

FOCAL POINT

A National Bulletin on Family Support and Children's Mental Health



**Partnering
with Families**



Summer 2004

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Research and Training Center
on Family Support and
Children's Mental Health (RTC)





PARTNERING WITH FAMILIES

During the past twenty years, work at the Research and Training Center on Family Support and Children's Mental Health has been guided by a vision of family-professional partnership within systems of care serving children with emotional or behavioral disorders and their families. This vision sees families and professionals working together as mutually respected equals, engaging in open and honest two-way sharing of information. Families are seen as sources of strength, and they are recognized for their expertise concerning their children. This form of partnering supports families and youth as they take leadership in decision making about how services and supports should be designed, organized, and delivered.

When the Center was first conceived, this vision of partnership was not widely held, and many professionals involved in the field of children's mental health worked under the assumption that families were primarily to blame for their children's difficulties. An important shift was signaled in 1984, however, when Congress authorized the Child and Adolescent Service System Program (CASSP) with the goal of improving services for children with serious emotional disturbances and their families. One of the key components of the program was its support for

extensive family involvement in the planning and implementation of services and service systems.

In the first years of CASSP, knowledge about what it would take to achieve extensive family involvement was limited, and goals were correspondingly modest. For example, states that brought just one family member (yes, one person, likely not a representative of a family organization) to a meeting were given accolades. There was little organization of families for support and advocacy, and virtually no national policy about children's mental health.

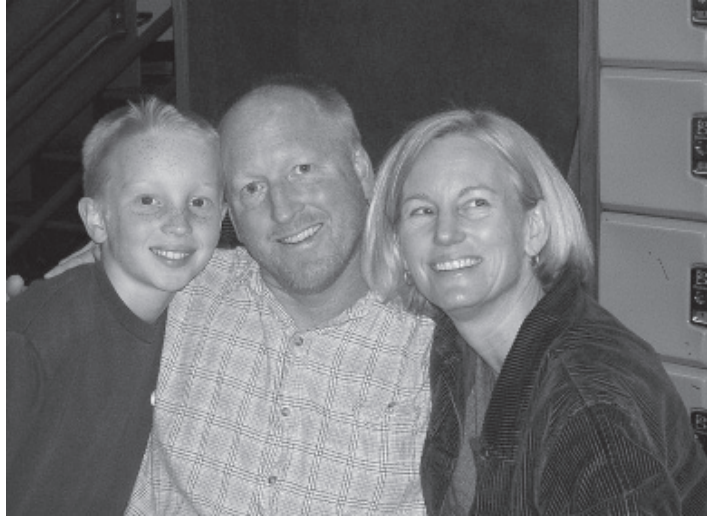
The intervening years have seen the expansion of national family organizations such as the Federation of Families for Children's Mental Health, growing legitimacy for the principle of partnership, and higher expectations and increased sophistication in understanding about what partnerships with families and youth can and should be. At the same time, we have gained a deeper appreciation of the complexity and challenges of developing partnerships based on an authentic youth and family voice. For example, consumer- and family-driven, individualized mental health care is a policy recommendation of the President's New Freedom Commission on Mental Health, yet we are only beginning to understand how to recognize when services, supports,

and service delivery truly reflect adherence to this value. Similarly, the evaluation of the federally-funded Comprehensive Community Mental Health Services for Children and their Families Program requires family involvement at all levels of implementation, including evaluation, yet many communities struggle to realize this goal.

The articles in this issue of *Focal Point* focus on Center's current work, which reflects the evolution of expectations for partnering with youth and families. Partnering successfully requires not only a philosophical commitment to the value, but also intentional, specific steps to redesign services and reallocate resources so as to remove logistical and interpersonal barriers that impede family and youth participation. The articles also highlight new thinking about responses to the complex needs of children and families. In particular, our findings help to move the idea of partnerships beyond the formal service sector into other arenas of community participation, such as education and the work life of family caregivers.

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Disclosure and Reciprocity: ON THE JOB STRATEGIES FOR TAKING CARE OF BUSINESS. . .AND FAMILY

The concept of *family friendly companies* emerged in response to the unprecedented number of mothers entering the workforce in the 1980s. Organizations have continued to develop initiatives in response to the needs of employees, particularly employed parents, for less rigid boundaries between work and home. Employers recognize that their ability to accommodate employees' lives beyond the workplace affects recruitment, retention, and productivity. Work/life programs are specifically designed to identify benefit packages, work arrangements, and community resources that support the personal lives of employees. Onsite child care, elder care resources, and flextime work schedules are examples of support offered by many workplaces. The concept of *work/life integration* describes a further softening of job/home boundaries, implying a more seamless flow across roles and responsibilities in the two spheres.

Workplace support and flexibility to respond to family matters during employment hours is crucial for parents caring for children with mental health disorders. For these parents, uninterrupted focus on job responsi-

bilities is often the exception rather than the rule. A telephone call from the child's school, a caregiver, or even the child herself may disrupt the parent's concentration at any time. The call may be about a minor concern that is handled quickly by the parent, allowing a return to job tasks after only momentary disruption. On the other hand, a crisis with the child could necessitate the parent leaving the workplace immediately without knowing when return to the job will be possible. Without a responsive workplace, parents are often unable to secure paid work, maintain employment, or manage the stress from the overwhelming and competing demands of home and job (Rosenzweig, Brennan, & Ogilvie, 2002; Freeman, Litchfield, & Warfield, 1995).

Common Ground? Families and Employers is a research project designed to gather information about how parents' employment is affected when caring for a child with a mental health disorder. Specifically, *Common Ground* seeks to identify 1) the barriers and strategies to finding and sustaining employment, 2) workplace characteristics (from parents' perspectives) that enhance work/family

integration, and 3) workplace policies and practices (from employers' perspectives) that are responsive to needs of families with children who have serious emotional or behavioral disorders. Understanding employment challenges and solutions will empower parents to make informed job choices, position employers to become more family responsive, and encourage communities to provide more family support services.

An on-line survey of parents caring for children with serious mental health disorders was conducted by *Common Ground* staff. The survey, posted on the Research and Training Center website, solicited participation from parents who were currently caring for children with serious emotional or behavioral disorders at home and who were employed, seeking employment, or unemployed by choice to care for the children with emotional or behavioral disorders. Eligible parents answered 30 questions about how they manage both employment and family responsibilities.

Over three hundred parents responded (N=349). The typical respondent was a college-educated Eu-

ropean-American woman in her forties. Sixty percent of the respondents worked full-time and 19 percent were unemployed. Of those employed, most were in professional or technical positions. Nearly two-thirds of the respondents were in partnered relationships and most were biological parents of their children. A total of 766 children were represented, 60 percent of whom were identified by the respondents as having serious emotional or behavioral disorders. The majority of the children with disorders (73 percent) were boys. The mean age of all the children was 13 years old.

The effect of caregiving on employment status for the respondents was significant. Nearly half (48 percent) reported that at some time they had to quit work to care for their children with mental health disorders and 27 percent indicated that employment had been terminated because of work interruptions due to care responsibilities. Of those respondents who were unemployed, 11 percent reported that they were currently unable to find a job because of care demands.

The survey asked parents about their perceptions of workplace support that assisted them in meeting caregiving responsibilities. Parents replied to questions about support from individuals—supervisors and coworkers—as well as family friendly policies. Parents also identified actions or strategies they used to sustain employment while responding to family care needs. Two strategies frequently practiced by the parents, *disclosure* and *reciprocity*, are discussed and guidelines for effective utilization are offered.

Disclosure

Employed parents caring for children with serious emotional disorders face a decision about whether or not to disclose their children's mental health status to individuals within the workplace. The decision to disclose at work about a child's mental health is a strategy that may be used to gain

interpersonal and organizational support for meeting family and work responsibilities. Disclosure can provide personal and social benefits including opportunities to receive emotional support, reduce stigma, and educate others (Ellison, Russinova, MacDonald-Wilson, & Lyass, 2003). Employees disclosing may gain greater access to benefits and improve work/family integration. However, disclosure is not a strategy without risks. Revealing personal family information can be misperceived, leaving the parent vulnerable to discrimination in the hiring process, job evaluations, work assignments, or promotions. It can also lead to job insecurity or job loss.

Respondents in our survey were asked if they had told their current supervisor or coworkers about their child's mental health problems. The vast majority of the sample indicated that they had disclosed about their child's emotional disorder to both supervisors (83%) and coworkers (86%). Parents also reported receiving a high level of support from

within the workplace that helped them respond to the needs of their children with emotional or behavioral disorders. Eighty-eight percent of supervisors and 87 percent of coworkers were rated as *very supportive* or *supportive*. Further study is necessary to more fully understand the complexities of workplace disclosure and support. For example, is there a level of support from supervisors or coworkers that precedes parent's disclosure? What workplace characteristics enhance or deter disclosure?

Disclosure within the workplace about a child's mental health status is an individual and personal decision. Only the parent knows the scope of both the family situation and job issues. Disclosure is a process that is multidimensional and requires careful consideration of key variables: 1) the target audience, 2) timing, 3) type of information revealed, and 4) confidentiality.

Issues related to disclosure are highlighted in these comments by parents surveyed:

CONSIDERATIONS FOR DISCLOSURE

■ **WHY AND WHEN?** Identify the goals, benefits, and risks of disclosure. List the pros and cons of different timing options: during the interview process, when the job is secured, when a positive performance pattern is established, when a response to a non-crisis family matter is needed, when a crisis with your child occurs, or never.

■ **WHO?** Identify whom you might tell. Think about how you might benefit from a specific person knowing and the possible consequences. Consider your options: no one, your employer, your immediate supervisor, a higher-level manager, one or more coworkers, human resource personnel, or employee assistance program staff.

■ **WHAT?** Think about and rehearse what information you want to share. You can be general or specific about your child's situation. For example you might say that your child has a disability, a chronic illness, or a mental health disorder. Perhaps you prefer to name and explain the specific diagnosis, describe the behaviors involved, or identify treatments and supports required.

