THERAPEUTIC CASE ADVOCACY
A Model for Interagency
Collaboration in Serving
Emotionally Handicapped Children
and Their Families

by
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Introduction

The phrase Therapeutic Case Advocacy was first used by Jane Knitzer in her seminal monograph, Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services (Knitzer, 1982). The purpose of that work was to assess the adequacy of children's mental health services nationally. In the course of her research, she and her assistant, Lynn Olson, visited many programs in operation throughout the United States. Typically, the programs provided either 24-hour residential treatment, partial day treatment and education, or some form of office-based ("outpatient") therapy. Some, of course, provided combinations of all three.

She noted that few programs attempted to combine "traditional clinical sensitivity and expertise" with a pattern of reaching "beyond the therapist's office to provide case advocacy for children and families caught between numerous caring systems and help families with needs like food, child care, and shelter" (Knitzer, 1982:17).

These observations prompted Knitzer to recommend the development, formal recognition, and funding of a category of mental health care that she designated Therapeutic Case Advocacy: a service that would offer children and their families, "a spokesperson to help work with various agencies and get needed services delivered in an appropriate, coordinated, and sensitive fashion" (Knitzer, 1982:16).

This kind of advocacy goes beyond traditional case advocacy, which does not require special clinical sophistication or sensitivity by the advocate. And it is more than case management, because it requires knowing not only what services are available, but also how to work with the various systems involved to ensure that quality services are provided (Knitzer, 1982:17).

Knitzer did not elaborate on her recommendation except to note that the only program in her survey where the idea had been implemented had been forced to close down due to cutbacks in funding. The purposes of this paper, then, are to discuss why there continues to be a need for a new conceptualization of children's mental health services, propose a theoretical underpinning for Therapeutic Case Advocacy, describe its component parts, and suggest ways in which it could be implemented.

The Problem

Children with emotional disabilities are singled out for concern periodically because of the perception that they are either not recognized and served, or served inadequately by one or more of the four major child caring systems: education, child welfare, juvenile justice, and mental health. Knitzer's monograph is the most recent plea for a change in both policies and practices, but it follows those of the President's Commission on Mental Health (1978) and the Joint Commission on the Mental Health of Children (1969) published during earlier periods of concern for the plight of these children and their families.

Ironically, when children with emotional disabilities do receive special attention from these systems, the services are criticized for being segregating, isolating, fragmented, and incomplete. Segregating because they group emotionally disabled children together apart from children not similarly disabled; isolating because they remove the child from his or her family and school to a treatment facility or center; fragmented because many of these children receive services from two or more agencies that, it is alleged, do not coordinate their activities with one another; and incomplete because the services provided are only those that a given agency has to offer, rather than those that the child and family need. More recently, these services are being criticized also for failure to include the children's parents as partners in assessing, planning, and providing treatment and services (Friesen, Griesbach, Jacobs, Katz-Leavy and Olson, 1988).

The resurgence of concern for children's mental health services is due to several factors. Most obviously, it is fueled by the Child and Adolescent Service System Program initiated by the National Institute of Mental Health in 1984 (Lourie and Katz-Leavy, 1984). More fundamentally, however, a large scale secular change appears to have taken place between 1966 and 1981 in the organized provision of children's services generally and in children's mental health services in particular.

In general, the deinstitutionalization of children's services resulted in the replacement of larger, geographically remote, publicly operated facilities by a proliferation of smaller, privately operated facilities located in or near population centers (Young, Dore and Pappenfort, 1989). Within the field of children's mental health services specifically, this general trend was accompanied by a marked increase in the numbers of children in psychiatric
facilities and residential treatment centers and a significant decline in their average length of stay (Young, Dore and Pappenfort, 1988).

One result of these changes was an increase in the demand for out-client mental health services. Unfortunately, there was no federal investment in children's mental health services analogous to that made in adult mental health services through the Community Support Program. In fact, there is some evidence suggesting that during the early 1980's a retrenchment in funding for children's mental health services took place, that is, at precisely the time when they should have been expanding to meet the increased demand for them (Young, 1984).

