interviewer was given a list of students for whom we had already collected two to three years of mental health information via the Achenbach youth self-report (YSR) and/or teacher report forms (TRF) and asked to contact their parents to schedule an interview. This list included students who had received services from the project (experimental) and students who had never received services from the project (control). The focus of the survey was on children who ranged in age from 7-13 years.

The survey instrument used in these interviews explored the following areas: (1) assistance received by families from the school and other service agencies; (2) parent
involvement in the school and their child's education; (3) child behavior and social interaction at school; (4) child behavior at home and interaction with parents, siblings, and neighborhood friends; and (5) familiarity with programs and services available at the project site. The interview concluded with a “life events” checklist which asked about any extreme events or crises that may have occurred within the past six months of the interview. The survey also collected basic information on each family, such as the number of children in the family, their ages, and the schools they attend, as well as the marital status, education, and occupation of the parent interviewed.

The ethnicity of the families interviewed were representative of the ethnic breakdown of each of the demonstration school sites. In San Antonio, almost all of the families interviewed were Hispanic (95%). In the Austin site, the ethnicity of the parents interviewed, like the site itself, was more diverse (50% Hispanic, 40% Black, 10% Anglo). Both sites are faced with many severe social problems such as high unemployment, prostitution, drugs, and gang-related violence.

The early part of the discussion briefly described the similarities and differences between the two Texas communities that were highlighted in this presentation. These two highly ethnic, disadvantaged urban neighborhoods in Austin and San Antonio were described by exploring the parents' ethnicity, education, marital status, socio-economic status, and employment. These differences and similarities help to place other survey responses offered by the parents into some context. Responses from parents discussed in this presentation were: their relationship with their children, their knowledge and opinion of their children's behavior at school and at home, their participation in school activities, their comfort with going into the school and meeting with teachers and the principal, and their thoughts on their children's chances later in life.

Results from this paper demonstrate that some common perceptions many of us hold about families living in disadvantaged communities are in reality, common misperceptions. Despite living in poor, highly stressful, and violent communities, many of the responses offered by parents regarding their family life and involvement in their children's education closely match what we might expect from families living in many “typical” middle class suburban neighborhoods. Examples of this are: (1) types of discipline used by parents when their children are “bad” and types of rewards when they are “good”; (2) how often parents visit their child’s school and teacher and how they feel about the school; and (3) frequency and types of parental assistance with their children’s homework.

There are still some responses that appear to be unique to these families. These include: (1) Why they do not help with homework (its not that they don’t want to help, it’s that they are unable to help); and (2) what they think about their child’s opportunities for the future (many “don’t know” because they don’t think that far ahead – they are too
concerned with whether or not their children will survive to their 18th birthday). Many of the activities that go on everyday in these communities have a great impact on what these parents see, what they believe, and their hopes and dreams for the future.
Respite care is widely believed to be an important service for families raising a child with a disability. All caregivers need a break from time to time, and the need may be even greater when the caregiver is coping with the additional stress associated with a child's disability. A number of studies have demonstrated that respite care can improve family functioning (Cohen, 1982), reduce stress (Rimmerman, 1989; Wickler & Hanusa, 1990; Appoloni & Triest, 1983), and delay out-of-home placement (Cohen, 1982; Upshur, 1982) for families with a child who has a disability.

In 1993, the New York State Office of Mental Health began a three-year research and demonstration project to study the effectiveness of three models of intensive, short-term (4-6 weeks), in-home, emergency services for children in the Bronx, New York, who might otherwise be hospitalized due to a psychiatric crisis. Presenters provided an overview of the study which is described in detail elsewhere (Evans, 1992; Evans, Boothroyd, & Armstrong, 1997).

In two study conditions, in-home and out-of-home respite care was available to families in conjunction with intensive in-home services. Respite was available on both an emergency and planned basis. Respite workers were trained to care for children with serious emotional disturbances (SED) and selected to match the needs of the child and the family. Both English and Spanish speaking respite providers were available. Given the short-term nature of the interventions in this study, out-of-home respite stays were limited to three days per occasion. In-home respite services did not have to take place within the home, allowing respite workers to engage in recreational activities with a child such as going to the zoo, seeing a movie, or having a pizza. Respite care was not restricted to the identified child, but also was available for other children in the home.

During the first year of this study, the use of in-home and out-of-home respite fell below anticipated levels. In year one, 26% of the 70 eligible families used in-home respite. Utilization improved to 35% of 81 eligible families in year two and 70% of 20 eligible families in year three. The overall utilization rate was 35%. Out-of-home utilization never exceeded 4% of eligible families.
When in-home respite care was used by a family, it was provided an average of 10 times per family with the number of times it was used ranging from 1 to 24. On average, 42 hours of respite care was provided per family, with the number of hours ranging from 2 to 123. Respite sessions averaged 4 hours in length.

Researchers took several steps to better understand why utilization of respite fell below anticipated levels. We looked closely at characteristics of users and non-users for anything that might help us understand utilization patterns better. We examined program fidelity data collected at discharge to assess caregivers' knowledge of respite. Caregivers and professionals participated in focus groups and caregivers completed mailed surveys. In each of these activities we sought to better understand caregivers' need for respite; what professionals and caregivers see as barriers to utilization; and what are some important features of a respite program from a caregiver's perspective.

There were no differences between respite care users and non-users regarding the child's diagnosis, assessed dangerousness of the child's condition, gender, the number of children living in the home, the number of adults living in the home, or the primary caregiver's formal education level or income. Caregivers who used respite did have younger children (10.6 versus 12.7 years), had children with a greater number of assessed functional impairments (1.6 versus 1.3), reported a lower level of informal supports (average 74 versus 87), and reported greater difficulty controlling their children's behavior, understanding the problems their children were having, and identifying services that might be helpful.

At discharge, a significant percentage of caregivers reported that they were not told about the availability of in-home respite services, or did not remember whether or not they were told. The percentage of caregivers who remember having been told about respite has improved as we have stressed the importance of providing this information to all families, developed informational brochures, and discussed the need to discuss the availability of respite on more than one occasion. Nevertheless, many caregivers report that they were not told or did not remember being told about in-home respite (27%) or out-of-home respite (38%).

These and other data illustrate the importance of assessing how it is that families understand information they are being given. Clearly, some families were not informed about respite which makes it impossible for them to be partners in planning for their child. Others were informed, but the message may not have been clear to them. Furthermore, focus groups underscored the importance of cultivating an understanding by both professionals and caregivers as to how a new resource -- in this case respite -- could be helpful. Several steps were taken during the project to improve communication with families and among professionals: (1) brochures were developed; (2) the respite coordinator began to work more closely with staff to individually assess each family's need for respite; (3) providers incorporated suggestions from parents about how to talk
about respite with families who might be wary; and (4) staff were encouraged to exchange ideas about the different situations in which respite might be helpful.

Finally, presenters contrasted caregiver and professional perspectives on several issues which seemed to surface repeatedly in focus groups and in survey responses: the relevance of respite, safety, coordination of services, information, flexibility, and worker qualities. While caregivers and professionals shared many concerns, the differences in their viewpoints are important if programs are to be designed in keeping with caregiver’s needs and concerns.

Among the differences in perspective noted were the following:

1) Caregivers were certain of the value of respite, while some professionals expressed doubts about "non-therapeutic" services.

2) Professionals were concerned that adding a respite worker might be overwhelming to families and worried about coordination of services. Caregivers were concerned that professionals were making decisions without their input on issues such as this where each family is different.

3) In terms of respite worker qualities, professionals emphasized the training of the respite worker as well as their ability to provide respite without interfering with the work of the primary service provider. Caregivers emphasized the personal qualities of the respite worker: She enjoys my child, understands my child's needs, and respects our family.

Although not the primary focus of the research and demonstration project, the respite sub-study has produced some interesting information on the use of this type of service by children with SED and their families. Few studies on respite focus on the families of children with SED. It will be important for children's mental health researchers and parents to continue to collaborate on the design and evaluation of respite care models.

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* Affiliation of Boothroyd and Evans at time of 1996 conference. See page 93 for current address.
During the past decade, published reports have highlighted the bleak family, school, and community outcomes for children who have emotional or behavioral disorders. In recent years, it has become widely recognized that, to a large extent, these bleak outcomes are due to fragmentation and ineffectiveness within the categorical educational, mental health, health, juvenile justice, and social service systems. As a result, efforts have intensified to develop and implement community-based integrated systems of support, with a child-centered and family-focused approach to service delivery. This ecological orientation is based on the premise that social networks are the key to effective assistance to these children and their families.

To accept an ecological approach to supporting children and families means not only to elicit parent perspectives regarding the nature of the current community support systems, but also to incorporate their input and expertise to improve service delivery. Further, the provision of appropriate support services must begin by identifying each child and family’s social network. In spite of philosophical agreement across disciplines that an ecological approach is reasonable, parent input and recommendations are rarely systematically sought and considered when planning, implementing, and evaluating community-based support systems.

This statewide study of Oregon families asked parents to report the nature and extent of the support their families received from their informal social networks and from paid professionals, and how helpful these types of support were in meeting the needs of their children with emotional or behavioral disorders and their families. Findings suggested that a larger number of formal organizations and paid professionals provided support to these families than did informal organizations and unpaid individuals. However, spouses and family members were the most helpful sources of support to help parents cope with the daily challenges of raising their children with emotional or behavioral disorders.

Family service coordination is considered the cornerstone of direct service to each child and family within a community-based system of support. However, there is currently no common definition for family service coordination and a paucity of research and evaluation efforts examining what constitutes effective service coordination within the
context of community support systems. This study examined the extent to which parents received assistance to coordinate services for their child and family and relationships between receipt of service coordination and child and family well-being. Results indicated that the greater the number of functions of service coordination received, the more successful parents were in getting needed support and the more satisfied they were with family quality of life.

The results of this study provided preliminary data for a follow-up study currently being conducted by the investigator. The follow-up study utilizes qualitative research methods to explore what constitutes effective family service coordination from the perspectives of parents and the professionals they nominated as helpful in providing the functions of service coordination.

Emerging themes from the follow-up study suggest that service coordinators continue to be linked with specific programs. Therefore, when a child or family exits a program, the professional who has provided assistance to coordinate services concludes her/his involvement. In addition, parents and professionals consistently recommend the availability of 24-hour telephone support to parents. Preliminary analysis of parent interview data strongly suggests that professional acknowledgment of parent perspectives may be a prerequisite to parent perceptions that the professional can effectively support their child and family.

Mail survey research methods were used to explore the nature and extent of support families received. The following areas were examined: (1) characteristics of children with emotional or behavioral disorders and their families; (2) types of informal and formal support families received; (3) relationships between child and family characteristics and support received; (4) parent perceptions of helpfulness of the support received; (5) the extent to which families received functions of service coordination; (6) the relationship between receipt of functions of service coordination and parent success in getting needed help; and (7) the relationship between receipt of functions of service coordination and child well-being and family quality of life.

A random selection procedure was used to identify a sample of 250 families from the Oregon Family Support Network (OFSN) database of 1000. Questionnaire packets were mailed to the 250 families. Of the 120 questionnaires that were returned, 100 surveys were used for data analysis (i.e. a return rate of 40%).

A self-administered questionnaire was used for data collection. The questionnaire was divided into five parts. Part I included questions about family characteristics, Part II asked about child characteristics, Part III asked about the types and helpfulness of support which families received from organizations and individuals, Part IV asked questions specific to receipt of family service coordination, and Part V was an open-ended question that asked for parent comments and recommendations.
The questionnaire was developed by the investigator, after reviewing numerous mail survey instruments and consulting with researchers who conduct studies related to family support for families with children who have disabilities. In addition, the instrument was pilot tested with three parent-run support groups affiliated with the OFSN. These 18 parents represented urban and rural communities, a range of socioeconomic backgrounds, child age and disability labels. The instrument was finalized after minor revisions were made, based on parent feedback.

Test-retest reliability procedures were conducted for the first four parts of the survey instrument. The percent of agreement for Parts I, II, and IV was above 80%. The percent of agreement for Part III (types and helpfulness of support) was somewhat lower, at 77%. Pearson Correlation Coefficients were calculated for all questionnaire items with interval data. Reliability coefficients ranged from .76 to .90, except for the section of the questionnaire related to helpfulness of support from organizations. The reliability coefficient for that section was .73. One explanation for lower reliability may be a change of circumstances over the one month period between the time the original questionnaire was completed and the time parents completed the reliability questionnaire. Inter-rater reliability was calculated for Part V. Average agreement between raters for coding open-ended responses was 85%.

Within an ecological orientation, the first and foremost assumption is that the professional community should seek input from and become partners with the children and families to whom they are responsible. This input should occur at both the macro-level and the micro-level. Findings from the current study showed that families with children who have emotional or behavioral disorders represented a wide range of socioeconomic levels and relied on a variety of tangible, informational, and emotional supports, provided by both paid and unpaid people in their social networks. While there were similarities between child and family characteristics and support needs, individual child and family circumstances appeared to change over time, as indicated in parent anecdotal comments. This study supports the need for individualized, child-centered and family-focused service delivery that incorporates the informal and formal support networks of each child and family.

Even though family service coordination is touted as perhaps the most essential unifying factor in a community-based system of support, findings from this study showed that the functions of service coordination identified in the literature were received by only a small number of families. In addition, older adolescents and young adults appeared to receive less functions of service coordination than younger children, yet their parents appeared to be greatly concerned that there was no community support for their children once they left school, and that their children did not have the skills to survive as adults in their communities.

An additional implication of this study is that schools appear to be a natural hub for
establishing contact with parents and families of children who have emotional or behavioral disorders, since most of the children in this study attended their neighborhood schools either part-time or full-time. However, results indicated that school personnel were not adequately trained to understand specific disabilities, manage disruptive behavior, and work as partners with parents to ensure school success.

Findings from this study, combined with findings from previous research that relied on parents’ input, indicate that future research should continue to build the foundation for better understanding the extent to which an ecological approach can be effective in creating and maintaining support systems for children with emotional or behavioral disorders and their families. These efforts should include family members and members of informal social networks on research teams. In addition, participatory and action research methods may provide more in-depth understanding of what is required to effectively support troubled children and their families within specific communities from the perspectives of the people who live there.

This study suggests the need for more in-depth examination of the following topics: (1) accessing troubled children and their families who have become isolated from the mainstream; (2) examining ways to reduce out-of-home placement by effectively supporting children and families in their homes and communities; and (3) incorporating informal and formal social networks into the development and implementation of integrated systems of support. Finally, to design and implement support systems that produce positive outcomes as perceived by families, it is essential to rely on input from those who will be most affected: the children, the youth, and their families.
Title: School-linked Human Services: Do They Make a Difference in Student Success?

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The purpose of this symposium was to present an overview and initial findings from a descriptive longitudinal study being conducted on the effects of school-linked human services to students in South Central School District (SCSD). The District is small, (2200 students), relative to most others in Puget Sound, and it is unique also in that it is comparative in percentages of student risk factors to large urban centers such as Seattle and Tacoma. In order to deal with the growing needs of its students, South Central has, since 1991, actively recruited human services from the surrounding communities to integrate with those services already provided by District staff. During the past school year there were over 52 different human services valued at approximately $1.3 million delivered to students in SCSD. The effectiveness of these services in improving school performance has been an ongoing question. As the 1994 school year began, the District initiated work to design a study which could provide evidence of the effectiveness of these services.

The first part of the symposium dealt with the design and implementation of the study. Several variables were selected as the focus of the study by members of the District's Cities In Schools Advisory Board (composed of community, business, school and human services representatives). The study focused on students’ (1) academic performance (as measured by grades, test scores, and course completion); (2) attendance rates; (3) physical, mental and social health; and (4) discipline referrals.

In order to implement the study, data about the variables (listed above) was to be collected as a product of the District's student intervention program, which had been in place for two years. The program was designed to address the needs of students whose school performance was of concern by student, parent or school staff. The following is a summary of the process: In order to initiate a referral for interventions, a simple form is submitted to the referral team established at each school. The teams are composed of school staff, specialists, parents and the student as appropriate to the specific referral. Teams meet weekly and conduct a review of each student's case, including records of school performance. One or two goals for improvement (as measured by school performance) are set, with input from student, family, appropriate school staff, and the key service providers who will provide the interventions. Some benchmarks are set which will be used to monitor progress towards the desired goal. The type of data to be used to measure progress is identified. A case manager is selected (usually the teacher or
someone who has regular contact with the student) and is able to coordinate the various services with school activities. A schedule of future dates is developed on which the data that is being collected about the student's progress will be monitored by the team.