■ **CONFIDENTIALITY AND PRIVACY.** Don't assume that the information will be held in confidence. Ask if the information will need to be shared or if it will be written down. Request that the information be held in confidence.

Honesty with my employer—that has been the main strategy and working very, very hard when life is going well to make up for the times when I have to be out from work.

I communicate more with my supervisor. I don't feel stigmatized.

I do try to be up front with selective people about this. Some people I tell about my son's emotional disorder; to others I just say that my son has a chronic illness that sometimes requires hospitalization.

Reciprocity

The option to alter the times and physical location of work tasks, referred to as *workplace flexibility* (Lewis, Kagan, & Heaton 2000), is pivotal to a parent's ability to fulfill job duties and respond to the child's changing mental health needs. Parents caring for children with disabilities, however, are often apprehensive about requesting flexibility arrangements, concerned that their commitment to the job will be questioned (Lewis, Kagan, & Heaton, 2000).

Gaining the necessary flexibility is a process that involves personal decisions and workplace dynamics. Par-

ents initiating a request for flexibility will, out of necessity, confront the issues of disclosure. Typically, responsibility for granting flexibility to employees is at the discretion of line managers or supervisors (Yeandle, Wigfield, Crompton, & Dennett, 2002). Supervisors must consider policies and practices, relationships, and the workplace culture before responding to the request for flexibility.

A strategy used by some parents to enhance their access to flexibility is reciprocity. Workplace reciprocity is a relational process of mutual exchange between the parent/employee and the immediate supervisor or co-worker resulting in benefits to both the parent and the workgroup. For example, the parent may agree to accept less prestigious job assignments in exchange for a later start time. The parent gains increased autonomy over the work schedule and the workplace profits from the employee's increased loyalty and work engagement (Sherony & Green, 2002). Reciprocity may be a formal process involving permanent modifications in the work arrangement, or an informal one-time agreement. Formal or informal, reciprocity requires negotiation and subsequent accountability for the commitments made.



Respect and trust between the parent and supervisor or parent and co-worker are essential ingredients of successful reciprocity agreements.

Parents' use of reciprocity is reflected in their comments:

I work for an airline and it provides me with great flexibility. I am able to trade shifts with other people to accommodate my needs.

I have tried to be open and honest with my supervisors to assure them I can handle my job and family responsibilities and will work overtime if I have to. I also offer to help co-workers in [hopes that] they can help when I need it.

I have been employed in small, family owned businesses that understand the need for parents to be accessible to their kids. They have more flexibility to their positions, especially when you prove how valuable you can be to their business and give 150% when you are there.

It is a give and take relationship with flexibility, and understanding during times of crisis and when things even out, I attempt to give back 150%.

Reciprocity arrangements, like disclosure, can have unintended costs for the parent and repercussions in the workgroup. For example, to demon-

GUIDELINES FOR RECIPROCITY

■ **BE PROACTIVE.** Find out what options may be available if you need to flex your work schedule or location.

■ **OFFER WIN-WIN SOLUTIONS.** Make suggestions about possible arrangements. Identify benefits to the organization. Think about the unique skills you have to offer to the workplace as a direct result of your experiences as a parent of a child with mental health disabilities. Use them as bargaining power.

■ **DEMONSTRATE COMMITMENT.** Follow through on your agreement. Communicate your appreciation to your supervisor and coworkers for their support.

■ **KNOW YOUR LIMITS.** Be realistic about what you can and can not do. Reciprocity is mutually beneficial and should reflect equity.

strate work commitment and show appreciation for flexibility, the parent may overfunction while at work. Also, coworkers may interpret the supervisor's agreement to reciprocity as favoritism, or a supervisor may risk reprimand by management for not following organizational practices.

Conclusion

Disclosure and reciprocity are two strategies identified by respondents in this study as helping to achieve work/life integration. Each strategy involves bringing personal family issues into the workplace so as to increase options for fulfilling job obligations while maximizing availability for care responsibilities. Some parents may find these strategies useful, while other parents may perceive the risks as outweighing the potential gains. Additional research is needed to fully understand the characteristics of

work settings in which these and other strategies function best.

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WHAT EARLY CHILDHOOD DIRECTORS SHOULD KNOW ABOUT WORKING WITH MENTAL HEALTH PROFESSIONALS

The increasing numbers of young children with challenging behaviors and emotional problems have led many child care providers and early childhood education programs to employ or contract with mental health professionals (Lavigne et al., 1996). Head Start programs, for example, are required by federal performance standards to utilize services of mental health professionals that are “sufficient” to meet the needs of children and families. However, there has been little research to help program managers make informed choices about who might provide the best services, what services are most important to support staff and families, and how to make the best use of limited program resources.

In 2002, *Guidance for Early Childhood Program Design* project staff conducted a nationally representative survey of over 950 Head Start program directors, mental health coordinators, mental health consultants, teachers, and parents to collect data that could begin to address these important questions. The survey included questions about program structure (such as size and number of sites, percent of budget spent on mental health, number of persons providing mental health services, and hours of consultant time available); beliefs, attitudes, and practices of staff, directors, and mental health professionals (specific to early childhood mental health); frequency of specific



services provided by mental health professionals; and perceived effectiveness of mental health services and supports. In this article we summarize some of the key findings from this national research.

Best Practice Principles

There is growing evidence that organizations that are effective in providing early childhood mental health services share a set of core principles or “best practices” in providing services for children and families (Simpson, Jivanjee, Korolof, Doerfler, & Garcia, 2001). These ten principles describe effective services as being strengths based, individualized and comprehensive, relationship based (i.e. focused on building positive, nurturing relationships with each child and family), family focused, preventative, inclusive, culturally sensitive, and integrated. The principles further specify that services should promote staff wellness and strong community partnerships.

While not new to the field of either mental health or early childhood, the principles warrant particular attention when applied to the issue of early childhood mental health. In our study, staff and mental health professionals who indicated that their programs were more completely implementing these best practices also reported that their mental health services were more effective—both in reducing children’s problem behaviors and in increasing their positive and pro-social behaviors. Moreover, best practices were related to staff perceptions of program outcomes *even controlling for the frequency of services provided by mental health professionals and the amount of money spent on mental health consultation by the program*.

Although nine of the ten principles were consistently associated with higher staff ratings for program outcomes, two were particularly important: *cultural sensitivity* and *family focus/parent involvement*. The ability of staff and consultants to recognize and be sensitive to cultural variability in approaches to and beliefs about mental health was important over and above all other best practices. Those programs where staff and consultants valued and were able to more successfully involve parents in working collaboratively to address children’s mental health issues were also perceived as being more effective. The only principle that was *not*

consistently associated with staff perceptions of positive outcomes was *inclusion*. This seemed to be due to the fact that staff were less consistent in their attitudes about inclusive child care. For example, some staff who strongly endorsed all other best practices still indicated that they thought children with challenging behaviors would be best served outside the regular child care environment. Clearly, more support and training around the issue of inclusive child care is needed.

Effective Consultants

In our survey, we included a number of questions related to the characteristics of the mental health consultants and the programs they worked with. Several of these characteristics turned out to be surprisingly *unimportant* to program outcomes as perceived by staff, including: total number of hours per child of consulting provided; percent of program's budget spent on mental health services; size of program; program location (urban vs. rural); primary race/ethnicity of families served; and credentials of the consultant (social workers vs. clinical psychologists, for example, or years of education—although all consultants had at least some post-college training).

So, what was important? First, the relevant *experience* of the mental health professional in working both with young children and with low-income families. Not surprisingly, programs struggle to find mental health professionals with expertise in both of these areas. Second, the ability of consultants to make a *long-term commitment* to working with a program appeared important: Those with longer-term relationships were generally perceived as being more effective. Third, the consultants' *approach* to service delivery was critical: Consultants who were able to provide services consistent with the best practice principles described above, and whose approach reflected their understanding of the Head Start program philosophy in general,

were seen by staff as being more effective.

Effective Consultation Services

Cohen & Kaufman (2000) define two general types of service that can be provided by an early childhood mental health professional. The first is more traditional, problem-focused services that target the specific needs of a child or family, sometimes referred to as *individual level consultation*. This includes services such as assessment and screening of individual children, direct service to a child or family to ameliorate identi-

fied problem behaviors, and making referrals to services for specific children. The second type of service, called *program-level consultation*, aims to improve overall program or classroom quality and to help the program and its staff address broad issues that affect more than one child, family, or worker. These activities include formal and informal training for staff, meeting with staff to discuss overall classroom prevention or intervention strategies, participating in management team processes, helping to select curricula, and other organization-wide assistance.

Do's and Don'ts For Integrating Mental Health Professionals (MHPs)

DO

- Ask the MHP to provide regular training to staff.
- Ask the MHP to visit classrooms frequently.
- Provide staff with guidance around how to contact the MHP if needed.
- Ask the MHP to meet with staff regularly and informally, to provide suggestions about particular children and general strategies for supporting all children.
- Consider asking the MHP to participate in management team processes.
- Involve the MHP in helping to develop a formal mental health vision.
- Involve the MHP in staff support, supervision, and emotional wellness efforts.
- Make sure parents know the MHP. Ask the MHP to provide parent trainings and orientation, and to attend Head Start family events.
- Make sure MHP has an attitude of collaboration with staff and families.
- Seek a long-term relationship with a MHP having proven child expertise.
- Try to have an "in-house" MHP providing services.

DON'T

- Put up many barriers or gatekeepers to staff direct access of the MHP.
- Hire a community clinic and get "rotating" MHP. Seek continuity.
- Limit your consultant's role to providing child-focused direct service.
- Assume your MHP knows "what to do" to support staff and parents. Be clear about expectations and roles.
- Assume staff know when and how to interact with the MHP. Provide training and encourage communication.
- Despair! (Do remember that relationships and choice of activities matter more than time and dollars spent!)

