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# FOCAL POINT

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



Transitions



Spring, 2001

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**Focal Point:** Elizabeth Caplan, Editor  
[caplane@rri.pdx.edu](mailto:caplane@rri.pdx.edu)  
Denise Schmit, Publications Coordinator  
[rtcpubs@pdx.edu](mailto:rtcpubs@pdx.edu)

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## TRANSITIONS FOR CHILDREN AND YOUTH WITH EMOTIONAL AND BEHAVIORAL CHALLENGES

Transitions are difficult for all of us, but for children and youth with emotional and behavioral challenges, transitions are often both more difficult and more frequent than for their peers. Even “normal”, age-defined transitions such as the transition to kindergarten or the transition to independent living are often extremely difficult for children and youth with emotional and behavioral challenges, and for their families or other caregivers. Transitions—accompanied by the disruption of routine and the need to interact with unfamiliar people—are precisely the types of situations that are often most unsettling and stressful for these children.

Due to their unique needs, children and youth with emotional or behavioral challenges are also disproportionately likely to face transitions which are neither planned nor desired by their families or themselves: a parent may be asked to withdraw her child from a daycare or preschool, one teenager may be transferred from a mainstream classroom to an alternative school, while another is treated on an in-patient basis at a psychiatric hospital, and yet another enters residential care. One child may be placed in foster care, while another becomes involved with the juvenile justice system and ends up in a long-term correctional facility. Even when the child and family are not in crisis and things are going smoothly, discontinuity is often the norm: programs and funding come and go, therapists retire, caseworkers return to school, insurance coverage changes, and laws and policies are continually revamped.

This issue of *Focal Point* presents a variety of voices—the voices of young people and their family members, as well as the voices of researchers and service providers—discussing the topic

of transition. The unfortunate refrain, from a variety of voices describing a variety of transitions, is that transitions for children and youth with emotional and behavioral challenges are frequently chaotic, painful times when the children and their families suffer and struggle. What is more, the research described and cited in the articles reaffirms that despite the best efforts of families and children, transitions all too often end up with results that can only be considered unsuccessful.

But there is also a more hopeful message that emerges from the articles in this issue: we continue to learn about how to make transitions more successful. Encouraging models for transition are emerging around the country, making it possible to envision successful transition as the norm rather than the exception for children with emotional and behavioral challenges. What is also encouraging is that successful transition programs and experiences tend to rest at least in part on a shared set of basic features, regardless of whether the transition is from a correctional facility to the community, from residential treatment to home, or from high school to work or further education. The articles reveal that, across these settings, successful transitions are facilitated when treatment planning, services, and supports:

- build in and build on what remains stable in the child's life, particularly family relationships and relationships with others who are providing ongoing support;
- are individualized and family- and child-driven, taking into account the unique situations and the particular capacities, needs, cultural values and goals of children, their families, and their communities;
- capitalize on and enhance the strengths of the child and maintain

activities, program involvement, and other supports which have worked in the past;

- anticipate and prepare for transition well in advance and maintain transition supports past the actual point when a setting or situation changes; and
- are coordinated, while also managing and sharing information in a way that is both efficient and respectful to the child and family.

Furthermore, a number of the articles point out that much of the trauma associated with transition can be eliminated when transitions are made less frequent or when they are avoided all together. If staff at a preschool can be supported to maintain a challenging child in their program, that child may not have to face the transition to a new setting until kindergarten. Similarly, if a child and family can be supported with community services and respite, the difficult transitions to residential care and back home may be completely avoided.

Implementing transition programs and plans based on the attributes listed above is of course difficult to do well. Furthermore, each transition plan or program has to fill in the specifics behind these generalities in ways which creatively address the challenges surrounding a given type of transition. The articles in this issue provide this level of detail, and offer descriptions of programs and experiences which demonstrate that the elements on this “wish list” of transition attributes can indeed be made real in ways that positively impact the lives of children and youth with emotional and behavioral challenges, and their families, supporters and allies.

