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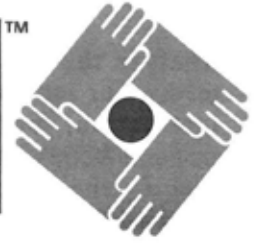
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FOCAL POINT™



Therapeutic Case Advocacy: A Summary

Therapeutic Case Advocacy (TCA) is one approach to helping emotionally handicapped children and their families. It is described here as a multi-level model to improve services for this population for two reasons. First, the approach typically requires planned, coordinated activity on three levels: the child and family, the lead organization providing services, and interagency collaboration. Second, the word "model" conveys the idea of what the real thing might look like.

The model is a preliminary pattern, a plan for guiding the actual process of helping emotionally handicapped children and their families. It is not a recipe. Any actual process of helping guided by this model may vary from that described here according to individual child and family need, organizational capacity, and community context. Nevertheless, there are three core components of this model for helping that, if adopted, would improve services for emotionally handicapped children and their families.

The first is the use of case advocacy to create an individualized system of care for each emotionally handicapped child and his or her family. The second is the use of a set of interpersonal interventions in order to engage the child and family in the process of designing, constructing and maintaining a system of care; persuade others in their organizations to approve and finance certain components of the system of care; and facilitate the interagency collaboration necessary to coordinate the activities of staff from two or more agencies and integrate them with the efforts of natural helpers in the family's personal community. The third is the application of care management skills to sustain the child and family and, selectively, both the formal and natural helpers contributing to the system of care.

The use of each component is guided by certain principles and requires certain skills listed below.

Component No. 1: Case Advocacy

Principles

1. The primary, over-arching goal is to create a system of care that surrounds and supports the child and family on a daily basis.
2. The "targets" of case advocacy efforts often are people too. Nothing is to be gained by declaring them enemies; advocacy can be partisan without being adversarial.
3. Child and family involvement in all aspects of the advocacy process is essential so that one end result of the advocacy is an enhanced capacity of children and their families to speak for themselves.

Skills: To Be Able To...

1. Identify "target areas" within an ideal system of care.
2. Define the resource development task for each behavior setting encompassed by the system of care.
3. For each behavior setting, locate who could provide alternative instruction, support, and reward for the child and/or family.
4. Acquire the history, if any, of previous interactions between child/family and potential providers.
5. Use the process of assessing the discrepancy between what child/family needs and what is currently provided to forge a personal relationship with the provider.

6. Analyze the "price structure," in personal terms, for mobilizing the modified set of instruction, support, and reward desired in each behavior setting.
7. Specify the basis for having leverage in the situation.
8. Consider the effect of timing on the success of a request to provide (or allow provision of) alternative instruction, support and reward.
9. Formulate and prepare contingency plans in the event that the alternatives provided provoke a crisis between child/family and provider.
10. Propose, persuade, or entice potential provider to try alternative instruction, support, and reward.



Therapeutic Case Advocacy Project staff: (from left) Principal Investigator Tom Young, Project Manager James Mason, Center Associate Katie Yoakum. (Photos by Marilyn McManus.)

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We invite our audience to submit letters and comments.

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Component No. 2: Interpersonal Interventions

Principles

1. The primary, over-arching goal is to engage and sustain the child and family in the process of working out a new accommodation between them and their environment.
2. Interpersonal interventions are carried out in the service of case advocacy and management efforts to establish and maintain a system of care, not vice-versa.
3. The use of interpersonal interventions is not synonymous with providing psychotherapy. These skills are relevant to work with both the official client and with others in the client's environment.

Skills: The Ability To...