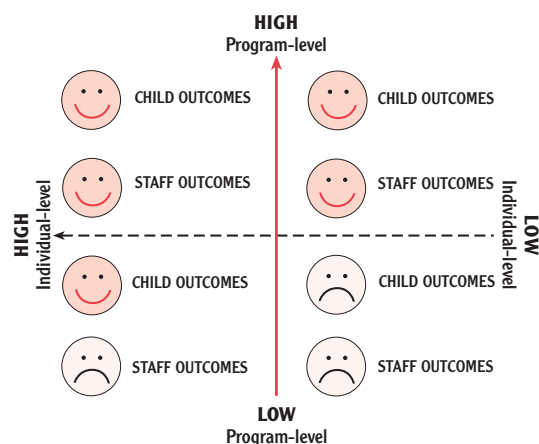


Figure 1: High program-level consultation is associated with more positive outcomes

Our research suggests that while both of these strategies can work well, programs that utilize mental health professionals to provide program-level consultation may be getting “more bang for the buck” than those who provide primarily individual-level, child-focused consultation. Figure 1 shows how staff perceptions of service effectiveness vary for programs with different levels of both individual- and program-level consultation. High levels of either type of service were associated with perceptions of positive outcomes for children. However, only program-level consultation at a high level was also associated with more positive perceptions of staff well-being. In fact, we found that the effect of program-level consulting on child outcomes was due entirely to its influence on staff’s ratings of items such as: level of confidence with difficult children, job satisfaction, organizational support, and emotional well-being. Thus, we found that consultants who work more broadly to support program quality also support staff in feeling better about their jobs, and that these staff, in turn, may be better able to successfully work with children with challenging behaviors. On the other hand, as might be expected, providing direct services to children *does* lead to positive child outcomes, but staff miss out on some benefits.

consultant was available and accessible when they had questions, were more likely to report positive mental health outcomes for children. Interestingly, these more *integrated* consultants also seemed to provide more services to a program, regardless of the number of hours they were being paid for: Integrated consultants reported more frequent activities of all sorts, compared to those who were less integrated. The sidebar on the preceding page presents some suggestions for ways to structure staff-consultant relationships so that mental health professionals are more integrated into overall program functioning.

Leadership & Shared Vision

While effective mental health services depend on experienced and well-trained staff and consultants, program management and leadership play an essential role in setting the tone for how an entire program thinks about and approaches early childhood mental health issues. Results of our study suggest that program leaders should pay particular attention to three things: (1) ensuring that program staff across all levels share a similar vision for early childhood mental health efforts that is strongly rooted in best practice principles, (2) becoming visible advocates for resources to support staff and families around early childhood

mental health issues, and (3) structuring and facilitating the work of mental health professionals to best support staff and families. Program leaders can ensure that programs have a written mission statement specific to children’s mental health, and can facilitate staff input into such a mission statement. They have an important role to play in linking early childhood programs to community resources that support child, family, and staff well-being. Finally, program directors and managers are in a position to identify and contract with appropriate mental health professionals, and to facilitate relationships that support an integrated model of consultation that includes ample program-level consulting. In our study, the effect of strong program leadership on mental health outcomes was due primarily to its influence on the level of integration of the consultant: Strong mental health leadership supported more positive staff-consultant relationships, which led to staff perceiving more positive program outcomes.

Conclusion

Finding ways to effectively address children’s mental health issues remains a challenge to early childhood providers. Resource challenges, attitudes, and beliefs about what “mental health” means in an early childhood context, as well as the need to attend to a myriad of other important concerns can act as obstacles even for the most dedicated providers. Building successful program approaches that can promote children’s positive socio-emotional development and prevent problem behaviors from emerging need not require expensive clinical interventions, however. By creatively building strong partnerships with experienced and committed mental health professionals, programs can gradually enhance staff capacity to support such successes. By focusing resources on overall program quality, and on building a holistic vision and approach to children’s mental health, staff can do their jobs more effectively and have

less need for more expensive and intensive mental health services. Within such a program context, both staff and children can achieve positive social and emotional well-being.

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PROMOTING INCLUSION IN CHILD CARE CENTERS: LEARNING FROM SUCCESS

Finding child care that is accessible, affordable, and that fits the needs of individual family members is difficult for many families (Center for Policy Alternatives, 2004). When families have children with challenging behaviors, appropriate child care settings may be almost impossible to find (Rosenzweig, Brennan, & Ogilvie, 2002). Even if parents do find child care, research shows that it is often unsatisfactory (Emlen 1997). Instability and repeated expulsions from child care arrangements adversely affect the well-being of families who may already be dealing

with considerable stress. However, when families have access to the services they need, the experience can be very different.

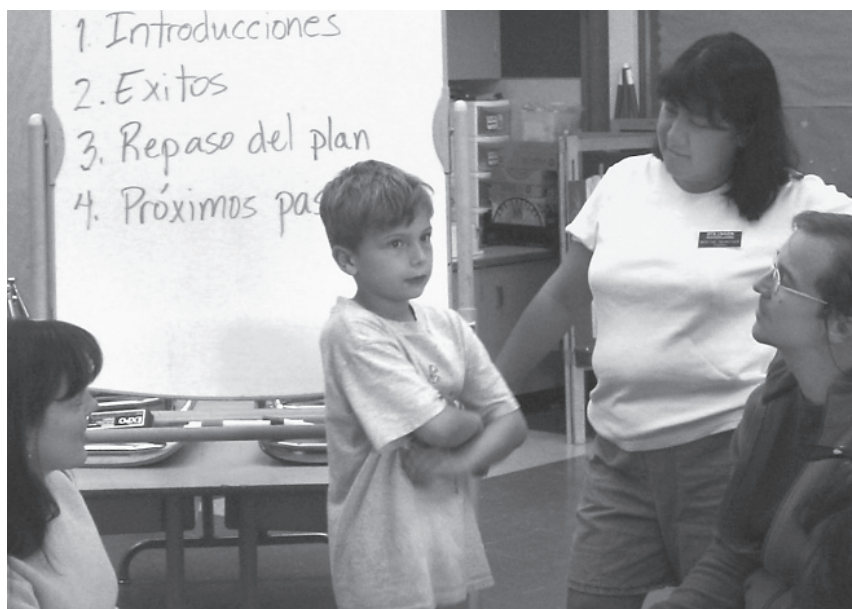
The purpose of this article is to share findings from research on nine child care centers that successfully provided child care for children with emotional and behavioral challenges alongside their peers without specific challenges (Brennan, Bradley, Ama, & Cawood, 2003). Following a brief overview of the research study, we focus a lens on the classroom, where staff selected and developed practices that included all children. The lens is

then widened to view a broader picture of inclusion, such as the ways that the centers work with families, and the structure and culture of the organizations.

Project Overview

The centers that participated in this research were nominated for their success in meeting the needs of families with children who have emotional and/or behavioral challenges. The main objectives of the project were

- to learn from family members, center directors, and center staff, about what made the centers successful.



- to describe promising practices for high quality, culturally appropriate, inclusive child care.
- to understand how families and centers communicate and work together.
- to identify the challenges experienced by staff and families, and how they were addressed.

The results reported here are based on the analysis of 88 interviews with parents of children with and without challenges, with the directors of the nine centers, and with staff members. In addition classroom observations were conducted in five centers.

Promoting Classroom Inclusion

Staff interviews revealed six broad principles that provided the basis for staff members' work with the children and families, and that shaped their practice to include children with challenging behavior in the day-to-day life of the classrooms: "Everyone is included: We find a way." The principles are listed below. Examples of practice strategies that flow from the principles are provided in Table 1.

Value and accept all children. Child care providers made clear that they endorsed the ideal of accepting all children. "We've had... kicking, fighting, biting...I'm going to take what's there and I'm going to

work with it and build on it."

Provide a natural environment for care. Staff members strove to develop high quality, developmentally appropriate settings that benefited all children. They noted that "If you have [the appropriate environment] then inclusion will be a lot easier."

Adapt the program to meet individual needs. Administrators and staff at the centers "put the child's needs first." Learning about the needs of individual children enabled staff to adapt the program and use practice strategies that promoted children's social and emotional development, and that transformed negative emotions and challenging behaviors.

Deliver family-centered services. Child care professionals viewed family members as allies and partners in the care of their children. "We are there to help everybody kind of work together and make that connection for their child's best interest." They exchanged information with parents, sharing strategies that worked for individual children in the classroom and in the home setting.

Promote a successful experience for children and their families. Staff emphasized their desire to have every child succeed in their centers, even children who had previously been asked to leave other centers due to

their behavior. Staff fully expected each child to meet realistic goals that were set for them, and assumed that they would be successful. "Sometimes that would be enough to kind of turn the tide for the child...Kids are very smart and they can read what's going on."

Recognize socio-emotional development as a precursor to school success. Staff members and administrators at the inclusive centers acknowledged that for children with emotional or behavioral challenges, "It is the social-emotional pieces that really make for a child's school success...They are able to attend to task, they are able to cooperate with peers, they are motivated to learn."

Specialist Support

It was evident that many of the children in these centers had complex needs. Access to support from specialists in mental health, language, and other disciplines was crucial to the success of these children and to their child care providers. Consultation from specialists can support staff and enable children to experience success alongside their peers, rather than be separated in a "special classroom" or face expulsion from the center altogether (Donahue, Falk, & Provet, 2000).

In these nine child care centers, mental health consultation was provided by professionals with training in different disciplines (e.g. special education, counseling, or social work) and included both internal and external consultants. As the examples below show, the consultants worked at different levels, including individual and family assessment and consultation, program consultation, and technical assistance.

For example, one director with mental health training described how she provided consultation on environmental changes that might support a child experiencing difficulties in the classroom.

I'll also come in, and sometimes it is just making observations, because... [we want to avoid] be-

havior plans.... [We see] if there are other adaptations we can make to the environment.

Similarly, a director describes how an external consultant provided support to classroom teachers, and worked with the family to develop individualized plans to meet the needs of a particular child.