Janet Walker  
[walkerj@rri.pdx.edu](mailto:walkerj@rri.pdx.edu)

# WE ARE COMPELLED TO TELL A STORY

Once upon a time there was a husband and wife who decided to conceive a child. That was the easy part. The pregnancy was typical: baby showers and prenatal exams, eating lots of everything-that's-high-in-everything-baby-needs foods, only smelling that great bottle of red wine, getting plenty of both rest and exercise. Nine months later on a cold winter morning a bouncing baby boy arrived just as the sun peeked over the mountains. And oh, what a joy he was. Fat cheeks, fat thighs, and fat smiles. They kissed his "owies", ignored his tantrums, noted his first words on the calendar, and read *Goodnight Moon* and *The Big Book of Trucks* until all three of them could recite the text by heart.

The boy grew. He went to story-time

at the library. He went to the park on sunny days, to gymnastics, to music and to preschool. Teachers described him as "full of life, passionate, affectionate, funny, and talkative." Play dates were arranged with other preschoolers. Birthday parties were hosted. The boy continued to grow and laugh and hug and sing.

However, at this point in the story things began to change. Comments from other adults about quick mood swings, tantrums, and not playing nicely with his classmates were heard and worried about. Mom and Dad talked. They read books and surfed the Net. They reduced stress in the boy's life and increased structured play dates with peers. We implemented behavior management plans. Slowly the pile of books beside their bed changed from the latest Barbara Kingslover and John Updike novels to *Raising Your Spirited Child* and *Real Boys*. Still the boy laughed and chattered, made his first trips to both Disneyland and Keiko, built with Legos and read and re-read his favorite Richard Scary Books.

Kindergarten was met with great delight. The boy confidently carried a bucket of dirty dishes *all* the way down to the cafeteria without getting lost, became an expert on spiders, excavated great trenches of dirt on the playground and proudly donned his first YMCA soccer jersey. The mom and dad had their first parent-teacher conference

and heard about his eagerness to share all he knew about the world, his love of the classroom rat, his passion for books and reading. However, they also heard about his talking out of turn, not keeping his hands to himself, losing his temper, and defying adults. The mom and dad consulted experts and professionals, scheduled assessments, and set up play therapy appointments, and followed everyone's advice. The boy still sang and laughed, read his books and rode his bike, albeit rarely with a friend. But he also began to growl and glare when asked about his struggles at school. "I don't want to talk about it" became his anthem.

Mom and Dad pursued more evaluations and finally a diagnosis was found. Having a name for his problem has been mostly a relief for them, and progress is slowly being made. The boy looks the same as he always has: healthy and robust. His disability is not as obvious as a red-tipped cane or a limp or imprecise speech; however, it is there just the same. But the boy thinks it's too late; he can't be fixed, he's not good at anything, and no one wants to be his friend. Now the boy isn't brave enough to try again with classmates; his first reaction is to say "no," rather than run the risk that someone else beat him to the punch. He's not laughing and singing much these days.

We're losing our fat cheeked, giggling, inquisitive little boy. We ask your help in finding him again. We ask your understanding that right now life is incredibly hard for one little boy in our community, that there is one little boy who is never invited to play, one little boy who because he sometimes makes a bad choice is excluded and thought of as "the bad kid," one little boy who is rarely given the benefit of the doubt. We ask for him, simply, your tolerance, compassion, and yes, maybe a play-date.

**Joyce Van Anne**, Ashland Oregon, mother and Special Educator. She can be reached c/o the Editor, [caplane@rri.pdx.edu](mailto:caplane@rri.pdx.edu)

**RESEARCH AND TRAINING CENTER ON FAMILY SUPPORT AND CHILDREN'S MENTAL HEALTH**  
Regional Research Institute for Human Services  
Graduate School of Social Work  
Portland State University  
P.O. Box 751, Portland, OR 97207-0751  
(503) 725-4040 (voice); (503) 724-4180 (fax)  
[www.rtc.pdx.edu](http://www.rtc.pdx.edu)

**Research and Training Center:** Barbara Friesen, Director [friesenb@rri.pdx.edu](mailto:friesenb@rri.pdx.edu) • Nancy Koroloff, Director for Research [korlon@rri.pdx.edu](mailto:korlon@rri.pdx.edu) • Jennifer Simpson, Co-Director for Training & Dissemination [simpsj@rri.pdx.edu](mailto:simpsj@rri.pdx.edu) • Janet Walker, Co-Director for Training & Dissemination [walkerj@rri.pdx.edu](mailto:walkerj@rri.pdx.edu) • Art Bridge, Assistant Director for Operations [bridgea@rri.pdx.edu](mailto:bridgea@rri.pdx.edu) • Paul Koren, Center Methodologist • Rachel Elizabeth, Public Information and Outreach Coordinator [elizar@rri.pdx.edu](mailto:elizar@rri.pdx.edu) • Andrea Hanson, Jay King, Donna Fleming, Support Staff