Another less well documented but nonetheless visible effect of these trends was that they changed the nature of the demand for children's mental health services. More children with more severely incapacitating emotional disabilities were in need of services. Typically, their mental health needs were embedded in other needs of their own (educational, vocational, recreational) and of their parents (housing, employment, medical care, child care, and marital satisfaction). Not infrequently both the children and their parents reported difficulties related to family violence, sexual abuse, and abuse of drugs and/or alcohol. Increasingly, children with "mental health service needs" become prominent in protective service caseloads, foster family care placements, juvenile justice facilities, and special education classrooms.

Office-based, insight-oriented treatment approaches for such children and their parents seemed questionable at best, although clearly some kind of help was needed. The various family therapies appeared to hold some promise but typically did not address the pressing concerns in the family's environment. And behavioral approaches alone often foundered on the family's difficulties in maintaining a monitoring and reinforcement regimen in the midst of their already overwhelming lives.

Rutter has already summarized how our thinking about children's mental health needs has changed as we have learned more about the impact of environmental conditions on emotional growth and development (Rutter, 1982). What remains is to develop therapeutic approaches and interventions that are equal to the complexities of peoples lives as they are known to us now. Therapeutic Case Advocacy is one such attempt.

As described below, Therapeutic Case Advocacy is a model for helping that is designed to produce services that are normalizing, socializing, coordinated, comprehensive, and sensitive to parents as both partners and beneficiaries. It seeks to do so by creating an individualized system of care surrounding each child and family. The process for doing so typically involves the child and parents as partners in the process; a sustained commitment on the part of the Therapeutic Case Advocate's agency; and the collaboration of two or more agencies in a given community. In practical terms, then, it is three models in one: a practice model, an organizational change model, and a model of interagency collaboration.

**The Model**

Therapeutic Case Advocacy is an approach that attempts to change things in or about the environment so as to accommodate the child's disability. To describe the model here, we set forth its goals, the perspective on emotional disturbances that the model presumes, the component skills necessary to implement the model, the three levels at which they are to be applied, and the importance of establishing a system of care for the long term success of the model's application.

**Goals**

The primary goal of Therapeutic Case Advocacy is to organize, or modify the behavior settings that constitute a child's environment such that together they function as a system of care. This is accomplished through the instrumental goals of modifying the expectations, instructions, supports, and rewards in each behavior setting so that they are attuned to the child's capacities to perform there. These goals reflect the revised conception of emotional disturbances in children to be discussed below.

**Emotional Disturbances as Handicaps**

As Lane and Schwartz (1987: 133) have noted, "emotion is a complex phenomenon which is only incompletely understood." Emotion is not synonymous with affect. Following Basch (1976), we understand affect as genetically programmed sensorimotor response patterns and emotion as "subjectively experienced states...always related to a concept of self vis-a-vis some particular situation" (Basch, 1976:768). Affects are expressive reactions
Disturbances of emotions can occur in several ways. They can be disturbed by some self-shattering event such as physical or sexual assault, death of a loved one, failure in school, sudden unemployment, loss of a limb, or atrophy of some central physical or mental ability. Another way the emotions can be disturbed is through prolonged, pervasive failure of the human environment to understand, value, and nurture the child, including especially the emotions as they develop. Children raised in families organized around an adult alcoholic member, for example, have reported the effects of such prolonged, pervasive experience on their emotions and, not surprisingly, on their sense of themselves. In a different way, children born with temperaments that are difficult—either because their temperaments are different than expected or because of neurological impairment—may suffer profound disturbances of their emotions by virtue of the dissonance between their capacities and their environment's expectations (Chess and Thomas, 1984:21; Palumbo and Feigon, 1984).

What seems to be critical in determining whether these various disabilities become handicaps or not is the response of the environment. If the environment can adjust its expectations, instructions, supports, and rewards to the individual's capabilities, then the disability(ies) need not be a handicap in that environment. If the environment cannot make such adjustments, then the environment handicaps the individual and may, in the process, reinforce the disturbance of the emotions in the way we have described.

