FOCAL POiNT

Research, Policy, and Practice in Children's Mental Health

Strengthening Social Support

Winter 2006

Winter 2006

Please update your contact information! Help us keep our lists up to date by letting us know about any changes in your contact information.

You can also add your email to the **rtcUpdates** email list to receive information on the latest developments in family support and children's mental health.

To do either, go to our home page at

www.rtc.pdx.edu

and click on "Join Our List" (under "Resources" at the right side of the page). Then follow the instructions to update or add your contact information. Or you can email your contact information to **rtcpubs@pdx.edu** or leave a message at 503.725.4175.

For reprints or permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175 or rtcpubs@pdx.edu.

Winter 2006 **FOCAL POiNT** Staff:

Janet S. Walker, **janetw@pdx.edu**, Editor
Nicole Aue, **aue@pdx.edu**, Assistant Editor

The Research and Training Center makes its products accessible to diverse audiences. If you need a publication or product in an alternate format, please contact the publications coordinator at 503.725.4175 or **rtcpubs@pdx.edu**.

STRENGTHENING SOCIAL SUPPORT:

RESEARCH IMPLICATIONS FOR INTERVENTIONS IN CHILDREN'S MENTAL HEALTH

A large body of research evidence demonstrates that people who are involved in supportive social relationships experience benefits in terms of their health, morale, and coping. Conversely, low levels of social support have been repeatedly linked to poor physical and mental health outcomes. Recognition of the benefits of social support has fueled the development of a wide variety of interventions designed to improve the quantity or quality of the support that people receive. Unfortunately, evaluation of these interventions has so far not yielded clear information about what sorts of intervention are most likely to be successful. Indeed, it is not even clear that social support interventions—as they are currently implemented—are actually successful at increasing social support for people who lack it (Cohen, Underwood, & Gottlieb, 2000;

Hogan, Linden, & Najarian, 2002).

The lack of knowledge about whether and how social support interventions work is an important issue within children's mental health. There is a growing consensus in the field that strengthening interpersonal and community ties is a promising resilience- and development-promoting strategy for all children and families who are affected by mental health difficulties. For children and youth with the highest levels of need, the field is increasingly embracing the idea of community-based care as an alternative to out-of-home placements. A common element of models for community-based care—including wraparound, multisystemic therapy, and intensive family preservation services, among others—is the emphasis on strengthening family ties to supportive people within the family's social environ-

ment. Yet, as is the case with research on social support interventions more generally, evaluations of these models of community-based care have not so far demonstrated success from efforts to increase social support (Cox, 2005).

When thinking about the implications of this research, it is obviously important to maintain a sense of realism and to acknowledge that the field does not at this point have a wide repertoire of proven and potent strategies for strengthening social support for children and youth with mental health difficulties and their families. What we do have are a few strategies that appear promising and a few that have been modestly successful. Most of these strategies focus on providing support to caregivers. With the exception of mentoring programs, strategies for increasing social support for ado-

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to
reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

lescents or children have not been well studied. On the other hand, this does not mean that other strategies that are currently in use have been disproven, nor does it mean that we cannot build on what we are learning in order to improve existing strategies and create new ones.

This issue of *Focal Point* explores some of what we do and don't know about strengthening social support. This introduction outlines some of the major concepts and themes in research on social support, and some implications of this research for interventions in children's mental health. This sets the stage for the rest of the issue, which presents information and examples that can be helpful in future efforts to design and implement social support strategies and interventions for children and families.

Types of Support

The literature offers many definitions of social support; however, most definitions refer to the exchange of one or more of three main types of support—emotional, informational, and instrumental—that people provide to friends and family members in times of need. *Emotional support* involves the expression of empathy, reassurance, and positive regard, and is believed to enhance well-being by promoting self-esteem, reducing distress, and providing an emotional context for positive coping efforts. *Informational support* involves the provision of guidance, advice, or other information that can reduce confusion, increase perceptions of self-efficacy, and form the basis for positive coping strategies. *Instrumental support* refers to the provision of money, goods, and services that can be used in coping and problem solving efforts.

Additionally, some theories of social support also highlight the impor-

tance of *social integration*—a sense of belonging—and the role of *companionship*—participation in social and leisure activities. Many social support interventions are aimed at fostering *peer support*—emotional support from people who share key experiences with the recipient. In the case of children's mental health, peer support to caregivers is seen as helping to reduce feelings of social isolation and reduce feelings of shame and self-blame.

Families can access social support through both natural and more formal support systems. *Natural support*, also often called *informal support*, is most typically provided in relationships with friends and family, while *formal*

support is provided by professionals. Many sources of support, however, do not fall neatly within one or the other category; support offered through community or peer-run organizations, for example, may mix the two. Within children's mental health, a key distinction is whether or not the support is from sources that are likely to endure in the family's life. It is thought that families who receive consistent support from these enduring sources will not only achieve higher levels of community integration and well-being, but will also become less entangled with (and dependent upon) formal services. Efforts to intervene thus typically focus on strengthening a family's connections to natural support systems and to community organizations such

as clubs, religious organizations, and peer-run support organizations.

Lessons from Research

The research on social support interventions comes from many different fields and encompasses many different intervention strategies. Consequently, results may or may not be relevant for interventions in the field of children's mental health. What is more, methodological, analytical, and conceptual difficulties make it difficult to draw firm conclusions from the existing literature. In reviewing existing research, it is thus important to avoid jumping to premature conclusions: There is much we don't know at this point about the specifics of whether and how social support interventions "work." Despite these shortcomings, the literature does point to some particular challenges that should be acknowledged—and some promising strategies that can be incorporated—in the design, implementation, and evaluation of future social support interventions in children's mental health.

In the field of children's mental health, efforts to increase social support for caregivers typically use one of two basic types of interventions: those that aim to mobilize peer support and those that strive to increase support available from naturally occurring social networks.

Peer Support

As is true with the research on social support intervention more generally, conclusions from research on peer support can only be tentatively drawn; however, in general, it appears that providing support through peers is a promising approach. Peer-to-peer support interventions generally fall

into two basic types: peer support groups, and peer support at the individual level.

In peer support groups, participants can both offer and receive aid, usually emotional support, but sometimes also informational and instrumental support. In addition, peer support groups offer an opportunity for members to add new relationships to their social networks. Despite the popularity of such groups, there are relatively few studies that evaluate their outcomes. While some of these studies show benefits from participation, others do not (Hogan et al., 2002). Research has typically documented participants' satisfaction with groups (Helgeson & Gottlieb, 2000), but a small number of studies have shown other benefits, including improved social support and general well-being. There may be many reasons for these inconsistent findings, but researchers caution that in loosely structured support groups, the quality of support may be quite variable. Group members may interact in ways that actually increase stress, undermine self-confidence, and promote the use of ineffective problem solving strategies. Thus, structured groups that are led by well-trained facilitators, and that offer an educational or informational component may be most helpful (Helgeson & Gottlieb, 2000).

Individual-level peer-support interventions typically pair program participants with support providers who share salient experiences or conditions. Such interventions usually aim to increase emotional support, but also often include an explicit focus on informational support; they may also target instrumental support by teaching advocacy skills and/or by having the peer interveners help participants access community resources. Hogan (2002) finds the research on these types of interventions "encouraging," particularly when peer supporters are trained to interact with program participants in ways that maximize emotional supportiveness and offer problem solving

strategies and information. However, since the number of research studies is small, and since the interventions differ substantially one from another, existing research does not provide firm guidance about which intervention components or strategies might be most effective, or under what circumstances.

The articles on Parent Connections (pages 10-14 in this issue) and Keys for Networking (pages 15-18) describe peer support programs that are consistent with main themes from existing research. Both rely on well-trained peers who provide a combination of emotional and informational support. Peer supporters in both programs also model and teach advocacy skills, which are a route to increasing the instrumental support available to families. Importantly, both programs also offer opportunities for participants to give and receive support. Newer commentaries on social support intervention often highlight the idea that support is most beneficial when the support relationships are reciprocal. Offering support increases feelings of self-efficacy and competence, and builds a sense of belonging to and being valued by a social group. It is possible that this is particularly important for people at times when self-worth is challenged by stressful events and stig-

ma. Finally, both programs also have the backing of a larger peer-run organization, though this is more central to the intervention in the Keys model. Connecting caregivers with the larger organization provides access to a variety of different people, activities, and groups, and a wide variety of potentially supportive relationships. An

organization also has the potential to provide a stable source of support over time. This can help guard against 'burning out' individual support givers, or over-reliance on a particular relationship, since support can come from multiple sources. This may be particularly important when support is being provided by caregivers who may experience periodic crises arising from their own children's difficulties. Having access to a variety of supportive relationships and activities is also in line with recent interpretations of research that suggest that support will be more effective when it is matched with recipients' needs (Gottlieb, 2000). A larger organization offers choices so that people can access the kinds of support that they find most comfortable and helpful.

Intervening in Natural Networks

The most compelling rationale for intervening to increase support in natural networks is that there is a long-term commitment from friends and family members that is not typically available from paid relationships. The support of friends and family is particularly predictive of positive health and mental health outcomes (Cutrona & Cole, 2000; Werner, 1995). What is more, support offered through the

> *It is thought that families who receive consistent support from enduring sources will not only achieve higher levels of community integration and well-being, but will also become less entangled with (and dependent upon) formal services.*

natural network is more likely to be culturally appropriate, and may be easier to accept than professional help. Natural network interventions vary along a number of dimensions, and the number of research studies is small; however, once again, research indicates that this approach can be beneficial (Cutrona & Cole, 2000; Ho-

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to
reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT 5

gan et al., 2002).

The most-researched approach to intervening in natural networks involves the use of interventions that are intended to improve the quality of relationships within an existing network. These interventions are motivated by some studies showing that "negative support" (behavior that is perceived as harmful, critical, or hostile, or that contributes to stress or anxiety) has a stronger link to outcomes than positive support (Hogan et al., 2002). Even among well-intentioned friends and family, interactions intended to be supportive may have the opposite effect. This can happen, for example, when supporters minimize a problem by implying that it is not serious, or when sympathetic supporters go too far in the other direction by catastrophizing the problem.

Interventions thus focus on working to improve interactions within the support network by teaching a variety of relationship skills, including problem solving, communication skills, and/or assertiveness. One type of approach focuses on teaching friends and family how to improve the quality of the support they provide to people who experience chronic stress. This kind of approach is one of the components of family psychoeducation, a set of evidence-based practices used with adult mental health consumers and their families (McFarlane, 2003). Other interventions have focused on teaching relationship skills to people in need of support, and the results of these studies have been encouraging (Hogan et al., 2002). The best-evaluated interventions to improve relationship skills are those that have been created and led by professionals, and the distinction between this kind of intervention and various forms of psychotherapy is not always clear. On the other hand, this distinction may not be as important as other dimensions of the interven-

tion, such as whether it is delivered in a strengths-based or recovery-oriented manner. What is more, the same types of intervention can also be designed and delivered by peers. For example, family advocacy organizations have offered peer-led programs that include many of the same components as professionally-led family psychoeducation programs.

The articles on wraparound (pages 26-30) describe other strategies for intervening in natural networks: engaging network members in providing specific forms of support, coordinating support available from an existing network, and recruiting new members into the network. These strategies have intuitive appeal, and they are a core component of several varieties of person-centered planning. A number of studies of these kinds of interventions have been published, and positive outcomes have been documented; however, the evaluation strategies used were often weak. Thus these studies offer only limited insight into whether or when these strategies are helpful in producing long term increases in social support or other desired outcomes. Given the increasing popularity of wraparound and allied interventions within children's mental health, it is clearly important to build knowledge in this area.

Interventions for Youth

For younger children, the family is the most important source of support, and many therapeutic interventions have been developed to increase the supportiveness of family relationships. However, these are not usually considered social support interventions per se. Throughout later childhood and adolescence, young people develop wider social networks that include peers and others from the community. The research described in the article by Silverthorn and DuBois (page 23-25) supports the hypothesis that good outcomes for youth are promoted when young people receive social support that is balanced between peer and adult sources. The article also describes GirlPOWER!, a mentoring program designed to increase available social support. Mentoring is perhaps the best studied social support intervention for youth, and research has provided guidelines for developing effective programs (Herrera, Sipe, & McClanahan, 2000). In essence, mentoring programs like GirlPOWER! are designed to add new, competent adults to a young person's social network. Mentors are trained to offer emotional support, and often, as is the case with GirlPOWER!, programs also include informational support that focuses in part on how to build healthy—supportive—relationships with peers and to recruit additional support from adult sources. This type of intervention combines many of the components of interventions for adults described above, and often occurs in the context of a community or youth-serving organization that offers youth multiple routes to access social support through participation in a variety of activities and relationships.