1. "Listen with a third ear" for things others would like to talk about but feel they cannot.
2. Absorb verbal abuse and aggression in response to the offer of help.
3. Understand and describe one's own feelings directly.
4. Acquire an empathic comprehension of another person's difficulties and convey that in both words and gestures.
5. Translate another person's psychological needs into plans for enhancing, restructuring, or otherwise modifying his/her environment's provision of instruction, support and reward.
6. Clarify one's own role and the purpose of the relationship, namely, to design and establish a system of care.
7. Break a larger problem or difficulty down into manageable but meaningful tasks to be pursued sequentially.
8. Encourage repeated feedback on both helpfulness of the relationship and the process of accomplishing tasks.
9. Anticipate the demands that new accommodations among children, parents, and their environments will make upon each other and devise opportunities for respite and reward as part of the process of constructing the system of care.
10. Set enforceable limits on the behavioral expression of anxiety, impatience, frustration, or anger and negotiate the consequences for when those limits are exceeded.

Component No. 3: Care Management

Principles

1. The primary over-arching goal is to coordinate, integrate and maintain a network of services that together with natural helping sources establish and support a functioning balance between child, family and their environment.
2. The guiding idea behind care management is the routinization of an individualized system of care that remains flexible and adaptive over time as needs and circumstances change. Accountability, therefore, is ultimately to the child and family.
3. The process of care management is more important than its product. By definition, the process is individualized, interactive, and pluralistic.

Skills: The Ability To...

1. Assemble the people involved in each of the child/family's behavior settings to design the individualized system of care and each person's contribution (the TCA service team).
2. Involve the child and family in the process and verify mutual understandings and expectations.
3. Define goals for each component within the system of care against which accomplishments can be assessed at a future point in time.
4. Select a care manager from among the members of the TCA service team.
5. Review plans for modifying the provision of instruction, support, and reward in each behavior setting and establish a time/task chart that records who has planned to do what and by when.
6. Schedule meeting times and places for subsequent reviews and modifications of the planned provision of alternative instructions, supports, and rewards.
7. Establish measures of satisfaction with the system of care to be completed by the child, the parents, and each of the constituent members of the system of care.
8. Devise a system of 24-hour response capability for crisis intervention, preferably one that rotates responsibility among team members.

9. Create support systems for the providers in the system of care.
10. Formally evaluate the adequacy of the system of care from both the consumers' and providers' perspectives.

Assumptions

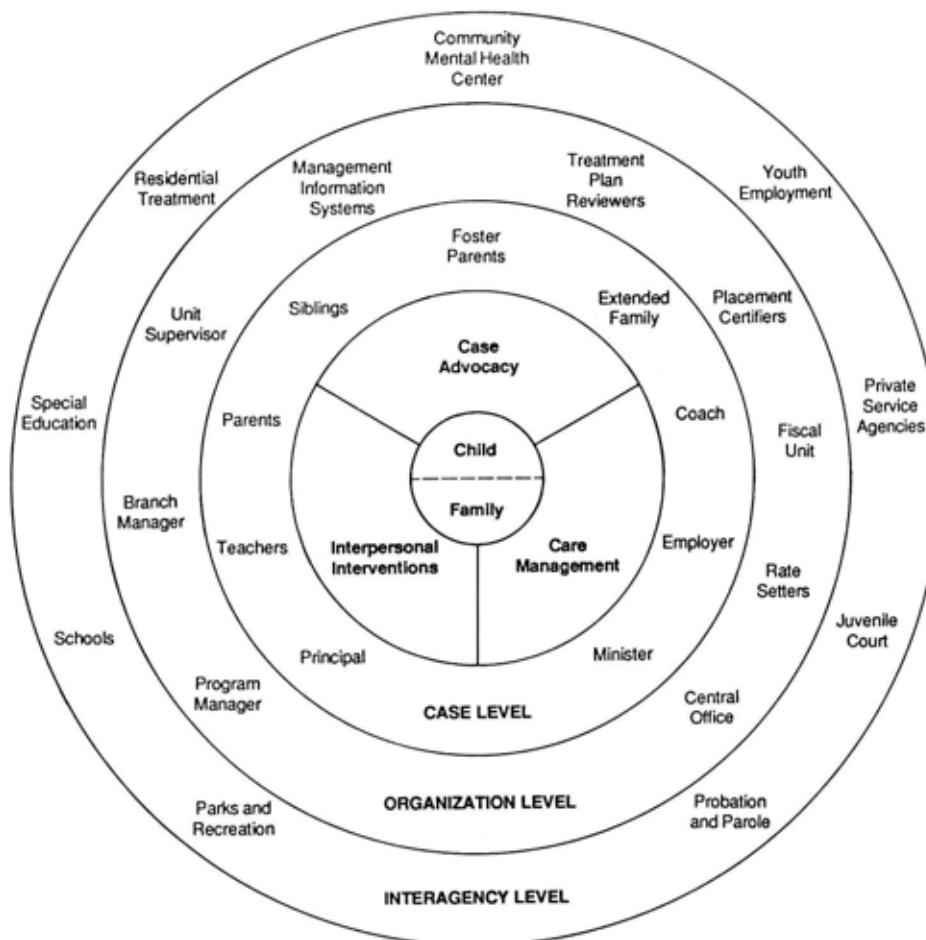
Two fundamental, and potentially controversial, assumptions of the model are that:

- emotional handicaps are affective and behavioral reactions to unmanageable discrepancies between what a child is capable of and what his or her environment expects and provides in the form of instruction, support, and reward; and
- to be effective, the system of care must include both services from formal organizations and help from natural support networks or personal communities.

The Role of Treatment

In attempting to construct and sustain individualized systems of care, Therapeutic Case Advocacy seeks to modify environments -- creating special environments for children with special needs. Therapy or mental health treatment is but one modification of a child and family's environment. What is therapeutic about Therapeutic Case Advocacy is the recalibration of expectations, instruction, support, and reward in each sector of the child's environment encompassed by the system of care. These changes make the child's interaction with it more manageable; and that is intrinsically therapeutic.

Some people object to this point of view, preferring instead to make mental health treatment more central. Our view is that while it is important, it is not central unless the therapist is reorganizing the interaction between the child and his or her environment. It is precisely because those interactions are so difficult to



Therapeutic Case Advocacy:

A Multi-level Model for Interagency Collaboration to Improve Services for Emotionally Handicapped Children and Their Families

change that this model is a multi-level model. In many situations, only concurrent interventions at all three levels can mobilize the resources necessary to effect such changes.

Comprehending the model is made difficult by its complexity. In part, this is because in practical terms it is three models in one. It is a *practice model* for working directly with emotionally handicapped children and their families. It is also an *organizational change model* for managing the conflict within organizations that is generated by the practice model. And it is an *interagency collaboration model* for implementing (creating and sustaining) the systems of care for individual children and their families. The diagram is an attempt to describe the model's three levels in one picture.

What this diagram still does not depict adequately is how actions taken at one level have important effects on the other two levels. For example, when a worker using this model unites his agency and several others with the child's parents, extended family, and church to design and implement a system of care, the worker is engaged simultaneously at all three levels. The initiative of his agency is an incentive for other agencies to collaborate, as is the participation of representatives from the child's personal community. Simultaneously, the resources made available through the interagency level provide both incentive and enhanced capacity for those

at the case level to attempt modifications in the instructions, supports, and rewards they bring to the child's interaction with their environment.

Conclusion

This model is still in the process of development. We do not claim to be its sole inventors. Many others in the field have provided us with ideas, clarifying suggestions, and encouragement to proceed further in its development, demonstration, and evaluation. At the present time, therefore, our efforts are directed at the preparation of a training guide and an evaluation procedure. These will allow us to pilot test the model's introduction into a community and document its effects.

We continue to learn of others' efforts that are similar or at least compatible with ours. We are most eager to pursue the possibility of arranging a national conference at which those working in these ways on behalf of emotionally handicapped children and their families could meet and share their experiences. If you wish to participate in such a conference or to obtain additional information about Therapeutic Case Advocacy, please address your inquiries to us c/o Marilyn C. McManus, Resource Services Coordinator.

Thomas M. Young, Ph.D., Principal Investigator, Therapeutic Case Advocacy.

Case Management or Care Management?

Some of our colleagues have asked whether Therapeutic Case Advocacy is not just a form of intensive case management. Others have questioned our use of the phrase care management instead of the more familiar case management. We would like to take this opportunity to clarify our own point of view on the issues raised by these questions.