The study was implemented in several phases during the 1994-95 and 1995-96 school years. After the design was finalized and types of data to be collected were identified, a feasibility review was conducted to see if the school staff had the skills needed to collect the data and if the district had in place the necessary data collection process. A number of activities were required in order to put the additional prerequisites into place. It was found that the state student records management system (WSIPC) was able to collect and report the desired data; however, not all of the data was being recorded at that time. Additional procedures and computer screens were designed, and staff was trained to use them. The District was not able to hire staff dedicated to this project alone, so the tasks were distributed over several district staff members, as well as paid consultants and UW graduate interns. This required some additional effort to coordinate all of the various activities underway.

During the 1994-95 school year, data collection about student interventions was initiated. An initial data base of 104 students was established. Training and monitoring of the quality of data continued while initial reports of data were generated. By using the state student records management system, performance reports of individual students or groups of students could be generated. Initial reports some tentative findings and problems were identified from these reports.

More elementary students were being referred than were those in secondary schools. According to the service providers and school staff, this was more a function of the reporting process than of actual fact. This pointed to the need to increase staff training and monitoring of the process. Also, increased feedback to the service providers about the findings must be given.

In most grades, the percentage of males/females and students of each race/ethnicity was the same, when comparing the group of students receiving services to the group that was not receiving services. This was good news, in that there did not appear to be bias in the referral process; however, there is a question about the grades in which this was not the case.

Goals were reached in about 50% of the cases. Reaching these goals was seen as positive, but not conclusive enough evidence to define the interventions a success. This is due to the present state of the art in our understanding of school-linked human services. The literature does not yet contain studies which provide data about the pace at which school performance can be achieved through school-linked human services. Without this standard, we are using benchmarks, which do not necessarily reach the standard that should be reached. Another study will be undertaken to better define standards.
A pilot study of student, parent, and staff satisfaction with the intervention system was conducted in April and May, 1996. This produced a survey that will be used in the future as a companion tool to the data being collected through the student records management system. It was learned from this pilot that students and their families must be involved more actively throughout the intervention process.

As this study is enlarged and refined, it is expected that it will provide the first evidence of its kind about this question: Do school-linked human services make a difference in student/school performance?
Multiple theories, methodologies, and confused terminology rooted in different paradigms of thought have contributed to an inadequate service structure in which professionals utilize medically driven models as the perceptual prism to define families of children with serious emotional disturbance as dysfunctional. European in origin, a North American alternative to this expert model is emerging which has been loosely termed “wraparound process” and which has coalesced around a broadly stated, strengths-based, family-centered, ecological approach emphasizing individualized service and treatment in the most appropriate and least restrictive setting (Boyd, 1991; Burchard & Clarke, 1990; Duchnowski & Friedman, 1990; VanDenBerg & Grealish, 1996).

Applications of wraparound are now emerging from an early developmental stage in which it has been defined through value-based, philosophic principles that begin to differentiate it from the professionally driven process characteristic of more traditional forms of family-centered practice. However, the maturation of wraparound is threatened by a developmental paradox. Those who have been trained in the old theories of assessment and remediation of deficit, and whose careers have been shaped by the professionally driven process of traditional service models, must still play transformative roles in the emergence of this promising alternative. This threat is exacerbated by and echoes through a “Tower of Babel” of terminology used to describe seemingly similar approaches to working with children and their families. Amidst this confusion, the value-based principles which have guided wraparound have all too often been misinterpreted and misapplied as emergent case management methodology.

This essential change, from categorical to integrated and individualized services, and from deficit assessment by professionals to ecological strengths enhancement which engages families as decision-making participants, has occurred without articulation of its implicit roots in constructivist and critical thought, nor of its slightly more explicit basis in ecological systems theory. This paper presented initial data from a case study design (Yin, 1989, 1994) which evaluated, as a basis for wraparound fidelity, a single construct and operative focus: families acting as decision making participants in a process of ecological strengths enhancement.

This descriptive, exploratory study generalized to theory, not to population. It contended that, when consciously applied in tandem, these elements anchor wraparound process in its implicit basis of constructivist and critical thought and ecological systems theory.
Without their application from this basis, the wraparound process reverts toward professionally-driven and deficit-focused efforts typical of more traditional forms of family-centered practice. Cases in this study were defined as all participants in the development and implementation of family support plans in the Family and School Support Team (FASST) program. Seven cases, opened in October and November 1995, formed the basis for the study which focused through the experiences of all participants in the purposively sampled cases.

A critical review of the literature focused on the social and paradigmatic emergence and transformation of family systems theory and the related development and transformation of family-centered practice through a wide range of disciplines. This review differentiated and operationalized five levels of family-centered practice as focused through the complementarity of family and professional roles and their use of strengths in support planning and implementation which is presented here in Table 1. The first three levels reflected more traditional forms of family-centered practice within expert models focused upon deficit remediation. Levels four and five described when families acted as decision making participants in a process of ecological strengths enhancement, the posited basis for wraparound as a collaborative model of family-centered practice.

(See Table 1)

Two opposing sets of a priori propositions derived from the review of the literature and from these operational definitions of family-centered practice were applied in this study. These propositions described and assessed through three methods of data collection and at different points in the development and implementation of the family support plans, the presence of elements of each of these two models in the seven cases. The patterns which emerged at the conclusion of the study in May, 1996, will answer the research question: “When families act as decision-making participants in a process of ecological strengths enhancement, how do applications of wraparound -- a collaborative model -- differ from family-centered practice within the expert model?” The propositions testing for wraparound as a collaborative model of family-centered practice were:

1) Families will act as participants of a community team in which assessment and implementation decisions are reached by consensus. When consensus cannot be reached, the team will value and abide by the decision of the family;

2) Community participants will share their expertise and perspective in a way which provides information as well as access to service while respecting the families’ perspectives.

3) Families will have sufficient information as well as access to services to voice their perspectives, strengths, and needs.
4) Decisions made by this team will recognize and combine the strengths of the family with the strengths in the community, including the more traditional service structure which may be more flexible.

5) The combined ecological and family strengths will be the basis for individualized activities which target specific needs.

Propositions testing for family-centered practice within an expert model were:

6) Families will provide information to professionals who assess problems or needs and who then attempt to remedy them by matching each to an existing service.

7) Community participants will present their perspective and expertise in a manner which limits the role of the family as an equal decision making participant and which does not respect the family’s perspective.

8) Services delivered to the family will not reflect the family’s perspective of what might best meet their needs.

9) If strengths are identified, they will primarily be within the family and they will not be actively and overtly utilized to meet identified needs.

10) Activities in the family support plans will not overtly seek to combine strengths of the family with strengths in the community.

The study employed a multi-method, multi-source approach with three primary sources, or waves, of data: (1) systematic observation of community team meetings in which issues and perspectives were explored with referred families and in which the family support plan was developed (October & November 1995); (2) semi-structured interviews with family support plan participants in the seven cases (January through March 1996, 44 hours of interviews with 56 people); and (3) systematic review of the formal FASST case files. At the time of the 1996 Tampa research conference, the first wave of data had been coded for evidence of propositions. Based on this initial analysis, three cases were assigned to a collaborative model cell. This meant that at the assessment and planning, the process between family members and other participants appeared to fit operational definitions 4 or 5 of family-centered practice, the posited basis for wraparound fidelity. Four cases were assigned to an expert model cell because coding indicated that assessment and planning appeared within operational definitions 1, 2, or 3 of family-centered practice.

On a case by case basis, wave 2 semi-structured interviews would then be analyzed and coded for evidence of all propositions, while the systematic review of FASST case files in Wave 3 would be utilized to corroborate, disconfirm, or enrich data which emerged from
the first two sources. Through this within-case analysis, movement from one cell at assessment and planning toward the other cell in implementation could be documented. This multi-source, multi-method design would then be utilized to develop converging lines of inquiry through identification of pattern convergence or divergence through triangulation or replication in all waves of data. Patterns between cases in the same cell would be examined in similar manner in an iterative process to develop converging lines of inquiry to delimit multiple explanations or to uncover a few explanations which would hold under predictable situations.

The final level of analysis was planned for May, 1996, in which between cell patterns would be compared and contrasted to answer the research question: “When families act as decision making participants in a process of ecological strengths enhancement, how do applications of wraparound, a collaborative model, differ from family-centered practice within the expert model?” The answers to this question will begin to establish a theory and paradigm basis which may better ensure fidelity than the easily misinterpreted value-based principles which currently define wraparound. This will provide a preliminary and essential step toward ensuring the integrity of wraparound applications. As such it may provide greater clarity in conceptualizing frameworks for more successful collaboration between families, schools, and communities as well as provide a foundation and means for process evaluations and program development of wraparound initiatives. By developing a foundation and means for ensuring wraparound fidelity, outcome evaluations cost-benefit analysis, and surveys of participant satisfaction could be more meaningfully compared with more traditional forms of family-centered practice and service delivery to better guide policy and funding decisions. Final results from this study will be available at the 1997 Portland conference.
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<td>Needs are matched to more traditional services</td>
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<td>Professional</td>
<td>Psychodynamic; Behavioral; Structuralist family systems theory (1970's)</td>
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Evaluation of treatment fidelity in the implementation of a wraparound approach has presented a challenge to the field of children's mental health services. This challenge is due, in large part, to the lack of an articulated theory that can offer constructs to better anchor practice within this promising model. Without demonstrated fidelity, program evaluations produce confused and sometimes disheartening results.

This paper was presented as part of a symposium focused upon evaluation and development of the Joint Venture Family School Support Team (FASST), an emerging school-based program in Tampa, Florida, which employed a wraparound approach. FASST's target population was children who had received or were at risk of receiving a diagnosis for emotional or behavioral disturbance. The program was split between two supporting mental health centers and delivered service through six elementary schools in a predominately low income area of Tampa. It was guided by a manager, and each school had a team of a masters level family support coordinator, as well as a paraprofessional family advocate who had a child attending that school. These two staff met with referred families to develop initial support plans which were then brought to a standing community team that met monthly for refinement and review of the plans.

The FASST program began operations in fall, 1993, with a new and relatively inexperienced staff who received traditional mental health in-service training, as well as some exposure to interpretations of the value-based philosophy of the wraparound approach. Soon thereafter, doctoral students and the director of the University of South Florida’s (USF) Child and Family Policy Program began a process of participatory research and evaluation which would guide program development.

Initial participant observations of the community team meetings, as well as program staff meetings, had shown that well-intentioned, enthusiastic family support coordinators and
family advocates were confused and pulled in different directions by the multiple perspectives and actions of school, mental health, and social service system participants in the family support plans. Roles in the program were not well defined and the process enacted with families appeared, at best, like team case management within an expert, medically driven model.

To develop a common base of operations, USF doctoral students, acting as consultants, led program staff through participatory evaluation of their roles and the program which asked three deceivingly simple questions: (1) What worked? (Best Practice); (2) What didn't work? (Barriers to Best Practice); and (3) What did they need to make the program work better? The answers to these questions guided subsequent program development which used what was working and combined it with what staff had identified they needed to make the program work better to then address the barriers to best practice. This was a consciously constructed isomorphic process of participatory evaluation and planning which mimicked the evocation of multiple perspectives, the development of consensus, and the combining of strengths to meet needs which occurs in a wraparound approach.

By the end of fall, 1994, FASST staff had requested and received considerable support in developing strengths-needs-based support plans, as well as in how to engage families as decision-making participants. This support was provided through the Child and Family Policy Program and the Research and Training Center for Children's Mental Health at the Florida Mental Health Institute. Combining this support with what they felt were the strengths within their program, FASST staff then identified that the standing community teams were themselves undermining the integrity of a wraparound approach. Each community team had representatives from the school, mental health, and social service agencies who brought their professional expertise to the development and review of the family support plans in a manner which did not well acknowledge nor utilize the perspectives and strengths of the family, and which limited the family role primarily to one of informant and recipient of service. Plans which emerged from these teams typically identified needs solely in the family and matched them to existing services.

Facilitated by the USF consultants in the winter of 1995, FASST staff developed a questionnaire to assess the community team members’ understanding of the roles of participants and process within a wraparound approach. The questions focused on a key construct and its operative focus which was in the process of development by one of the consultants to use as the basis for conceptualizing and testing a theory base for wraparound fidelity: Families acting as decision-making participants in a process of ecological strengths-needs-based planning and implementation.

Survey results from 41 of 60 possible respondents were then scored by the entire FASST staff over a period of one month, in a participatory process facilitated by the USF consultants. Though at times painfully slow and tedious, this participatory approach enhanced greater staff cohesion and understanding of the key construct. This appeared to
anchor and to differentiate wraparound as an emerging collaborative model of family-centered practice from more traditional family-centered practice within expert models of deficit remediation. Results also indicated that professionals on these community teams had difficulty transcending the formal training they had received in deficit theories and the expert model of practice. Though these professionals articulated a role for families as “partners” in the planning and implementation, they primarily relegated families to roles of informant and recipient of service recommended by the team. The slippage into the expert model was further revealed by the FASST staff’s rating these responses on a scale measuring strengths-based planning, which placed the community team members solidly within a deficit remediation focus, typical of more traditional forms of family-centered practice.

These data were then used in yet another participatory process facilitated by USF consultants, in which FASST staff developed a program brochure which described the intended roles of families and professionals in a process of ecological strengths-needs based assessment and implementation. Subsequent outcome and process evaluations were conducted and reported in papers presented by Norin Dollard and Bob Sleczkowski and by Rosalyn Malysiak
Failure to ground the wraparound model in more than value-based philosophic principles is leading to its adaptation as another form of case management by professionals whose training and experience has been in expert models of deficit remediation. These models limit the decision-making voice of families while ignoring or failing to utilize their perspectives and strengths. Thirty months of participatory and simultaneous program evaluation and development between the University of South Florida's Child and Family Policy Program and a mental health-supported, elementary school-based program in Tampa, Florida were presented in this symposium which addressed the critical question of fidelity of intervention and its relationship to outcomes for children and their families.

The Joint Venture Family School Support Team (FASST) was implementing a “family-centered, strengths-based” approach which they called wraparound. However, key informant interviews conducted in November, 1993, with eight policy makers from the Hillsborough County Public Schools and the Children's Board of Hillsborough County, indicated that the lessons learned from the Ventura Project (Jordan & Hernandez, 1990) had not been applied. There was no agreement on target population, no consensus on desired system change, and no common understanding of the wraparound model which they chose to implement through the FASST program. The three papers presented in this
symposium describe how simultaneous participatory processes of evaluation and program development measured outcomes, defined the wraparound model, and identified program policy, management, and practice which were undermining the integrity of the chosen model.

REFERENCE

Title: Empowering Families to Protect Children: Developing Family Group Conferences in England and Wales

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In recent years, the United Kingdom's child welfare system has changed substantially, with a new law, the "Children Act of 1989,” and with applied research that is actively developed into policy and practice. The new developments, in common with those in many other countries, emphasize the need to involve families in child welfare and protection processes, seek to make those processes reflect the cultural norms of the families, and attempt to strengthen links between children and their families. An emphasis on partnership between workers and clients is the common thread in the different changes.

However, in current practice in higher risk areas such as child protection, despite a process which involves multi-disciplinary conferences which link parents and professionals, there is still limited family involvement beyond the mother. Also, despite normally having a reasonable assessment, there is often an inflexible and unimaginative use of services, and cultural sensitivity is still limited.

The current model of partnership decision-making which is used by practitioners is based to a large degree on professional meetings and conferences with family involvement, and it is, in practice, one of limited family participation. It is predominantly concerned with the ways that the family (primarily parents, and primarily mothers) can help professionals do their job.

Moving beyond this limited participation is not easy. Recent research at the University of Sheffield, England, highlights both the opportunities for better practice but also the difficulties faced by staff when trying to implement partnership ideas in the context of existing attitudes and working practices.

Action research at Sheffield, in conjunction with a voluntary advocacy group and the work of a number of pilot social service agencies, is now supporting a more radical model of practice which seeks to protect children's welfare by building on family strengths in ways which reflect that family's culture. This model is the “family group conference,” whose origins lie in developments in New Zealand. The conferences are also being developed and tested in Australia, Canada and the USA.