MY GREATEST ALLY

After arriving home from a hard day's work, I slip off my jacket and boots. I look out the kitchen window to glance a peek at the snow-covered ground on a beautiful December day. The lawn is all dressed in white. As I look across the street at a cozy yellow ranch home, I notice the evening sun reflecting off the icicles growing from the roof's drip cap. Suddenly, my eyes begin to fill with glee and my heart fills with joy as I reminisce fond winter childhood memories of a small city off the shores of Lake Michigan where my family used to live.

In those days, the snow was my dreamland. My two sisters and I would eagerly come home from school to hot chocolate and a tasty snack mom would prepare for us almost daily. A little snack was essential after walking five blocks in snowy conditions, or at least that was what we led mom to believe. After happily consuming our treats, completing our homework, and viewing some television, we would venture outdoors. Since we lived on a city block, the only hill available to slide on was the snow hill in the front yard that dad created from the snow he shoveled from the driveway. We would slide down our snow hill until our boots were soaked and our little fingers were numb. Then we would return indoors where mom kept warm as she prepared our delicious hot meals. After our meals and kitchen duties, it would be bedtime. Bedtime was also an anticipated time, as mom and dad together would snug-ly cover my sisters and me in our beds. Throughout the night I would dream of how exciting the next day would also be. But, like the night, the dream did not last much longer.

When I was 9, my father left us. Consequently, things were never the same, My hero, the one I most ad-mired, abandoned us for a new life. What he did not realize was that the lives of my mother, my sisters, and me were taken away because we were no longer good enough. For the first time in my life I felt horrific pain, like a stab to the heart. This is much more difficult to heal than average pain. The anguish would grow for years to come. At this point, my behavior started to change. It began at school. I would leave my class briefly to visit the restroom and then scurry to the main office where I would claim to be ill, adamantly requesting to go home. This was routine for several months. Later, my conduct developed into act-ing out in class and skipping school. These actions were unlike me. Teach-ers were beginning to become con-cerned with my transformed behavior.

My mother soon arranged therapy for me at Catholic Social Services. None-theless, I refused to comply with the several therapists who had seen me. Meanwhile, my negative actions con-tinued as time progressed.

When I was 11, my mom, my sis-ters and I moved 55 miles away to a small town. Here would be a fresh start. My mother even remarried. Eventually, regard-less of the changes, my conduct re-sumed. Then my behavior escalated at full throttle. This led to my involve-ment in the court system. My mom worked with the school system and community mental health in search of a solution to my be-haviors. I was start-ed on medications. Then I was often hospitalized for med changes as a result of having my diag-nosis altered. The process was drain-ing for my family and me, and it lasted eight years. At home my mom made many efforts to keep safety a priority. She provided a safety plan at home in case I lashed out or attempted to inflict self-harm. She also arranged a support system with wraparound, a family strengthening process to keep me from out-of-home placement and to strengthen family values.

When a child with emotional challenges is going through behavior changes, a support system is vital. Not only does the child benefit from the support system, but their family does as well. The support system I believe in most is provided through the family focused planning that is at the center

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to
reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT   7

of wraparound. This was more beneficial than one-on-one therapy. In fact it was not therapy at all. My entire family would meet for discussion in the comfort of our own home. Friends and other family members would also join in for many of our meetings. We discussed our family and personal issues in a strength-based way. This allowed us to better understand one another and the full spectrum of the issues surrounding us so we could target them together. There were moments of tear shedding, and hugging was common. During this process I grew closer to my family members and my relationships with friends also grew stronger.

In my time of need, it seemed as though everybody who had worked with me tried to be a therapist. But this was not what I needed. I needed a friend; someone who would sit down with me, listen to what I had to say and give me friendly advice, not lecture me. And I was fortunate enough to have many who would offer this type of positivity throughout the wraparound process and thereafter.

The toughest part of this family-focused process for me personally was realizing how badly my issues had affected those whom I love the most. Up to that point, it was hard for me to think of anyone other than myself. However, this process opened my eyes in the greatest ways. I began to realize that everybody's heart aches just as my own, and my behavior had to change, not only for my own good, but also for the good of my family, especially my loving sisters. All they knew is that I had problems, and because of that I had to be the main focus. So they felt as though they had to put their own feelings aside so I could get the help I needed, and that makes me feel sad. Their understanding was sincere. I am blessed to have such wonderful sisters. They are very dear.

I now realize that throughout these hard times in my life, I had a wonderful family who loved and cared for me. They will always be my greatest support system. And now at 23, I am no longer involved with Mental Health, and I am no longer on medications. I am trying to lead a positive life with a positive future to inspire those who feel as though hope is out of reach.

And so I glance another peek out the kitchen window. These snow-covered hills are once again my dreamland. Glorious and content, they've withstood my pain and forever they will stand as a symbol of my priorities, to stay sound and pure with my soul.

Craig Delano

Cont. from pg. 6: Strengthening Support

Thus while the mentor him- or herself may not become an enduring part of the young person's social support network, the organization may continue to link the youth with support opportunities over time.

Other types of interventions designed to build or increase support from youths' natural networks are not well researched. In principle, wraparound aims to increase the social support available to youth as well as caregivers, but, as noted previously, the success of these efforts has not been well studied. At least one strategy for adding friends to the social networks of children with disabilities has been described (Cook, 2001), but not as yet formally evaluated.

Conclusions and Cautions

It bears repeating that we know relatively little about whether or how social support can be created or mobilized for children and youth affected by mental health difficulties and their families. The research reviews cited in this article include studies of a wide variety of support interventions that focus on providing support to diverse populations, from people with chronic medical conditions to impoverished single mothers to recovering addicts. This relatively small yet heterogeneous body of research may label certain types of interventions "encouraging" or "promising," but evidence of their effectiveness is by no means definitive. These studies can inform interventions developed for our own field, but more work will need to be done to design, implement, and evaluate programs suited specifically to our needs.

Several reviews of social support interventions conclude by suggesting that reciprocity may be an important element in successful interventions. Some research supports the idea that merely receiving support may not be as potent as mutual exchanges of support. It is worth considering how opportunities to give and receive support can be built into future interventions.

The same reviews also suggest that interventions would likely be more effective if greater attention were paid to matching a person's support needs with potential sources of support. Some people, particularly those who are highly introverted or independent, may not desire additional support, even if their networks are relatively small. In general, women are more likely than men to use social support as part of their efforts to cope with stress and adversity (Taylor, Dickerson, & Klein, 2002) and may thus benefit more from intervention to increase support. This implies that interventions should include an assessment of support needs and potential support resources. Armstrong (pages 19-22) describes some methods that

are currently used for assessing available and/or potentially available social support.

While there is little enough research on whether interventions can increase social support over the short run, there is even less information about whether such increases are sustained over time. In fact, there is some evidence that deterioration can follow when support is withdrawn (Rook & Underwood, 2000). People planning social support interventions should thus consider carefully how to maintain support once the intervention has ended. Linking people to supportive organizations is one strategy for addressing this concern.

Finally, it should be remembered that most of the research on social support focuses on mitigating stress and managing threats and crises. Relatively little attention is paid to the role social support may play in promoting thriving or positive development. Interpersonal relationships are a source of enjoyment as well as intellectual, artistic, and moral stimulation. Companionship is a form of support that may be particularly essential for promoting experiences that enhance well being. As we contemplate the design of interventions, it is essential not to overlook these important aspects of social support.

References

Cohen, S., Underwood, L. G., & Gottlieb, B. H. (2000). Social relationships and health. In Cohen, S., Underwood, L.G., & Gottlieb, B. H. (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 3-25). New York: Oxford University Press.

Cook, J. (2001). Friendship facilitation. *Focal Point: A National Bulletin on Family Support and Children's Mental Health, 15*(2), 11-13.

Cox, K. F. (2005). Examining the role of social network intervention as an integral component of community-based, family-focused care. *Journal of Child and Family Studies, 14*, 443-454.

Cutrona, C. E., & Cole, V. (2000). Optimizing support in the natural network. In Cohen, S., Underwood, L.G., & Gottlieb, B. H. (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 278-308). New York: Oxford University Press.

Gottlieb, B. H. (2000). Selecting and planning support interventions. In Cohen, S., Underwood, L.G., & Gottlieb, B. H. (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 195-219). New York: Oxford University Press.

Helgeson, V. S., & Gottlieb, B. H. (2000). Support groups. In Cohen, S., Underwood, L.G., & Gottlieb, B. H. (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 221-245). New York: Oxford University Press.

Herrera, C., Sipe, C. L., & McClanahan, W. S. (2000). *Mentoring school-aged children: Relationship development in community-based and school-based programs.* Philadelphia: Public/Private Ventures.

Hogan, B. E., Linden, W., & Najarian, B. (2002). Social support interventions: Do they work? *Clinical Psychology Review, 22,* 381-440.

McFarlane, W. R. (2003). Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy, 29,* 223-245.

Rook, K. S., & Underwood, L. G. (2000). Social support measurement and interventions: Comments and future directions. In Cohen, S., Underwood, L.G., & Gottlieb, B. H. (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 311-334). New York: Oxford University Press.

Taylor, S. E., Dickerson, S. S., & Klein, L. C. (2002). Toward a biology of social support. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 556-569). New York: Oxford University Press.

Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Science, 3,* 81-84.

Janet S. Walker is Director of Research and Dissemination for the Research and Training Center on Family Support and Children's Mental Health in Portland, Oregon. She is also Editor of FOCAL POiNT.

Melanie Sage, MSW, is a PhD student in the Social Work Program at Portland State University. She is a Research Assistant at Portland's Regional Research Institute for Human Services.

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.rtc.pdx.edu. For reprints or permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT   9

BUILDING FAMILY-TO-FAMILY SUPPORT PROGRAMS: RATIONALE, GOALS, AND CHALLENGES

Many states and communities are working to strengthen their child mental health systems by supporting intensive home and community-based services for children with serious emotional or behavioral disabilities and their families. Family-to-family support programs, often operated by family-led organizations, are an essential component of these efforts. The President's New Freedom Commission on Mental Health supports this concept by recommending that child-serving systems increase the opportunities and capacities of consumers to share their inspiration, knowledge, and skills.

Family-to-family support has intuitive appeal. In theory, families who are facing similar challenges of raising children with serious emotional or behavioral disabilities can find common ground and prevent feelings of isolation or hopelessness by sharing practical information, providing encouragement to each other, and swapping stories of survival. But the actual task of developing, implementing, and sustaining meaningful family-to-family support programs presents major conceptual, logistical, and financial challenges. Few scientific studies on effective family support practices are available and specific techniques for building family-to-family support programs remain ill-defined.

Parent Connections was a joint project of Families Involved Together (FIT), a parent-to-parent support organization, and faculty from the Johns Hopkins School of Public Health. This team of parents and researchers worked longer than five years developing, implementing, and evaluating the program. The development and evaluation of the project was supported in part by a major grant from the National Institute of Mental Health.

This article is intended to highlight program theory and format, challenges encountered, and key scientific theories and findings. This material may provide insight and direction for family support organizations, mental health programs, and others wishing to craft a useful approach to providing peer support for families in their own communities.

Types of Support

We define support as "information leading people to believe they are esteemed and valued and that they belong to a network of mutual obligations" (Cobb, 1976). We view Parent Connections as a method for generating family-to-family support by offering intensive personal attention and information-sharing oppor-

tunities, thereby building a network of mutual obligations among participating parents. As a practical matter, this was achieved by linking "veteran" parents with parents of school-aged children with serious emotional or behavioral disabilities. Knowing that the veteran parents had "walked in their shoes" helped participating parents feel a sense of trust and safety, which in turn allowed them to expand their ability to learn, make changes, and manage the needs of their children more successfully.

The staff of Parent Connections dubbed the veteran parents Parent Support Partners (PSPs). Our PSPs had children over 18 years old who had been identified as having emotional or behavioral disabilities when still in school. The PSPs worked with seven or eight families and were paid for up to 10 hours of work per week. They made weekly telephone calls to each assigned mother, and worked to build a supportive relationship with each family. The intervention also included a series of 15 educational workshops facilitated collaboratively by parent advocates and mental health professionals. The workshops provided opportunities for PSPs and families to meet each other, strengthen support networks, and share expertise. The goal of these activities was to provide informational, affirmational, and emotional support to participating parents.