There have been times when he has just made recommendations to the teachers about rearranging the environment”.... “There have been other times... in more severe cases, where he has asked the parents to come in and we have sat down and worked out a behavior... plan to be used at home and at school.

Consultation played a vital role promoting the social and emotional health in children and in supporting the collaboration with families that was the foundation for their success.

Working with Families

Fear is a major barrier to inclusive child care arrangements. Parents worry about their children’s physical safety, the amount of attention their children receive, and about negative consequences of exposure to others’ “bad behavior.” Although the parents we talked to shared these concerns, their fears were alleviated through trusting relationships with the center staff and open discussion of the issues that arose.

Many parents reported a “family atmosphere” in their centers, where all children were valued and parents, children, and staff members were seen as “one big family.” Attention to relationships fostered openness among parents and children so that “everybody helped each other.” Constant communication by any means necessary, including telephone, e-mail, and even home visits, nurtured the family atmosphere. Staff worked with parents to form individual goals for their child. Everyone, including other children and other parents, pitched in to help a child achieve his or her goals. One mother of a child with physical challenges was sur-

Practice Strategies

for Promoting Positive Emotions and Prosocial Behavior

1. Build a relationship with the individual child based on trust and respect.
2. Form a team with family members to work toward the child’s success.
3. Work from knowledge about individual children and their challenges.
4. Deliver a developmentally appropriate curriculum that meets the needs of all children at the center.
5. Create a consistent, predictable environment while maintaining flexibility.
6. Assist children to feel safe and calm by teaching self-soothing and providing quiet spaces.
7. Use multiple sensory channels when working with children with challenges.
8. Support children through times of transition by signaling transitions and teaming with other staff.
9. Provide opportunities for children to master behavior necessary for learning.
10. Create and support a wide variety of out-of-school activities for school-aged children.
11. Set clear boundaries for acceptable behavior while maintaining flexibility for school-aged children.
12. Teach empathy and responsibility through care of animals, plants, and younger children.

for Transforming Negative Emotions

1. Engage in pre-emptive planning to minimize negative feelings and behavior.
2. Develop formal behavior plans to manage challenging behavior, involving family members in planning.
3. Help children to be more verbal and express needs and frustrations in words.
4. Suggest alternative behaviors, including the use of drawings and art as a vehicle of expression.
5. Teach problem solving to children by talking through issues or using drawings and action figures.
6. Employ redirection to stop negative behaviors and distract from distressing emotions.
7. Focus attention appropriately and ignore some negative behavior.
8. Plan strategies to keep children safe from their own actions and those of other children.
9. Work as a team of staff members to address negative behavior: Bring in “fresh patience.”
10. Set consistent limits as a staff and communicates these to school-aged children.
11. De-escalate the emotional level of the classroom by learning to back off and not feed a child’s anger.
12. Have the school-aged child participate in the development of a formal behavior plan.

prised to see “all the smaller kids helping [her daughter] walk around the gym.”

Centers changed their environments to better suit the children enrolled at any given time. If a child was having a problem with circle time, for example, staff and parents would adapt activities until circle time worked for everybody. Centers were willing to try new things based on parental advice. “I’ve seen a lot of positive evolution in the way the staff handles things,” one mother said. This is exactly the type of change that fostered trust among parents for their providers.

Alleviating parents’ fears is the first step toward enabling inclusion. Trusting relationships among experienced staff, parents, and the children enrolled in a center alleviated fears parents brought to new centers. Some parents believed inclusion improved the overall quality of a center. One mother explained,

I think that the program is better now than it was [a few years ago]. It was good [then] but I think that probably they have learned from the various special needs kids who have passed through.

Organizational Culture

A philosophy of inclusion permeated all levels of these organizations, and was integrated into the centers’ activities. These child care centers were “clear what our mission is.” A transparent goal to provide services for all children was important in guiding the decisions that directors and staff faced. Newly recruited staff members were required to commit to working with all children.

Structures were created that enabled staff to be successful in their work. The staff-to-child ratio was sufficient to allow for back-up assistance to be available when necessary, and to allow staff to take “time out” to “de-escalate.” Directors and experienced staff provided mentorship for less experienced co-workers. Professional development and continuous learning were emphasized both



through on-the-job learning and attending training. Some centers had weekly meetings out of the classroom to review each child’s progress, and to develop and agree on new strategies. This was an example of how centers used a single mechanism both for planning and accommodation of individual children, and for staff learning and support.

The support of, and respect for, individual families were mirrored in an organizational culture in which staff were treated well and supervisors were “directly accessible [to staff] all the time.” Directors recognized that working in the classroom could be difficult and demanding. They discussed the importance of avoiding staff burnout, and reminding “each other of our success stories.” Staff talked about the importance of developing trusting relationships with co-workers, such that staff members would “feel safe communicating with each other.” It was also important that the children witness “the adults working together” as a positive model of co-operation and problem solving. This required openness to learning, recognizing that “there’s always more than one way to do everything,” and being able to ask for help when appropriate.

Conclusion

These centers demonstrated that when child care is inclusive and is part of a larger system of family support, the lives of children and families can be substantially improved. Such support needs to be more widely available to enable families to participate in their communities, employ-

ers to retain valuable workers, and children to have opportunities to engage in activities with their peers that support their cognitive, social and emotional development.

In the next phase of the research, we are interviewing state child care administrators about state-level efforts to make child care more inclusive of children with emotional and behavioral disorders. The full report on the inclusive programs and more information on the state level study can be found at www.rtc.pdx.edu/pgProjInclusion.php.

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The Underrepresented Researchers Mentoring Program is a training project of the Research and Training Center at Portland State University. The program offers undergraduate and graduate students research opportunities in the field of children's mental health. The project coordinates and evaluates a mentoring program targeted toward students of color, first generation college students, and students with disabilities. It is designed to encourage students to pursue an interest in research and to acquire a variety of research skills and experiences. Mentees work directly with at least one existing research project. In addition to learning about the field of children's mental health at academic and

practice-based levels, participants gain an understanding of the expectations, demands, role requirements, and necessary strategies within research as an academic profession.

Since its inception, the project has had a high level of success in providing mentees with an entrée into research. All students who have participated in the program have continued to pursue research activities, with several planning careers in research. As of May, 2004, six students have participated in the mentoring program. Of the six students, three were undergraduates and three were graduate students, four were students of color, and three were first generation college students.

UNDERREPRESENTED RESEARCHERS MENTORING PROGRAM: ONE MENTEE'S STORY

I became a mentee in the Underrepresented Researchers Mentoring Program in April 2000, during my first year in the Masters of Social Work program at Portland State University. I learned about the mentoring program after mentioning to one of my professors that I was very interested in research. At the time, I had almost no previous research experience, save for an undergraduate class in basic methodology. So when I said, "I love doing research," what I meant was that I loved looking stuff up and finding things out. I had no idea of the intricacies or rigor involved in doing large-scale, collaborative, government-funded research.

When I started the program, I was introduced to the basics; most basic of all, learning to run the copy machine. This may sound insignificant, but looking up academic literature through our library databases was a much simpler task than trying to make multiple copies of articles to share with my research teams. I'll never forget how intimidated I felt. Using the fax machine was another anxiety-producing event, one which I'm not sure I am yet immune to—it has now been four years. Then there was the issue of being around "all these academics," attending professional conferences, and the unavoidable meeting and mingling with other academics from across the country. To say "anxious" does not really convey the depth of my fear; terror was more like it.

After participating in the mentoring program, I finished my MSW in 2001, and started the Ph.D. program in Social Work and Social Science at Portland State. During that time I was able to secure a federally-funded fellowship through the Council on Social Work Education (CSWE), which now supports me financially and emotionally as I make my way through the doctoral program. Currently, I am nearing completion of



my first solo-authored journal article, entitled "Racism in mental health." This accomplishment represents a tribute to my mentor from the Reserach

and Training Center, Jennifer S. Simpson, and to the Director of CSWE's Minority Fellowship Program, Dr. E. Aracelis Francis, both of whom have provided ongoing and unfailing support.

Four and one-half years ago, I entered graduate school grudgingly, and never imagined why in my lifetime I would ever want to pursue a doctorate, and yet, here I am. It is true that I gained valuable research knowledge and skills, but I think the most important thing for me as a mentee, and later a graduate research assistant, was gaining confidence. Of course, gaining knowledge and research skills is important to gaining confidence, but for me it was a matter of learning to negotiate through the daily rigors of academic research. Because those who mentored me were patient and also very good teachers, I was able to learn that asking for help did not mean I was incompetent, that I have something valuable to contribute the research endeavor, and that the people working with me were people just like me.

If I can do it, anyone can.

—María L. García Gettman



TEAM PRACTICES TO INCREASE INDIVIDUALIZATION IN WRAPAROUND

Within children's mental health, *wraparound* has become one of the primary strategies for improving services and outcomes for children with the highest levels of need. Wraparound is defined as an individualized service planning process undertaken by a team that includes the family, child, natural supports, agencies, and community services working together in partnership. The plan created by the team is to be culturally competent and strengths based, and should include a balance of formal services and informal, community, and natural supports.

In practice, however, it seems to be quite difficult to realize this vision for wraparound teamwork. In particular, it appears that teams have great difficulty creating plans that are truly individualized and that creatively blend formal, community, and natural supports and services (Burchard, Bruns, & Burchard, 2002).

The *Teamwork in Practice* project at the Research and Training Center has focused on building an understanding of how team member *practices*—i.e., specific kinds of

skills, techniques, or procedures that team members use—are linked to desired outcomes in wraparound. Here, we describe research results showing that teams that engage in a greater number of *creativity-enhancing practices* tend to produce plans that are more highly individualized than teams that engage in fewer such practices.