Both questions require a generally accepted definition of case management from which to proceed. That, of course, is part of the problem. As Weil, Karls, and Associates have said in *Case Management for Human Service Practice*, "case management is a developing method of service coordination and accountability in the human services." (Weil, et. al. 1985:1) Recognizing the diversity of conceptions inherent in a developing concept, they supply their own definition.

"Case management is a set of logical steps and a process of interaction within a service network which assure that a client receives needed services in a supportive, effective, efficient, and cost effective manner." (Weil, et. al. 1985:2)

They note that "throughout its history, case management has had dual sets of goals -- one set related to service quality, effectiveness, and service coordination and the other related to goals of accountability and cost effective use of resources." (Weil et. al. 1985:2)

Care management is very much "a set of logical steps and a process of interaction within a service network" with goals of maintaining the provision of effective, coordinated services. But it is not concerned with efficiency or cost effectiveness. It is concerned only with the qualitative response of the system of care created

through use of the Therapeutic Case Advocacy approach. Nor is it concerned with accountability, except to the child and his or her parents. Finally, unlike case management, care management includes persons in the informal or personal community of the child and family.

We think these are very important differences. Too many applications of the case management concept have been "geared to the needs of the service network" rather than to the individual needs of clients and the development of resources to meet those needs. The planned inclusion of the child and family's personal community is part of Therapeutic Case Advocacy's view that the system of care will be managed best by the people who care the most. Together, we think these two differences shift the focus in a fundamental way from the management of a case to the continuation of personal care. As the late Nicholas Hobbs put it: "No one wants to be a 'case', and no one wants to be managed." (Hobbs, 1979:30)

Modrcin, Rapp, and Chamberlain, in their work to develop a model of case management for use with (adult) psychiatric disabled populations, outlined the many roles case managers were expected to fill and noted that they varied according to which model for case management was being used. They observed that the intensity of the case management process increases as the case manager assumes a greater number of roles. (Modrcin, et. al. 1985:35-40) In this sense, Therapeutic Case Advocacy certainly is intensive, requiring a worker to fill the roles of counselor, advocate, broker, manager, coordinator, spokesperson, and (at times) therapist. But, obviously, there is much more to Therapeutic Case Advocacy than managing cases. The organizational level of the model, particularly, adds a new dimension to most other models of case management.

Modrcin, et. al. also reviewed case management research. They found "substantial disagreement over the best way to operationalize case management"; "no conclusive evidence that case management significantly improves care" for the chronically mentally disabled (adult) population; and "experimental studies comparing models of case management non-existent." (1985:55-57)

More importantly, perhaps, for this discussion are the findings they culled from descriptive studies of case managers in mental health settings. These findings suggest that the case managers preferred not to be identified as

such, spent most of their direct client time engaged in counseling or psychotherapy, and underutilized community resources on behalf of their clients. (1985:45-46)

We think the research suggests that, at least in mental health settings, the therapist-case manager dilemma first articulated by Lamb (1980) remains unresolved. And further, both the substantive content of case management and its efficacy remain undetermined. For these and other reasons, we have attempted to develop a model of helping, Therapeutic Case Advocacy, with a distinct role for care management within it.

Therapeutic Case Advocacy views the coordination of formal services and natural helping resources as central rather than auxiliary. Its foundation is the use of case advocacy at each of the three levels described in the lead article and its goal is to modify those interactions between the child and his or her environment that are handicapping. Instead of wrapping auxiliary services around mental health treatment, Therapeutic Case Advocacy sees the system of care that such services make possible as intrinsically therapeutic. In these ways, Therapeutic Case Advocacy is of a different order than any model of intensive case management.

Thomas M. Young, Ph.D., Principal Investigator, Therapeutic Case Advocacy

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Interagency Collaborative Efforts

In the last issue of *Focal Point* we asked for information regarding programs using inter-agency collaboration to establish comprehensive systems of care for seriously emotionally handicapped children and their families. The following is a summary of the responses we received.