Informational Support is shared information about childhood behaviors, developmental transitions, parenting skills, coping techniques, and community resources. This type of support can be offered over the phone or by mail. However, a large part of this support occurred during our educational workshops. These sessions provided a safe environment for parents to admit what they didn't know, the first step toward building a stronger foundation of knowledge. In addition, the PSPs helped their assigned mothers identify difficulties, issues, or unmet needs, and then modeled various ways to find alternative strategies for resolving these issues or meeting these needs. PSPs also encouraged mothers to discuss their children's care with mental health and education professionals and to increase their access to relevant and up-to-date information, knowledgeable advice-givers, and needed services.

Affirmational support is focused on enhancing a mother's confidence in her own parenting. PSPs sought to reassure mothers that their concerns were appropriate and shared by others in similar situations. To do this, PSPs continuously sought out opportunities to identify parenting competencies. This feedback encouraged mothers' positive self-evaluations and elevated them to the roles of "expert" and potential "advisor."

The PSPs provided emotional support by establishing a relationship of trust. They aimed to listen closely to a mother's concerns, demonstrate a continued interest in her viewpoints and experiences, and communicate an understanding of her feelings. PSPs also encouraged the growth of mothers' natural support networks by discussing means for finding and strengthening emotionally supportive relationships with relatives, friends, church members, and other key people.

Program Theory

Parent Connections is a family-to-family support program that encompasses five primary principles or assumptions that are drawn from specific theories of social support and related concepts. (For further details see Ireys, DeVet, & Sakwa, 2002.)

A strong support network linking relevant information and resources can improve parents' responses to the challenges of raising a child with a serious emotional or behavioral disorder. Basic information about where to get help, how to overcome administrative obstacles, and how to perform effectively in crisis situations was provided through PSP contacts and the educational workshops. Increasing a parent's knowledge level in this way can contribute to more effective parenting, thereby improving a child's functioning and preventing further deterioration of his or her mental health.

Support can help parents deal more effectively with their own wor-

> *Encouragement by a trusted supporter can help parents overcome their fears and manage their potentially crippling anxiety.*

ries and doubts. Virtually all parents of children with serious emotional or behavioral disabilities have serious doubts about whether they have the knowledge and emotional resources required to help their children grow into capable, independent adults. Encouragement by a trusted supporter can help parents overcome their fears and manage their potentially crippling anxiety.

Support can diminish feelings of stigma. Parents of children with serious emotional or behavioral disorders often cannot find naturally occurring sources of support in their communities because stigma prevents parents from freely discussing their child's emotional or behavioral disorders with relatives, neighbors, or church congregants. Without personal knowledge of the causes, signs, and treatment of children's emotional disorders, family members, neighbors, and others are not likely to understand the special challenges parents face. Too often, this lack of empathy leads to blaming and judgmental thinking. As a result, the parent and child become isolated from those who should serve as their

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT   11

system of natural supports. The process of family-to-family support essentially "grafts" experienced parents into the social network of families struggling with their child's behaviors and needs.

Family-to-family support may allow professional treatment to work more effectively. Parents who have sufficient support may be more likely to stay in treatment, develop collaborative relationships with the child's therapist, make use of resources in the educational system, and implement effective behavior management techniques at home. Confident, knowledgeable parents are more capable of partnering with providers from various child-serving systems. Overall, family support and education programs can increase the value of mental health and educational services.

Building parents' knowledge and skills can produce a heightened sense of efficacy, both at home and within the mental health and education systems. Parent Connections designed workshops to increase parents' capacity to identify and advocate for more appropriate services to meet their child's needs, use behavior modification techniques effectively with their child, and be aware of their own strengths and limitations. Better skills in these areas can lead directly to behavior changes at home and better access to appropriate treatments.

Implementation Challenges

In the process of developing, implementing, and evaluating Parent Connections, we encountered several obstacles. First, we had to find the right PSPs. Although many parents of children with serious emotional and behavioral disabilities want to "give back" and help other parents, an effective PSP requires additional attributes. These include being able to listen carefully, to distinguish between "help" and "support," and to manage their own emotional reactions to the struggles of other families. Therefore, we required PSPs to be parents of young adults who had received mental health services as a child or adolescent. This allowed them to communi-

UNMASKING LENA

For so many years, I wore an invisible mask. Before I came to Families Involved Together, the acronym F.I.T. meant Faking It 'Till (I make it). As a wounded child, one of my disguises was laughter. Unfortunately, I made poor choices in men that led me to becoming a single mother. Though I love my son very much, his special needs presented great challenges. The responsibility of motherhood brought on additional stress that caused me to indulge in unhealthy behavior. Years later, I finally sought help from a wonderful community program and I began to put my life's puzzle back together. While this process set my life on a better path, I had not totally let go of my mask.

One day, I ran into a friend who was working as a Parent Support Partner at Families Involved Together. She said FIT was looking for new support partners and that I should call for an interview. I was accepted and invited to participate in FIT's Parent Connections project. I attended many hours of training that prepared me to offer constructive encouragement toward growth and insight by parents just like myself. The sessions were quite intense at times. We were learning information and skills that I wished I had known while raising my son. Despite that regret, I noticed that something new was happening to me.

Eventually, I was matched with several parents who were going through what I had struggled with years before. Many began the Parent Connections workshops looking very down-trodden. They felt as if they had come to the end of the line. They expressed great fear for their children's future—and their own.

My assigned parents and I spoke by phone during the week and met in-person at the scheduled workshops. These educational sessions presented ideas and skill-building that these parents had never experienced. In time, the parents seemed to develop a sense of trust and affection when we spoke or met. When they graduated, the mothers were no longer sad and apprehensive. They were bright and hopeful. They shared with me how much the program—and I—had meant to them. I listened to them tell me how much I had done for them and the changes they were able to make because of my friendship and support.

I was, of course, very proud and happy for their success knowing I had contributed to it. But more than that, I also began to realize that, somehow, my own life had also totally changed—a metamorphosis of sorts. I had dropped my wooly outer layer, which was my defense mechanism. I had emerged as something quite beautiful. Now clothed with knowledge and truth, I was able to fly above past circumstances and soar into my own fantasy. I had arrived! I finally had discovered my true "FIT" and become the person I was meant to be—one without a mask, one without pretense.

Lena Gladden

cate their personal experiences while maintaining some emotional distance from the day-to-day issues of raising a young child. We also established a three-stage process for recruiting PSPs. In the first stage, we developed an interview that assessed a mother's ability to maintain boundaries and objectivity, avoid being judgmental, and encourage trust and self-confidence in others. In the second stage, all parents who were accepted on the basis of the interview participated in a short-term, skill-building training. This served as a way for us to get to know them and for them to get to know the program. In most cases, those who were not suited for the position dropped out. Those who stuck with the program participated in the third stage of the training: an intensive program designed to further strengthen their listening and communication skills.

Second, we had to find a way to invite families to participate in Parent Connections. We pursued several routes, including a general invitation to families associated with Families Involved Together. In addition, we worked with all of the major child mental health clinics and schools in the area to help identify parents who might be interested in participating.

Third, we needed to provide continuing support to PSPs during the months in which they were working with families. To accomplish this, PSPs met weekly with the program directors to share their own concerns, find their own affirmational support, and develop effective ways of responding to difficult situations that arose with their assigned families. The solidarity that developed within the team of PSPs was critical in sustaining their commitment to the project.

Fourth, it was important for administrative purposes to ask PSPs to document their work. The PSPs were effective listeners, coaches, and advocates but, for some, recording their good works proved quite formidable. The process for tracking their activities had to be modified more than once to accommodate the needs of both the PSPs and supporting agencies. Even-

tually reporting forms were developed that combined the right levels of simplicity and comprehensiveness.

Our final hurdle was obtaining additional funding to continue the program after the research project was complete. Despite positive results from the evaluation, it was difficult to

identify a continued funding source because this type of program is not typically reimbursable under public or private health insurance plans. We were, however, able to combine the dollars of two private foundations to continue Parent Connections for one year beyond the study.

Evaluation Results

We evaluated Parent Connections using a randomized controlled clinical trial design with two groups: a low-dose control group and an experimental group. The control group received a packet of information on services and resources for families of children with serious emotional disorders. The experimental group received the identical information packet. Additionally, they were offered the opportunity to participate in the full Parent Connections program.

Although the evaluated program lasted 15 months, data were collected at enrollment and 12 months post-enrollment. We used this approach because our experience with similar studies suggested that measuring out-

comes at the very end of a project can lead to detecting temporary negative effects brought about by a sense of loss as the program is terminating. This common response by participants can obscure an otherwise more enduring positive effect. In addition, we viewed one year as a more natural

intervention assessment period than 15 months.

The project utilized data collected from 257 families enrolled at baseline. We examined effects on child functioning and the impact on maternal mental health and perceived support. Perceived social support was measured using items from the Multidimensional Social Support Inventory (MSSI; Bauman & Weiss, 1994). These items were used to assess perceived availability of support across five areas, including having someone to confide in or having someone to talk to about the child's needs. For example, one item asks: "Does anyone show that they are interested in and want to understand your concerns about raising a child with a serious emotional or behavioral disorder?" Items from this scale have been used in prior evaluations of similar parent support programs (Ireys, et al., 1996; Ireys, et al., 2001). To assess perceived adequacy of support, interviewers asked parents whether they got the support they needed all, most, some, or none of the time.

On the measure of perceived

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to
reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT   13

breadth of support, the mean increase for the experimental group was significantly greater than for the control group. At the second data collection point, all participants were asked "whether there was ever a time in the last year when you wished you could have talked to someone about your child's condition," and, if they did wish this, whether they actually talked to anyone. About three-quarters

in light of the many factors that influence the functioning of low-income, urban families. Nevertheless, what we have learned represents an important step toward a better understanding of how to support parents of children with serious emotional or behavioral disabilities. Our findings should encourage further study of Parent Connections or other well-defined models of family-to-family support.

> *Building parents' knowledge and skills can produce a heightened sense of efficacy, both at home and within the mental health and education systems.*

of mothers in the experimental group indicated that they wished they could have talked to someone and of these about three-quarters actually did so. In contrast, about two-thirds of mothers in the control group indicated that they wished they could have talked to someone and of these only about half actually did so.

To assess changes in maternal mental health status, we examined whether the two groups differed with respect to change in levels of anxiety. Nine percent of the mothers in the control group moved from high anxiety at baseline to lower anxiety 12 months later. In contrast, 22 percent of the mothers in the experimental group moved from high to lower anxiety.

Conclusion

This study is an example of a methodologically strong evaluation of a theory-driven, family-to-family support program for low-income families with high-risk children and multiple other stressors. Overall, the study provides evidence that Parent Connections produced modest positive effects. It is not surprising that the program demonstrated only a modest impact

References:

Bauman, L. & Weiss, E. (1994, May). *Psychometric properties of the Multidimensional Social Support Inventory.* Paper Presented at the Psychosocial and Behavioral Factors in Women's Health Conference. Washington, DC.

Cobb, S. (1976). Social support as a modifier of life stress. *Psychosomatic Medicine, 38,* 300-314.

Ireys, H., DeVet, K. & Sakwa, D. (2002). Family support and education. In B. Burns & K. Hoagwood (Eds.), *Community Treatment for Youth.* New York: Oxford University Press.

Ireys, H., Chernoff, R., DeVet, K., & Kim, Y. (2001). Maternal outcomes of a randomized controlled trial of a community-based support program for families of children with chronic illness. *Archives of Pediatrics and Adolescent Medicine, 155,* 771-777.