Family group conferences are convened by a coordinator who has specific responsibilities
for this task. Professionals give evidence to the conferences, but all evidence must always be shared with the family, and the family has its own private session during the conference without any professionals present. The family members will nearly always include members of the extended family as well as parents, and older children may be present as well. The conferences follow a standard and organized agenda, but the process can be substantially affected by the family's culture (for example, the conference may begin with a welcome to all members from a respected grandparent).

The new approach has many positive factors: Family members do generally have a strong role in the development of child protection plans; professionals are providing the family with more understandable information and advice; and issues of power and control are more explicit.

The research under way at Sheffield has been evaluating the five substantial pilot projects that have now been running in England and Wales for around 18 months. Results so far are promising, although professional problems with implementation are prominent, as they are in other areas where genuine partnership is being developed.
Employed parents of children with serious emotional disorders must manage the competing demands of home and job. Although every situation is unique, all parents cope daily with the interface between employment and home. As the number of single employed mothers and dual-worker households has increased, so has the research on work and family. A review of this literature offers an examination of the different ways work and family relate within the busy lives of employed parents. Three primary models emerge from the review that describe experiences of mothers and fathers challenged by meeting both the needs of family members and the responsibilities of work-life. The literature does not identify whether or not the parents have children with any special needs. This review serves as a foundation for research that will specifically focus on parents of children with serious emotional disorders.

The conflict model of work and family describes the pressures occurring due to role conflict. Work-family conflict has been defined as the extent to which a person experiences incompatible demands due to role pressures in the work and family domains (Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964). In examining the incompatible demands, three forms of work-family conflict have been suggested: (1) time-based conflict, in which the time spent in one domain is seen as taking away time that might well be spent in the other domain; (2) strain-based conflict, in which the strain experienced in one domain affects the performance of roles in the other domain; and finally, (3) behavior-based conflict, which refers to the incompatibility of behavioral styles appropriate for each domain (Loerch, Russell, & Rush, 1989).

The spillover model of work and family describes how an individual’s activities and psychological experiences in the domains of job and home influence each other. The influence, commonly referred to as “spillover,” may have neutral, positive, or negative consequences for the employed parent. In other words, the events and resultant feelings in one domain may enhance or compromise the individual’s performance and affective experience in the other domain. For some individuals, the spillover is primarily unidirectional, from family-to-work or work-to-family. Many individuals, however, who report spillover, experience the flow in both directions. The occurrence and experience of
spillover are determined by personal, familial, organizational, and sociocultural factors. The spillover of stress from one domain to another may enhance or inhibit role functioning in the recipient domain. The extent and nature to which the stress from one domain influences the relationships, roles, and performance of activities in the other domains varies across the multiple combinations of family and employing organizational structures, type of stressors, and coping resources (Eckenrode & Gore, 1990).

The third model, segmentation, postulates that the work and family environments are distinct in the areas of activity and effectivity and that each exists and functions without influence from the other. The two environments are separated by where the person is located, what the person is doing, and the positive or negative satisfaction derived from the activity (Evans & Bartolome, 1984; Payton-Miyazaki & Brayfield, 1976; Ledeck & Mosier, 1990; Judge & Watanabe, 1994). Zedeck and Mosier (1990) summarize Piotrowski (1987) by stating that “the family functions as the realm of effectivity, intimacy, and significant ascribed relations, whereas the world of work is viewed as impersonal, competitive, and instrumental rather than expressive” (p. 241).

Each work-family model suggests a different set of consequences for the well-being of the individual, the family, the employing organization, and the community. The areas of family relationships, psychological functioning, health issues, job satisfaction, and role quality are all impacted by the challenges of balancing job and home. The literature describes a limited number of strategies that buffer and lessen the negative effects of conflict and stress experienced by working parents. Couple and family-centered strategies include division of household chores, maintenance of social relationships, and role-cycling. Organizations are beginning to assume their responsibility by instituting family-friendly policy initiatives, such as parental leave, flextime, job sharing, and part-time work.

Work-family experiences unique to employed parents of children with serious emotional disorders need to be explored. The successful coping strategies and advocacy efforts generated by these parents should be included in the work-family literature and shared with other parents in similar situations.

REFERENCES


Medicaid funds a large and growing portion of all mental health services, especially those for those children and adolescents who have the most severe emotional disorders (SED). To control rising Medicaid costs, many states like Pennsylvania are requiring Medicaid enrollees to participate in various types of managed care plans. The two most common types of Medicaid managed care plans are prepaid or capitated plans (Prepaid-MH) and Primary Care Case Management (PCCM) or gatekeeper plans. Prepaid plans pay providers a monthly fee per person covered regardless of use, while the PCCM model generally pays providers on a Fee For Service (FFS) basis for mental health care rendered (FFS-MH). Thus, the incentives for restricting utilization are much more pronounced in the prepaid plan since the plan is ‘at-risk’ financially for care that exceeds the capitation rate. While the limited amount of research about the different types of managed care plans suggests that financing mechanisms employed in managed care plans dramatically affect use of services for enrolled populations of adults, no published data on enrollment practices, use of services, or outcomes of care for youth with serious emotional disorders (SED) exist.

We propose to evaluate the enrollment of youth with SED in two distinct types of Medicaid mental health managed care plans: Prepaid-MH and FFS-MH. We will be looking at those youth who are continuously Medicaid-eligible in Allegheny County (Pittsburgh) and who have psychiatric hospitalizations and multiple service needs. Specifically, the extent of enrollment in the plans and the characteristics associated with such enrollment will be examined, employing state Medicaid tapes and health plan data. We will also examine differences in use of mental health services, restrictiveness of care, access, family centeredness and cultural competence of mental health services, and clinical outcomes, including measures of symptoms, functioning, and contact with various service sectors for a cohort of youth with SED, continuously enrolled in Medicaid during their transitions into and out of managed care services. In addition to the utilization data obtained from health plan and Medicaid tapes, these patients and their families will be interviewed after enrollment in one of the two plans and then again at 6 and 12 months to examine change over time. We suggest that youth in FFS-MH will have more restrictive types of care and fewer family-based services, but greater perceived access than youth in Prepaid-MH. Finally, we will conduct in-depth ethnographic interviews of 50 African-American families to examine help-seeking behaviors, perceptions of health plans, and basic assumptions about need for services among minority families.
This evaluation study was submitted for funding as a collaborative effort among the State Office Of Mental Health, the State Children’s Bureau, the Western Psychiatric Institute and Clinic (WPIC), and Medicaid managed care plans in Allegheny County. The evaluation team is composed of experienced investigators with extensive involvement of clinicians, family organizations and community groups. Allegheny County, the study site, is characteristic of many metropolitan areas currently undergoing rapid transformation to a managed care environment and results are expected to be generalizable to Medicaid eligible youth with SED in many parts of the country.
PART II - ADVOCACY, TRAINING, AND FAMILY-CENTERED PROGRAM DEVELOPMENT

Title: Parent Resource Developer: An Essential Component of the Community Wraparound Initiative in Illinois.

Presenters: Cheryl Anderson, Carol Anne Redditt, JoBeth Antos, and Mary Lu Gebka.

Affiliation: Community Wraparound Initiative
1820 S. 25th Ave.
Broadview, IL 60153

The structure of a Center for Mental Health Services initiative in Illinois was presented. Parent Resource Developers, parents who have children with emotional disturbances and are familiar with the wraparound process, are employed to assist in the service coordination and support of families in the initiative. Examples of parent/professional partnerships in a wraparound project were demonstrated. Essential ingredients of successful collaboration were discussed. The role of the Parent Resource Developers as consultants to the initiative to preserve the integrity of the wraparound model was discussed. These consultation interactions are both formal and informal. Formal avenues are initiative team meetings, case conferences, and governing council level meetings. More informal interactions take place during Child and Family Team meetings and individual consultations with staff.

Parents also assist the initiative in the capacity of data collectors. These parents call families who are receiving wraparound facilitation to collect evaluation information and document this data. Challenges to family partnerships were discussed with a range of solutions offered and many examples of actual experiences were offered. An extensive question and answer session followed the presentation. Handouts distributed included: (1) major elements of Wraparound; (2) a form for Parent Resource Developers’ documentation of their activities; (3) personal perspectives of parent/professional collaboration, (4) a Community Wraparound brochure; and (5) a copy of Focal Point, Winter 1988, checklist.
This presentation outlined the growing school-linked services movement and collaborative effort between a school of social work and a public school district designed to enhance this effort in their community. The workshop reviewed the history of school-linked services beginning in the 1890s and the current state of school-linked services covered; the central role of collaboration in forming and implementing these programs; and described the Barry University - Dade County Public Schools collaboration which has served to enhance the lives of children and families, while also providing excellent learning opportunities for interns training as masters-level social workers.

While the move towards school-linked services (also known as full-service schools) is gaining momentum in the 1990s, social services in schools have existed for a hundred years. The emergence of this trend in the 1890s was prompted by many of the same factors that encourage it today: industrialization, urbanization, and immigration. Schools which had previously accommodated only wealthy children found their classrooms increasingly populated by a broad cross-section of children representing diverse ethnic and socio-economic backgrounds. This initial call for school-linked services began from outside the schools and from a range of professionals including doctors, dentists, members of women’s clubs, settlement house workers, foundations, and government workers. Support for these programs, which attempt to provide health and social services to children and their families at or near school sites, has ebbed and flowed over the century. The current move for school-linked services grows out of two primary goals: (1) to provide for families’ basic needs so that children can come to school ready to learn (i.e. not “distracted” from learning by hunger, disease, excessive emotional distress, etc.), and (2) to address service fragmentation within the health and social service systems that deliver overlapping, piecemeal and therefore often ineffective services. The premise behind full-service schools is the development of a system of services for children and families that are designed and administered collaboratively, and where there are neither gaps nor unnecessary duplications.

Collaboration is the preferred means of designing and administering school-linked
services. In its ideal form, it involves joint development and agreement on a common set of goals, shared responsibility for obtaining these goals, and working together to achieve them using the expertise of each collaborator. Collaborators in school-linked services often include clinics, mental health agencies, social services, legal services, departments of parks and recreation, and universities, along with the schools.

In 1994, Barry’s Associate Dean, Jacqueline Mondros, began collaborating with Dade County Public Schools to develop school-linked services programs. Grants were co-written and funded at two elementary schools: Gratigny and Fienberg-Fisher. In 1995, Barry hired a faculty-based field instructor to further develop and administer these programs, including supervising four M.S.W. interns at each site. The programs have developed very differently, based on a number of factors including funding sources and levels, population, and school climate and services. The characteristics of each program are outlined in the chart that follows. Elaborate qualitative and quantitative program evaluations are presently being conducted and the program will be expanding to middle and high schools in the coming academic year.
<table>
<thead>
<tr>
<th><strong>PURPOSE</strong></th>
<th>GRATIGNY ELEMENTARY</th>
<th>FIENBERG-FISHER COOL SCHOOL</th>
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<tbody>
<tr>
<td></td>
<td>To provide outreach services to families most in need.</td>
<td>To prevent gang involvement for at-risk 4th-6th graders.</td>
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<thead>
<tr>
<th><strong>FUNDING</strong></th>
<th>GRATIGNY ELEMENTARY</th>
<th>FIENBERG-FISHER COOL SCHOOL</th>
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<tbody>
<tr>
<td></td>
<td>As part of a larger Knight Foundation grant geared towards development of local community (identified as Pockets of Pride) Barry University allocated $27,000. towards the DCPS-BUSSW partnership.</td>
<td>A large grant of $280,000. was written by BUSSW and awarded to DCPS. DCPS subcontracted with BUSSW to provide social services for the project. The grant came from Metropolitan Life through the State Attorney General’s office.</td>
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<tr>
<th><strong>POPULATION</strong></th>
<th>GRATIGNY ELEMENTARY</th>
<th>FIENBERG-FISHER COOL SCHOOL</th>
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<tr>
<td></td>
<td>In-depth services are being provided to approximately 40 families, with less intensive programming for many others.</td>
<td>Services are being provided to approximately 150 students and families through this therapeutic after-school program.</td>
</tr>
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<tr>
<th><strong>ETHNICITY, RELIGION &amp; IMMIGRATION</strong></th>
<th>GRATIGNY ELEMENTARY</th>
<th>FIENBERG-FISHER COOL SCHOOL</th>
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<td></td>
<td>Population around school has been changing rapidly with increasing numbers of new immigrants. Student population is presently 80% Haitian.</td>
<td>Student population is 77% Hispanic from a variety of countries. Community is changing rapidly with increasing development and many new immigrants.</td>
</tr>
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<tr>
<th><strong>SOCIAL WORK INTERN ROLES</strong></th>
<th>GRATIGNY ELEMENTARY</th>
<th>FIENBERG-FISHER COOL SCHOOL</th>
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</thead>
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<tr>
<td></td>
<td>In-home family treatment; liaison for parent-teacher collaboration; broker for concrete services; facilitator for parenting groups and groups for children; planning and facilitating wellness fairs and workshops; program development, implementation and evaluation.</td>
<td>Facilitator for children’s groups; liaison with Cool School teachers; crisis intervention; referrals; individual and family counseling; program development, implementation and evaluation.</td>
</tr>
</tbody>
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<thead>
<tr>
<th><strong>ROLE OF PROGRAM IN FULL-SERVICE SCHOOL</strong></th>
<th>GRATIGNY ELEMENTARY</th>
<th>FIENBERG-FISHER COOL SCHOOL</th>
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<tr>
<td></td>
<td>Full-service school is expected to be fully implemented in 1996-97. This program is first component.</td>
<td>Full-service school became fully operational in 1995 and is a rich site for referrals and services for Cool School students and families.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>BUSSW COLLABORATIONS</strong></th>
<th>GRATIGNY ELEMENTARY</th>
<th>FIENBERG-FISHER COOL SCHOOL</th>
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<td></td>
<td>In funding with the larger university; in practice with School of Nursing &amp; School of Education; with community agencies, teachers, school administrators and of course, families.</td>
<td>In funding with DCPS, in practice with regular school and after school teachers and administrators, Washington Avenue Association, Miami Beach police department, and of course, families.</td>
</tr>
</tbody>
</table>

**Title:** Challenge Course/Youth At Risk Evaluation:
A Strength-Based Prevention Program

Presenters: Diane Davis
            JoAnn Ray

Affiliation: Eastern Washington University
             School of Social Work
             Cheney, WA 99004

Ropes Challenge Courses have become increasingly common as interventions among adolescents with behavioral and social problems since the 1960s. They are typically structured to include one-half to two days of outdoor group sessions that are focused on building trust, self-esteem, and teamwork, or whatever topic is most important to the particular group of participants. The design requires participants to engage in group problem-solving to address the physical challenges in a low or high course of outdoor obstacles, and to debrief and process the experience in an attempt to make applications to “real life.”

Outdoor structured activities, such as Ropes Challenge Courses, are typically utilized as interventions for youth coming from urban settings. Evaluation of such programs is scantly at best (Johnson, 1992). In this instance, the establishment of a Ropes Course in the midst of a remote rural region was a unique attempt to respond in a preventive way to the cumulative effect of unemployment, isolation, substance abuse, and poverty. The project draws youth (ages 10-19) from three remote rural counties clustered in the far north of a mountainous western state. This area has an 18% Native American population on two different reservations. One county has the lowest per capita income of the state and an unemployment rate of 16.9%. Parents are losing jobs in the two main industries, logging and mining. Preventive interventions that support families were scarce prior to the establishment of the Ropes Course intervention.

Approximately 1,000 participants completed the training yearly. Groups sampled included juvenile justice referrals, children of color, and intact groups such as schools or clubs. Like many rural projects, collaboration was a necessity for both the existence and maintenance of the intervention. Initial funding came from joint US Department of Agriculture and Juvenile Justice funds, but over 30 different agencies, youth organizations and community groups in the three counties provided adult volunteers and agency staff to collaborate with the Ropes Course staff on site. These included a tribal fire crew, staff from a treatment program for youth, the Northwest American Indian Children of Alcoholics sponsors, and county community mental health staff.

The expressed objectives of the project were to provide youths with a positive experience which was to increase life-skills, specifically: (1) to recognize and accept differences in others; (2) solve problems; (3) relate positively to others; (4) experience challenge as fun; (5) experience success; and (6) feel more comfortable with people. Participants commit
to a Full Value Contract, which emphasizes the importance of working together on individual and shared group goals, adhering to the safety guidelines preserving the emotional and physical safety of self and others, giving and receiving honest feedback in a sensitive manner, and experiencing fun.