LANE COUNTY DIRECTION SERVICE
Eugene, Oregon
Marshall Peter, Executive Director

The agency addresses clients' needs by arranging coordinated interdisciplinary/inter-agency service planning on both a long range and short term basis, mediating between parents and professionals and providing materials for training workshops.

LANE COUNTY JUVENILE DEPARTMENT
Eugene, Oregon
Kevin Collins, Program Manager

Many juvenile offenders are considered behaviorally disordered or emotionally disturbed. Juvenile department staff make daily contact with clients' family, school, work, recreational and other settings to monitor client performance and environmental support. Their interagency teams have included judges, police officers, probation and parole officers, training school personnel, special educators, mental health providers, child welfare workers, recreation workers, and alcohol and drug treatment staff.

**WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH/
OFFICE OF BEHAVIORAL HEALTH SERVICES/ CHILD AND
ADOLESCENT SERVICE SYSTEM PROGRAM**
Charleston, West Virginia
Susan Mann, Program Coordinator

This new organization is planning a statewide conference designed to generate a sense of interagency ownership of the problems associated with serving children with serious emotional handicaps. They may develop a task force comprised of conference participants who will outline interagency protocol recommendations.

**MAINE DEPARTMENT OF MENTAL HEALTH AND MENTAL
RETARDATION/ BUREAU OF CHILDREN WITH SPECIAL
NEEDS/ CHILD AND ADOLESCENT SERVICE SYSTEM
PROJECT**

Augusta, Maine
James B. Harrod, Ph.D., Technical Assistance Coordinator

The project has three sites (Bangor, Portland, and Saco) and is the central referral point for parents, mental health professionals, educators, and others who serve children with serious emotional handicaps. The group works closely with several service systems, including education, mental health, child welfare, and juvenile justice. Services are tailored to the strengths and needs of the child. Transition services are coordinated and parents are assisted with education, self-help, and other support activities.

**CONTINUUM OF CARE FOR EMOTIONALLY DISTURBED
CHILDREN**
Columbia, South Carolina
Jeanne Rivard, Coordinator of Program and Staff Development

This small state agency's mission is to ensure continuing delivery of appropriate services to seriously emotionally disturbed children whose needs are not met by existing services and programs. Each child is assigned a service coordinator who provides case advocacy and management services.

**THERAPEUTIC IN-HOME EMERGENCY SERVICES: A
PROGRAM OF THE CRISIS INTERVENTION CENTER OF
STARK COUNTY AND CASSP**
Canton, Ohio
Carole Pastore, Program Coordinator

The center offers intensive in-home crisis intervention and family therapy to prevent out-of-home placements. Ongoing services are provided following the period of crisis intervention. Therapists are available 24 hours a day.

**CHILD AND ADOLESCENT SERVICE CENTER DAY
TREATMENT PROGRAM**
Canton, Ohio
Sandra Dragomire, M.A., Associate Director

The program relies upon a multidisciplinary team and an active case management system. Case managers follow-up on recommendations, which may range from community/home visits to contracts with social service systems.

The Personal Community

We all belong to at least one community and many of us belong to several. From our community affiliations we develop relationships with individuals we trust and seek out to help us interpret our experiences in the world. Many families and particularly those with seriously emotionally handicapped children need the support of this kind of community structure to handle the pressures they face. Workers, too, need a source of support and encouragement in serving emotionally handicapped children and their families.

Systems of care can be structured in ways that support both clients and professionals by providing a collaborative environment conducive to addressing the needs and solving the problems encountered by seriously emotionally handicapped children and their families. Such care systems impart a sense of 'community' to their members; that is, a common notion of purpose, belonging, value to the group, and mutual support. In particular, such a system of care will validate the client's (child and family) role in the treatment process, while relieving professionals from the burden of providing service in isolation from other professionals and the family's natural support network. A system of care that supports clients, professionals, and other concerned individuals is what we call a "personal community."

In addition to including individuals important to serving the seriously emotionally handicapped child and family comprehensively, a system of care is a personal community when it encourages the development of supportive relationships among its members and is flexible, dynamic and, at times, even fun. The individuals involved come to recognize their interdependence and how they can function in complementary fashion. As a result, all of its members are empowered and supported in working on behalf of a particular child and family. The personal community is personal in the sense that it pursues *client-specific* needs and goals through social service systems that are essentially impersonal.