Ireys, H., Sills, E., Kolodner, K., & Walsh, B. (1996). A social support intervention for parents of children with Juvenile Rheumatoid Arthritis: Results of a randomized trial. *Journal of Pediatric Psychology, 21,* 633-641.
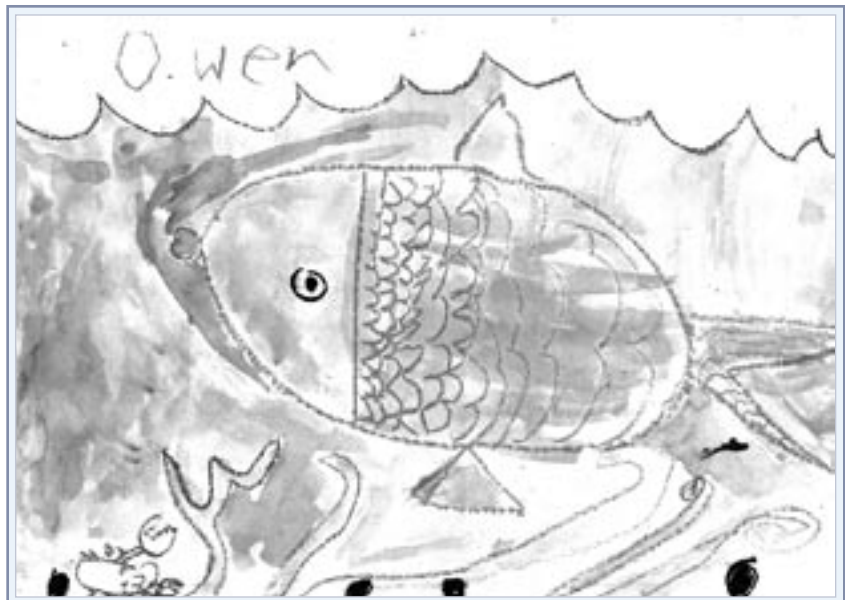
Diane Dvoskin Sakwa has addressed the need for change in child and adolescent systems of care as both parent and advocate by sharing her encouragement, knowledge, and voice with thousands of families and professionals for close to 20 years.

Henry T. Ireys is currently a Senior Researcher at Mathematica Policy Research, Inc., in Washington DC and for many years has been examining the effectiveness of support programs for families of children with special needs.

THE "KEYS FOR NETWORKING": TARGETED PARENT ASSISTANCE

Parents in Kansas whose children have or are at risk of emotional and/or behavioral problems call Keys for Networking seeking help. Parents call when they cannot get the response they need from agencies. Most report feeling isolated, alienated, disconnected, alone, or abandoned, even by family members. They often doubt their ability to help their own children. In the process of learning how to obtain effective plans and appropriate programming, however, they become connected with a statewide social support network that offers contact with other parents who have had similar experiences. Keys for Networking, or "Keys," is this statewide organization. It is managed and staffed by parents.

Since 1987, Keys has offered peer-to-peer support to parents so they can advocate first for their own child, and then for other children. Not only do Keys' parent staff meet callers' immediate needs for information, they strive to connect parents to other parents so they can support each other. Keys develops and sustains the network by supporting long-term relationships between Keys and parents, among parents in the network, and between parents and their child's providers.

With targets and benchmarks to engage parents at their level of experience and interest and to affirm their role as primary decision maker for their child, the Keys Targeted Parent Assistance (TPA) model includes procedures, interventions, and technology-based tracking mechanisms. Developed with support from the American Institutes for Research, TPA provides the system infrastructure to create and sustain parent connections. With TPA, the parents who have received help and become connected to the network develop into help-givers and sustainers of the network: They hold the keys to networking.

TPA is based on a ten-level continuum that was developed from Dr. Barry Kibel's Outcome Engineering (Kibel, 1996) and Journey Mapping (Kibel, 2000). The continuum describes the movement of parents toward family and system advocacy. Using the continuum, Keys staff details each parent's progression from seeking help to emerging as a problem solver to becoming a systems change agent. Figure 1 depicts the continuum's ten levels of parent engagement and groups them into three stages: *Initiation, Solution-Focused*, and *Expanding Interests*.

In the Initiation stage, the three levels are about "getting to know you." Parents at level 1 call Keys seeking information about what Keys can do for them. Keys staff provide immediate answers to "What do I do know?" questions and offer Keys and local service contact information and emotional support. Parents remain at level 1 until they initiate a second contact. At level 2, parents may say, "I am interested in more information. Tell me more about exactly what I can do." Staff limit discussion to the questions asked and encourage parents to attend Keys' trainings related to their interests. They offer mileage, childcare, lodging, and travel connections with other parents from their geographical area. Connecting families, with their permission, builds relationships and increases the likelihood that new parents will attend. It sustains the commitment of experienced families and involves them as mentors to new families. Parents move to level 3 when their actions—such as completing training—indicate deepening involvement. The support relationship between Keys and parents at level 3 evolves into exploring larger system and family issues.

At the Solution-Focused stage (levels 4-6), parents work with staff on strategies to improve and monitor planning documents, secure necessary services, and integrate programming. At level 4, parents contact Keys frequently and Keys staff call them to revise Individualized Education Plans, mental health treatment plans, wraparound plans, and other formal service planning efforts. Staff may attend meetings to support the families. At level 5, parents report that some part of the original problem that brought them to Keys is resolved: "My child is back in school," or "We have attendant care." At level 6, parents have resolved their initial problem and decide to take on additional areas of concern. Parents at this level may say, "Help me think about how to do this." During this stage, staff en-

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to
reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT 15

gage parents to expand their skills and self-confidence. Staff members invite them to attend sophisticated trainings on topics such as IDEA legislation and wraparound facilitation.

The Expanding Interests stage (levels 7 through 10) focuses on outreach to others and system issues. This stage begins at level 7 when parents offer to help other families. They may say, "I would like to get involved. How can I help someone else?" or "I don't want what happened to me to happen to anyone else." These words denote expanding interest outside one's own family. Responding quickly to these statements with training and helping opportunities is critical. At level 8, parents complete training to help others. At level 9, parents assist other parents. They call Keys often, not for themselves, but for advice to further their work with others. They are attending meetings, revising plans, and sharing advice with other families. At level 10, parents ask for assignments to work on local and state committees, join boards, testify to legislative bodies, and participate in policy-making efforts. They serve as vocal and effective system advocates, offering testimony in very public forums. They support and organize other parents and sustain the family organization

and state services. They have come full circle, returning the help they got from Keys to other families in a wide variety of ways, facilitated by an organization whose mission is to build a statewide network of informed families.
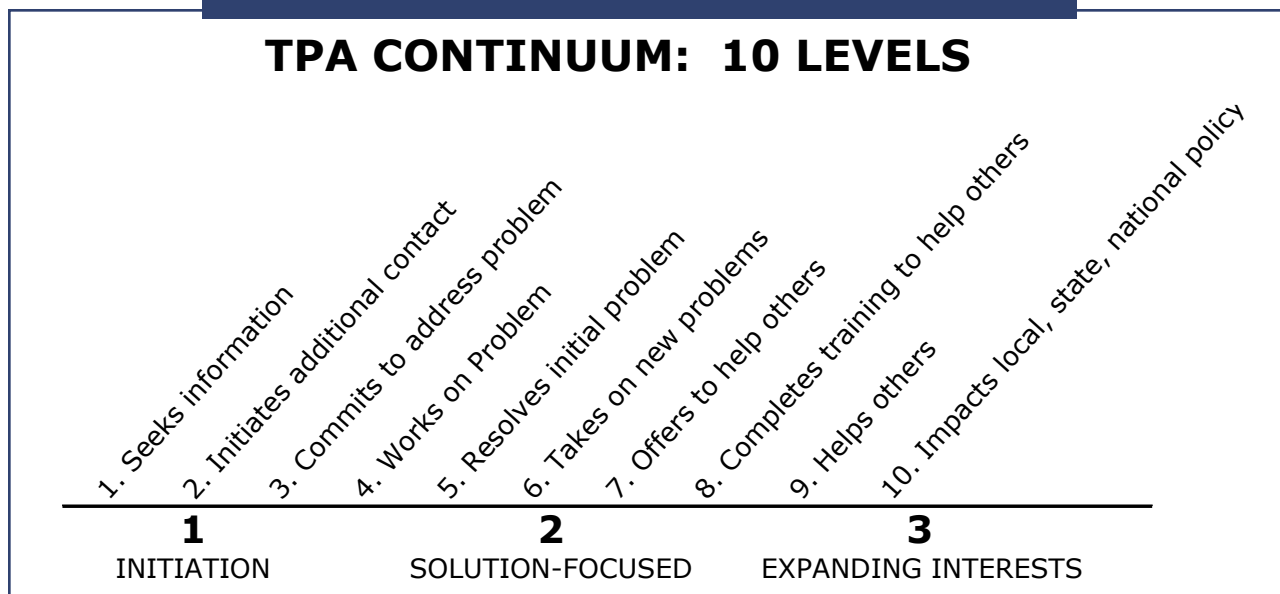
Monitoring individual parents and groups of parents along the TPA continuum, Keys staff members provide information and support appropriate to the parents' readiness level, while also promoting movement to higher levels. TPA marks change increments in parents' engagement with Keys and with service providers and systems. It documents the interventions offered and tracks the usefulness to parents of Keys' suggestions by check-in calls to parents at least monthly that allow staff to ask, "What is working?" When parents do not respond or do not show up at a meeting, staff members examine contact notes to identify problems with Keys' intervention. They may determine that the intervention was sound but was offered at the wrong level of the parents' readiness to use it.

The majority of parents move quickly through the first three levels (averaging 2.5 months per level), slowing when they reach level 4. Levels 4-6 average 4.6 months per level,

and levels 7-10 average 6.3 months per level. Graph 1 (adapted from Cheon & Chamberlain, 2003) shows the average duration of time at each level. Time is an important consideration in building relationships and establishing reasonable expectations when asking parents to deepen their involvement, complete training, attend meetings, advocate for their child, or commit to system change efforts.

The Keys TPA model provides the structure to document process and outcomes. Staff members track the interventions delivered and note which ones move parents forward. Data from a study conducted by the University of Kansas School of Social Welfare (Cheon and Chamberlain, 2003) show that parents move forward over time along the continuum. The data shows that parents who reach higher levels of engagement on the TPA continuum stay active with Keys over longer periods of time than parents scoring at lower levels. Only 26.3% of low-level (1-4) parents maintain contact with Keys for two years, compared to 67.2% of high-level (5-10) parents. Most parents who become inactive do so at level 1 (50.4%). The data shows that only 29% of minority parents remain active after two years compared to 44.5% of Cauca-

FIGURE 1: TPA CONTINUUM

TPA CONTINUUM: 10 LEVELS

1. Seeks information
2. Initiates additional contact
3. Commits to address problem
4. Works on Problem
5. Resolves initial problem
6. Takes on new problems
7. Offers to help others
8. Completes training to help others
9. Helps others
10. Impacts local, state, national policy

1 INITIATION   **2** SOLUTION-FOCUSED   **3** EXPANDING INTERESTS

sian parents.

To improve retention and promote depth of engagement, staff must respond quickly at lower levels (1-3) to parents needs with interventions that parents find useful and that are appropriate to parents' concerns and interests. Concerns vary by stage, as do parents' ability to use the information provided. At the Initiation stage (levels 1-3), 30.4% of parents ask about Keys program information, 20.3% have service system concerns (mental health, child welfare, juvenile justice), and 19.8% have specific school issues. They really want to know most what Keys can offer and what service providers should do. At this stage, the most useful intervention is to answer the specific questions asked. With very different interests at the Solution-Focused stage (levels 4-6), the majority of parents want help resolving specific service concerns. At the Expanding Interests stage, 30.3% of parents had questions about Keys' programs and services, 28.9% had no concerns, and 19.7% had service system concerns. In the Expanding Interests stage, parents want Keys to support them to assist other parents, to invite them to serve as spokespersons at events, and

to bring parent voice to boards. Keys staff link these parents to people and programs where they can serve, train them in sophisticated content areas, and encourage them to call when they need help with their own children.

Table 1 (also adapted from Cheon and Chamberlain, 2003) identifies the frequency of Keys' interventions offered by stage. In the Initiation Stage, when most parents call to learn what Keys can do for them, 46.6% of the interventions involve description of Keys' services and an invitation to Keys events. During the Solution-Focused stage, Keys' most frequent interventions are discussing options and following up to make sure issues are resolved. At the Expanding Interests stage, the interventions focus on linking these advanced parents to Keys activities where they can serve as spokespersons and following up to provide them with what they have asked of staff.
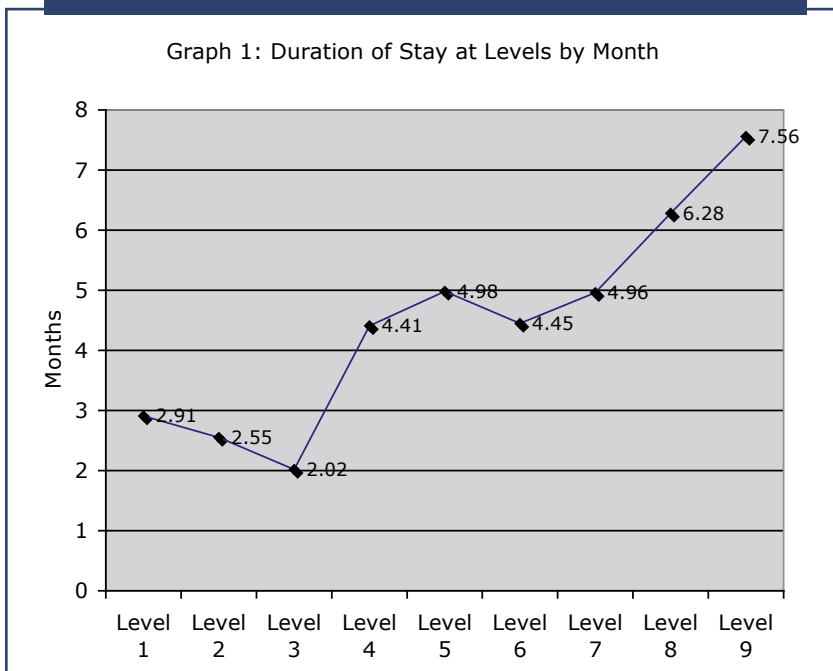
Bobbie's story illustrates the journey of one parent who has benefited from TPA and demonstrates her growth from family crisis to family and systems advocacy. Her testimony shows her commitment to her own children and her drive to learn,

to transfer what she knows to help other families, and to build service pathways across Kansas for families whose children have serious emotional and/or behavioral problems. Her children still have many problems, but her capacity to manage them and relate effectively to the service world has changed dramatically. She is a parent who Keys helped and who now helps Keys and all Kansas families.