The uniqueness of the project and the broad objectives presented a challenge and dictated an evaluation plan that combined both quantitative and qualitative data gathered before, during, and after the Challenge Course experiences. Perceptions were obtained from youths, leaders/chaperones, observers, and key community leaders, in order to capture the impact of the intervention on the larger rural community as well as the individual youth.

Data were available on 266 youths who completed the course from March, 1992, to December, 1994. Youth completed the modified Beauvais Instrument* (measures attitude change) prior to taking the training and 52 completed it approximately six months later. The Ropes evaluation instrument (effect of Challenge experiences on six objectives) was completed by 215 within two weeks after their Challenge experience. The participants ranged in age from 10-18, with a mean age of 12.9. The majority (80%) ethnically identified “a lot” or “some” as white, 45% as Native American, and 11% as Hispanic American.

While the results of the evaluation are positive, the interpretation still must be cautious because of small sample size, low return rate, and subjective instruments. The results of the evaluation indicate that at least some of the Challenge Program participants are experiencing the training as a positive influence immediately after the training. In addition, the post-test findings (six months after the Challenge Program) indicate that there may be longer term changes in attitudes related to the program objectives for some of the participants. The scores from the Ropes Evaluation instrument completed two weeks after the completion of the course continue to be high in each of the six objectives targeted by the project. The written comments by the participants reinforce the positive interpretation of the statistical findings.

The view of observers on the course substantiate further that there are differences in group dynamics related to the objectives from the beginning to the end of the training. Participants are learning to work together cooperatively, to trust, to accept each other, to relate positively, to have fun, to experience success, and to feel comfortable with people.

The responses to the follow-up questionnaire by leaders/chaperones indicate that the interest in using the course is high. The leaders are using the course in very creative ways to help both adults and children to develop trust, experience success, experience challenge as fun, build self-esteem, enhance communication, accept people with differences, solve problems, and build teamwork. Perhaps the greatest impact from the Ropes Challenge Program has been achieved by incorporating the Full Value Contract into the activities of already formed groups. Leaders report that the participants
internalize the concepts of the Full Value Contract and use them in their daily lives.

The community-wide acceptance of the Course is as exciting as the individual changes reported by some of the youths completing the course. The Course has become a permanent program with funding from the tribe, schools, and the collaborators. It is being utilized by diverse groups in the community: schools and youth clubs; a youth treatment program; the local Job Corps and Americorp programs; a substance abuse prevention program; a domestic violence/sexual assault treatment program; and the mental health center.

Thus, a common language and experience has permeated a large geographic area, even though people are geographically remote from each other and the population is culturally diverse. The program has earned acceptance partly by “saturation” in a conservative area, where resources are scarce and it often takes a long time for new ideas to gain a foothold. It is providing groups and organizations with experiential learning strategies that encourage individual growth and enhance relationships among persons in groups.

Several service implications are suggested by these findings. Prevention programs for high-risk youth in a rural setting require an array of interrelated activities in order to be successful and long lasting. In the case of the Ropes Course intervention, the ingredients for success include: (1) a simple, yet elegant philosophy (The Full Value Contract); (2) tangible performance accomplishments; and (3) assistance in generalizing success to other situations. The impact of the simple philosophy was enhanced by translating it to the idiom of the particular age group and by using the concepts in relation to situations and dilemmas that were real to the specific group of youngsters. Performance accomplishments were framed as cooperative rather than competitive. Winning meant risk-taking and learning from mistakes; thus, no one “failed.” Success was generalized at the end of each activity, at the end of each day, and by continued use of the concepts in other group settings. Group leaders in the community participated in the training with their group members, so a common bond of language and experience was established to carry over into the “real world.”

* Complete references not available from presenter.
The Louisiana Federation of Families for Children’s Mental Health has become a powerful force for ensuring that family participation in planning, delivery of service, and evaluation be considered an indispensable and intrinsic feature in assessing the health care needs of children with emotional disorders. The Federation recognizes the fact that families, working in a collaborative effort with health care professionals, are the best spokespersons in advocating for the child.

Experience has taught us that it takes more than professional knowledge and/or book expertise to deal with human beings. Basic human needs dictate that qualities such as love, caring, sharing, and nurturing remain prevalent forces in the cultivation of meaningful relationships. When a child who suffers from a disorder is subjected to an environment that lacks the presence of those he/she is most familiar with or those who have provided some form of bonding experience in the past, that child tends to respond by acting out, no matter how pleasurable the surroundings. Needless to say, health care professionals who recognize the value of having parents or family members present during an interview make their job of assessing the child’s needs easier and can, oftentimes, access doors to options of treatment that may otherwise remain closed.

Through the Louisiana Office of Mental Health and the Louisiana Federation of Families for Children’s Mental Health, the Louisiana Planned Respite Program for families of children with emotional/behavioral or mental disorders has been developed. Using the Federation’s philosophy for parental and family involvement, a respite care model program was developed utilizing the collaborative efforts of a task force comprised of mental health professionals, respite care providers, and parents from across the state. At the program's inception, two regions were identified to serve as pilots for the state: Region VI (Alexandria, Louisiana) and Region VIII (Monroe, Louisiana).
In May of 1993, the Louisiana Federation accepted a proposal from Alexandria Mental Health and the Volunteers of America to conduct a demonstration project. The project was to be a facility-based respite camp operated during the month of June. Based on the overwhelmingly positive response of family members to the camp, Alexandria Mental Health administrative staff decided to explore the possibility of continuing a facility-based planned respite program of this type and expanding it to offer services during the school year. A local task force was established to develop a formal respite plan for the region. It was the consensus of this task force that a facility-based planned respite camp operating year-round would meet the respite needs of a majority of families in the region. In addition, the group developed a plan that included a full range of respite services and provided for delivery of these services throughout the region, with special emphasis on isolated rural areas. Out of this initial program called PROPS, the Louisiana Planned Respite program for Region VI blossomed.

The first strategic planning meeting was held with the Family Crisis Center, Region VIII Provider, on March 15, 1994 to discuss implementation of the Planned Respite Pilot Project. This meeting was attended by family crisis administrators, regional mental health managers, and Federation of Families staff, parents, and family members. Among the issues discussed were training, program monitoring, evaluation, and quality assurance expectations. This meeting was the first of many to come but was instrumental in fostering a strong and productive relationship between the participants.

Throughout the developmental and ongoing phases of the program, families have played a definitive role in providing what they deem to be most important in organizing a productive and stable base for a results-yielding program. Placement of policies and procedures governing the program has been largely the responsibility of parents who have taken the initiative in (1) deciding how the program is to be run; (2) who will be the principal employees; and (3) what measures are to be used in acquiring data and feedback to gauge the effectiveness of the program.

Decision making for the respite program is carried out by a board of directors, made up of parents who have children with emotional, behavioral, and mental disorders. This board has gained the respect of mental health specialists and other professionals across the state. Their efforts in ensuring that parents have a voice in all aspects of their children’s treatment are evidenced by the number of parent support groups placed within the system and by the number of parents who are involved in the coordination process of getting families and professionals together for rallies, conferences, fund-raisers, and fairs.

Because the type of service provided is that of a respite camp, planning is crucial for success. The parent co-trainers devote a large percentage of their time to assisting personnel as they plan for such service. Once plans have been established and agreed on, the co-trainer is usually charged with the implementation process and begins by making initial contact with various merchants and vendors to purchase and/or acquire needed
items for camp. They also assist in providing transportation, technical assistance, and collection of monthly and tri-monthly data from parents who receive services from the program. On a routine monthly basis, Parent Satisfaction/Child Satisfaction surveys, consisting of a battery of questions on service and participation, are gathered up and taken to the many homes of families who participate in the program. Through a progression of dialogue and written queries contained in the surveys, important data and information is collected to be later used in the calculation process to chart and measure the satisfaction level of services provided and to gauge the effectiveness of the program in meeting the needs of both the parent and the child.

Data collected to date suggests that the services offered by the program are being well-received and are meeting families’ space needs for respite. The respite program is facility-based, and is held several times each month. Results have shown that of the families served by this type of respite, almost all are adamant about staying with the program and consistently express a high degree of satisfaction with the kind of service they are receiving.

There is some concern, however, as to the continued validity of the results, because of the frequency with which surveys are being conducted. General findings suggest that parents may respond more positively if allowed a break from the monthly routine of filling out survey questionnaires. In the next year of the program, attention will be given to putting together a focus group involving parents whose task it will be to offer input on how the survey instruments can be improved and to give suggestions as to the frequency of evaluations. Eventually, we hope to have respite programs set up in each of our state’s 10 regions. These programs will be operated under the direction of the Louisiana Federation of Families for Children’s Mental Health with parents being the principal administrators.

Of this there is no doubt: Families are being equipped with the knowledge and know-how necessary to make qualitative decisions as to the needs of their children as they continue to set the pace for involvement in the collaborative efforts of planning, service delivery, and evaluation with mental health care professionals.
Attention Deficit Disorder (ADD) is a neurobiological disorder which affects approximately five percent of all children. Researchers believe that neurotransmitters, the chemical messengers of the brain, do not work properly, causing symptoms of ADD. Inattention and impulsivity, the two major characteristics of ADD, can make complying with parental requests and succeeding in school more difficult for these children.

Symptoms of ADD vary from mild to severe. These symptoms improve with age and approximately 50 percent of adults outgrow the disorder. Some children with ADD do extremely well in school and pursue demanding academic careers such as medicine or law. However, for many others, underachievement in school is a hallmark characteristic of ADD.

Three major types of ADD have been identified: ADD/I/WO (predominately inattentive); ADD/H (predominately hyperactive-impulsive); plus ADAD (a combination of both hyperactivity and inattention). Children who have ADD/H tend to be very energetic, talkative, and outgoing. In contrast, children with ADD/I/WO, previously called ADD without hyperactivity, tend to be lethargic, less likely to talk in class, and introverted. Although many children are diagnosed and treated in elementary school, some children, especially those who are very bright or who have ADD/I/WO, may not be diagnosed until middle school, high school, or college.

Although they may be bright intellectually, many children with ADD lag behind their peers developmentally (3-4 years). They are less likely to remember their chores or assignments or to complete their work independently, are more likely to say things or act impulsively before thinking, and the quality and amount of their school work will fluctuate from day to day. Consequently, parents and teachers may need to provide more positive feedback, supervise chores and home and school work more closely, give reminders of chores or homework, and interact more frequently with each other to help the child cope with this disability.

Research has shown that medication can help most children with ADD improve their
behavior and performance at home and school. Medications commonly used to treat ADD, such as Ritalin or Dexedrine, help the neurotransmitters norepinephrine, dopamine, and serotonin to work properly. As a result, attention and concentration improve, more chores and school work are completed, compliance with adult requests increases, hyperactivity and impulsivity decrease, and negative behaviors decrease.

Frequently, ADD may coexist with other problems—learning disabilities (30%), sleep disturbances (50%), anxiety (30%), depression (25%), or oppositional behavior (65%)—which further complicates their treatment and school work.

The majority of children with ADD will experience difficulty at school (90%). Common learning problems and their practical implications for home and school performance are described below. However, keep in mind that each child with ADD is unique and may have some, but not all, of these problems:

1. **Inattention/poor concentration**: difficulty listening to instructions at home and in class; may daydream; spaces out and misses requests to do chores, or lecture content or homework assignments at school; lack of attention to detail, makes careless mistakes in work, doesn't notice errors in grammar, punctuation, capitalization, spelling, or changes in signs (+,-) in math; difficulty staying on task and finishing chores or school work; distractible, moves from one uncompleted task to another; lack of awareness of time and grades, may not know if passing or failing class.

2. **Impulsivity**: acts or speaks before thinking; rushes through chores or work; doesn’t double check work; doesn’t read directions; takes short cuts in written work especially math (does it in his/her head); difficulty delaying gratification; hates waiting.

3. **Cognitive processing problems**: slow processing of information; reads, writes, and responds slowly; slow recall of facts; more likely to occur in children with ADD/I/WO.

   **Listening comprehension**: becomes confused with lengthy verbal directions; loses main point, difficulty taking notes; difficulty following directions; may not "hear" or pick out homework assignments from a teacher’s lecture.

   **Spoken language**: talks a lot spontaneously (ADD/H & ADHD); talks less in response to questions where must think and give organized, concise answer; avoids responding in class or gives rambling answers.

   **Written language**: slow reading and writing; takes longer to complete work; produces less written work; difficulty organizing themes; difficulty getting ideas out of head and on paper, written test answers or themes may be brief; poor reading comprehension; can’t remember what is read.
4. **Poor organizational skills**: disorganized; difficulty getting started on tasks; difficulty knowing what steps should be taken first; difficulty organizing thoughts, sequencing ideas, writing themes, and planning ahead; loses homework;

*Impaired sense of time*: loses track of time, is often late; doesn't manage time well, doesn't anticipate how long tasks will take; doesn't plan ahead for future.

5. **Poor memory**: difficulty memorizing material such as multiplication tables, math facts or formulas, spelling words, foreign languages, and/or history dates.

*Forgetful*: forgets chores or homework assignments, forgets to take book home; forgets to turn in completed assignments to teacher; forgets special assignments or make-up work.

*Math computation*: difficulty automatizing basic math facts, such as multiplication tables, cannot rapidly recall basic math facts.

6. **Poor fine motor-coordination**: handwriting is poor, small, difficult to read; writes slowly; avoids writing and homework because it is difficult; prefers to print rather than write cursive; produces less written work; themes or discussion questions may be brief or poorly written.

Difficulties in school may be caused by a combination of several learning problems: a child may not do well on a test because he reads, thinks, and writes slowly, has difficulty organizing his thoughts, and/or has difficulty memorizing and recalling the information. A child may not take good notes in class because he can’t pay attention, can’t pick out main points, and/or his motor coordination is poor. Identification of learning problems plus implementation of appropriate adaptations in the regular classroom are critical. As explained in the U. S. Department of Education Memo of 1991, children with ADD whose ability to learn is adversely affected by the disorder are eligible for adaptations under IDEA, Section 504, or both.

Common classroom adaptations which are extremely helpful to children with ADD include: untimed tests; use of calculator or computer; modification of assignments (every 3rd math problem); elimination of unnecessary writing--write answers only, not questions; written homework assignments given by teachers; utilization of note takers or guided lecture notes, and dropping the lowest homework or test grade. Adaptations should be individual and made to accommodate each child’s specific learning problems.

Other factors related to ADD may also influence the child's behavior at home and performance at school:
1. **Hyperactivity**: Can't sit still in seat long enough to complete school work or participate in scouts or religious activities.

2. **Sleep disturbances**: Many children with ADD (50%) have difficulty falling asleep at night and waking up each morning. Approximately half of them wake up tired even after a full night's sleep. This suggests that there are problems with the neurotransmitter serotonin. Children may go to school after having major battles with parents because they don't get up on time. Since they may come to school feeling tired, they may sleep in class.

3. **Medication wears off**: Since effects of medications such as Ritalin or Dexedrine (regular tablets) wear off within approximately three hours, children may begin having trouble paying attention around ten or eleven o'clock in the morning. Behavior problems or school failure may occur during the window of time between 10 and 12:30 when medications are no longer effective. A sustained-release medication such as Dexedrine SR may be a good alternative to ensure all day medication coverage at school.

4. **Low frustration tolerance**: Children with ADD may become frustrated more easily and "blow-up" or impulsively say things they don’t mean, especially as their medication is wearing off. They may blurt out answers in class or impulsively talk back to parents or a teacher. Transitions or changes in routine, such as when substitute teachers are present, are also difficult for them.

Since most children with ADD are not as easily motivated by consequences (rewards and punishment) as other children, it is very difficult for them to have a natural love of learning. Although they would like very much to make good grades on a test or at the end of the semester, these rewards do not occur quickly enough nor are they strong enough to greatly influence their behavior. Frequently, they start out each new school year with the best intentions, but cannot sustain their efforts. Positive feedback or rewards are effective but must be given immediately, must be important to the child, and must occur more frequently than for other children. Consequently, sending home daily or weekly reports regarding school work should help improve grades. Remember, it is critical to make consequences instructive not just punitive. Teach the child the desired behavior.