Each system of care, then, can be structured to serve as a personal community. It can contain the peers, mentors, friends, and other people we need to generate and maintain focus, values, and goals. For seriously emotionally handicapped children, their families, and their workers this type of system of care envelops them in a climate that supports and empowers them in what tends to be very demanding and often frustrating work.

James L. Mason, Project Manager, Therapeutic Case Advocacy

Process Evaluation of Interagency Collaboration Effort

The Therapeutic Case Advocacy Project (TCA) conducted a process evaluation of an interagency collaboration effort called CAPS, funded by Multnomah County, for the Portland metropolitan area. This undertaking encouraged community mental health centers to work with other child serving agencies in the community to provide comprehensive, integrated services for children and youth with emotional handicaps. TCA staff were involved in the planning and implementation of the CAPS project, as evaluators and consultants. At the end of the project's first year, TCA staff submitted a process evaluation to the County which helped persuade the Multnomah County Board of Commissioners to fund the effort for another year.

The CAPS project model is similar to that

being developed by the Therapeutic Case Advocacy Project, especially in the area of team planning on the case level to develop a system of care for each child. Due to the interest expressed in this local effort to implement interagency collaboration at the practice level, TCA project staff edited the process evaluation for distribution to those in other communities concerned with line level implementation of collaborative efforts. The evaluation report documents the planning process -- its problems, compromises, successes, and pitfalls. The report also includes a description of the team process and recommendations based on both participants' and administrators' observations. To order a copy of this report, see page 11.

Families as Allies Regional Conferences

Strategies to improve and promote collaborative working relationships between professionals and parents of children with serious emotional handicaps were the focus of four Families as Allies conferences held throughout the country during May and June. Equal numbers of parents and professionals met in regional conferences held in Kansas, New York, Alabama and Indiana.

All four regional conferences addressed problems of current service delivery systems for children with emotional handicaps and their families, barriers to collaboration between parents and professionals, and strategies to enhance parent and professional partnerships. Participants in each of the regional conferences attended as members of state delegations composed of parents, policy makers, program administrators, and direct service providers.

Panels of parents and professionals in **Overland Park, Kansas**, described barriers to effective services, and the successes and frustrations in establishing a partnership between parents and professionals. The panel members discussed common problems such as misdiagnosis, the lack of respite care for parents, lack of communication between agencies in planning, problems of transportation, and lack of comprehensive insurance to cover the costs of care and treatment. Panel members emphasized the importance of parent and professional collaboration to enhance parents' roles as sources of information about their children, and fully involve parents as team members in the planning, provision and evaluation of services. Parents were urged to recognize the limitations and constraints experienced by providers, and to become involved in local parent support and advocacy groups to assist in the improvement of services for children with emotional handicaps.

The **Albany, New York** conference opened with a "Challenge to Partnership" by a professional and a parent. Obstacles to parent-professional collaboration were addressed through a psychodrama experience that demonstrated that both parents and professionals experience many of the same frustrations in trying to reach a common goal -- a better, more responsive system of care. The participants then engaged in small group, structured experiences which identified ways parents and professionals can collaborate in effecting change. A panel presentation dis-

cussed the organization of parent support and self-help groups in a variety of settings.

Participants in the **Mobile, Alabama** Families as Allies conference attended a variety of workshops dealing with support groups for parents, special education laws, working with cultural and ethnic minorities, and dealing with multiple systems of care. Plenary session panels spoke to the need for parent-professional collaboration and specific techniques and strategies for creating and nurturing such collaboration. A film festival on the second evening of the conference provided participants an opportunity to view selected films on a variety of issues concerning services to youth and their families, including program examples and topical issues such as AIDS education.