My interest in advocacy began six years ago when I met the people at Keys for Networking. Before I knew the Keys staff, I was too afraid to leave my house. I was raising four children on my own. In May 1999, I attended a conference in Topeka. Keys staff held parent information meetings and provided childcare during these meetings. It was at this meeting that I got their phone number. I kept the number almost a year before I called to ask questions about why it was taking so long to get my son's testing done. I talked to Angie, who told me she was a parent of a child with serious emotional problems. She suggested I talk to the IEP team about my concerns. She called me back four days later to ask how I did. I could not believe it. She invited me to a training about my child's school rights. I said yes on the spot. She told me I could attend by phone and would not have to leave home. At that training I connected with other parents whose children had the same problems as mine. I learned that my son was eligible for additional services. I requested additional testing and the school agreed.

The Keys staff started calling me, to check on me, they said. For almost a year, I did not return their calls. They left messages to call if I needed help. In August of 2001, I attended the annual Keys Oscars event. I nominated my son's case manager for an award, which she won. In October 2002, Keys hired me to bring parents to a meeting with the Department of Education about the connection between NCLB [the federal No Child Left Behind Act] and reauthorization of IDEA [the Individuals with Disabilities Education Act]. About this time, my younger son started getting in trouble. I knew what to do. I asked for a special education evaluation and started him on an IEP. I started thinking maybe other parents could use my help. I attended

GRAPH 1: LEVEL ACHIEVEMENT SPEED

Graph 1: Duration of Stay at Levels by Month

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to
reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT 17

wraparound and parent support trainings and then called Keys for direction on how I could help a family get mental health services for their child. In March 2003, Keys called to give me information about legislative issues and encouraged me to talk to senators and representatives if I cared to discuss these topics. They gave me my legislators' names and phone numbers. I was invited to attend Mental Health Advocacy Day at the Capitol. In July of 2003, Keys invited me to serve on their NCLB state advisory council. In May 2004, Dr. Adams called to ask if I would help a family prepare for a wraparound meeting so their child could come home from the hospital. I did. Also, the Governor appointed me to the Mental Health Services Planning Council. At that point, I was feeling pretty connected.

Then in July my daughter tried to commit suicide. I was so overwhelmed I did not know where to turn. Keys staff came to my aid and fast. They kept telling me I was a good mother and that I knew what was best for my child. They said they were behind me all the way. They encouraged me to ask for a 504 Plan to help my daughter succeed in school. In September 2004, I testified at the Capitol, encouraging the legislature to develop policies against school seclusion and restraint. In May 2005, I facilitated a group at the Freedom Commission Goal 4 Summit with over 200 people. I brought my daughter and she participated. Recently, I called for help with my son's IEP and the wording for his behavior plan. The problems with my children don't stop. Most of the time I am able to handle them. I know where to get help when I need it. I am not afraid any more to ask for help. Other parents in my community see me as a resource when they need help. And, through me, they see Keys as a resource when I cannot help them.

Summary

TPA is a reciprocity model. Parents who seek help become help givers. By design, they join a state network of natural and professional supports that benefits them and allows them to give back what they learn. TPA provides opportunities for parents to affiliate with a large body of Kansas parents who represent the 70,000 children (10% of Kansas' youth population) whom the Kansas State Department of Social and Rehabilitation Services estimates have serious emotional disturbance. They see that they are not alone. As parents grow in their self-advocacy abilities, they also experience a renewed (and in some cases new) sense of self-worth and capacity to help others. When parents take the step of offering to assist and advocate for other families with Keys' support, their sense of belonging and feelings of reciprocal services to Keys and to the community of parents is strengthened. Parents who experience success in helping other families recognize the magnitude of need on a system-wide level and are welcomed to the network of parent advocates through trainings and meetings, and they are given other opportunities to speak for children and families in policy-making activities.

References

Cheon, J., & Chamberlain, R. (2003). *Targeted parent assistance: What Keys for Networking, Inc. did for the families and children with mental health problems in Kansas.* [Unpublished manuscript]. University of Kansas School of Social Welfare, Lawrence, KS.

Kibel, B.M. (1996). Evaluation using results mapping. *New Designs for Youth Development, 12,* 9-15.

Kibel, B.M. (2000). *Outcome engineering toolbox.* Pacific Institute for Research and Evaluation.

Jane Adams is Executive Director of Keys for Networking, the statewide organization of the Federation of Families for Children's Mental Health. Dr. Adams represented the child family consumer voice on the President's New Freedom Commission on Mental Health, 2003.

Elizabeth Westmoreland analyzes Keys' monthly TPA records and reviews them for progress and success/failure of interventions offered. Her adult sister and brother and her mother have chronic mental illnesses.

Corrie Edwards is Program Director at Keys for Networking. Corrie has a sister who has experienced chronic mental and emotional problems.

Sarah Adams is Director of Information Systems and programmer for the Filemaker Pro data base, which integrates daily journaling by staff with the Keys 1-10 targeted outcomes.

TABLE 1: INTERVENTIONS OFFERED BY STAGE [MOST FREQUENT HIGHLIGHTED]				
Interventions	**Initiation**	**Solution-Focused**	**Expanding Interests**	**Total**
Provide Information	6.8%	12.4%	14.3%	10.9%
Discuss options	13.2%	22.9%	15.6%	19.2%
Follow up issues	18.3%	35.0%	37.7%	30.2%
Refer to others	7.3%	7.7%	2.6%	7.0%
Provide advocacy & action	7.0%	9.1%	6.5%	8.4%
Describe and/or invite to Keys programs/events	46.6%	12.9%	23.4%	24.2%

TECHNIQUES FOR ASSESSING SOCIAL SUPPORT

This article reviews a number of techniques for assessing a family's social support network. Some of the techniques are typically used in care planning or treatment to gather information about support that can be mobilized to help families meet needs or reach goals. These assessments are usually easy to use and can be adapted for use with adults, adolescents, or children. Other techniques are more formal and are used to measure social support for research and evaluation purposes.

Techniques for assessing social support are valuable in a wide range of planning, intervention, and evaluation contexts; however, this article focuses on how they can be used by wraparound teams or programs. Wraparound is a collaborative, family-driven process for creating individualized plans of care for children and youth with emotional or behavioral difficulties. One of the principal goals of the wraparound process is to strengthen the family's social support and community connections.

Informal Assessment

Social support assessments are useful in the wraparound process because they help the team pay attention to important information that may otherwise be overlooked. Given the empirical evidence for the importance of social support for families caring for a child with a disability (Beresford, 1994; McDonald, Gregoire, Poertner, & Early, 1997; Snowdon, Cameron, & Dunham, 1994), the identification of actual and potential social support resources is an essential part of the team's assessment process. Individuals who offer informal supports to parents or youth can be valuable resources in the implementation of a plan of care.

What is more, these individuals will probably be available for the youth/child and family after wraparound and other formal services have ended.

An ecological map or eco-map (figure 1) is one technique that teams can use to show a family's relationships with helping resources. To create an eco-map, the team begins with a piece of paper that has a large circle (representing the family) in the middle, and a number of smaller circles around the larger circle. Family members are asked to identify both people and services that serve as resources for them. Possible resources are extended family, church, recreation activities, friends, health care, and school.

The family then indicates the nature of the connections between themselves and the resources by drawing different kinds of lines between the large circle and the smaller circles, and/or using a descriptive word that can be written on the map. Typically, a strong positive connection is indicated by a solid line, a moderate connection by a broken line, and a stressful connection by a line with slanted lines drawn through it. Arrows can also be used to illustrate whether the relationships and flow of resources are reciprocal, or in one direction only. The team can use the information on the completed map to identify supports that may be useful in the development of the service plan and to identify gaps where additional supports may be needed.

Another tool for depicting the relationships between a caregiver and her

FIGURE 1: ECO-MAP

Eco-Map by Jan M. Markiewicz

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT   19

social systems is the Social Network Map (Tracy & Whittaker, 1990). This instrument attends to both the structure (the number and quality of social relationships) and the function (the various types of supportive exchanges) of informal social supports. A circle mapping technique is used to portray network members and a grid is used to identify the supportive and non-supportive functions of relationships. For example, who provides what types of

supports, which relationships are conflicted, and which are reciprocal? Information is collected about network size, reciprocity, perceived availability of support, closeness, directionality, stability, and frequency of contact.

There can be a number of advantages of using the Social Network Map. The map helps to identify and evaluate not only resources but also sources of stress and strain within the family's social environment. Responding to the mapping and grid questions helps caregivers review existing resources and identify new sources of potential support. Using the tool may also provide a vehicle for discussing other issues, such as current stressors, that the caregiver may be experiencing. Finally, caregivers sometimes find that using the instrument is empowering, because it helps identify specific steps they can take to use their networks more effectively.

The Community Connections and Team Composition Questionnaire, designed by the King County Blend-

ed Funding Evaluation Team (2001), creates a list of the individuals, services, and activities that a youth has been connected to over the past three months in five categories: family, friends, school/work, community, and formal services. After all the supports are listed, the parent rates the strength of the connection on a scale of 0 to 3, with 3 being the strongest connection. As a final step, the parent identifies the members of the wraparound team, if there is one, and provides information about how often each person attends the team meetings and the types of support that the team member provides for the parent and/ or the child.

The EMQ Connectedness Model (EMQ Children & Family Services, 2003) is another technique that is used collaboratively with a child and family to discover social supports and connections. The technique is used to generate a Connectedness Diagram (Figure 2). The diagram begins with a genogram, which shows the child's biological relationships using horizontal tiers for the child's generation, parents' generation, and grandparents' generations. This part of the diagram is done in blue. The next step is to identify the individuals who the child loves, and by whom the child feels loved. These connections are done in red, to represent the heart, and may extend beyond the biological relatives and include friends, teachers, coaches, siblings, foster grandparents, etc. The color green, standing for the fertile and creative mind, is used to represent those from whom the child learns and those the child teaches. These may include teachers, siblings, aunts and uncles, coaches, and others with whom the child has a positive connection. The spiritual dimension is diagrammed in yellow, represent-

ing the light of the soul. As each of these individuals and resources is identified, the team can ask whether they can be mobilized as a strength or support, or whether they can provide a specific activity that can be built into the child's service plan.

Teams should keep several things in mind when assessing social support using any of these techniques. First, information gathered through such a process may be limited since the data is self-reported. It can be affected by factors such as the type of social support, the individual's recall skills, and social desirability. Through using the instrument, the team may overestimate or underestimate the social network's strengths and capacity for offering support, as well as the family's capacity for receiving support. Interpersonal relationships also change over time, and change may be particularly likely when the team attempts to increase the support offered by particular individuals in a family's interpersonal network. Thus, the team should remember that the assessments provide only a starting point for an evolving understanding of the family's social network and its potential for offering support.