Typically their misbehavior is not malicious but rather the result of their inattention, impulsivity, and failure to anticipate the consequences of their actions. "Ready. Fire! And then Aim” may more accurately describe the behavior of children with ADD. Belatedly, and with remorse, they realize they should not have said or done certain things. Giving children choices regarding chores or homework, for example, selecting their chore, determining which subject is first and establishing a starting time, will increase compliance and productivity, and reduce aggression.
Youngsters with ADD have many positive qualities and talents (high energy, outgoing charm, creativity, and figuring out new ways of doing things). Although these traits may be valued in the adult work world, they may cause difficulties for the child with ADD in a classroom. Their high energy, if properly channeled, can be very productive. Although sometimes exasperating, they can also be extremely charming in their self-appointed role as class clown. Typically, children with ADD/I/WO tend to be quieter and present no discipline problems. When they graduate from school, these youngsters can do well in life. Having parents and teachers who believe in a child is essential for success!!!
At some time in our lives, we have all been delighted by the beautiful changing patterns of a Kaleidoscope. By shifting the pieces, we are presented with an ever-changing array of colorful patterns, each one unique. I would like to turn the Kaleidoscope of our thinking and consider a new view of working with children in residential care that shifts the pieces and connects them in a pattern that offers families and children a new view of themselves and hope for the future. Kaleidoscope of Alternative House is a 60-day emergency care residence for children, ages 5 to 12, who have been abused, been neglected, or experienced some other traumatic event. These children are either seriously emotionally disturbed or at risk of becoming so.

The traumatic impact of abuse, neglect, and other stressful life events on children and on family relationships has been well documented. Compounding these problems is the grief of separation and loss that children experience when they are placed outside their family home or moved from one residential placement to another. As a result, these children often require a higher level of structure and care than is possible in a regular family environment. When a child is removed from his family, placing him in a stable, home-like residence helps prevent further psychological harm and begins the process of healing for the child.

A need existed in Northern Virginia for emergency out-of-home placements for children that would reduce the emotional trauma of the child's removal from the home and provide a stable environment while long-term plans are formulated. To increase the likelihood that the long-term plan would be successful, the emergency placements must be long enough for a thorough assessment to be made on which to base that plan. Kaleidoscope of Alternative House was developed to meet this need.

It is the mission of Alternative House programs to help children and youth live in family settings that offer nurturing parents or caregivers and the opportunity to develop caring and continuing relationships. All programming at Kaleidoscope is built on the fundamental belief that children develop their view of the world primarily from within their family environment. If we are to be successful in helping children we cannot treat them in isolation.

Stressful life events have a major impact on the child’s development and contribute to their emotional crisis. The degree of imbalance resulting from a stressful event is moderated by both one's crisis-meeting resources and the perception or appraisal of the
event. The development of a sense of competence is essential for clients to have the
courage to take the necessary steps to effect change. Competence is less a matter of
possessing skills than of developing a sense of your capacity to move forward in a healthy
manner. However, developing that sense lies in experiencing success in coping with
important tasks.

In developing the concepts that would guide this program, it was our goal to emphasize
family continuity within a framework that would reinforce the strengths and meet the
needs of children and their families. The ability to respond to the needs of these children
and their families requires a multidisciplinary, goal-directed plan based on a
comprehensive assessment of both child and family.

The short-term nature of the Kaleidoscope program dictates an approach to assessment
and service that provides for the child and family a means of transition to a new view of
themselves. Our primary task is to find ways to help them see themselves as potentially
successful and competent and able to build upon the strengths and resources they already
have. To do this, we must help our clients make sense of their experience and help them
see things differently -- “turn the Kaleidoscope.” This new perception will allow for the
continuation of the development of more acceptable and successful behavior after they
leave our program.

Within a home-like environment, the Kaleidoscope staff works to achieve the identified
service goals of the organization. These goals include:
1) Reduce trauma associated with removal from home.
2) Reduce frequency of re-placements.
3) Stabilize situation/behaviors leading to need for shelter/respite.
4) Provide multi-dimensional assessment of child and family needs.
   a. Physical and mental health assessment.
   b. Behavior assessment.
   c. Environmental assessment, including family, school and community.
5) Maintain appropriate ties between child and family during residential stay.
6) Recommend appropriate post-residential services, treatment issues, community
   resources and support in consultation with families and involved service agencies.
7) Provide residential family-focused services and post-residential follow-up.

Achieving these goals in a relatively short period of time is a challenge. The strategies
used are the heart of the program and woven into the fabric of the daily schedules.

The daily program is structured to provide a consistent environment that provides the
reassurance and safety of predictability. Most of the children have known only chaos and
unpredictability in their lives. A structured environment is essential, providing the child
with a sense of safety. An in-house alternative school, staffed by a teacher from the local
school system trained in special education techniques to meet the unique needs of
children with emotional disturbances, has proved less disruptive for the children during a time of crisis by providing a consistent environment.

A part of the structured environment at Kaleidoscope is a set of behavior expectations or “House Rules” that is explained to the resident on admission to the program and consistently enforced throughout their stay. The “Rules” are stated in positive language and focus on “Do” rather than “Don't.” Consequences aim at providing an opportunity for the child to discover something new about themselves, their behavior, and their ability to control their behavior and its outcomes.

A number of behavior management techniques have been adopted that increase positive behavior, decrease negative behavior, and address the special needs of the abused child, the aggressive child, and the isolated child. Physical restraint is used as a last resort and only when the child's behavior is a serious threat either to the child or to others, or could result in significant property damage.

One of the key components in implementing the individualized service plan and motivating the children is the “Star Chart” incentive system. The Individualized Services Plan is translated into daily goals which are listed on their Star Chart. Each child works toward an individual weekly incentive. All the children work cooperatively toward a weekly group incentive selected by the entire group. This group incentive builds teamwork and teaches social skills.

Family work begins at intake. The assessment process is ongoing throughout the child's stay in the program and is facilitated through family therapy sessions and weekly visits to the program. When the child is not returning home upon discharge from Kaleidoscope, the family is also involved in helping the child make a smooth transition to the next placement. Parents who call or visit with their children regularly provide the connection and sense of continuity so important to a child's sense of well-being. We encourage parents to call their children regularly. A special family visitation time is set aside for Saturday and Sunday afternoons. Other visits are arranged on request.

We have made an effort to structure our behavior management techniques in a manner that can be used in a normal family environment. The counselors prepare a list of behavioral observations and make recommendations about what methods seem to work or not with the child.

We consider Kaleidoscope a “work in progress.” We are constantly challenging our assumptions about how to best work with these children and their families. Our hope is to see additional emergency-care residences developed. Additional programs will expand our ability to work toward the mission of the organization: To help children and youth live in family settings that offer nurturing parents or caregivers, as well as the opportunity to develop lifetime relationships.
Most studies of incarcerated juvenile offenders reveal that emotional, behavioral, learning, and developmental disabilities are found in disproportionate numbers in this population. Characteristics such as impulsivity, poor judgment, inadequate problem solving skills, and truancy are often mentioned in describing young offenders. These behaviors are also typical of disabilities such as Attention Deficit Disorder (ADD), learning disabilities, and Conduct Disorder, which are the disabilities most commonly identified in this group. Other disabilities found in greater numbers than in the rest of the population are developmental disabilities, depression, and Post Traumatic Stress Disorder.

Moreover, it is not uncommon for more than one disability to coexist with another. For example, learning disabilities and depression are often found to coexist, and, among the more chronic offenders, Attention Deficit Disorder and Conduct Disorder are commonly identified. It is not unusual to see persons with Mental Retardation and ADD become involved in aggressive behaviors.

Once many of these youngsters enter the corrections system, there appears to be no consistent mechanism to enable them to receive the educational, vocational, and mental health services to which they are entitled under IDEA, the federal Individuals with Disabilities Education Act. Ironically, for many of these youth, the acquisition of academic, verbal, and vocational skills and social competencies could reduce feelings of frustration and failure that are also associated with a higher risk for violent or criminal behavior.

The presence of a disability is never an excuse for engaging in criminal behavior. But knowledge of a disability should necessitate the development of a dispositional plan that integrates special education and related services. Greater effort needs to be made in the courts to identify those youths whose behaviors may warrant further screening or evaluation. It is estimated that 50% of young offenders have undetected learning disabilities.

The presence of a disability is only one risk factor in the development of violent or criminal behavior. A number of social, environmental and behavioral risk factors are thought to interact in this complex process. Representative factors in each of these
categories include: low birth weight, birth trauma, and attachment difficulties; history of family violence, abuse and neglect; early aggressive behaviors and disciplinary contact with authorities; early association with a deviant peer group; access to firearms; alcohol and drug abuse; and a family history of mental illness.

Youths with disabilities who enter the juvenile justice system could be categorized in the following way: (1) those who qualify for special education services and currently have an active Individual Education Plan (IEP) or a 504 plan, (2) those who at one time received these services and have dropped out of school, and (3) persons who have disabilities but who, for a variety of reasons, have never been identified within their school districts.
Kenai, Alaska is a small rural fishing community with a population of roughly 12,000 for the area. The mental health center services Kenai, Soldotna, and approximately six other communities. Tourism, fishing, and oil are the mainstays of the economy, with 18% unemployment by November each year. The community consists of a multi-cultural population, including Alaska Natives and members of Indian tribes, Taiwanese, and Caucasians, who are all consumers of the mental health center.

Central Peninsula Counseling Services is offering a new, innovative program to children and their families, to promote the stability and community support of children and adolescents who are severely emotionally disabled. The program, called Intensive Rehabilitation Services (IRS), is modeled after the Alaska Youth Initiative program, providing “individualized wraparound” services, which are created and utilized in the community according to the needs of a particular youth and his or her family.

IRS youth are Medicaid eligible, have severe emotional disabilities, and are at risk of being placed in a residential setting, a hospital, or a foster home. The goal of IRS is to maintain the youth's stability in the home, school, and community in the least restrictive setting. The program provides “individualized wraparound” services as needed by the youth and family to achieve this goal.

Initially, a therapist will do a complete assessment of a youth under the age of 18. This assessment will include meeting with the youth and his/her family to identify strengths and problem areas and services which have and/or have not been utilized. The therapist may recommend a psychological or psychiatric evaluation as a part of the assessment. If the youth is at risk of placement outside of the home, has a history of multiple placements, or is at risk of additional placements such as foster care, hospitalization, and or a residential facility, s/he may be referred to IRS.

Once a referral has been made to the coordinator of IRS, the core service team members are identified. The team may consist of, but is not limited to, the youth, parents, foster parents, respite providers, therapist, program coordinator, school/tribal representatives, a child protective services social worker, and a guardian ad litem. Each of these individuals is invited to the initial team meeting by the program coordinator.
At the initial team meeting, the core service team determines eligibility of the youth for this program. S/he must be eligible for Medicaid under which a request for prior authorization, authorization, and/or extensions must be filed as appropriate. The team must decide whether or not IRS will meet the needs of this youth and the family. To determine this, the team examines the needs of the youth and family in the home, the school, and the community.

After acceptance into the IRS program, the team evaluates the services that are already being provided to the youth and his or her family. In order to individualize wraparound services, the team must be prepared to create services where there is a need, but no service is being provided. For example, if the parents are in need of respite in order to reduce the stress in the home, then the team must support hiring a respite provider. It is important to note that this program is meant to build on the services that are already being provided, not replace them.

The Coordinator sets to work training and hiring for parents, foster parents, respite providers, and aides. Since many of the youth in this program are in the state's custody, it is important to reciprocate coordination with the Division of Family and Youth Services, in terms of hiring respite and foster care providers. The therapist can be critical in assisting in training aides and respite providers regarding specific issues of the youth and the family. It is often the therapist's responsibility to bring the biological family in contact with the therapeutic foster family in the healthiest way possible. A powerful therapeutic tool is to have all of the adults in the youth's life working together.

It is the core service team's responsibility to create the treatment plan. Among the list of services on the treatment plan, Intensive Rehabilitation Services must be listed. In addition, more specific services which will meet the youth's needs should be listed as strategies to address the objectives of the treatment plan, such as (1) a one-on-one aide; (2) individual, family, or activity therapy; (3) a therapeutic foster family; (4) crisis intervention; and (5) family support. Everyone involved in the life of the youth should be working from the same plan, which has been signed by all of the core service team members. The treatment plan is an adaptable set of problems, objectives, and treatment strategies that can and does change as the youth changes. As issues are identified and resolved, the treatment plan should reflect this progression.

A 30 day review team meeting is scheduled at the initial meeting. By the end of the first 30 days it is expected that all services should be on line and the treatment plan implemented. Once the services have been reviewed and it is determined that all needs are being met that are possible, then the team will meet every 90 days, unless an emergency meeting is called by one of the team members.

The team should discuss transitioning the youth out of IRS at the initial determination of treatment goals and objectives, as well as during the time they are being completed and
when stability has been achieved. This transition period may take place over a period of months, slowly backing off on the services, and allowing and encouraging the family to use their own resourcefulness to handle day-to-day problems, instead of relying on the team and the aides. Transition can be exciting yet scary for the youth, the family, and the team. It is during transition that we have seen regression of the youth, and problems resurface that seemed to be under control. It is important for the team to work together to make transition as smooth as possible.

Once the youth has successfully completed the transition phase and stability has been achieved and maintained for the duration, the youth is then discharged from the program. Services may still be provided to the youth and her/his family, but with less intensity, relying more on the family's own resources and problem-solving skills.

This program has shown a great deal of therapeutic promise: It addresses the needs identified by the family and supports multi-agency community collaboration. Additionally, the team supports the family strengths, helping to build on those strengths by providing counseling addressing the youth's needs in a therapeutic manner. It is essential to recognize the team as a family support system, which helps to preserve the family unit.
There is much agreement across disciplines that parents of children with disabilities need to be empowered. There is a growing acknowledgment that populations that are the target of research should be full participants in that research. For parents to be full participants they need to be given at least a basic training in research methods. Parents are especially important in research on empowerment.

In seeking to include parents of children with disabilities in discussions of research on empowerment, two separate but equally important components must be addressed. First, not only parents, but almost anyone who has not had formal instruction in social science research is likely to believe that research is dull, technical, intimidating and not something he or she would like or understand. Research is associated with statistics and academia, a world unto itself. However, the basic information needed to understand and even help design research can easily be taught in a couple of hours.

It is not necessary to be a scholar to become conversant with what aspects of the topic have been studied, what the findings were and to formulate opinions about what else needs to be studied and the best way to gather information from the population of which the individual is a member. Rappaport (1987),** in a list of eleven considerations for developing a theory of empowerment, stated that “The people of concern are to be treated as collaborators; and at the same time, the researcher may be thought of as a participant, legitimately involved with the people she is studying.” To participate fully, parents need training in the fundamentals of research and a context for understanding the topic in question.

The second component has to do with the concept of “empowerment” itself. As widespread as it is elusive, the concept of empowerment is of the utmost importance for parents of children with emotional and behavioral disabilities. At the same time, the term is losing its potency due to overuse and lack of definition. Some interesting work has been written on the subject by authors such as Carl Dunst (North Carolina); Julian Rappaport (University of Illinois, Champaign-Urbana); Craig Anne Heflinger, (Vanderbilt University), Moncrieff Cochran, (Cornell University); and Paul Koren, Neal DeChillo and Barbara Friesen (Portland State University), among others.
One common view of empowerment is as a process by which members of a
disenfranchised, oppressed or otherwise marginalized group gain control of and/or access
to needed resources and/or their environment. Exactly how this process is triggered and
how it unfolds is less well known. It appears to be developmental in nature, and a better
understanding of the process would be helpful for all “would-be” and experienced
advocates and organizations, to better assist parents in becoming effective or
“empowered.”

No really systematic research has been done on how advocates develop. However,
Charles Keiffer (1984) and Rosalyn Benjamin Darling (1987) are two authors who have
addressed the processes formally. Both have outlined stages which are roughly parallel
(1984) studied community activists. The common element at the outset was an event
which seriously threatened the security and stability of the individual or family. As the
individual proceeds, there is a process of learning and maturation. Darling, (1988) likens
it to a career. Often, the scope of the individual’s advocacy becomes broader and moves
beyond the parent's own immediate concerns.

Looking at advocacy and empowerment as a developmental process gives some
objectivity and structure to the role of the parent in advocacy. Much damage to a cause
can be done by “immature” advocates lacking guidance. Understanding the process
equips the advocate to better help him/her self and others. Keiffer, (1984), defined
empowerment as “a process of becoming, as an ordered and progressive development of
participatory skills and political understanding.”(p.17)

By learning to access and participate in professional research, parents widen their
perspective, gain credibility in communicating with professionals, and become better able
to contribute to the development of concepts and practices which may impact them and
their children. This workshop served as an introduction for parents to social science
research. It provided an overview of the literature on “empowerment” useful not only to
parents, but also to clinical professionals who do not have time to search the literature on
a given topic.