The Families as Allies Conference in **Bloomington, Indiana**, spoke to a wide array of problems and issues faced by those seeking to improve the system of care. Workshop topics included respite care, educational rights, legislative and case advocacy, case management systems, parent support groups, and community advocacy strategies. Keynote speakers discussed the nature of the current crisis in service provision to children with emotional handicaps, the importance of the parent-professional partnership, and some recommended future directions.

State delegations at each of the regional conferences met to identify barriers to collaboration and strategies to promote collaboration within their individual states. Members of each state delegation left the conferences with a plan of action for their state, many of which included proposals to improve coordination of advocacy groups, develop parent support groups, develop parent information packets, and offer state level Families as Allies conferences.

NOTES & COMMENTS

IN MEMORIUM

We were saddened to learn of the death of Art Sands, the administrator of the Kansas Child and Adolescent Mental Health Services Office. We extend our sympathies to his family and friends. In addition to the personal loss to those closest to him, his death is a loss nationally to the Child and Adolescent Service System Program, as well as to the people of Kansas. We will remember him for his boundless energy and devotion to children's mental health services.

RESEARCH AND TRAINING CENTERS' CONFERENCE AND CONGRESSIONAL RECEPTION

The National Association of Rehabilitation Research and Training Centers (NARRTC) held its ninth annual training conference in Washington, D.C. in May. The thirty-six rehabilitation research and training centers funded by the National Institute on Disability and Rehabilitation Research (NIDRR) are all NARRTC members. Highlights of the conference included speeches by David Gray, Ph.D., NIDRR director and the presentation of the association's Distinguished Service Award to Connecticut Senator Lowell Weicker, Jr.

The theme of the conference was facilitating personal independence through research. Participants shared their research with one another and explored methods of enhancing personal independence through minimizing physical impairments, improving the community environment, improving vocational opportunities, minimizing barriers found within particular cultures, and improving family opportunity and community linkages.

NIDRR Director David Gray explored the concept of interdependence. He emphasized the coequal relationship between professionals and disabled patients or clients. For example, the responses of doctors and patients are not independent; they are interdependent. Success requires mutual effort and respect.

NARRTC's Distinguished Service Award was presented to Senator Lowell Weicker, Jr. at the association's first Congressional reception. The reception, which was held in the Rayburn House Office Building, provided the association

with an opportunity to honor a member of Congress who has contributed greatly to rehabilitation research. Invited guests included members of Congress, their assistants, guests from NIDRR and other government agencies involved with rehabilitation research. Each of the research and training centers had the opportunity to exhibit its products and display its significant accomplishments.

CASSP PROJECT DIRECTORS MEETING

The Child and Adolescent Service System Program (CASSP) project directors held their Spring meeting in Portland. Ira Lourie, Assistant Chief of the Community Service Systems Branch of the National Institute of Mental Health, announced that CASSP would achieve branch status. CASSP will have the distinction of becoming the first children's branch within NIMH.

Featured presentations included an overview of the Medicaid program, a summary of the use of media by mental health agencies, a review of paraprofessional partnerships with troubled youth in Idaho, and reviews of the Kansas Family Input Project and Washington state's Strategic Planning Training Project. The staff of the Portland Research and Training Center presented overviews of the Therapeutic Case Advocacy model and the Youth in Transition Project, as well as a review of videotaped and written resources designed to promote parent involvement.

The highlight of the meeting was a one day "Focus on Families" session. The seventy participants explored ways to facilitate collaborative efforts between families and professionals. Participants explored the similarities and differences in the agendas of CASSP personnel and families, strategies for involving families, the lack of available respite services, and CASSP directors' need for knowledge about how to assist in the development of parent support groups. The Georgetown University CASSP Technical Assistance Center is currently preparing a summary of proposed solution strategies.

The Fall CASSP Project Directors meeting will be held September 14-15, 1987 in Washington, D.C.