Any structured instrument can also miss population-specific or cultural nuances related to social support. For example, in one study of social support, parents of a child with a chronic disability reported the unique challenge of resource maintenance within their support network (Bregman, 1980). Given the long-term nature of their child's challenges, parents' supports can burn out unless parents direct attention and resources into maintaining and re-fueling the members of their support network. In addition, reciprocity with the social support network is difficult because the parents' needs are often large and ongoing. A structured technique may miss these aspects and, thus, ignore the risk of the family depleting or losing a vibrant support network. Cultural differences in the types of interactions that are seen as supportive have been documented. People from

FIGURE 2: THE EMQ CONNECTEDNESS MODEL
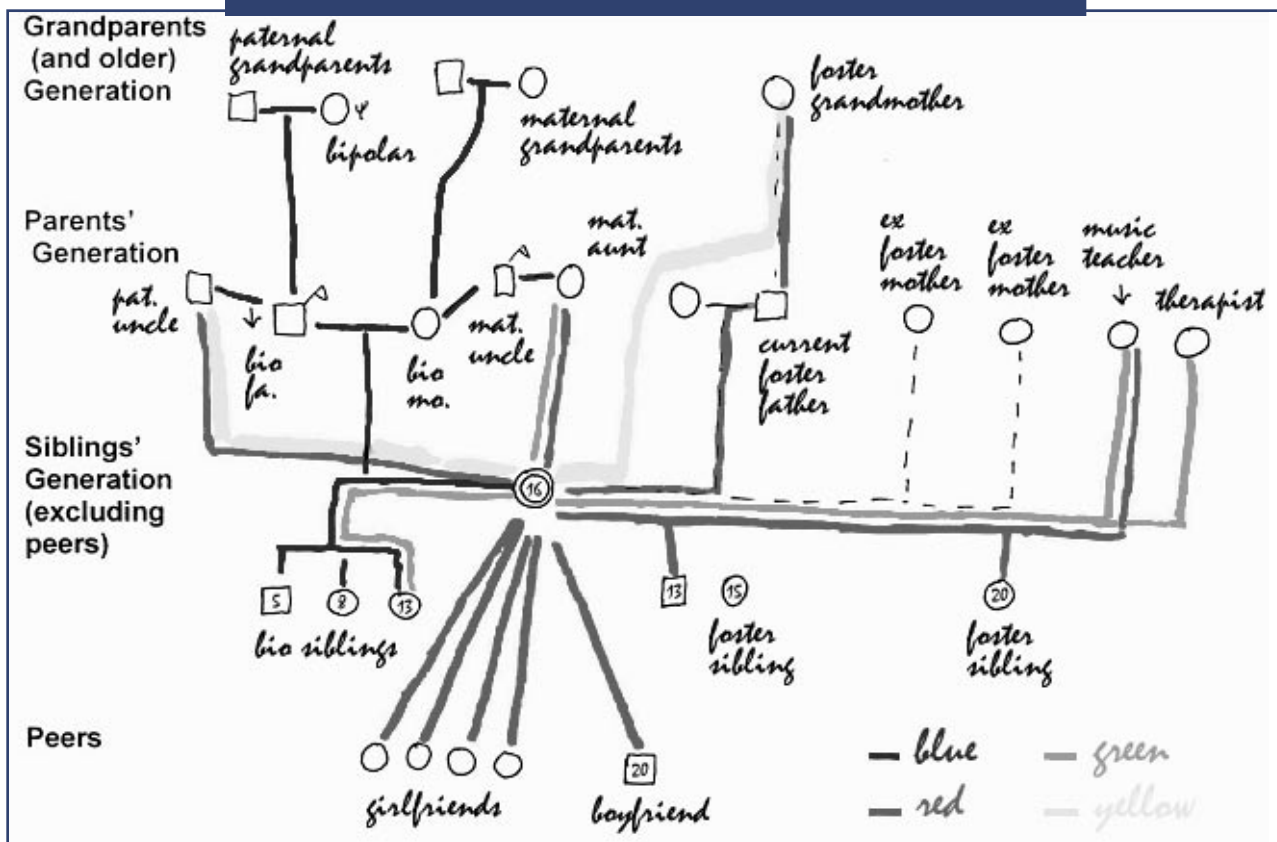
different cultures also may have different ideas about the kinds of support or resources that can be appropriately exchanged between friends and relatives. Being aware of these differences can help the team make adjustments as new information about a family's social support network emerges over time.

Formal Assessment

The techniques that are described above are useful for child and family teams because they are directly related to the team's purpose--the development and implementation of an individualized service and support plan. In research and formal program evaluation, social support is often included as an independent variable, contributing to positive child and family outcomes, or as a dependent variable when the research question is about how social support can be facilitated and maintained. There are a number of standardized instruments that are used to assess social support in these studies.

The Inventory of Socially Supportive Behaviors (ISSB; Barrera, 1981) is a 40-item self-report measure of received support. Its purpose is to gather information regarding the support recipient's perceptions of available social support. Respondents are asked to assess the informal supports received from different individuals during the past 30 days using a 5-point scale from 1 (not at all) to 5 (about every day). Concurrent validity of the ISSB total score with measures of network size has been demonstrated with correlations of .24 and .42 (Barrera & Sandler, 1984). Internal consistency coefficients range from .90 to .94, with a test-retest reliability over a one-month interval of .80 (Barrera, 1981).

The Quality of Relationships Inventory (QRI) was developed to assess perceived availability of support in specific relationships and is based on the interactional-cognitive model that distinguishes between general and relationship-specific perceptions of social support. The QRI is composed of three separate dimensions labeled support, depth, and conflict. The QRI is a self-report questionnaire with 25 items that participants rate using a four-point scale regarding their perceptions of a specific relationship. It takes approximately four minutes to complete for each relationship. Studies testing the psychometric properties and validity of the QRI scales reflect a broad range of methodologies, including cross-sectional, longitudinal, experimental, observational, and retrospective designs. Internal consistency for each of the scales has been shown to be high, with Cronbach's Alpha in the .80's and .90's. In addition, QRI scores have high test-retest reliability, with correlations between scores on each scale across a four-month period ranging from .66 to .82, with an average correlation of .75 (Pierce, 1994).

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to
reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT 21

Some research studies also collect data on social support through observations of child and family team meetings. For example, observers will record whether one or more natural helpers are present at the meeting, whether social support is mentioned and/or assessed during the meeting, and whether social support is included in the family's service plan.

Conclusion

Social support assessments are obviously useful in both practice and research. Informal assessments help stimulate thinking about ways that interpersonal relationships can be mobilized to help children and families meet needs and achieve goals. More formal assessments help develop knowledge about whether or not strategies designed to increase social support actually succeed in doing so, and whether increasing social support contributes to other positive outcomes for children and families. It is important to remember, however, that these assessments are only approximations of what a family's "real" social support network may be. Social support is a complex concept and a complex phenomenon, and knowledge about the best ways to measure social support continues to evolve.

References

Barrera, M. J., Sandler, I. N., & Ramsay, T. B. (1981). Preliminary development of a scale of social support: Studies on college students. *American Journal of Community Psychology, 9*, 435-447.

Beresford, B. A. (1994). Resources and strategies: How parents cope with the care of a disabled child. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 35,* 171-209.

Bregman, A. M. (1980). Living with progressive childhood illness: Parental management of neuromuscular disease. *Social Work in Health Care, 5*(4), 387-408.

EMQ Children & Family Services (2003). Using the EMQ Connectedness Model. Campbell, CA: Author.

King County Blended Funding Evaluation Team (2001). Community Connections. [Questionnaire]. Renton, WA: Washington State Organization of the Federation of Families for Children's Mental Health.

McDonald, T. P., Gregoire, T. K., Poertner, J., & Early, T. J. (1997). Building a model of family caregiving for children with emotional disorders. *Journal of Emotional and Behavioral Disorders, 5*, 138-148.

Pierce, G. R. (1994). The Quality of Relationships Inventory: Assessing the interpersonal context of social support. In B. R. Burleson, L. A. Albrecht & I. G. Sarason (Eds.), *Communication of Social Support* (pp. 247-266). Thousand Oaks, CA: Sage Publications.

Snowdon, A. W., Cameron, S., & Dunham, K. (1994). Relationships between stress, coping resources, and satisfaction with family functioning in families of children with disabilities. *The Canadian Journal of Nursing Research, 26*, 63-76.

Tebes, J. K., Kaufman, J. S., Adnopoz, J., & Racusin, G. (2001). Resilience and family psychosocial processes among children of parents with serious mental disorders. *Journal of Child and Family Studies, 10*(1), 115-136.

Tracy, E. M., & Whittaker, J. K. (1990). The Social Network Map: Assessing social support in clinical practice. *Families in Society, 72*(8), 461-470.

Mary I. Armstrong is Assistant Professor and Director of the Division of State and Local Support at the de la Parte Florida Mental Health Institute, University of South Florida.

Social Support from Adults and Peers in Early Adolescence:
It's a Balancing Act

The period of transition from childhood to adolescence is a challenging time for many young people. Even in the best circumstances, it can be daunting for adolescents to cope with the biological, cognitive, emotional, and social changes that are unfolding in their lives. Supportive relationships are vital for ensuring the continued healthy development of young people as they journey through adolescence. To design interventions and policies that enhance the availability of appropriate supports for young adolescents, two key questions must be addressed: First, who is best equipped to offer assistance? Second, what are the ideal amounts of assistance that should be obtained from each type of support provider?

Our recent research finds that support from both peers and adults is important to the healthy development of young adolescents. Adjustment during the transition to adolescence is affected by whether or not youth receive balanced amounts of support across peer and adult sources. The finding that adolescents need a mix of support from peers and adults is not surprising. After all, this is an age group known for its gravitation toward peer companionship, as well as its complicated and sometimes ambivalent stance toward help from parents and other adults. Our findings highlight promising directions for innovation in interventions for young adolescents, and have noteworthy implications for both practice and policy.

Research on Social Support During Early Adolescence

In one of our recent studies, we investigated the levels of social support that 350 young adolescents (grades 5-8) received from both peers and adult sources (e.g., parents, teachers) over a two-year period (DuBois, et al., 2002). Findings revealed that youth who reported receiving higher overall levels of combined support from peers and adults exhibited significantly better behavioral and emotional adjustment throughout the course of the study. We found that those youth for whom there was a lack of balance in the direction of greater peer- versus adult-oriented support were at heightened risk for behavioral problems such as aggression and delinquency. When youth receive support predominantly from peers, this may be an indication of estrangement or conflict in their relationships with parents and other adults. Under these circumstances, young adolescents are less likely to obtain the adult guidance and encouragement that they need to cope with different challenges they encounter in areas such as schoolwork or friendships. We also found in a follow-up study (DuBois & Silverthorn, 2004) that youth who relied on peers as their main source of support were more likely to associate with other youth who were exhibiting problem behav-

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to
reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT   23

ior, thus amplifying their own risk for engaging in such behavior.

At the same time, other research we have conducted points toward an equally troubling downside for those young adolescents who have imbalanced relationships with adults accounting for a disproportionately large source of their social support. The absence of support from peers appears to leave youth susceptible to emotional difficulties, including symptoms of anxiety and depression (DuBois, et al., 1999). Such liabilities likely stem at least in part from the premium placed on peer group acceptance during early adolescence. Peers may be especially qualified to offer support in many of the areas of greatest concern to this age group, such as their friendships and appearance.

Application to Interventions for Young Adolescents

The research findings that we have summarized have important implications for the design of effective interventions for young adolescents. To be optimally beneficial, our results indicate that programs, policies, and interventions for this age group should be devised with the goal of promoting support from both peers and adults. It is not uncommon for current interventions to focus predominantly on promoting support from only peers or adults (e.g., social skills training to improve peer relationships, family interventions to strengthen parent-child relationships).

In our own research, we are exploring the value of introducing innovations focusing on social support in mentoring programs for youth. Mentoring programs currently enjoy widespread popularity, with approximately 4,500 youth mentoring programs operating in this country (Rhodes, 2002). Mentoring programs have focused most directly on increas-

ing the access of youth to social support through a relationship with a caring adult volunteer. It is noteworthy that youth participating in mentoring programs have also demonstrated improvements in their relationships with peers (Rhodes, Haight, & Briggs, 1999). Evaluations of mentoring programs reveal that they can provide benefits to youth in several areas, including emotional, behavioral, social, and academic adjustment (DuBois, et al., 2002). However, the magnitude of

these benefits has typically been modest. It thus appears that there is potential to strengthen mentoring programs through promoting both adult and peer support.