* Affiliation at the time of this presentation.

** References unavailable from presenter.
The research has indicated that it is migration, the movement of people from one region to another, that has allowed for the diversity of cultures that are evident in this society (Ernst, 1949; DeVore & Schlesinger, 1991; Jenkins & Morrison, 1978). It is also this migratory pattern that has allowed for many of the families that find themselves in a given community residing in transient or marginal living situations. The research also supports the evidence that migratory patterns results in a change in group membership, which often necessitates the individual’s need to restructure his or her role in a given environment (DeVore & Schlesinger, 1991). This need to restructure one’s role can lead to the development of behaviors that are perceived as maladaptive which can then plummet families into the child welfare system (Derezotes & Snowdon, 1990; Laird & Hartman, 1985).

Family support programs, with their emphasis on parental involvement, provide a critical service within this transient, homeless population. These programs serve to deter the placement of children in foster care while providing the needed support to families with children who have emotional impairments. This presentation looked at an existing family support program as a viable means of intervention in order to deal with difficulties within homeless families, especially as they transition from various homeless facilities in the social welfare system. The model for this family support program is preventive in its approach rather than curative in approach, as is typical of most programs in the social welfare system (Weiss, 1989). This family support program continues to focus on building on the strengths of families rather than focusing on the perceived deficits of these families (Zigler & Black, 1989).

We also explored the role of professional staff as potential sources of motivation that can be harnessed by families in order to promote positive and enduring changes within the family systems (Laird, 1985).

REFERENCES


As indicated by the trend in society today, minority families do not receive the same in-home services and treatment that other ethnic groups benefit from. Often this occurs because the service agency does not know how to recognize and deal with the problems of the families. It is not only the system that is not prepared, but the workers are often not prepared to deal with what they find in minority families.

In South-Central Los Angeles there is a program that is addressing these issues: The Black Family Investment Project. This program is under the auspices of the Los Angeles County Department of Children and Family Services (DCFS). DCFS also investigates all cases of alleged child abuse and is responsible for the safety of every child in Los Angeles County. DCFS, as of January 1994, showed that 57,263 children and their families received protective services. Of the families served, 47% were African American. Over 50% lived in South Los Angeles. These figures are staggering and continue to show the need for family preservation services for African American families in South-Central Los Angeles as well as other areas of Los Angeles County.

The Black Family Investment Project was formed in 1990 out of the mutual concern of the Los Angeles Black Employees Association and the African American Social Workers of the Los Angeles County Department of Children and Family Services. There were four main issues that both of these entities wanted to focus on: (1) the disproportionate numbers of African American children in foster care and group homes; (2) the changing African American family structure; (3) the decline in the socioeconomic status of the inner-city; and (4) the existing gang crisis within South-Central Los Angeles which directly impacts African American children and their families.

The purpose of the program is to help African American families stay together, by assisting parents to develop new strategies to rear their children, and techniques to guide their children in their struggle away from anti-social activity and destructive gang involvement. Specifically, this project provides short term, intensive, in-home family and community-based services to African American families, and culturally sensitive, pre-placement prevention and family preservation/support services to children at risk of removal from their families, within a highly impacted area of South-Central Los Angeles.

All direct services are provided by Children's Social Workers (case managers) who have been certified by the California State University-Northridge Pan African Studies
Department, and the National Council for Black Studies as Black Family Specialists. Each family agrees to remain in the program for six months. The main goal of the program is to return the graduating family to the formal structure of the community. Additionally, an alumni group is formed to serve as a continuing support network (an extended family substitute).

To date, 87% of the families served remained together: Only 12% of the families were involved with the Court and only 5% of children were placed in foster care. The mission of the Black Family Investment Project and the Department of Children and Family Services is to: PROTECT CHILDREN AND STRENGTHEN FAMILIES!
This presentation outlined the therapeutic model developed by the Albuquerque Area Indian Health Board child and family program, to provide effective, early intervention mental health treatment services for Native American children at-risk. The program is based on strengthening families by fully engaging parents in the therapeutic process, and giving them their rightful place as their children's teachers and positive role models.

Our work is based on a synthesis of traditional and western psychological concepts and practices. We incorporate the belief that we are all related and interconnected, and the value of the extended family in child raising, into a systems approach which assumes that the well-being of children is dependent on the strength of the family as a whole. We work as male and female co-therapists, which helps us to model a variety of interpersonal relating skills and enables us to provide a variety of interventions, sometimes concurrently. For example, one of us might work with a child, or children, in the playroom, and the other with the parent in our family room. When we are working with couples and the family as a whole, as therapists we are strengthened by our partnership to model skills our clients wish to learn, and to deal with multiple issues that arise in each session, some of which we might miss, get caught up in, or be overwhelmed by, if alone.

Within many Native American families, specific historical traumas and losses such as forced removal of children to far off boarding schools, relocation of whole tribes, confiscation of land and livestock, and introduction of disease and alcohol, cut people off from each other, their roots, their traditional practices, their livelihood, and themselves. Within every troubled family we see that there are broken connections and appropriate feelings of pain, anger, sadness, fear, loneliness, and mistrust which have led to inappropriate behaviors such as chemical dependency, domestic violence and/or physical and sexual abuse. At the heart of the healing journey is an effort to restore connections among family members, and re-frame events and behaviors to help people find positive elements in the past, in themselves, and in each other which they never believed existed. By placing individual problems within a larger context and connecting these problems with a lack of awareness of alternative ways of being, we relieve children and parents of blame, honor their efforts to survive under very difficult conditions, and create an expectancy for positive change in the future.

Enhanced awareness is a major element in the healing journey. We begin our work with children and their families by identifying the strengths and resources already utilized in
their survival efforts. This approach helps engage our clients and lays the foundation for trust and for lasting, positive change, because the potential for change is rightfully perceived as within themselves. We work together with each family to set achievable goals for the family as a whole and for each individual member (because there are many risk factors in our families where everyone is affected, including poverty, divorce and single parenting, alcoholism and abuse), and identify the resources needed to reach these goals. Our treatment plans are a joint effort to make an honest appraisal of who needs to work on what, and of how we will go about it. Our aim always is to support the natural desire of each parent for their children to grow in a good way. We use many different tools and techniques from different traditions, and rely heavily on the use of stories, symbols, and metaphors that reach into the heart and spirit, wherein we believe lie our greatest natural healing resources.

We provided a practical application of our model through the story of our work with “Redwing,” a five-year-old boy whose father fatally shot first the boy’s mother, then himself, and of our collaboration with his maternal grandmother who is raising him. In Redwing’s story, we see how loss, pain, and uncontrolled rage have dominated the lives of people in this family for four generations, and how it is being channeled and transformed in Redwing. We illustrate how symbols, such as that of the butterfly, naturally emerge to facilitate the therapeutic process. This story, and those of each of the families whose healing journeys we have been fortunate enough to be part of, supports our conviction that each of us inherently possess strengths and resources for healing, including an instinctive knowledge of what needs to be done to handle even the most difficult situations that help us move beyond tragedies such as the one Redwing and his grandmother experienced. It also teaches us what effective therapy is about, and how a true collaboration with our clients facilitates our own growth.
Title: Bridge Builders: Individualized, Tailored Care
By Parent Partners

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Bridge Builders is an independently functioning group of parents, trained and experienced in individualized, tailored care service (a.k.a. wraparound). The Bridge Builder is a trained parent partner who is responsible for the mentoring of other parents in the wraparound model. They serve as a member of a family's Child and Family Team, and act as a parent/mentor, helping the family understand the process and assisting them in getting their needs met. The primary goal of the Bridge Builder is to assist the family in obtaining the necessary support to enable their child to live at home and in the community. These supports may include: (1) Parent mentoring one-on-one; (2) acting as a liaison between systems and the family; (3) acting as a sounding board for the family; (4) acting as a voice for the family when the family feels they cannot speak for themselves; (5) acting as a partner with the family to create a natural support system; (6) being on a Child and Family Team, mentoring and advocating for the family; and (7) being a source of information and referral for the family.

The primary goal of this project is to enable families to move toward independence in accessing and engaging the community's involvement and resources. The objective of the Bridge Builder is: (1) to increase family self-sufficiency so that the child will be able to live at home and in the community; (2) to help the family become productive, contributing members of the community; and (3) to help the parents become self-empowered and have less disruption in their lives due to socioeconomic and environmental influences. If at-home placement is not a possibility, then the goal for the child is the most appropriate, long-term placement available.

Currently, there is an interagency oversight committee which meets regularly to oversee and work on the development of this project. The committee includes representatives from the Clark County Regional Support Network and the Clark Alliance for the Mentally Ill, a program coordinator, and several trained parents.

To participate as a Bridge Builder you must: (1) receive training in individualized, tailored care; (2) be the parent of a child with complex needs or have observed a Child and Family Team at work; (3) commit to at least six months as a Bridge Builder on a
team; and (4) commit to regular training and a support group. The configuration of the teams allows for cultural competency in that the team should be at least 51% natural support for the family. This support consists of the family and friends who best know the child and his or her circumstances.
Since 1990, the Illinois State Board of Education has made significant efforts to support the development and delivery of comprehensive community-based services for children with emotional and behavioral disabilities (E/BD) and their families. Specifically, the Illinois State Board of Education has provided funding to eleven project sites designed to identify and develop the network of comprehensive supports needed by families to maintain their children in their homes, schools, and communities. The major focus of each of the projects was the development of collaborative partnerships with community agencies, schools, and families as the first step toward improving the traditional system of care.

The projects were created in response to the recognition that students identified as having emotional and behavioral disabilities have been served by a system that is fragmented, under-funded, and has little or no flexibility in service provision. Most significant is the lack of parent voice and partnership in all levels of service delivery.

To address the absence of opportunity for family involvement, projects assessed existing structures and procedures within schools and agencies in order to begin the process of moving toward a more flexible, family-centered, and coordinated system of care.

The wraparound model was used by each of the sites to achieve project goals. The wraparound process requires a flexible, non-traditional approach to working with students and families. A network of supports are "wrapped" around a youth and family, and the community is viewed as the natural site of intervention. Plans are individualized and are
based on the strengths and skills of each family. Parents are not only viewed as partners: They drive the planning process by identifying supports and services needed to help them maintain their children at home.

This presentation focused on one of the project sites that has moved from poor parent access to including parents as team members to the current practice of hiring parents to work with families to develop and coordinate wraparound plans. Two parents described in detail their challenges and perspective on navigating the service system as advocates and facilitators. Issues concerning continued funding, training needs, and support from various systems were discussed.
In 1990, United Parents for Children and Adolescents with Emotional, Behavioral, and Mental Disorders was founded as an independent parent support organization dedicated to teaching the parents of special needs children to understand the complex multiple systems upon which their children and families were dependent for care. United Parents (UP) became an equal partner in that system and worked closely with Ventura County Mental Health and other county agencies in developing programs that truly met the needs and desires of the families.

In 1994, this partnership reached its pinnacle when United Parents was asked if they would like to be partners in a respite program funded by federal grant money. After agreeing to participate, completing the grant application, and receiving notification of funding, UP, Ventura County Mental Health, and Interface Children and Family Services sat down and outlined plans for the respite program and the roles each entity would play in the operation of the program.

The original concept for the respite care program was conceived by Ventura County Mental Health as therapeutic and crisis service. A needs assessment was developed in cooperation with UP and it was learned that what most families of children with serious emotional disorder (SED) want is access to child care and community supports, like any family. They lose access to traditional community support such as the YMCA and Boys and Girls Clubs because their children are excluded due to their behavior. By having the families design and operate the respite care services, the emphasis focused on strengthening community child care systems and providing family to family support.

Ventura County Mental Health was the grant writer and is the fiscal agent for the grant, and also serves as a consultant. Interface hired a program coordinator who hires and trains respite workers. The program coordinator provides ongoing consultation and support to the workers. She also trains the staff at the recreation sites targeted to provide services to our families. The coordinator helps with the matching of the worker and the family. UP is the first and primary contact of the families. UP is the administrative
agency for the program, keeping records and files for the families and – with the families – developing and modifying program guidelines to meet families’ ever changing needs.

The program, named the FUN project, offers planned respite care for families by trained workers. Each family is allotted 20 hours of respite care per month which they pay for based on a sliding scale. Community programs are available as a resource to families, allowing our kids a chance to participate in social and recreation activities. Special activities include an overnight campout, picnic, hayride, sailing trip, and visits to local attractions of interest to the kids. The respite program now provides free child care to families during monthly UP meetings.

At the time of this presentation, after one-and-a-half years in existence, we have 50 families with children ages 5-16, 30 trained respite workers, and seven trained sites, including Boys and Girls Clubs and YMCAs. We have been able to aid in emergency situations such as suspensions from school. Some of our workers are receiving college credit for working in our program. Future plans call for expansion of the program to include Boy and Girl Scouts, soccer association, Little League baseball, and other after-school athletic programs.
Hawaiian-Style Training: An Analysis of Curriculum Development in Support of Families Whose Children have Serious Emotional Disorders

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Hawaii Families As Allies (HFAA) was established on the premise that family members of children with emotional, mental, and behavioral disorders should always be active and equal participants with service providers in assessing the need for and developing the types of services their children require. During the past several years of conducting community training workshops and support group meetings, HFAA received numerous comments and suggestions from parents and family members as well as from educators, mental health workers, and other service providers throughout the state of Hawaii about providing support to families in their quest to obtain useful information and appropriate services for their children. In addition, the entire HFAA staff had the ability to draw upon their own personal experiences, since they are all parents or foster parents of children with serious emotional disturbances.

In early 1995, HFAA decided to utilize all this valuable community input and incorporate it into the development of a new training curriculum. The final result was that not one, but three new training tools were developed by HFAA which: (1) are based upon the expressed desires and needs of family members; (2) provide participants with an understanding of serious emotional disturbance in children and adolescents; (3) acknowledge and validate the feelings and emotional reactions of family members about their child's behavior; (4) offer family members coping strategies and skills to deal with the child's behavior; and (5) promote the development of appropriate services which address the unique needs of the child and family.

The first curriculum offers participants an overview of behaviors and symptoms which might be associated with serious emotional disturbance; briefly discusses the different types of disorders (e.g., anxiety, conduct, attention deficit, schizoid, oppositional, pervasive developmental, etc.) and how they affect a child's functioning; takes participants through the Hawaii Department of Education's (DOE) identification and evaluation
The second curriculum takes participants on a tour of various emotions and feelings they might encounter on their journey of rearing a child with serious emotional disturbance (e.g., shame, guilt, sorrow, denial, anger, withdrawal, fear, confusion, etc.); allows participants to identify and express their personal reactions to their child's behavior in a drawing and then interpret their drawings for each other; acknowledges and validates participants' feelings about their child's behavior in preparation for them to move on to the next step; offers suggestions for coping strategies; and ends with an invitation to participate in other training workshops and support groups offered by HFAA. Materials for this workshop consist of excerpts from “Taking Charge: A Handbook for Parents Whose Children Have Emotional Handicaps” which was produced and distributed by the Families As Allies Project and Portland State University’s Research and Training Center on Family Support and Children’s Mental Health and used with their permission.

The third curriculum features some of our favorite comic strip characters in classic situations which depict characteristics of Attention Deficit Hyperactivity Disorder (ADHD or ADD). Participants receive a copy of the DSM-IV criteria for ADHD/ADD and an introduction to the Hawaii Department of Education's (DOE) identification and evaluation procedures and time line once again, utilizing the official DOE Evaluation Request Form. The curriculum ends with an invitation to participate in other training workshops and support groups offered by HFAA.

Since May 1995, these trainings have been presented in several communities to parents and family members, caregivers, educators, mental health workers, and other service providers. It is notable that Hawaii is a state where every community contains a culturally and racially diverse population. Data collected regarding the trainings has included the following: (1) number of times each curriculum was presented; (2) number of participants (parents/caregivers, professionals, others, total); (3) participant ethnicity; and (4) participant evaluation ratings of training objectives, curriculum content, hands-on activities, materials/handouts, and effectiveness of the presenter. A statistical analysis of this data indicates that the training curricula have been well received by family members and service providers alike, providing the kind of information and support they desire and find useful.
This symposium described a new program initiative entitled F.A.S.T. (Family Advocacy Support Team) aimed at assisting urban families with a child who has an emotional/behavioral disorder. The presenter described the rationale for providing comprehensive, community-based, and in-home services for families and the existence of F.A.S.T. as a viable model for family support.