In earlier work (Walker & Schutte, in press), we proposed that wraparound teams are more likely to develop creative, individualized plans that effectively meet child and family needs when the team adheres to a high quality planning process. While it might seem obvious that high quality planning is necessary—though not sufficient—for effective wraparound, findings from early phases of our research indicated that many teams did not appear to be using the elements of planning that have been linked to team effectiveness across a variety of contexts. In particular, we found relatively few teams engaging in activities that stimulate the type of creativity that would seem to be essential in creating plans that are truly individualized.

Creativity and Effectiveness

Research on team creativity and effectiveness in other settings has shown that teams are better able to come up with good solutions to complex problems when they employ two particular sorts of creativity-enhancing practices: practices for *broadening perspectives*, and practices for *generating multiple options* (for a review of the research on creativity enhancement in teams, see Walker & Schutte, in press). Broadening perspectives and generating multiple options have a positive impact on team creativity and effectiveness for several reasons. First, broadening perspectives—i.e., examining an issue from new vantage points or considering new information—has the potential to promote increased mental effort during problem solving and decision making, thus paving the way for increased effectiveness in strategizing. Second, generating multiple options—i.e., considering several different solutions or strategies for solving a problem or reaching a goal—has the potential to increase the quality of solutions or strategies available to the team since

ideas generated later on during problem solving tend to be of higher quality than those generated first. Finally, both broadening perspectives and generating options are processes that stimulate further insight into the nature of the problem under consideration, and can lead to a better match between goals and strategies.

Research on teams has also linked specific team practices to creativity and effectiveness. For example, there is research support for the usefulness of brainstorming and similar structured procedures that can be used for broadening perspectives and for generating multiple options. Another technique for enhancing creativity is to consider input from every team member during discussions and decision making. Within wraparound, we propose that team activities around strengths are also practices that enhance creativity, serving as means both to broaden perspectives (by providing new information or new vantage points) and to generate options (particularly when the team consciously constructs goals and strategies from information about strengths).

Observational Study

In order to explore hypotheses about team practices and their effects on team process and outcomes, we studied 72 wraparound meetings from communities around the country. We observed the meetings, collected a variety of kinds of information about the teams, and interviewed team members about their experiences during the meetings. One method of data collection we used was the *observation report form*. The form included a total of sixteen indicators of high quality planning. For each meeting, we checked off whether or not we had observed each indicator during the meeting. Six of the indicators focused on creativity enhancement, and are listed in Table 1. The checklist also included eight indicators

for plan individualization, which were intended to reflect the extent to which teams appeared to be attempting to create plans that used community-based strategies and that reflected attention to the unique needs and strengths of the child and family. These indicators are also listed in Table 1. Reliability was assessed by comparing two observers' responses on the observation report form for a subset of the meetings. Overall agreement was 87%.

As can be seen from Table 1, there was a high degree of variability in the frequency with which the indicators were observed. Among the creativity indicators, *mentions specific strengths* was observed in a large majority of teams, but none of the other indicators was observed during more than about one fifth of meetings, with two indicators observed very infrequently. Regarding the indicators of plan individualization, a large majority of teams made

minor changes to formal services, and about half of the teams discussed providing a *regular community service*, such as a membership to a health club. However, at fewer than one in six meetings was there evidence that teams actually were coordinating, facilitating, or funding such a service. About one quarter of teams were facilitating a *natural support activity*, i.e., a volunteer activity provided uniquely to the family. Coordinating or facilitating a *tailored community support*—i.e., an experience provided by a community member or organization that is like those provided to other community members but that has been tailored by the team—was rare.

To explore the issue of the impact of creativity-enhancing practices on plan individualization, we summed across the creativity indicators and the individualization indicators to create two scores for each observed meeting. The sum for creativity in-

Table 1
Percentage of Meetings Where Indicators Were Observed

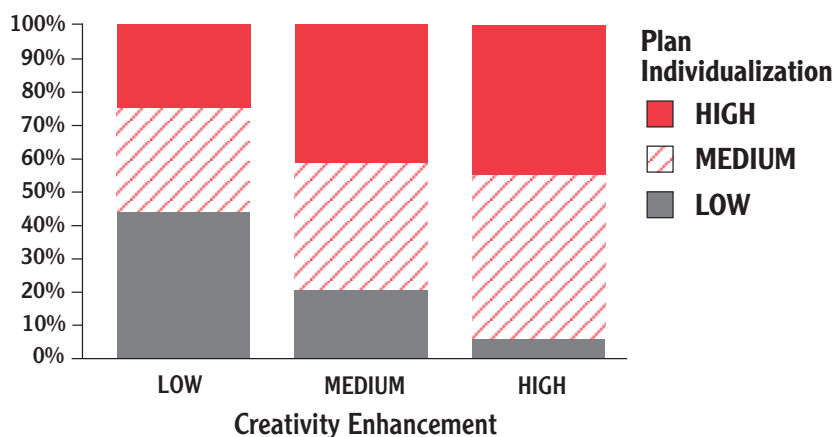
Indicators of creativity enhancement

1. Team engages in brainstorming or other activity to stimulate options or broaden perspectives.	13%
2. Team generates several distinct options before making a decision.	20%
3. Team uses a clearly defined procedure to prioritize goals, needs, or strategies.	6%
4. Team elicits opinions or perspectives from each team member.	7%
5. Team mentions specific strengths or assets of the child and/or family.	72%
6. Team engages in an extended strengths-related activity.	22%

Indicators of plan individualization

1. Team makes minor changes to formal service.	89%
2. Team significantly tailors formal services.	34%
3. Team investigates a regular community service.	47%
4. Team coordinates or facilitates a regular community service.	16%
5. Team investigates a tailored community support.	9%
6. Team coordinates or facilitates a tailored community support.	6%
7. Team investigates a natural support activity.	26%
8. Team coordinates or facilitates a natural support activity.	26%

Figure 1: Creativity and Individualization



indicators varied from zero to four with a mean of 1.3, and the sum for individualization indicators varied from zero to six with a mean of 2.5. We called meetings with a sum of zero “low” in terms of their use of creativity-enhancing practices, while teams with a sum of one were “medium,” and teams with two or more were “high.” Similarly, teams with zero or one indicator of individualization were “low” in that area, teams with two or three were “medium,” and teams with four or more were “high.” Statistical analyses showed that these two

sums were highly associated with one another, such that an increasing level of creativity-enhancing activities was associated with a higher likelihood of greater plan individualization ($\gamma=.325, p<.02$). Figure 1 provides a graphic representation of this result.

Conclusion

Of course, there is more to high quality planning than creativity enhancement, and there is much more to wraparound than high quality planning. However, the potential benefit of creativity enhancement

within wraparound should not be underestimated. In addition to the positive impacts on problem solving, creativity-enhancing procedures have other important benefits as well. In this regard, generating multiple options is particularly powerful. For example, when team members generate a variety of options for ways to meet a need or achieve a goal, they are not just improving their chances of successfully solving a problem. More importantly, they create the opportunity for the family (and other team members as well) to see a range of possibilities, and to select from among them the one which they feel is most likely to produce the desired results *while also* building on or enhancing strengths or assets, supporting family culture and values, and/or promoting integration into valued roles in home, school, and community. Given this range of important benefits, it seems there is great potential for wraparound teams to improve their performance by increasing their use of creativity-enhancing practices.

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WRAPAROUND AND JUVENILE JUSTICE: MAKING A CONNECTION THAT WORKS

My role as a family assistance specialist is defined as helping to make sure that the parent voice is heard and helping to locate and access community services, but I find that much of the assistance I provide is way outside this realm. Yes, I do take parents to meetings with other agencies, but more value is often found in the car ride there than my presence at the meeting. I am able to talk about what is happening in their lives and share stories of my own experiences to help them feel less isolated and alone. I do try to make sure that their opinions are clearly heard in the meetings and yet much of what we talk about never makes it to the meeting room. We cry together, we laugh together, we share together, and that is where the true “assistance” comes in.

—Patricia Roe, a family assistance specialist at Connections

The name *Connections* expresses the idea that the needs of youth and families are met best when all the pieces of the service and support “puzzle” are interlocked. One of the ways that these connections are facilitated is through the work of family assistance specialists, like Patricia Roe, who is quoted throughout this

article. But truly bringing together service providers, families, and members of their natural support systems around a common mission entails moving beyond conventional thinking about how services are provided. Through collaboration with those that have a stake in successful outcomes for youth and families, appropriate and effective service and support strategies can be developed.

The Connections program grew out of the realization that, in Clark County, Washington, many youth were simultaneously receiving services in both the juvenile justice and mental health systems. Recognizing the unique needs of juvenile offenders with behavioral health issues, the county developed a specialized program designed to integrate services and coordinate resources to meet the need of these young people and their families.

The Connections program was implemented in October 2001. The program represents a partnership between the juvenile court and the mental health community that is designed to enhance services through stronger community connections. Using a Wraparound/Individualized and Tailored Care model, Connec-

tions employs a strength-based approach to link youth and families to local resources so as to better meet their individual needs. To this end, families are full partners in developing, delivering, and implementing interventions.

Program Features

When I was raising my son, I never dreamed that his teenage years could be so awful. This child who had been the light of my life for 12 years suddenly turned into the child of Frankenstein. I understand how the parents in our program must feel. We love our kids but we hate them at the same time. I think that one of the greatest values of this program is helping parents work their way through this. We help to normalize behaviors and rebuild the connection between family and child, the most important connection anyone has in this life.

Innovative juvenile justice service delivery. Connections is designed to deter youth from continued criminal activity and to stabilize them by establishing effective community-based support systems that will remain in place after court-ordered supervision

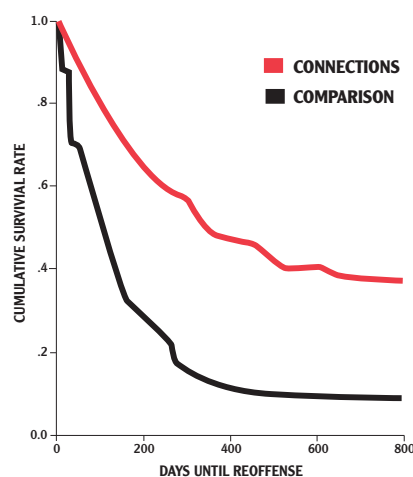


Figure 1. Survival curve—time until reoffense

expires. Program staff work collaboratively with youth and families in the wraparound model to build on youth and family strengths, address identified needs, and connect families to interventions and resources. Families are considered equal partners in the Connections program. Each family involved in the program is assigned to a family assistance specialist whose primary role is to support and advocate for the parents of probationary youth.