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Research and Training Center Resource Materials

- ☐ *Annotated Bibliography. Parents of Emotionally Handicapped Children: Needs, Resources, and Relationships with Professionals **
Covers relationships between professionals and parents, parent self-help, support and advocacy groups, parent participation, parents' problems and guidelines.
- ☐ *Annotated Bibliography. Youth in Transition: Resources for Program Development and Direct Service Intervention**
Transition needs of adolescents: educational and vocational issues, programs and curriculum, research overviews, interpersonal issues, skills training.
- ☐ *Child Advocacy Annotated Bibliography*
Includes selected articles, books, anthology entries and conference papers written since 1970, presented in a manner useful to readers who do not have access to the cited sources. \$7.00 per copy.
- ☐ *Families as Allies Conference Proceedings: Parent-Professional Collaboration Toward Improving Services for Seriously Emotionally Handicapped Children and Their Families**
Held in April 1986 and attended by delegations from thirteen western states. Includes: agenda, presentation transcriptions, biographical sketches, recommendations, worksheets, and evaluations.
- ☐ *Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children*
Findings from Idaho, Oregon, and Washington, covering current services, successes, service delivery barriers, exemplary programs and innovations. \$2.00 per copy.
- ☐ *The Multnomah County CAPS Project: An Effort to Coordinate Service Delivery for Children and Youth Considered Seriously Emotionally Disturbed*
A process evaluation of an interagency collaborative effort is reported. The planning process is documented and recommendations are offered. \$3.00 per copy.
- ☐ *National Directory of Organizations Serving Parents of Seriously Emotionally Handicapped Children and Youth*
The U.S. organizations included provide one or more of the following services: education and information, parent training, case and systems level advocacy, support groups, direct assistance such as respite care, transportation and child care. \$5.00 per copy.
- ☐ *Parent Information Workbook on Emotional Handicaps*
This self-teaching workbook for parents addresses topics such as parents' feelings about themselves and their children, labels and diagnoses, types of professionals and treatments, and legal issues. Single copies free to parents of children with emotional handicaps while supplies last. All others, \$3.00 per copy.
- ☐ *Parents' Voices: A Few Speak for Many* (videotape)
Three parents of children with emotional handicaps discuss their experiences related to seeking help for their children (45 minutes). A trainers' guide is available to assist in presenting the videotape. Brochure describes the videotape and trainers' guide and provides purchase or rental information.

* One copy free per address while supplies last.

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WASHINGTON STATE FAMILY INITIATIVE

Washington State CASSP project staff are developing a comprehensive family support model that includes crisis resolution, education, skills development, support and advocacy. They are seeking curricula that have been developed or can be easily adapted for use with families with children who have emotional/behavioral difficulties. Topical areas include effective verbal/non-verbal communication, problem solving, stress management/coping skills, behavior management, social support network development, service systems and case advocacy. If you know of such materials, please contact: Dennis Olson, Washington State CASSP Project, MS: OB-42F, Dept. of Social and Health Services, Mental Health Division, Olympia, WA 98504.

NATIONAL SCHOOL STUDY

Jane Knitzer, author of *Unclaimed Children*, and her colleagues at Bank Street College are conducting a national study of how well schools respond to children with emotional and behavioral difficulties. She would welcome any information about individual programs and/or school districts that are particularly responsive to the needs of troubled children, and their families. If you know of such programs or school districts, or wish to share other perspectives on the issue, she would welcome hearing from you. Contact her at: Bank Street College of Education, 610 West 112th Street, New York City, New York 10025, (212) 663-7200.

TELEPHONE NUMBER CHANGE

The prefix for all Portland State University telephone numbers has changed. The Research and Training Center's new telephone number is (503) 464-4040.

FOCUS: YOUTH IN TRANSITION

The Youth in Transition Project is developing an approach for addressing transition issues faced by emotionally handicapped adolescents as they leave youth-serving systems and move toward the assumption of adult roles. The next issue of *Focal Point* will feature the Youth in Transition Project. We would like to identify innovative transition programs which serve emotionally handicapped adolescents. Programs should be oriented to facilitating the adjustment of emotionally handicapped youth to adult roles. Social skills training, vocational opportunities, and independent living experiences are all critical components of a transition approach. If you know of programs or models for youth with emotional handicaps that have a transition focus, please notify: Matthew J. Modrcin, Youth in Transition Project Director.

PORTLAND STATE UNIVERSITY

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