F.A.S.T. represented a three-year project, funded through a private foundation, to build a system of support for families from urban areas faced with the challenges of raising a child with serious emotional problems. This presentation demonstrated how communities can reinvest in and minister to themselves through volunteer involvement and outreach to families.

The F.A.S.T. program consisted of five program areas: (1) Emergency response family assessments; (2) Community education for families; (3) In-home psychoeducation and support; (4) Community education for providers; and (5) Development of staff/volunteer training manual.

The F.A.S.T. program was offered to families of urban Essex County in New Jersey which consists of four primary cities including Newark (New Jersey’s largest and most densely populated city), East Orange, Orange, and Irvington. The make up of the families served closely paralleled the populations of these cities. Most of the families served were African American; some (especially from East Orange), were families of various Caribbean nationalities. There were some Spanish speaking families of Puerto Rican or Central American descent.

Conference participants were asked to volunteer introductions of themselves, focusing on what they felt was their best quality and/or shining accomplishment. In addition to this exercise providing an introduction, it also served to bring to light the difficulty that many people have in announcing their qualities, talents, accomplishments, or, in a word, STRENGTHS. This was an important concept to raise in the context of a "Building on Family Strengths” Conference. It was noted that for some individuals such disclosure may be difficult due to personal/cultural beliefs and practices. We also discussed the fact that persons or families exposed to intense or long-ranging difficulties, such as coping with childhood emotional/behavioral problems, poverty, and racial/social oppression, often have a tendency to be focused on coping with crisis rather than having a balanced
awareness of positive situations in their lives or relationships. After initial introductions, a slide show with audio commentary from children, families, staff, and volunteers provided a first hand view of the program at work.

F.A.S.T. defined family as any group of caring and care-giving persons involved in a child’s life, whether they be part of the traditional nuclear family, extended family, or nontraditional family constellation. Most of the families served by F.A.S.T. consisted of single-parent-headed families that were either isolated from other family or neighbors or who were part of an extended family system. Many were grandparent-headed families, with grandmothers often raising children in the parents’ absence. In these cases, parents were often absent from the family due to drug use, incarceration, mental illness, or death (many families were affected by losses through HIV/AIDS).

Volunteers and staff approached families from a supportive perspective in order to lend support and information to those coping styles and strategies that the family used. Respect for family strengths and for cultural diversity was emphasized.

Advocacy related to the F.A.S.T. worker's role of encouraging family members to be strong self-advocates and advocating with, or on behalf of, families as necessary. For many of the families served, the stresses that they face in raising a child or children with serious emotional/behavioral difficulties have decreased their capability to be effective self-advocates. They may have been blamed and shamed for their children’s problems and are feeling defeated and lacking self confidence. They often feel completely unprepared to deal with such problems. Feeling overwhelmed, they do not know what to do or ask for and therefore take a passive stance, accepting advice and treatment without questioning – even when such assistance does not feel right to them. In many cases, the family’s anger and frustration in coping with such difficulties and navigating fragmented, non-responsive systems of care may cloud their ability to advocate for their needs, so that only their anger is heard -- not their point or concern. Some individuals lack the self esteem and communication skills necessary for effective self-advocacy.

The goal of the F.A.S.T. worker was to understand the issues that the family faces and to affirm their advocacy efforts or assist in building more effective self-advocacy skills. Here are a few examples of how workers approached strengthening advocacy abilities:

**Obstacle:** Stigma, guilt, self-defeat, lack of confidence.
**Approach:** Information, attention to strengths, role playing and rehearsing to increase confidence, modeling confident, assertive behaviors and communications.

**Obstacle:** Feeling like a “fish out of water;” intimidated, unsure, fearful.
**Approach:** Information and education; building self-esteem; demystifying professionals and diagnostic categories.
Obstacle: Anger, rage, and frustration.
Approach: Allowing opportunity for families to vent angry feelings; improving anger management skills and assertive techniques.

Obstacle: Lack of available resources, multiple needs and problems.
Approach: Help to prioritize goals, set reasonable expectations, acceptance of problems, and broadening scope of available resources.

Support for families in this program was anchored in the philosophy of respect. Family support was seen as a matter of consultation and collaboration. As such, the supportive actions taken were those most likely to be best suited to each individual family or family member. The general categories of support provided through the F.A.S.T. program included:

Home or community-based service capability.
We strove to overcome obstacles of limited time availability, travel constraints, schedule conflicts and some forms of resistance by making our services available to families at home or at a comfortable, community location. In cases where the family indicated a preference for meeting outside the home, we could also arrange to meet with them in one of our two offices at a time that was convenient for them.

Provision of information about the nature of their child’s problem or disorder and about local resources.

Collaboration with other persons, agencies or organizations on behalf of the family’s needs and interests.
This involved making telephone contacts with important persons involved with each family and being available to participate in relevant and important meetings.

Provision of psychoeducational services.
These were formal or informal efforts to provide information about psychological problems and coping strategies. Topics included developing self-advocacy skills, anger management and problem solving skills, special parenting skills and medication training.

Provision of group support to parents, children, siblings, and multi-family groups.

The F.A.S.T. program at the point of this presentation was completing a very successful second year. While initially this program was targeted to serve 75 families over a three-year period, we had nearly 100 referrals in the second year alone. In addition to two full-time F.A.S.T. employees, this program trained seven volunteers who represented community volunteers and student interns to serve as F.A.S.T. workers. The success of this program could be largely attributed to the last component of the F.A.S.T. acronym: TEAMWORK. The F.A.S.T. program involved teaming with parents or caregivers,
teaming with the child who was experiencing emotional/behavioral problems, teaming with siblings or other relatives, teaming with the family as a unit, and networking within systems and communities. The essence of teamwork in this program was based on respect and collaboration.

The program was implemented within the framework of the Family Resource Center at the Mental Health Association (MHA) of Essex County. Utilization of other Family Resource Center services complemented the work of F.A.S.T. Examples of such services included Kids Cope, a support group program for children affected by a loved one’s mental health problems; Parent Cope groups for parents of children with emotional/behavioral disorders; and psychoeducational lectures and trainings.

In addition to direct links and supports to urban families in need of F.A.S.T. services, this program also extended to other urban community organizations as well to provide information and support within the community. In-service training opportunities with local service providers have informed them of F.A.S.T. as a viable service for many of their clients, and raised awareness of the special issues these families face in the context of urban life.

The final area explored in this symposium was the implications for replication. The responsiveness on the part of families and communities throughout urban Essex County was very positive and we felt that this home-based, comprehensive, supportive approach was an important support for families with a child with serious emotional difficulties. In replicating such an effort, participants were encouraged to allow for a flexible approach in establishing collaborations with families, to seek out traditional and nontraditional resources in their locales, and to respect diversity while building cultural competence in the F.A.S.T. worker, whether staff or volunteer. Barriers to implementation included funding, transportation, security, and difficulties in establishing trusting and collaborative ties with either families or service systems. Developing a network of volunteers requires time in developing, recruiting, and maintaining volunteers but is an important aspect in providing holistic community support.
Title: Family Friendly Support and Collaboration: Metaphors, Changes and Service Provision

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Transforming how professionals, schools, and agencies interact with families is critical to current strategies for improving educational, mental health, and community outcomes for children and their families. The importance of families as service providers was recognized during the development of the modern children's mental health movement in the 1980s, and was embodied in principles of care and cultural competence. These principles were operationalized in the 1990s, as the family movement grew (particularly the Federation of Families for Children's Mental Health and its affiliates). Principles were further conceptualized between 1990 and 1994, as over one thousand diverse individuals from families, schools, and Head Start centers, mental health programs, and children's services helped to develop and to validate the National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance (U.S. Dept. of Education, September, 1994).

Although transforming the way in which families are viewed and treated has become a fundamental tenet of many human services and educational initiatives, problems remain at the operational level. Professionals often complain that families do not respond to them or respect their knowledge. Families still complain about being ignored or marginalized. These are not rare occurrences. Site visits to and reports from many programs suggest that service approaches remain agency-focused and “parent unfriendly.”

Recasting relations between families and other service providers is central to achieving all seven National Agenda targets to: (1) expand positive learning opportunities and results; (2) strengthen school and community capacity; (3) value and address diversity; (4) collaborate with families; (5) promote appropriate assessment; (6) provide ongoing skill development and support; and (7) create comprehensive and collaborative systems.

The evolution of the language of Target Four of the National Agenda reflects the importance of collaborating with families. The initial label for the proposed target was “support families.” After feedback from a national teleconference was evaluated, the language was refined to providing “family friendly service.” The validation of the National Agenda, which included extensive stakeholder outreach and seven focus groups, led to the final language of the target: “To foster collaborations that fully include family members on the team of service providers that implements family focused services to
improve educational outcomes. Services should be open, helpful, culturally competent, accessible to families and school, as well as community based” (p.11).

Changes amounted to more than simple “wordsmithing.” Language and metaphors reflect what we believe, and they structure how individuals interact, as well as how interventions are implemented (Ryan, 1969; Osher & Kane, 1993). For example, there is a difference between getting families on “your team” and sharing decision-making as partners. Team members support what you do, partners share decision-making and risk-taking. Similarly, there is a difference between viewing a service provider as a “case manager” and as “service coordinator” or “facilitator.” People are more than “cases.” The team manager implies a greater level of authority than facilitator or even coordinator. Language and metaphors do more than structure relationships. As Hibbits (1994) suggests, “. . . as an aspect of our mentality's deep structure, our metaphors can reveal a great deal about us, both as individuals and as members of a broader culture” (p. 235). Transforming the relationship between families and other service providers depends upon examining and reframing what Hobbs (1982) called institutional metaphors. This, in turn, depends upon analyzing the conceptual and social underpinnings of the language that we use.

Target Four of the National Agenda provides a case in point. Obviously, support for families (the focus of the first wording) is central to almost any intervention. Similarly, the ease with which families access services (the focus of the second wording) is central to the effectiveness of support. Nonetheless, family voice and authority — both in the case of individual interventions and in the case of policy — are central to defining the support needed and in delineating how that support can be made accessible to families. “Wrap-around” services look different when they are defined by agencies and professionals working without the meaningful participation of families. In the words of the National Agenda's fourth target, “. . . the object is to reorient family-school interactions to build a partnership in which service planning reflects the input of families' goals, knowledge, culture, and, in some cases, need for additional services” (p.11).

No partnership, however, is easy. Partnership challenges a century of hierarchical and culturally insensitive professional family relationships and a century and a half of “family blaming.” In addition, professionals, unlike families, have a status interest in their authority and expertise (Miller & Riessman, 1968; Berlin, 1969; Bledstein, 1976; Ehrenreich & English, 1979). In fact, professionals frequently maintain their status by employing mystifying language that may confuse, demean, or put off consumers (e.g., the medical language of “co-morbidity” as opposed to “co-occurrence”). The historic pattern of professional/client relations has been characterized as “disabling help” (McKnight, 1977), in which active professionals use their knowledge to “fix” passive clients (Goffman, 1961) who are only viewed in terms of deficits. This pattern is reinforced by agency-directed planning and by administrative regulations that often reflect the political lobbying of professional organizations (Lubove, 1965).
Hard to develop in all cases, partnership is particularly problematic in the so-termed helping professions (Rothman, 1980; Levine & Levine, 1992), with three primary factors to consider. First, these professions have roots (Lubove, 1965; Rothman, 1980; Gordon, 1994) in a set of assumptions that Cravens (1993) described in the following manner: “Normal children, raised in good, sound, white, Anglo-Saxon, Protestant homes, would grow up to be good citizens and contributors to the nation’s economic progress” (p.29). Second, professional socialization in these fields builds on a paradigm that Ryan defined as victim blaming: “... a process of identification (carried out, to be sure, in the most kindly, philanthropic, and intellectual manner) whereby the victim of social problems is identified as strange, different” (p.10) and the cause of his or her problems. Finally, the organizational models in which these professions have been organized have been characterized by what Mannheim (1949) called bureaucratic conservatism — “... the fundamental tendency of all bureaucratic thought is to turn all problems of politics into problems of administration” (p. 118). These three factors have buttressed what can be called three tendencies that have framed relations between families and other service providers: (1) viewing families as the root of their child's problems; (2) ignoring the social factors (e.g., racism and poverty) that contribute to poor outcomes; and (3) transforming political critiques and family input into managerial problems.

The Center for Mental Health Services' Child and Adolescent Service System Program (frequently referred to as CASSP) and the family movement have started change. Families (e.g., The Federation of Families' Family Leadership Initiative) have educated professionals regarding the benefits of collaborating with and effectively including families. As a result, more and more professionals have started to view family members as central to their own interventions. Some of these professionals, in fact, have started to avoid the language of dysfunction. Others have developed approaches that are family focused. Although they may view the agency and professional expertise as resources, they still focus planning around the needs and strengths of families.
Promising as they are, these changes are fragile ones. Alone, they will not transform the relations between families and other service providers or sustain new relationships. There is a difference between adopting a principle and operationalizing (or internalizing) it. Taylor and Bogden (1992) have analyzed how institutions transform language to manage the gap between goals and practice. In addition, the development of child and family-focused approaches is threatened by the way in which managed care may be implemented. A century of experience suggests that bureaucracies mediate how professionals deal with clients. Professionals in bureaucratic systems find it hard to relate to clients in an egalitarian manner (Blau, 1973). Moreover, they use their control over scarce resources to discipline clients (Wilensky & Lebeaux, 1958), isolate them from each other (Cloward & Piven, 1965), and control the expenditure of scarce resources (Lipsky, 1980). Meaningful change requires the development of family and youth directed approaches in which family members actively participate in the identification of problems, definition of issues, determination of action, and evaluation of process and outcomes -- both at the individual and policy level. If this is not done, it is likely that service providers will define “wraparound” and “systems of care” in an agency-oriented manner, selecting services from an existing array of services and providing services in a manner that reflects the needs of agencies.

Transforming the relationship between professionals, agencies, and families hinges on four important aspects of progressive change. First, the family movement must continue to gain strength. Second, family members -- particularly poor and working-class families and families of color -- must gain a meaningful voice in the development and evaluation of policy. Third, attention must be paid to the extent to which the traditional professionally oriented, agency-directed, deficit-focused paradigm is routinized in the day-to-day realities of agencies and in the language that many service providers choose to or are mandated to use. Finally, those who want change must identify and analyze both the barriers to as well as opportunities for meaningful collaboration between families and other service providers. If these developments do not take place, family-focused approaches are likely to deteriorate into agency-directed ones. If these changes do take place, family and youth-directed approaches will frame collaboration and help realize the vision that underlies the National Agenda: “A reorientation and national preparedness to foster the emotional development and adjustment of children and youth with or at risk of developing serious emotional disturbance, as the critical foundation for realizing their potential at school, work, and in the community” (p.3).

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Recent research indicates that social support is an important factor in an individual's mental health and interpersonal adjustment (Frecknall & Luks, 1992; Queen, 1994). Traditionally, family and close friends served as social networks which provided the individual protection against stress or adversity. Adolescents who show positive adjustment to ongoing stress often identify a relative, friend, or neighbor as a natural mentor who contributed to their success (Rhodes et.al., 1994). Rhodes, Ebert, and Fischer (1992) have shown that a mentor relationship helps adolescent mothers experience less depression and feel less distressed by interpersonal difficulties. Based on such research, it seemed reasonable to hypothesize that mentor relationships could have a positive, therapeutic effect on children/adolescents at significant risk for out-of-home placement.

Belief in the integrity and healing capacity of the family unit, coupled with the soaring cost of out-of-home placements, has led Waukesha County to develop creative, collaborative efforts to maintain troubled children within their homes. The Clinical Services Division of the Waukesha County Health and Human Services Department developed the Mentor Services Program in 1991, based on a community needs assessment that identified service gaps in the areas of social supports and respite care for children with severe emotional disturbance (SED). Primarily targeted as placement prevention, Mentor Services expand the array of clinical treatment resources and community-based care received by the child and family and can be tailored to individual interventions. The program is delivered through a services contract with the outreach department of a residential treatment center. The center staff recruit and hire mentors in part-time positions, matching the training, skills, and availability of the mentor to the specific needs and strengths of the participating child and family.