This view of disabilities and handicaps is consistent with the one promulgated by the World Health Organization (1980). Therapeutic Case Advocacy views what typically are considered emotional disturbances as emotional disabilities—affective and behavioral reactions to unmanageable discrepancies between what the environment expects and what the child is capable of doing in that environment (Chess and Thomas, 1984:21). Children with special needs require special environments. If the environment does not adjust, however, then the child's ability to perform is handicapped by the environment.

This implies that efforts to help emotionally handicapped children might be more productive if, instead of focusing on the child-as-problem, they focused on the environment-as-solution. This is what Therapeutic Case Advocacy attempts to do: focus on the various contexts or behavior settings that make up the child's environment; examine them for the structure of expectations, instructions, supports, and rewards they provide; and create, restore, or enhance them so as to be special environments or, in the language of the model, systems of care. Therapeutic Case Advocacy, then, is a model for systematically modifying the constellation of expectations, instructions, supports, and rewards of each setting within the child's environment such that the interaction between the child and the adults in each setting is less disturbing for the child emotionally and more conducive to his/her acquisition of competence in that setting.

Components

The component skills of Therapeutic Case Advocacy are case advocacy, interpersonal interventions, and care management. These skills are used to bring about and then maintain changes in the structure of expectations, instructions, supports, and rewards in the child's environment. In this model they are applied at each of three levels of activity: that of the child and family, the worker's own agency (the organizational level), and the level of interagency collaboration.

What follows is a brief discussion of the application of the component skills of the model to each of the three levels of intervention: direct work with the child and family, work at the organizational level, and work at the interagency level.

Direct Work with Child and Family

At the case level, or that of direct work with the child and family, interpersonal interventions may be necessary to help the parents overcome feelings of frustration, failure, hopelessness, anger and resentment in order to think through the kinds of resources they would like to have for their child and themselves and whether any of them might be available through their own "personal community" of friends, neighbors, and relatives. Direct personal
intervention may be necessary with the child as well in order to help him or her overcome feelings of distrust, fear, resentment, and anxiety and to become an active participant in designing the components for the system of care.

Some advocacy on behalf of the child vis-a-vis the parents and vice versa should be anticipated as a normal need. Emotionally disabled children and their parents are often sources of frustration, disappointment, and anger for each other. Speaking for each to the other may be an initial step needed to set the stage for them to work together. More typically, however, the Therapeutic Case Advocate will be speaking for and with both child and parents to representatives from other organizations such as schools, mental health clinics, churches, juvenile courts, and recreational programs. The purpose of the advocacy is to persuade other people to help out in a collaborative effort to, design, develop and sustain a system of care for the child and his/her family.²

Care management at the case level means repeated monitoring and modification of the system of care. This process is by definition pluralistic-meaning that not only the child but also the child's parents, other family members, and each of the participants from both formal and personal support networks meet periodically with the Therapeutic Case Advocate and each other to assess the adequacy of the system of care. Inevitably, the configuration of the system of care will change over time as the child's and other family members' needs change.

In applying case advocacy, interpersonal interventions and care management to direct work with the child and family, there are four characteristics of each behavior setting that must be examined for their adequacy. They are the expectations, instructions, supports, and rewards that those in charge of the setting have for children in that setting. If these are not compatible with the child's own ambitions, goals, given talents, and evolving skills in that context (Kohut, 1977), then the setting is contributing to the child's emotional handicap. On the other hand, if the setting calibrates its expectations to match the child's ambitions, provides support for the child to attain his or her goals, includes instructions commensurate with the child's given talents and skill level, and rewards each genuine attempt to improve or acquire additional skills, then the setting is modifying its characteristics in ways that make it more manageable for the child. To the extent that these modifications help the child acquire greater competence in the setting and bolster his/her sense of self as a vigorous and productive center of initiative, the setting becomes a less disturbing one emotionally.

The Organizational Level

At the organizational level, case advocacy skills may be used in seeking exceptions to certain administrative rules and regulations in order to have the resources necessary to support the system of care. For example, one worker appealed her agency's upper limit for foster care payments so that a foster father could spend more time at home in the late afternoon helping the emotionally disabled adolescent with his school work. The worker's success in doing so was based in part on her ability to demonstrate that without the increase in the foster care payment the foster father could not take the time off from work, and the child would have had to attend a day treatment program at much greater expense to her agency.