A Model for Integrating Adult and Youth Support

Our current research is focused on the development and evaluation of a community-based mentoring program for girls, GirlPOWER!, in partnership with Big Brothers Big Sisters of Metropolitan Chicago. The program is consistent with the findings of our earlier research in that it aims to foster support from both adults and peers. The GirlPOWER! program is designed to promote socially supportive relationships between youth and their mentors as well as to promote supportive relationships between other sources of adult support and participating youth (e.g., parents). An adult volunteer is matched with a child with a commit-

ment to meet one-on-one two to four times per month for at least one year. Youth-mentor pairs structure their own time together and may choose to participate in agency-wide activities. Each pair is also supported by ongoing monthly contact with agency staff. These innovations are complemented by several strategies directed toward enhancing access to peer support.

The GirlPOWER! program features a series of 12 psychoeducational workshops that are attended by a group of 10-15 participating girls (ages 10-13) and their mentors. During each workshop, active learning strategies are used to help the group explore topic areas that have important implications for healthy development (e.g., self-esteem, nutrition and exercise, romantic relationships, substance use). Each session has a MatchBuilder segment, in which a volunteer Match role-plays a challenging interaction between a hypothetical girl and her mentor, and the group then discusses ways to resolve the situation that is depicted in the role-play. Other activities for youth-mentor pairs are linked thematically with workshop content. Youth and mentors are asked to continue these activities for a 3-month period after the workshop series concludes, leading up to a group reunion at the end of the year. "POWER" is used as an acronym for five core concepts (Pride, Opportunity, Women-in-the-Making, Energy and Effort, and Relationships) that are interwoven through all program components. The "Relationships" concept reflects the program's focus on the cultivation of supportive relationships between girls, their mentors, other adults, and peers. The joint participation of mentors and girls in the sessions gives girls and mentors an "opening" and common language to talk about topics that are difficult due to their sensitive or challenging nature. Through

this process, the program seeks to enable mentors to move beyond companionship to providing girls with guidance and emotional support in dealing with a wide range of issues. The activities provide structured opportunities for mentors and youth to talk about workshop topics and begin to incorporate relevant activities into their relationships (e.g., regular exercise, healthy eating). There also is a session early in the program that is devoted specifically to developing the Match relationship by having youth and mentors set goals together and then plan for how they can support each other in reaching these goals.

Parents attend a program orientation and the final workshop in which girls and their mentors perform a talent show and graduate from the program. Parental involvement is encouraged throughout the program by having girls bring home an informational handout after each workshop. The handouts summarize session activities and provide parents with tips and suggestions for how they can support their daughters' healthy development in areas related to the workshop topic. Throughout the program, both girls and mentors also are encouraged to identify other adults in the girls' social networks and to invite them to join in activities where appropriate. In this way, the youth's mentor may be able to work cooperatively with other important adults in the youth's life. Likewise, through connections to the mentor's social network, the youth may be exposed to new positive adult role models and sources of support.

Several features of the GirlPOWER! program are designed to help girls establish supportive relationships with peers. These include the group setting for sessions in which girls are able to meet and spend time with other girls their age. The sessions are structured to foster positive interactions among girls through activities such as games in which they compete as a team against their mentors. The sessions also allow girls to practice interpersonal skills helpful to healthy re-

lationships with peers. These include, for example, skills for support-seeking, dealing with peer pressure, and assertiveness in dating relationships. The active involvement of mentors in sessions ensures that youth have access to adult support as they learn these skills. This involvement provides the mentor, too, with a valuable opportunity to deepen her understanding of the issues that influence the quality of the youth's peer relationships, enhancing her capacity to offer effective guidance regarding peer-related issues both in and out of program sessions.

Conclusions

Research indicates that young adolescents who receive social support from peers and adults are significantly better equipped to cope with challenges. An imbalance in the direction of over-reliance on either peers or adult

Youth participating in mentoring programs have demonstrated improvements in their relationships with peers.

sources of support places youth at risk for problems in their emotional and behavioral adjustment as they transition into adolescence. There is a need for interventions and policies that are designed to ensure that young adolescents benefit from supportive ties with both peers and adults in equal measure. The GirlPOWER! program described in this paper illustrates the types of innovation to existing models of practice that may prove successful for achieving this important goal.

References

DuBois, D. L., Burk-Braxton, C., Swenson, L. P., Tevendale, H. D., Lockerd, E. M., & Moran, B. L. (2002). Getting by with a little help from self and others: Self-esteem and social support as resources during early ado-

lescence. *Developmental Psychology, 38,* 822-839.

DuBois, D. L., Felner, R. D., Brand, S., & George, G. R. (1999). Profiles of self-esteem in early adolescence: Identification and investigation of adaptive correlates. *American Journal of Community Psychology, 27,* 899-932.

DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology, 30,* 157-197.

DuBois, D. L., & Silverthorn, N. (2004). Do deviant peer associations mediate the contributions of self-esteem to problem behavior during early adolescence? A 2-year longitudinal study. *Journal of Clinical Child and Adolescent Psychology, 33*, 382-388.

Rhodes, J. E., Haight, W., & Briggs, E. (1999). The influence of mentoring on the peer relationships of foster youth in relative and nonrelative care. *Journal of Research on Adolescence, 9,* 185-201.

Rhodes, J. M. (2002). Stand by me: *The risks and rewards of mentoring today's youth.* Cambridge, MA: Harvard University Press.

Naida Silverthorn is a post-doctoral fellow at the Institute for Health Research and Policy at the University of Illinois at Chicago.

David DuBois is Associate Professor in the Division of Community Health Sciences in the School of Public Health at the University of Illinois at Chicago.

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.rtc.pdx.edu. For reprints or permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT 25

WRAPAROUND AND NATURAL SUPPORTS:

COMMON PRACTICE CHALLENGES AND PROMISING COACHING SOLUTIONS

Wraparound is a support planning process that is facilitated and team-based. The youth (or child) and family, natural supports, and service professionals partner to develop and implement a strength-based, culturally competent, and highly individualized support plan with the goal of maximizing youth and family functioning and happiness. Natural supports are individuals identified by the youth and family who participate in the wraparound process. These are people who know the youth and family well, who care about them, and who provide support without being paid. Natural supports are the individuals who provide long-term support to the youth and family, and who thus permit the wraparound facilitator and other professionals to transition out of their intensive service

and support roles over time. The role of natural supports in wraparound plan development and implementation is crucial and central to the process, and is perhaps the aspect of the wraparound that most distinguishes it from other helping models.

As a wraparound trainer and coach, I support facilitators as they learn the craft of wraparound. Wraparound facilitators frequently report that they have significant challenges building natural supports. Since this is an essential element of wraparound practice, facilitators learning the model need effective coaching support from supervisors and others who guide their development targeted to this area if natural supports are to be successfully involved on wraparound teams.

In this article, I will discuss three

specific challenges frequently reported by wraparound facilitators in building natural supports: identification of natural supports, engagement of natural supports, and recruitment of surrogate natural supports.

Identification of Natural Supports

I have lost count of the number of times enthusiastic facilitators who are learning wraparound have said to me, "I know natural supports are an essential element of wraparound, but there just aren't any for this family." I typically respond by saying, "Let's slow down and back up a few steps." It is necessary to determine if the facilitator has established enough trust with the youth and family for them to disclose information about the indi-

viduals in their life from whom they derive support.

It is important for facilitators to establish a foundation of trust with a youth and family before beginning to identify natural supports. Premature initiation of the process of identifying natural supports can result in superficial responses from the family. This can lead the facilitator to falsely conclude that the family does not have any natural supports. Beginning facilitators may need support to strengthen their youth and family engagement skills so initial trust is reliably established before the natural supports discovery process is begun.

Wraparound facilitators must also learn to conduct a discovery with the youth and family that is of sufficient breadth and depth to reliably identify current and potential natural supports. Many skillful facilitators use life domains as a structure to guide their natural support discovery efforts. It helps them ensure that the natural support discovery process covers all areas of the youth and family's lives where current or potential natural supports might exist.

Life Domains (see sidebar) are a tool used to guide the discovery process that helps ensure that the discovery is broad enough to identify natural supports across all areas of life of the family and youth.

Skillful facilitators must learn strategies to conduct deep discovery in particular life domain areas. Domains that need deep discovery include family and extended family, spiritual and faith community, and friends.

For example, to support deep discovery in the family and extended family life domain, I teach novice facilitators skills so they can draw three-generation family trees for each wraparound family. To teach this skill to a new facilitator, we draw a family tree together using a wraparound family selected by the facilitator. We start the tree with the child or youth that was referred to wraparound. We next add the immediate family members and any other individuals who live in the household to the tree. Then we add family members not in the immediate household. Last we add maternal and paternal grandparents as well as aunts, uncles, and cousins and step-family members not already identified. I ask the facilitator to label people on the tree by first name and to note their whereabouts.

The beginning facilitator often recognizes that he or she has significant information gaps about emotionally significant relationships in the family and extended family life domain as a result of drawing the family tree. Common information gaps include: not knowing the names of one or several of the individuals who live in the household, not knowing the name or whereabouts of the youth's biological mother or father, and/or little to no information about the youth's grandparents and other extended family. I help the facilitator to understand that deep discovery of natural supports in the family and extended family life domain is not complete until all information gaps are filled. Only then can the facilitator make accurate conclusions with the youth and family about the presence or absence of natural supports in this life domain.

Engaging Natural Supports

Novice facilitators frequently tell me, "The youth and family have natural supports, but they don't want them on the team." Facilitators learning wraparound practice sometimes push prematurely for the involvement of identified natural supports on the wraparound team. Experienced facilitators recognize that taking time to build a rationale for involving natural supports on the wraparound team maximizes the potential for the successful involvement of these crucial supports. A family is much more likely to agree with the involvement of natural supports on their wraparound team when natural supports are invited to participate on the team to meet a specific need that has been identified by the facilitator and the family.

Here are two typical examples:

1. A mother who agrees that she is tired, alone, and needs more emotional support enthusiastically agrees to involve her best friend on the team when the friend's initial job on the team is to provide her with emotional support during the meetings.

2. A single father recognizes, with facilitator support, that his adolescent son would benefit from an adult female mentor. The father and youth agree that the father's sister might help meet this need. The father is pleased to have his sister invited to participate at the next meeting.

Another factor influencing a family's willingness to involve natural supports on their team is feeling shame. Novice facilitators sometimes fail to anticipate feelings of shame and do not adequately discuss and normalize these feelings before suggesting natural support involvement on the family's team. Skillful facilitators actively discuss feelings of shame as well as other feelings and fears, address issues of confidentiality, and define what sensitive information needs to be shared with team members in order to develop a meaningful support plan for the youth and family. Sensitive attention to these universal issues prepares families for the inclusion of natural supports on their teams.

In the process of discovery of natural supports, a youth and family may identify friends, relatives, and other natural supports who have provided

---

LIFE DOMAINS

Family and extended family
Friends
Emotional
Safety
Spiritual and Faith community
Work and financial
Residence and neighborhood
Legal
School and education
Medical
Fun
Other

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT   27

support to them in the past but who do not currently have positive relationships with the family. The family does not then see them as current sources of support. Novice facilitators often do not invest enough energy to determine if these previously supportive relationships can be restored. Experienced facilitators might say to a youth: "I understand you and Bill were best friends before the argument, and that since then, you aren't talking anymore. What would it take for you and him to make things right?" With needed support from the facilitator and others who care, some potential sources of natural support can be restored and then become available to participate on the wraparound team.

Recruiting Surrogate Natural Supports

Some families are truly isolated—they have lost their natural supports. In this circumstance, the facilitator must assist the youth and family to recruit surrogate natural supports to participate on the team. Skillful facilitators master various recruitment strategies, including the two that follow.

In the first strategy, the facilitator, with support from his or her colleagues and supervisor, develops a plan targeting community organizations often referred to as "brokers of natural supports." The plan is designed to identify potential surrogate supports and connect them to youth and adult caregivers who need them. Community churches, service clubs, and many other community organizations have members who are interested in volunteering their time in the service of youth and families who have needs. The community development plan begins by educating these broker organizations about the wraparound process. As relationships with broker organizations are

strengthened, a range of possible roles for interested volunteers from these organizations are defined, including support of youth and families by participation on wraparound teams and one-to-one mentoring of youth and adult caregivers. Willing volunteers are then engaged on teams to broaden the base of support of isolated youth and families.

The second strategy is strength-based recruitment of family-specific

surrogate natural supports. This strategy is based on the use of the youth and family's strengths to guide highly individualized recruitment efforts of surrogate team members. For example, a facilitator contacts a colleague's mechanic and asks him to meet with a youth in wraparound based on the youth's interest in automotive repair. The youth and mechanic hit it off. The mechanic mentors the youth in automotive repair and becomes a periodic participant on the wraparound team.