Mentors provide regular, consistent, face-to-face and telephone contact with children who have severe emotional disturbance. Mentoring is part of a coordinated team treatment effort to maintain and support children in their home communities by strengthening their family relationships and by facilitating their successful integration into existing community resources.

Mentors provide support and respite care for children and their parents through monitoring and supervision of the child's functioning in various settings (e.g., recreational
and educational); modeling and coaching of various social skills including sharing, sportsmanship, and anger control techniques; supportive counseling and utilization of child behavior management strategies; and assistance to families in child/parent conflict resolution. When appropriate and necessary, mentors provide assistance to schools by monitoring and addressing barriers to school success. Mentors provide verbal reports at least weekly to the referring worker and attend treatment team meetings to evaluate the child's progress. A written record of all contacts with the child/family is maintained and monthly summaries are prepared regarding the therapeutic connections between the activities and the on-going treatment goals.

In this study, 30 children meeting criteria for serious emotional disturbance (SED) and considered to be at extreme risk for out-of-home placement were enrolled in the mentor service for five hours each per week. All children carried a Diagnostic & Statistical Manual, Fourth Edition (DSM IV) diagnosis and according to County criteria for placement would have been expected to be placed within six months of their original staffing for SED. Of the 30 cases discharged from the program during 1991-1995, 22 remained in their family home six months post discharge. Five of the children had been placed into residential treatment and three had moved from our jurisdiction. This placement rate of 18.5% is significantly less than the placement rate experienced by a control group of 10 children who were referred for mentoring service but not served. The placement rate for the control group was 50% within six months of referral. The average monthly cost for all treatment intervention with the mentored children was approximately $2,300 per month, with mentor costs of about $430 per month. This compares to an average cost of approximately $4,500 per month for residential care and in excess of $10,700 per month for a state mental health institution.

Placement data suggest that mentoring can be a highly effective clinical tool for certain populations of at-risk children. Mentoring is more effective when the child carries a diagnosis of a disruptive behavior disorder and is less effective when the diagnosis is of an affective disorder such as depression. Mentoring also is more effective with an adolescent population than with children under the age of 12 or 13. Parents completed seven-point Likert scales on nine parameters designed to measure program effectiveness in reducing home, school, and community problems. Parents also completed 10 scales designed to measure their satisfaction with program characteristics such as child/mentor match, length of service, and respite. The results indicate that families view mentor services as an integral and effective component of the treatment process. Parental ratings indicate that mentoring has the largest initial impact on problems and conflicts within the home. Scale values for acting out behavior (e.g., substance abuse, truancy, legal problems) show the least deterioration over the six month span. Overall, changes associated with mentoring services are relatively stable over the six months following discharge from the program. Parents also highly rate the program as a respite service for family members, including the child.
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Introduction: The Support Network provides advocacy, education, information, and referral to families in the three contiguous communities of Chicopee, Holyoke, and South Hadley. These communities are located along the Connecticut River in the western part of the state. The population ranges from just over 9,000 (South Hadley) to about 40,000 (Chicopee).

Two of the communities, Chicopee and Holyoke, have significant Spanish-speaking populations; in contrast, South Hadley has less than 3%. The majority of Spanish-speaking people are Puerto Rican. The Puerto Ricans began migrating to Holyoke in the 1970s. They worked on the tobacco farms in the summer months and returned to Puerto Rico for the winter. Over time they began remaining in Holyoke year-round. Today, they represent 30% of the total population and almost 50% of the school population (16 and under). Other residents of Holyoke, who are primarily of French, Irish, and Polish heritage, have not been very hospitable to the Puerto Ricans. They do not support the need for bilingual education and in some instances openly resent the presence of these families.

In the late 1980s and through the '90s, the Puerto Rican families have migrated from Holyoke to Chicopee. Simultaneously, many of the manufacturing mills and business moved from the area which left many families without income to support their families. The economic dislocation (unemployment reached 10% of the area’s population) exacerbated the negative feelings and attitudes toward the Puerto Rican residents. Beginning in the early 1980s, many of the English-speaking families moved across the river to South Hadley. This has contributed to making it very difficult for these residents to participate cooperatively in projects with Holyoke residents.

The goal of the Support Network was to establish a network that would meet the needs of the families with children who were experiencing behavioral and or emotional problems so these families could achieve their own goals. This required an approach to the families
that is respectful, supportive, and culturally sensitive. To do so, we established a two-
person team: one staff person who is bilingual/bicultural to reach out to the Puerto Rican
families and one English-speaking staff person to approach the English-speaking families.

**Principles and Values**

We first defined key terms that support the principles and values.

**Culture**, according to Andre Malraux, “is the framework that guides and bounds life
practices. Culture is the sum of all forms of art, of love and of thought, which, in the
course of centuries, have enabled man to be less enslaved.” Lynch and Hanson (1989)
add that:

> The cultural framework is a set of tendencies or possibilities from which to choose; it
is a framework through which actions are filtered or checked. . . It is not rigid; it is
influenced by socioeconomic status, age, sex, education, religion, length of residence
in a locale.

**Diversity** is the condition of being different and allowing for variety. The differences,
regardless of basis, have equal standing. There is no right, or preferred, condition.

**Empowerment** is speaking and/or acting from the vantage point of believing in one's
ability/ capability to act with effect. Empowerment is the process by which individuals
and communities gain mastery over their lives. Self-help and mutual help are critical
elements. Family Centered Services are one successful outcome of empowerment.
Families make their own decisions.

**Multicultural** is a term that acknowledges the sum of the cultures found within a
community is greater than the sum of adding the cultures together. As cultures come
together, each acts on the others and enhances and enlarges the understanding of the
individuals about the other cultures.

**Cultural competence** is a developmental process and contains five essential elements
(Cross, Bazron, Dennis, & Isaacs, 1989). A culturally competent person (1) values
diversity; (2) has the capacity for cultural self-assessment; (3) is conscious of the
dynamics inherent when cultures interact; (4) has institutional cultural knowledge; and (5)
has developed adaptations to diversity. Competence implies that attitudes, skills,
policies, and practices must be congruent with all levels of the system.

Values that support the Network include: (1) respect for the unique, culturally-defined
needs of various client population; (2) acknowledgment that culture is a predominant
force in shaping behaviors, values, and institutions; (3) natural systems (family,
community, church, healers, etc.) are primary mechanisms of support for minority
populations; (4) “family,” as defined by each culture, is the primary and preferred point of intervention, and (5) diversity within cultures is as important as diversity between cultures (Cross et al., 1989).

**Practical Application and Recommendations**

1) We began by learning about each of the three communities. We identified ways to reach the families. (We did not have a ready made list of families; rather, we were dependent upon referrals). We approached traditional sources of service providers, such as agencies, child-serving programs, hospitals, and pediatricians, along with non-traditional sources such as churches, libraries, bodegas (corner grocery stores), restaurants, Laundromats, radio and TV, libraries, and places people might gather. Identification of community leaders opened additional doors for us.

2) We modeled the respect, trust, and cooperation of each staff member for the other in our interactions with families. This helped to reduce the distrust that seemed to be present for a number of the Spanish-speaking families.

3) We established ground rules of respect, trust, and confidentiality for each group meeting. This strengthened the trust of parents in themselves, in each other, and in the staff.

4) Our materials, both oral and written, are available in Spanish and English. As appropriate, both staff members participate in meetings. We found the radio station was an invaluable link to the Spanish-speaking families.

5) Parents set the agenda: They determine what they want, as well as when and where. For example, for the support meetings they choose the topic and determine whether to have a speaker or discussion among themselves. They also set the time, place, and day.

6) Child care, transportation and translation are provided at no cost to the families.

7) A variety of activities and events are offered: support group meetings, a library of reference material that can be copied, and notices of workshops and conferences parents may attend. Expenses for these activities, including registration, child care, and transportation are paid by the Network. An added benefit is the learning and exchange of information that occurs riding to and from workshops and conferences. Celebrations of cultural events such as Three Kings Day also are important.

8) As parents gained confidence in themselves and saw success in achieving their goals for their child and family, some were ready to move to a more systemic approach to problems that could result in changes that would provide a more ‘family-friendly’ service delivery system. Areas of learning covered the state services system, the state legislature, and the federal government representatives, as well as a broader understanding of topics.
such as education laws, medical insurance, state budget and human rights. Some families undertook advocacy with legislators and service providers.

REFERENCES


This presentation demonstrated the effectiveness of a model implemented in the Portland, Oregon public school system. The project is titled: The Family Empowerment Project. The purpose of the Arleta Family Empowerment Project is to build trusting relationships between school staff and families with the mutual goal of children’s academic, emotional, and social success. The process of developing these relationships is accomplished by empowering families on three levels: (1) empowering families within their own family structure; (2) empowering families in working as collaborative partners with the school system; and (3) empowering families in identifying areas of concern in their community and working towards revitalization of the community. The project employs strategies to help families integrate their children’s home, school, and community experiences into positive behaviors that enhance success in school. The needs of the Arleta community necessitate a family-centered intervention program to promote a positive educational experience for children. An increasing number of Arleta students come to school under stress because of the following issues: divorce, poverty, mobility, homelessness, substance abuse, family violence, community safety issues, and unmet medical needs. The program coordinator implements activities that include home, school, and community-based services.

The home-based program empowers families by providing multiple services including family counseling, community referral, education and support. The premise of the home-based program is that by empowering families within their own family structure, they are better able to handle challenges, solve problems that arise, and are confident in their ability to help their children grow and develop. Children from these families, in turn, arrive at school ready to learn. The home-based approach is designed to engage families who are unlikely to be involved with the school or other social service agencies under other circumstances. It is intended to address join a personal, comprehensive, confidential, and empowering manner issues of concern impairing school performance. Family participation is voluntary. A project premise is that families desire improved school performance for their children and will take part in a program that will help them realize and operationalize this goal if the program is sensitive to their needs and empowering to their family.

The school-based program empowers families in working as a collaborative partner with the school system. This type of interpersonal empowerment reflects both families’ rights
School-based services are directed toward the entire school community. Families are encouraged to act as collaborative partners in planning for their children’s needs at school. Arleta staff work collaboratively to offer educational, recreational, social, and other family involvement activities including family activity events and opportunities to learn of and experience what children do in school. Events encourage the participation of the Arleta community’s culturally rich and diverse population.

Because classroom teachers are the primary contact person for students and their families, the school-based program focuses on assisting school staff in understanding socioeconomic and cultural differences in families. The project coordinator works closely with staff, providing services and consultation in working with diverse families. By supporting staff in working with families, staff and families will be able to build trusting relationships and be better able to collaboratively address difficult situations as they arise, in addition to planning for children’s educational needs. By working with school staff to increase their understanding of the challenges families face and by teaching staff the skills needed to build partnership with families, staff are also empowered, thus minimizing their own frustration and level of burnout.

The community-based program empowers families by assisting them in accessing and utilizing existing community resources. In addition, community service providers are encouraged to work collaboratively with families and school staff in planning for children’s success at school. The community based program hopes to expand its focus to developing a forum for community people to gather and collaboratively work toward the revitalization of the Arleta area. This vision would include community residents, service providers, churches, business people, and school staff working together to improve the quality of life in outer south east Portland. The significance of the program is demonstrated by the holistic approach to serving Arleta students and their families. The project recognizes that it is not sufficient to merely provide disadvantaged families with services and resources; rather, it is also important to foster a process whereby such families have both control over current resources and a greater capability to obtain future resources. The project focuses on restoring families and the community by working collaboratively to achieve sustainable change -- a change that will empower them to break multi-generational patterns of problems and thus enable them to the use opportunities to build a healthier, stronger future.
Families who have children with severe emotional disorders are frequent recipients of family-centered services offered through various systems (e.g., mental health and child welfare). These families are often in need of support and are vulnerable to experiencing crises. Though these families present many problems, the family-centered worker is challenged to recognize the family's abilities and strengths in solving their problems.

This presentation described a six-phase model proven useful for identifying the behavioral strengths of each family member and the process of refining those strengths into skills the family can use to manage their children and resolve problems. The Phases Model provides a conceptual, yet clearly delineated approach for building on strengths. Despite the overwhelming chaos and confusion that may be occurring in the home, the model gives the worker guidelines for staying focused in the intervention so that goals can be accomplished. The family-centered worker learns that Phases can move a family from a problem-centered start toward solution-oriented outcomes. The highlights of each Phase are outlined as follows:

Phase I: The family's strengths, agenda, and cultural values are assessed. Therapeutic relationships are established in which the family members are considered partners in collaboration with the worker to resolve problems. The family's strengths are increased through praise.

Phases II and III: The family is assisted in using its strengths to address problems and to achieve goals. A variety of intervention techniques are used to help the family refine its strengths into skills that work to manage specific child and relational problems (e.g. anger control, communication and discipline).

Phase IV: The family members are taught how to use their skills to the best of their ability to maintain the progress made. How to trouble-shoot and use the skills consistently is emphasized.

Phase V: The family is encouraged to use the skills independently and learns how to use the skills to address a variety of problems it may encounter in the future.

Phase VI: The worker evaluates the effectiveness of the intervention and gauges the family's overall success at using skills that improve the functioning of the family.
The Phases model is respectful of the unique cultural values of the family and provides avenues for working within this culture to help the family fix problems. The methods of staying focused and setting measurable goals is integral to the Phases approach.

Not only does this model give structure and direction for the family-centered worker, but it can guide the process of supervision and evaluation. The benefits to families, service providers, administrators, and researchers are many. The Phases Model can be adapted to a variety of service programs from intensive in-home family preservation services to long-term family support programs. Outcome data obtained from an ongoing evaluation of the Model demonstrate that families report increased satisfaction, that they see an improvement in child behaviors, and that the majority of families are able to stay together.

REFERENCE

The Child Care Consultation Team's Role in Preventing Abuse and Strengthening Families in Child Care Centers

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Old proverb: An ounce of prevention is worth a pound of cure.

In tackling issues of child abuse and family dysfunction, Family Service of Morris County's Child Care Consultation Team seeks to mobilize diverse resources that can have important roles in the developmental environment of children.

Children are more vulnerable than ever. Healthcare and nutrition inadequacies, domestic and street violence, educational and social service cutbacks, and economic disruptions, combined with the stresses of life such as grief over the loss of loved ones, create an atmosphere which can more seriously affect some young children more than others.

Public child care centers provide the team with optimal opportunities to work with preschool children and their families at the earliest stages of their educational and social experiences. The staff members of the centers provide initial recognition of distress among the young children, the first threshold in bringing together relevant resources.

The team consultant and the other participants develop a planned approach to dealing with the child's problems from a holistic, multifaceted perspective that includes dealing with family and parenting stresses. Team members work onsite at the centers, with families in their homes, and even meet with parents at other convenient locations such as a diner during the parent's lunch or dinner break.

Our team, which serves nine public child care centers and has bilingual (Spanish and English) capabilities, becomes the catalyst in integrating the child-care staff and outside agencies, such as hospital evaluation centers for physical and psychological testing, with the children, their parent(s) and other family members.

As a result, the team can offer the children and their families, as well as the child care center staff, comprehensive responses to the needs of the family unit, as well as for the individual child.

The benefits of this approach include: (1) providing support for ALL adults (teachers and aides, parents, grandparents, etc.) who are involved with the children; (2) improving the
quality of child care programs; (3) reducing teacher turnover, increasing skills and improving job satisfaction; (4) creating an environment of consistent care for the children; and (5) helping to keep troubled children in quality programs.

Special attention is paid to connecting with the children in focused ways. One approach that has had a good deal of success is the “Worry Teacher” concept. As part of the pre-school curriculum, units on feelings, night and day, and dreams and nightmares are coordinated with class materials. Staff encouraged children to bring up anxieties to the “worry teacher” who was a “really good listener.” The children were told that the “worry teacher” would come every Wednesday and they were invited to talk about any worries with her. The significant point is that the children's comments were carefully written down in front of them so they knew that they were being listened to.

Every aspect of the program is evaluated by the families and the child care directors. Progress is rated according to guidelines that have been developed over the 10-year history of the Community Response Team program. By drawing together the resources available for pre-school children, while also enhancing parent and family abilities, we have found that the difficulties children encounter can be dealt with more effectively. Certainly, this is an approach that bears consideration for broader applications among the pre-school population.