Specific program goals include reducing recidivism, probation violations, and detention days. Additionally, the program aims to reduce the episodes and length of time in out-of-home care, increase protective factors, improve child functioning, increase family stability, and increase the family's capacity to provide adequate supervision and supports for youth.

Varied staff expertise. Connections staff are extremely dedicated to serving the families within the program in flexible and innovative ways. Because of the unique approach of this program and its goal of serving families' various needs, staff are frequently required to work long and odd hours. One of the program's unique aspects is that it brings together individuals with various areas of expertise within the juvenile jus-

tice system. The program consists of four teams composed of four full-time staff each, with a joint caseload for each team of approximately 25 youth and their families. The team includes a probation counselor, a juvenile services associate, a care coordinator, and a family assistance specialist. Each of these roles is described in more detail below. The program also employs a part-time clinical psychologist. All of the program positions were created with flexible work schedules in order to accommodate the needs of families. Connections contracts out for psychiatric services including medication management.

The probation counselor provides probation services that promote community safety, provide services to victims, increase youth competencies, and provide offender accountability, all under the umbrella of balanced and restorative justice principles. The responsibilities of the probation counselor include receiving and examining referrals to the juvenile court, making recommendations to the court regarding the need for continued detention, arranging and supervising diversion agreements, preparing predisposition studies, being present at the disposition hearing to respond to questions regarding the report, and supervising court orders of disposition.

The care coordinator/mental health therapist facilitates the wraparound planning process. In collaboration with the wraparound team, the care coordinator helps identify strengths, determine needs, and identify both formal and informal supports and

resources. The care coordinator is also responsible for monitoring the implementation of the team's plan, brokering services, providing written wraparound team meeting summaries, conducting mental health assessments, and providing crisis family counseling and intervention.

The juvenile services associate works primarily with the youth to set goals and develop an individual action plan to meet court and service requirements. Serving as a resource, mentor, and role model to program youth, a juvenile service associate provides advocacy services, teaches skills, and supervises restorative community service activities, all as part of an overall effort to increase competencies in youth.

The family assistance specialist is assigned to each family to assist with strengths assessment, system navigation, mentoring, support, and advocacy. Family assistance specialists are trained to empower families into action. They help families identify and connect with informal supports including relatives, friends, teachers, and church volunteers. As advocates, they help the families state their needs and make community connections. They make certain that the parent's voice is heard.

The staff clinical psychologist provides twenty hours per week to the program. In addition to performing psychological evaluations and assisting with program development, the psychologist is available to staff cases, consult with teams, and provide direct services to youth.

Family advisory committee. The

Table 1. Post-entry detention days over 790 days of follow-up information

	Connections 71 (73%)	Comparison 95 (97%)
Number and percentage serving detention days		
Among youth who served detention post-entry		
Mean number of detention days per episode per youth	13	14
Mean number of detention episodes per youth	4.4	7.5
Mean number of total detention days per youth	59	102

family advisory committee was created as an avenue for youth and parents to participate in program development and ensure family collaboration. The committee members act as advisors to the management of the Connections program. Specifically, the committee makes recommendations, reviews policies and best practice guidelines, and provides consultation to the program. The committee is comprised of participating family members and program staff.

A number of innovative ideas have emerged as a result of this collaboration.

For example, at the suggestion of families, binders detailing the program are created for families to help them manage information as they enter Connections. The family advisory committee also recommends activities such as an annual picnic and holiday open house that brings together Connections staff and participating families for informal gatherings. Families have also contributed to the development of family-friendly pamphlets and newsletters.

Outcomes

This program has allowed me to help other parents rediscover that they, and their families, can be successful. They can once again have dreams and achieve them. It sometimes means helping them modify their personal goals, and encouraging them to allow their kids to have goals of their own. The true value for me is when I meet with a parent and they are finally able to see that progress is being made. And when those big goals are met, it is amazing. There are no greater thanks.

In its first three years of operation, the Connections program has served over 200 youth and families, and it has demonstrated excellent outcomes. When compared to a similar sample of probationary youth with



mental health problems that were receiving traditional community mental health services, youth in the Connections program were less than half as likely to re-offend. Among youth who re-offended, those in Connections re-offended about half as many times as youth from the comparison group. Furthermore, in cases where youth in Connections did re-offend, they tended to commit less serious crimes. A time-to event analysis (Kaplan-Meier Survival) of the first hundred youth enrolled in Connections revealed that they also took significantly longer to re-offend. Half of the comparison group had re-offended by 100 days after identification, whereas it took 350 days for half of the Connections youth to re-offend (Log-rank (1) = 38.01, $p < .01$; see Figure 1).

Because of reduced recidivism, Connections youth used fewer detention days; in fact, over a two-year period after identification, 27% percent of Connections youth served no detention days at all; this compares to only 3% of the comparison group (see Table 1). Of the youth who did serve detention days, Connections youth had roughly 40% fewer detention episodes and total days. This difference in detention days may translate into significant cost savings because holding youth in detention

is very expensive.

Besides juvenile records, other measures also reveal improved functioning. Youth in Connections were interviewed at intake, 6-month, and 12-month follow-up about their involvement with various delinquent activities. By their own accounts, from intake to 12 months, fewer youth were engaging in many of the most common activities, including vandalizing property, being part of a gang, buying or selling stolen goods, breaking into a house or car, and threatening others with weapons.

They also reported less substance use and better overall functioning. Youth in Connections had significantly more strengths and significantly fewer problems between intake and 12 months, according to caregiver ratings on the Behavioral and Emotional Rating Scale, the Child Behavior Checklist, and the Child and Adolescent Functional Assessment Scale.

Conclusion

The value of working in wrap-around, and particularly in the Connections program, becomes clear when I can sit in court with a parent and watch their child take responsibility and consequences and feel a sense of pride for how far they have come.

Connections is an innovative service planning and delivery mechanism for juvenile justice that relies on building working relationships with entire families in order to meet the needs of the youth. The improved functioning, decreased recidivism, and decreased detention days demonstrate the value of non-traditional services, family participation in planning, family support, and a family-centered approach. While undeniably there are struggles with integrating wraparound principles and values with juvenile justice,

Connections is evidence that with ongoing efforts and dedicated staff it can be done.

Please visit our evaluation website for more detailed information about the Connections and Clark County System of Care evaluation, at <http://www.rrri.pdx.edu/ClarkCo/>.

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PARTNERSHIPS IN EVALUATION: TRAINING IMPLICATIONS

Increasingly, family members are becoming involved in evaluations of their children's mental health services. Family involvement in evaluation was recommended by the President's New Freedom Commission on Mental Health (2003) and the Surgeon General's Report on Mental Health (2001). Family participation is required in the evaluation of systems of care funded by the Center for Mental Health Services' Comprehensive Community Mental Health Services for Children and Their Families Program.

In order to prepare family members to participate actively in the evaluation process, the Federation of Families for Children's Mental Health (2002) has developed a three-part

training in evaluation. However, if collaboration is to be successful, professional evaluators need to learn to collaborate with family members. University training for research and evaluation has traditionally emphasized objectivity and maintaining distance from participants. As a result, evaluators may be skeptical of and/or unprepared for collaboration with family members and other stakeholders. In this article, we focus on the work of the *Families as Evaluators* project at the Research and Training Center. One of the primary areas of work in this project has been to build understanding of the training needs of evaluators participating on evaluation teams with family members. After reporting on findings from a study

of the perspectives of evaluators and family members on evaluation teams (referred to as *family evaluators*) on their work together, the article goes on to describe a training program to meet evaluators' needs for training in collaboration.

By becoming involved in evaluations of their children's services, families gain tools for influencing service improvements. Participatory evaluations are program evaluations in which people most affected by the program—in this instance, families—collaborate with evaluators in all aspects of a study. When family members participate in developing and conducting program evaluations, it is more likely that study questions will be relevant to the needs of families

and that findings will be used to improve services for children. Participatory evaluations also promote increased attention to cultural differences. As an additional benefit, family members who are employed on evaluation teams gain knowledge and skills that contribute to their professional development and their sense of empowerment.

Evaluation Study

To gain understanding of evaluators' experiences and learning needs in regard to family participation, we invited evaluators and family evaluators to tell us, in their own words, about their work together, their training for participatory evaluation, their training needs, and their recommendations for future training. Responses were recorded and analyzed to identify categories and themes.

Results reported here are based on interviews with 20 evaluators and 10 family evaluators from different regions of the U.S. Findings on the roles of family evaluators, work-related challenges, and effective strategies used on participatory evaluation teams are reported elsewhere (Schutte, Savage, Robinson, Jivanjee, & Pullmann, in press).

What preparation for undertaking participatory evaluation did evaluators and family evaluators receive?

Most evaluators reported that there had been no attention to family participation in their university training and over half reported being trained to maintain distance from research participants. They reported receiving little or no preparation to lead a team or offer staff supervision and support. Two-thirds of the evaluators reported that they learned to work with family members by doing the work, often commenting that they had "muddled through" or learned from their mistakes. Some evaluators reported creating a climate of mutual education in the team as a way to meet all participants' learning needs. To gain skills in participatory evaluation, evaluators reported learning

from a mentor, reading articles, talking with other system of care evaluators, or learning from members of local family advocacy organizations. Family evaluators reported that they received information and help from the lead evaluator on their project or from other family members and research assistants on the team. Some family members who had participated in the Federation of Families' training reported that the training had been helpful.