Strength-based recruitment maximizes "fit" of surrogates and the youth and family by matching them on one

or more areas of shared strengths, interests, preferences, and/or culture. Mutual acceptance between surrogate supports and youth and families maximizes benefits and the establishment of self-sustaining relationships.

Conclusion

Wraparound is a complex process whereby youth and families with multiple life challenges are supported by a team composed of professionals and natural supports. Natural support participation on the planning team and assistance implementing the service and support plan are essential and unique elements of the wraparound practice model. Wraparound facilitators often report practice challenges that can become barriers to building effective teams that include natural supports. Some of these common practice challenges were identified and discussed, and promising coaching strategies were reviewed. The preceding paper was neither comprehensive nor authoritative. Nonetheless, I hope it causes wraparound supervisors, trainers, and others responsible for wraparound practice quality to reflect on their current coaching activities in this area of wraparound practice. Further, I hope such reflection leads to additional exploration of the role of natural supports in wraparound, as well as improved coaching activities designed to strengthen facilitator effectiveness in building natural supports.

Greg S. Dalder is Executive Vice President of Vroon VanDenBerg LLP. Previous education in social work and experience in family therapy inform his current work, which is focused on wraparound training and the provision of follow-on practice coaching.

Natural Supports from a Parent Perspective
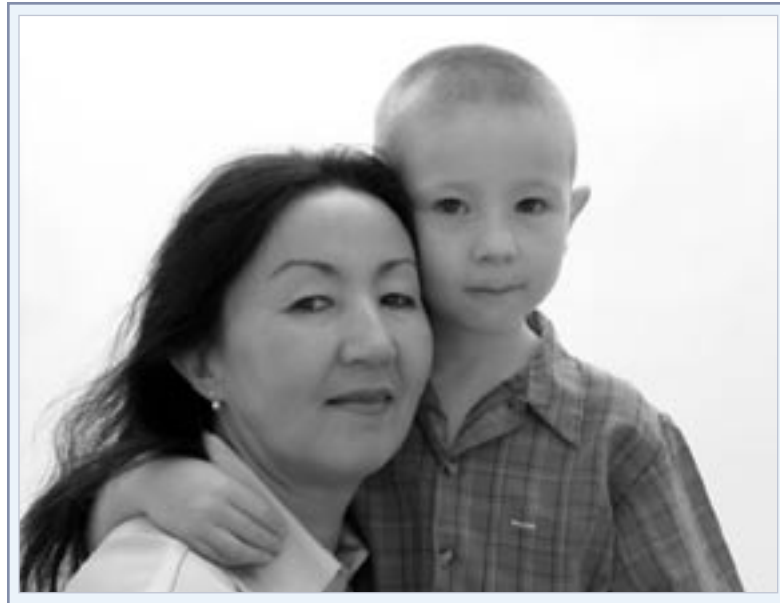
I am the mother of a grown son who had significant behavioral health and other challenges as a youth. I am also a wraparound trainer, trainer of youth and parent mentors, and an active leader in our local parent support organization. It is from these perspectives that I will share my thoughts about the importance of natural supports in the wraparound process.

My adopted son, Jason, presented many challenges. Some professionals thought his biological mother's heroin and cocaine addiction during pregnancy were the cause of his difficult and sometimes frightening behavior. He was given numerous diagnoses: Conduct Disorder, Bipolar Disorder, PTSD, ADHD, and Oppositional Defiant Disorder.

In 1994, when Jason was 14 years old, he was nearing discharge from residential treatment. A psychiatrist who had evaluated Jason told me he would likely need institutionalization for most of his life. I rejected this prediction and believed there must be a way for Jason to come home and stay in our community.

In the early 1990s, wraparound was in its initial implementation in King County, Washington. I was receiving support from parents involved in a parent organization in our area. One of the local leaders and a professional partnering with the parent organization suggested that a new support- and strength-based approach, wraparound, might be beneficial to Jason and me, since typical professional services had not resulted in sustained improvement in Jason and our family life. I was given a copy of a wraparound training manual, which I read on my own.

I learned that the core of the wraparound process was a child and family team and that the team should include professional service providers as well as natural supports—those individuals in the life of the youth and family who knew them best. I learned that the team's job was to provide support and to develop and implement an individualized and strength-based plan that addressed priority needs.

As I considered the possibility of the wraparound process for Jason and me, I recognized that the prospect of including natural supports on a team was a good "fit" with our family culture. The tradition and culture of our family emphasizes community, i.e., taking care of our own and each other are prominent values of the tradition. I was also raised in a Bible-believing family. Biblical scripture emphasizes supporting one another unconditionally in the community of faith. Involving natural supports on our team was consistent with our values, personal beliefs, and family culture.

I recognized that the idea of organizing natural supports to help Jason and me through the wraparound process felt comfortable, safe, and natural. Who better to provide support

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.rtc.pdx.edu. For reprints or permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

FOCAL POiNT 29

than those individuals whom we trust the most and who know us the best? Natural supports would be there with us over the long haul—professionals turnover and eventually go away—

and natural supports would be more accessible. I could call a neighbor or friend at 2 a.m. and know that they'd be there; not so with Jason's therapist.

I decided to conduct our own wraparound process. I convened and facilitated our own child and family wraparound team. Our initial team was composed of Jason's older brother and sister, my best friend from work, a boxing coach and his wife, my parents over long distance, our case manager, Jason's therapist, and a teacher. Later a neighbor couple joined the team along with Jason's friend Peter and his mother. All of these people already knew us, and knew our family's story; each person brought an ability, a strength to match a specific need. The boxing coach, for example, used his skills to teach Jason how to regulate his emotions, and a neighbor, who had

gotten to know Jason through shared interests in REI (A Seattle-based outdoor equipment company), could defuse his rages by simply coming to the door when I called for help. Jason's older brother—his BIG older brother, all of 6'3" and 240 pounds—also helped interrupt disruptive behavior, while Jason's older sister and her husband provided respite care.

Though there were many ups and downs, our team showed us persistent commitment, gave us much needed emotional and tangible support, and came up with many creative ideas we would have never thought of alone. One creative idea came from our neighbors. After we'd agreed that they would come over to my house to help calm Jason, we needed a reliable, quiet way to signal that help was needed. They found a solution: when we needed help, I would flick on Christmas lights in our kitchen windows (a porch light wouldn't serve the same purpose, and our porch was not visible from their home in any case). Surprising emotional support came

from an extended family member who organized an impromptu barbeque for me to relieve the unrelenting tension from one of Jason's frequent 'runs.' This simple act of celebrating as family and friends, rather than being consumed by worry and caught up in the 'drama' of my son's behavior, gave me a completely new perspective.

In the years since as a wraparound trainer, trainer of youth and parent mentors, parent partner, and as an active leader in our local parent support organization, I have been involved with many other youth and their families who were facing daunting challenges. My experiences with these families have validated over and over again the wisdom and importance of helping families to identify, mobilize and build sources of natural support. Natural support is suitable for the culture of most families as well as essential to achieving and sustaining functional outcomes.

Postscript

Jason is 25 now. His life is not perfect. He lives on his own. He lives in the community and we continue to have an important relationship with each other.

Jeanette Barnes is a Family Treatment Court Specialist with King County Superior Court, a Wraparound Trainer, Parent and Youth Mentor Trainer, and a Parent Organization Leader for A Village Project.

This article was written by Greg S. Dalder and Lyn Gordon, based on an interview with Jeanette Barnes.

SELECTED PUBLICATIONS ORDER FORM

This order form lists selected publications only. To order, use this order form, visit our web site, or contact the Publications Coordinator. Email: rtcpubs@pdx.edu; Phone: 503.725.4175; Fax: 503.725.4180. For a complete list of publications, visit our web site at www.rtc.pdx.edu/pgPublications.php or contact the Publications Coordinator. Publications (up to 5 copies) are free of charge. If more than 5 copies are needed, or if you need a publication or product in an alternative format, please contact the Publications Coordinator. We want to make sure our publications are available to all who want them.

Publications with this symbol (⌂) are available for free download from our web site.

Publications with this symbol (◉) are available on the "Select RTC Publications" CD-ROM.

SELECT RTC PUBLICATIONS CD

☐ The CD-ROM contains:
- 11 volumes of Conference Proceedings (including 2004)
- 117 Data Trends (through May 2005)
- 14 of our most recent and popular issues of **FOCAL POiNT**, as well as
- Eight monographs and reports

FOCAL POINT

Our most recent and popular issues:
(back issues are free upon request)

☐ RESILIENCE AND RECOVERY. 2005, 19(1), Summer.

☐ PARTNERING WITH FAMILIES. 2004, 18(1), Summer. ⌂◉

☐ QUALITY AND FIDELITY IN WRAPAROUND. 2003, 17(2), Fall.⌂◉

* CULTURAL COMPETENCE, STRENGTHS AND OUTCOMES. 2003, 17(1), Summer. ⌂◉

☐ ASSESSING AND ADDRESSING CULTURAL COMPETENCE. 2002, 16(2), Fall.⌂◉

☐ BUILDING ON STRENGTHS IN COMMUNITY SETTINGS. 2002, 16(1), Spring.⌂◉

☐ TRANSITIONS FOR CHILDREN WITH EMOTIONAL AND BEHAVIORAL CHALLENGES. 2001, 15(1), Spring.⌂◉

JOURNAL ARTICLES

☐ QUALITY AND INDIVIDUALIZATION IN WRAPAROUND TEAM PLANNING. 2005. *Journal of Child & Family Studies, 14*(2).

☐ TRANSFORMING MENTAL HEALTH CARE FOR CHILDREN AND THEIR FAMILIES. 2005. *American Psychologist, 60*(6).

☐ PRESERVING FAMILY BONDS: EXAMINING PARENT PERSPECTIVES IN THE LIGHT OF PRACTICE STANDARDS FOR OUT-OF-HOME TREATMENT. 2005. *American Journal of Orthopsychiatry, 75*(4).

☐ PRACTICE AND PROCESS IN WRAPAROUND TEAMWORK. 2004. *Journal of Emotional and Behavioral Disorders, 12*(3).

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

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

BUILDING ON FAMILY STRENGTHS CONFERENCE PROCEEDINGS

(includes presentation summaries)

*2004 Keynote, Jane Knitzer. ⌂◉

*2003 Keynote, John Vandenberg.⌂◉

*2002 Keynote, Terry Cross. ⌂◉

☐ **2001** Keynote, Carol Spigner. ⌂◉

☐ **2000** Keynote, Nirbhay Singh. ⌂◉

☐ **1999** Keynote, Beth Harry. ⌂◉

*available on CD and online only

REPORTS

❒ MANAGEMENT STRATEGIES FOR POSITIVE MENTAL HEALTH OUTCOMES: WHAT EARLY CHILDHOOD ADMINISTRATORS NEED TO KNOW. 2004.

❒ FAMILIES IN THE WORLD OF EVALUATION: THE EVALUATION OF THE NATIONAL FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH COURSE I, "HOW TO UNDERSTAND EVALUATION." 2003.

❒ IMPLEMENTING HIGH-QUALITY COLLABORATIVE INDIVIDUALIZED SERVICE/SUPPORT PLANNING: NECESSARY CONDITIONS. 2003.

❒ SETTING THE PACE: MODEL INCLUSIVE CHILD CARE CENTERS SERVING FAMILIES OF CHILDREN WITH EMOTIONAL OR BEHAVIORAL CHALLENGES. EXECUTIVE SUMMARY. 2003.

❒ MENTAL HEALTH CONSULTATION IN HEAD START: SELECTED NATIONAL FINDINGS. 2003.

❒ INCLUSION OF CHILDREN WITH EMOTIONAL OR BEHAVIORAL CHALLENGES IN CHILD CARE SETTINGS: AN OBSERVATIONAL STUDY. 2002.

ORDER FORM/MAILING LIST

Online ordering now available! www.rtc.pdx.edu (click on "Publications" and follow the instructions)

❒ Please send me the publications checked. (For more than 5 copies, shipping may apply. Contact the publications coordinator at rtcpubs@pdx.edu for exact amount.)

❒ Send **FOCAL POiNT** Back Issues Order Form.

CHECKS (if applicable) PAYABLE TO: PORTLAND STATE UNIVERSITY
MAIL TO: Publications Coordinator, Research & Training Center
Portland State University, PO Box 751, Portland, OR 97207-0751

Phone: 503.725.4175, Fax: 503.725.4180, Email: rtcpubs@pdx.edu
Our federal identification number is 93-6001786. Please allow 2 to 3 weeks for delivery.
Contact Publications Coordinator for rush orders.