Some of the interpersonal intervention skills also, can be useful at the organizational level as well. In the case example just described, the worker used the meeting with the TCA Unit to identify her own frustration with the agency's policy and the cumbersome appeal process. The group helped her redirect that energy into formulating a strategy for appeal. She was able then to elicit her supervisor's support by recognizing his personal reluctance to "rock the boat" and present the appeal herself rather than insist that he do it.

The application of care management skills at the organizational level requires a commitment to the system of care concept and a tolerance for the fact that things change over time. The system of care concept means that several people within and outside the organization have to meet together periodically to coordinate their activities with each other, review the progress of their efforts against their initial expectations, and change what they do in response to the changing needs of the child and family.

The mechanics of care management—multiple telephone calls to arrange mutually convenient meeting times, location of a suitable and easily accessible space to meet, preparation of progress reports—can become tedious and burdensome if they are viewed as just paperwork. Involving other members of the organization in this process is important, particularly in larger agencies. By doing so, the caring aspects of the enterprise are kept primary and this, in turn, makes the organization's response to unanticipated crises a more human one.
The Interagency Level

Once a worker has engaged the child and family in a process of defining the elements needed in a system of care for them, and developed the sanctioned support of his/her work group and own agency, workers from other agencies can be engaged. Typically they are delighted that someone is willing to take responsibility for organizing, orchestrating, and coordinating their efforts. Collaboration is a welcomed solution to the burden of feeling solely responsible for a complex situation without adequate resources. Most staff working directly with emotionally disabled children and their families know only too well that what their clients need exceeds what their agency provides.

For the worker attempting to initiate interagency collaboration, the three components of the model can be applied at this level as well. Both case advocacy and interpersonal intervention skills may help persuade supervisors and/or directors at other agencies to permit their staff members' participation. The initiating worker may discover that there is a price for participation: a telephone call, a meeting and perhaps some written assurance that this is an activity approved by the initiating worker's agency with the intent of minimizing duplication and counterproductive overlap of services.

Some care management skills may be applicable at the interagency level as well in order to help sustain the system of care and modify it as needed. That is, once some form of interagency collaboration is set in motion—even an agreement to meet again to review a proposed collaborative service plan—the initiating worker may use the care management skills to "take the pulse" of participation. Examples are inquiring directly as to clarity of roles, actual demand of time devoted to work generated by the collaborative effort, and what unanticipated obstacles may have arisen. In effect, the care management component of Therapeutic Case Advocacy extends beyond the child and family to those providing care as well.

Summary

Therapeutic Case Advocacy, a multi-level model for interagency collaboration, has been presented here as an evolving innovation in the provision of services and treatment for children with emotional disabilities and their families (Thomas, 1985). In discussing its assumptions regarding the nature of emotional disturbances, the suggestion was made that disturbances of the emotions become handicaps whenever environments fail to adjust their expectations, instructions, supports, and rewards to the capabilities of the child. The components of the model were described as means for modifying these characteristics of environments. The goal of the model is to effect such modifications in the several behavior settings that make up a child's environment. To do so typically requires the coordinated efforts of both formal organizations and natural support networks. When this is achieved, an individualized system of care results that surrounds and supports both the child and his family.

The complexity of the model is due in part to its attempt to address the complexity of clients' lives and in part to overcome the unintended fragmentation of services provided by two or more agencies or programs. It is presented here as an innovation in human services delivery because of its explicit emphasis on the creation of "prosthetic environments" (Weiner, Brok and Snadowsky, 1978) for children and their families rather than on the corrective rehabilitation of individual children to fit their environments.

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2. While we talk most often about the "child and his parents" we mean to include other family members also, as both architects and beneficiaries of the system of care. So, it may happen that interpersonal interventions and case advocacy may be invoked for use with them as well. Day care for younger siblings, after school recreational programming for older siblings, service center involvement for an elderly grandparent are all examples of components to a system of care that would make daily life more manageable for both the emotionally disabled child and his/her parents. Explicit reference to other family members in the discussion to follow, however, is omitted for the sake of brevity.
REFERENCES