What are evaluators' and family evaluators' learning needs in regard to family participation?

Evaluators described many situations in which they felt unprepared to respond to challenges in their work, for example, when called upon to help family members reconcile the dissonance between their roles as advocates and as evaluation team members. Evaluators also reported difficulties supporting family members to deal with the stress of parenting a child with mental health needs, while also completing their job-related responsibilities. Evaluators expressed a desire to learn concrete strategies to facilitate collaboration. Evaluators wished for opportunities to learn from other evaluator-family member teams about how to respond to challenges related to recruiting, hiring, training, and supporting family evaluators. Participants suggested that collaboration would be enhanced if they had access to "a compilation of effective strategies," "lessons learned and suggestions from those who have done it," "a comprehensive guide to how best to engage and benefit from family members' input," or a manual to guide evaluators in training family evaluators to do interviewing and other tasks.

While some family evaluators commented positively on the evaluators' personal attributes and skills, others noted evaluators' needs for training in collaboration. For example, one family evaluator said that evaluators needed to learn about "the challenges

and obstacles that the families have to face in the real mental health world." Others said that evaluators needed training related to cultural difference and "to communicate clearly and openly in everyday language." Finally, family members expressed a desire for more training in evaluation skills for themselves.

What training will be most helpful for participatory evaluation?

Evaluators wished for journal articles addressing evaluators and family members working together, a "comprehensive training guide," a manual, or other written materials. Members of both groups wanted access to face-to-face training provided by teams of evaluators and family evaluators who had collaborated successfully. They appreciated seeing evaluators and family members making joint presentations at conferences. There were also recommendations to incorporate training for collaboration in the existing training for systems of care, especially the training for new sites. Some evaluators wished for joint training modeled after the Federation of Families training for family members. Some evaluators recom-



rtcUpdates

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mended including participatory evaluation in university curricula. Finally, there were suggestions about using technology, including e-newsletters, listservs, and conference calls to deliver information and to build supportive networks among evaluators.

Implications for Training

Based on findings from our interviews and advice from members of an advisory group of family members and evaluators, we are developing training materials. The training is designed for use by evaluators, family members, and other stakeholders who are working together as teams, and it provides opportunities to practice the skills of participatory evaluation via experiential exercises. We believe that evaluators, often acting as team leaders, are well positioned to make training for collaboration a priority, to obtain training materials, to set aside time for team training, and to serve as facilitators or recruit training facilitators.

Training modules are based on principles of self-directed adult learning, which builds on an appreciation of what participants already know and can do. Modules are designed around case-based and experiential learning, with encouragement to organize follow-up activities and provide continual coaching for the team.

Each training module includes learning objectives; information about the topic; a case study, vignette, and/or role play; experiential exercises designed to improve participants' capacity to collaborate; and a reading list. Topics addressed in the training include

- team formation and stages of team development;
- team roles and negotiation;
- power dynamics in collaborative evaluation teams;
- staff support and supervision;
- the tensions between advocacy and rigor in evaluation;
- decision making, communication, and conflict management in teams; and
- the challenges of balancing work and family responsibilities.

Here we feature a summary of the first module on participatory evaluation as an example.

The first training module introduces evaluators and family members to participatory evaluation. Teams review training content in the manual and engage in a series of activities including a self-assessment of learning needs. A training exercise invites evaluators and family members to privately identify and then share their stereotypes about each other and discuss the extent to which these stereotypes are based in reality. A case study is provided so that participants may

engage in a role play in which they represent stakeholders in the early stages of developing an evaluation of a family support program. Participants in this role play are invited to identify and resolve tensions that arise between a new evaluator, who is hired to lead a collaborative evaluation, and family members who are determined to use the evaluation to influence local officials to make program changes.

In other modules, training participants go on to examine evaluator and family member roles in a range of evaluation activities, for example as advisory group members, evaluation team members, and even project co-leaders (Vander Stoep, Williams, Jones, Green, & Trupin, 1999). They practice collaborative activities at different stages of the project, including designing the study, reviewing proposals, developing survey instruments, collecting data, analyzing data, interpreting findings, writing reports, and disseminating findings (Osher & Telesford, 1996). Participants consider family members' varied levels of influence over the evaluation (Vander Stoep, Williams, Jones, Green, & Trupin, 1999) and differences related to culture, social class, and the "cultures" of the academic and service delivery worlds as they affect evaluation.

Conclusion

Despite the presumed benefits of family participation in evaluation, there are few models to guide evaluators in how to engage and involve family members. Given their varied roles, all members of evaluation teams need opportunities to reconcile their different world views and goals, and they need a repertoire of strategies for building collaborative teams while producing useful findings.

Responses gathered during our study indicated that if evaluators are to collaborate effectively with family members, they need strong communication skills, the capacity to manage a diverse work team, the ability to manage and resolve conflict, and



the ability to supervise and support team members. The training modules described in this article were developed to offer ideas for improving collaboration to evaluators with different levels of expertise and to teams at different stages of the evaluation process. We plan to complete the training materials and make them available on the web in September 2004.

Check our website at <http://www.rtc.pdx.edu/pgProjEvaluators.php> for progress reports.

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FAMILY PARTICIPATION IN OUT-OF-HOME TREATMENT SETTINGS: CHALLENGES AND OPPORTUNITIES FOR CHANGE

Throughout the life of the *Family Participation* project, the research team has struggled with the contradiction inherent in spending resources and energy studying families' experiences related to out-of-home settings when we are wholly committed to community based care, and to the principle that children should live at home with their families. We began the *Family Participation* project nearly ten years ago in response to a federal funding priority to examine "alternatives to living at home when family-based treatment is not an option." We believe that if sufficient resources and supports are provided, most families and children can be helped without out-of-home placement. We also know that thou-

sands of children enter residential settings each year, and we believe that they and their families should not be ignored. For these reasons, we decided to explore family participation and other topics of immediate concern to families whose children were in out-of-home care.

Here we summarize three journal articles focusing on family members' experiences when their children are in out-of-home placement. The first article presents findings from four focus groups conducted with families whose children were in out-of-home placement, and features the perceptions of African American parents. The second and third articles present information obtained from 102 families whose children had been in out-of-home

treatment for more than 30 days during the study period. Caregivers returned a questionnaire addressing family participation and other service delivery-related issues. The questionnaire was developed in part from issues and concerns raised by the focus group participants. Details on the study samples and research methods are included in the original articles, which are, or will be, available from the RTC. Together, these articles explore family participation in out-of-home services from the perspective of family members, and point to areas where practices, programs, and policy can be improved.

Focus Groups

The first article, "Family perspec-

tives on residential treatment: *Voices of African American families*" (Kruzich, Friesen, Williams-Murphy, & Longley, 2003) reports on four focus groups that were held at annual conferences of the Federation of Families for Children's Mental Health. Three of the focus groups were comprised primarily of European American parents, while the remaining group was comprised of African American parents. (In this article, we use "parents" to include other primary caregivers as well.) Participants provided rich information about their experiences while their children were in residential care, psychiatric hospitals, or group homes. Focus group members were asked to describe the nature of their contact with their children and involvement in education and treatment during the period of out-of-home care.

Common concerns. One common concern across all groups was initial and ongoing contact between parents and their children. Residential programs varied widely in the degree to which they encouraged or discouraged family involvement during the initial weeks or months of treatment. Some family members were told in advance that during an adjustment period there could be no contact with their children. One mother of a 5-year-old boy reported that she was told initially that there would be no contact, but that staff relented and let her have phone contact because her son was so young. Other parents reported not only that they were denied contact, but that their children were moved to different facilities without notification.

One of parents' most frequently expressed desires was to have contact with their children through visits and phone calls. Many family members expressed concern about the inflexibility of visiting rules and policies and lack of communication between the facility and home. Permission for children to have contact with their families was often contingent upon the child's behavior.

Many family members commented on the financial expense of maintaining contact, including long distance calls, travel costs, and meals during day visits.

All participants emphasized the importance of being involved in treatment decisions. Some were encouraged to be involved "right from the beginning," but others felt they had to be assertive and persistent in order to be involved.

Recommendations for improvement included increasing the extent to which caregivers were respected, valued, and involved in decision-making. A number of family members indicated a need for more flexibility and individualization. They also asked for meetings that included other family members, more program information, financial support for visiting and phone calls, and better interagency collaboration.

Unique concerns of African American family members. Members of the African American focus group expressed concern about separation of child from family and community. Many family members expressed apprehension about having to place their child in residential treatment. They were concerned that the staff would interpret the child's placement as relinquishing their child, and also that the child would feel abandoned. Many of the African American parents had doubts that their children could be well served in any out-of-home setting. Instead of focusing on improvements in residential care, the majority of comments focused on the need to redirect resources to families and communities. Members of the focus group also expressed concerns about the use of medication, including the effects of medication on their children, over-medication, the use of drugs as the sole treatment, and possible racist experimentation.

Racial and cultural dissimilarities between staff and families were also concerns. One mother said, "the people who work in the program

are not African Americans or Latinos. It is very demeaning when people speak about your family life, where you live, like it is some foreign country." The staff's lack of understanding was also seen as possibly leading to inappropriate treatment such as the concern expressed by one mother who feared that teaching her son to cry would result in his being bullied. Families also described instances where stereotypes of staff appeared to lead to differential treatment of their children, e.g., assuming that their problems were "social" rather than biological, giving more severe diagnoses, and punishing them for hairstyles, dress, and socializing with other African American youth.

The article concludes with recommendations for recruitment of staff from diverse backgrounds, staff training, and changes in agency policies and practices, especially with regard to increasing the cultural appropriateness of services.

Parent-Child Contact

The second article, "Preserving family bonds: Examining parent perspectives in the light of practice standards for out-of-home treatment," used the questionnaire data to examine parent-child contact when children were placed out of their homes for the purpose of mental health treatment. Support for the principle that parents and children should have regular and frequent contact resides in laws and court cases that address the rights of parents, in theories about attachment and bonding, and in research that



demonstrates the benefits of parent-child contact. However, it appears that practices with regard to parent-child contact often do not reflect this principle. The purpose of this analysis was to learn more about practices related to parent-child contact, and how parents' experiences compared to practices outlined in the current standards of national organizations such as the Council on Accreditation (COA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

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Contact during the initial period of placement. In response to the concerns of focus group participants, the questionnaire specifically asked about parent-child contact during the period immediately following placement. The standards, however, did not address different stages of placement; rather, they addressed the entirety of a child's stay. The standards call for written policies guaranteeing the right of parents to communicate with and visit their children and to have the frequency, length, and location of visits and telephone calls specified in service plans developed in cooperation with parents.

Nearly 60% of parents reported that there was a limitation placed on contact with their children for an initial period of adjustment. These restrictions lasted 1-8 weeks, with no significant difference based on age of the child or treatment setting. Predictably, parents who did not have custody of their children were more likely to report such restrictions.

Frequency of parent-child contact. The standards emphasize both regularity and flexibility of contact. Parents reported that telephone contact occurred most frequently, with nearly 90% of parents reporting phone contact once a week or more. Sixty-three percent reported weekly visits on campus, 33% off campus, and 24% reported weekly home visits. Younger children had more contact with their families, as did children in facilities closer to home. There were no significant differences in frequency of contact based on the child's sex, race, or severity of condition.

Standards addressing restrictions on contact. Regulatory bodies require that restrictions on contact be fully explained, disclosed prior to placement, demonstrate benefit to the individual served, and be determined with the participation of the individual and his/her family. Some standards require regular reviews of restrictions, and some limit the con-

ditions under which restrictions on parent-child contact may be imposed.

Fifty-nine percent of parents reported that after an initial period of adjustment, subsequent parent-child contact was contingent upon the child's behavior. Nearly 80% of parents reported restriction on at least one type of contact. Parents of girls, single parents, and parents who did not have legal custody of their children were more likely to report restrictions. Over half of the caregivers reported restrictions of parent-child contact based on point and level systems. Differences between those who reported that contact with their child was based on the child's behavior and those who did not varied significantly by severity of the child's problems (children who had less severe problems were more likely to have contact with parents contingent on their behavior) and income (83% of parents who earned very low incomes reported that contact was contingent on the child's behavior vs. 54% of caregivers who reported more income). Sixteen percent of parents reported that contact was contingent upon the behavior of peers in the treatment unit. Parents' reports of the reasons for limiting contact included staff discretion, restrictive facility policies, behavior modification programs, and maintenance of a therapeutic environment. Some caregivers felt that limitations were imposed arbitrarily or for the convenience of staff.

Despite many good reasons to promote parent-child visits, many organizations still restrict such contact. Thus, there appears to be a gap between current practice and contemporary thinking that highlights the importance of actively preserving children's attachment to their parents and minimizing the stress and trauma of separation. In addition, many parents reported the use of point and level systems that made parent-child contact contingent on the child's or the peer group's behavior. Although we recognize that

contact with family is a potent reinforcer for many children, we believe that it is problematic to base a child's contact with family on his/her behavior, especially because point and level systems are usually not individualized. Recent changes to the behavior health care standards of JCAHO emphasize individualization of interventions, and prohibit group contingencies based on a single individual's behavior. Implementation of these changes, agency self-examinations of policies regarding parent-child contact, and staff training designed to shift staff attitudes about families should help to support healthy relationships between children and their families.

Barriers and Supports

The third article to emerge from the work of the *Family Participation* project is entitled "Family caregivers' perceptions of barriers to and supports of participation in their children's out-of-home treatment." The analyses presented in the article focus on barriers and supports to participation identified by respondents to the questionnaire. Using a list of all possible barriers, parents were asked to indicate which had been barriers for them, and which was the single most important barrier they had encountered. A similar procedure was used for supports. For analysis, the barriers were divided into two groups: parent/family circumstances and facility characteristics. *Distance from service providers* was the most frequently identified parent/family circumstance, and was identified as a barrier by 45% of respondents. It was also the barrier most frequently identified as "most important." The other parent/family circumstances most frequently identified as barriers were *parents' work schedules* and *cost of transportation*. The most frequently identified facility characteristic was *lack of communication between staff in different programs*, identified as a barrier by 39% of respon-

dents. The other facility characteristics most frequently identified as barriers were *lack of open communication*, *lack of opportunity or encouragement to participate in the child's treatment*, *inflexible visiting and meeting schedules*, and *lack of clarity about whom to contact with questions and concerns*.

Two categories of support—concrete and interpersonal supports—were identified. The most frequently mentioned concrete support provided by the treatment program, identified by 81% of respondents, was *provision of a contact person*. Other important concrete supports included *notification of family when there were concerns or problems*, *flexible scheduling of meetings*, *provision of information about rights and grievance procedures*, *comfortable and private space for meeting*, *prompt return of phone calls*, and *inclusion of parents' comments in the child's records*. Among interpersonal supports provided by the treatment program, the most frequently identified was *parent treated with dignity and respect*. Other important supports were *parent made to feel his or her participation was important*, *caregiver made to feel welcome*, *all family members encouraged to participate*, and *responsiveness to the family's cultural values*.

Parents who reported more barriers also reported less total contact with the child, less satisfaction with the amount of contact, and a lower rate of participation in service and educational planning. Mirroring the results related to barriers, having more supports for participation was associated with having more total contact with the child, more satisfaction with the amount of contact, and higher rates of participation in service and educational planning.

These results emphasize the importance of the policies and practices of placement facilities and the attitudes of staff members. Addressing some of the tangible barriers, such as distance and the cost of



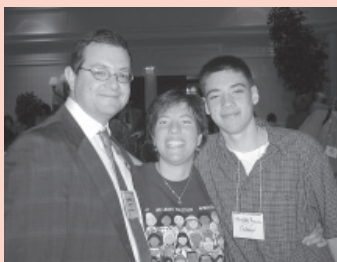
transportation, will require additional resources. Learning whether family members feel welcome and as if they are being treated with respect requires that programs develop ways to get feedback from family members about how they experience the program and what would be most supportive of their participation.

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BUILDING ON FAMILY STRENGTHS CONFERENCE



This year marks the 11th anniversary of the Research and Training Center's annual conference. Under the title **Building on Family Strengths: Research and Services in Support of Children and Their Families**, the conference has provided family members, youth, researchers, service providers and other human services professionals a place to share with and learn from one another; a forum to disseminate research findings and document program innovations; and an opportunity to leave—stimulated, re-energized and re-committed to meeting the needs of children and youth with emotional or behavioral challenges and their families.

Our keynote speakers over the last five years illustrate the Center's commitment to making available to a broad audience the best in current thinking in the field of children's mental health. In 2000, Nirbhay Singh described "Holistic approaches to working with strengths: A goodness-of-fit wellness model." In 2001, Carol Spigner advocated for family members in her address, "Keeping families at the center of reform: The challenge for research, practice, and community." In 2002, Terry Cross drew on a relational worldview in his presentation, "Culture as the cornerstone of family strength." In 2003, John VanDenBerg gave the provocative address, "Now more than ever! The steps that systems of care and the wraparound process must take to ensure outcomes." In the just-completed 2004 conference, Jane Knitzer brought us full circle with her opening talk on "Children's mental health: Looking backward, looking forward." Overall conference evaluations consistently reflect participants' positive experience of their time in Portland.

After the excitement of the conference, the sharing of ideas and stimulation of advocacy continues, through the use of web-based and printed materials. Following the 2002 conference, we began replication of presenters' PowerPoint presentations on our website, supplementing our publication of conference proceedings (which are also available in pdf format at our web site, www.rtc.pdx.edu). Please look at your leisure, then download to your heart's content.

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- ☐ 2000 Keynote, Nirbhay Singh. \$10.00 @▲
- ☐ 1999 Keynote, Beth Harry. \$10.00 @▲
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REPORTS

BENEFITS OF STATEWIDE FAMILY NETWORKS FOR CHILDREN'S MENTAL HEALTH: VOICES OF FAMILY MEMBERS. 1998. Describes issues, benefits, and impacts of statewide family networks in a user-friendly format with extensive quotes from family members to illustrate findings. @ (Available online only)

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☐ PROMISING PRACTICES IN EARLY CHILDHOOD MENTAL HEALTH. SYSTEMS OF CARE: PROMISING PRACTICES IN CHILDREN'S MENTAL HEALTH, 2001 SERIES, VOLUME III. 2001. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research. Develops a picture of state-of-the art practices in early childhood mental health services through an extensive literature

review and examples of promising practices. Free while supplies last, or download from CECP: <http://cecp.air.org/promisingpractices/>

NEW! SETTING THE PACE: MODEL INCLUSIVE CHILD CARE CENTERS SERVING FAMILIES OF CHILDREN WITH EMOTIONAL OR BEHAVIORAL CHALLENGES. 2003. Many families find it almost impossible to find appropriate child care if their children have emotional or behavioral challenges. In this monograph, we report the results of an in-depth study of nine inclusive child care centers that successfully met the needs of these families. @▲ (Available on CD and online only)

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Journal Articles (Free reprints while supplies last)

☐ **NEW! FAMILY CAREGIVER'S PERCEPTIONS OF BARRIERS TO AND SUPPORTS OF PARTICIPATION IN THEIR CHILDREN'S OUT-OF-HOME TREATMENT.** 2003. Psychiatric Services, 54(11), 1513-1518.

☐ **RESEARCH IN THE SERVICE OF POLICY CHANGE: THE "CUSTODY PROBLEM."** 2003. Journal of Emotional and Behavioral Disorders, 11(1), 39-47.

☐ **VOICES OF AFRICAN AMERICAN FAMILIES: PERSPECTIVES ON RESIDENTIAL TREATMENT.** 2002. Social Work, 47(4), 461-470.

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