**Underrepresented Researchers Mentoring Program**  
Jennifer Simpson, Principal Investigator

**Common Ground? Families, Educators and Employers:** Julie Rosenzweig, Principal Investigator; Paul Koren, Statistician; Eileen Brennan, Pauline Jivanjee, Project Collaborators

**Models of Inclusion in Child Care:** Eileen M. Brennan, Principal Investigator; Elizabeth Caplan, Project Manager; Shane Ama, Arthur C. Emlen, Childcare Consultant; Constance Lehman, Special Education Consultant; Anne Brown, Sherry Archer, Family Consultants; Julie M. Rosenzweig, Lynwood J. Gordon, Project Collaborators

**Guidance for Early Childhood Program Design:** Beth Green, Jean M. Kruzich, Jennifer Simpson, and Barbara J. Friesen, Co-Principal Investigators; Maria C. Everhart, Project Manager; Lynwood J. Gordon, Project Collaborator

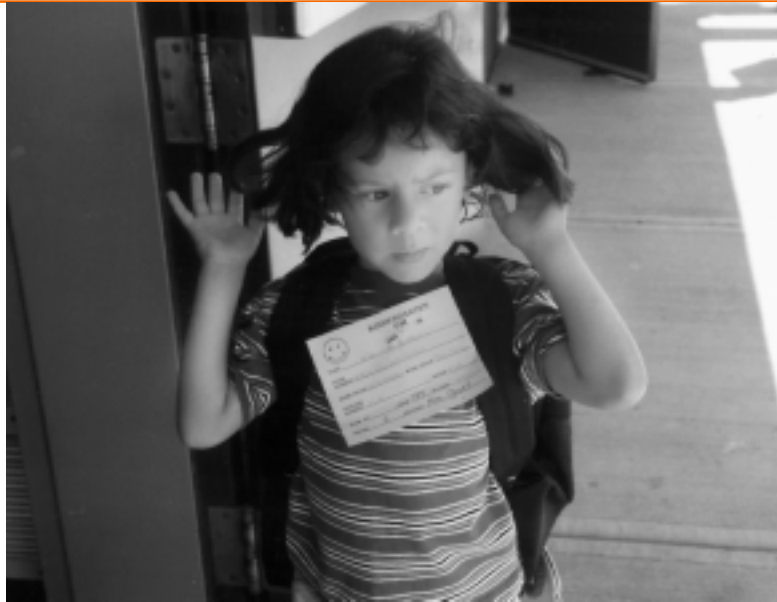
**Service Delivery Models:** Nancy M. Koroloff, Principal Investigator; Janet Walker, Project Collaborator; Kathryn Schutte, Research Assistant

**Teamwork in Practice:** Janet Walker, Principal Investigator; Nancy Koroloff, Project Collaborator; Kathryn Schutte, Research Assistant; Paul Koren, Methodologist

**Families Members as Evaluators:** Nancy Koroloff, Principal Investigator; Kathryn Schutte, Research Assistant; Adjoa Robinson, Research Assistant

**Focal Point:** Elizabeth Caplan, Editor [caplane@rri.pdx.edu](mailto:caplane@rri.pdx.edu)  
Denise Schmit, Pub. Coordinator [rtcpubs@pdx.edu](mailto:rtcpubs@pdx.edu)





## EARLY CHILDHOOD TRANSITIONS

**I**n order to provide the best opportunities for children with special emotional needs and behavioral challenges to successfully adjust to kindergarten, professionals and family members need models of support that address policies, staff and family training and partnerships, and individual child-focused services. Moreover, transition must be conceptualized as a process that occurs over time, not as a short-term move from one environment to the next. In this article, we discuss a conceptual framework for transition support models for young children with disabilities and their families. We then highlight important transition components identified in the literature and those included in models of transition for children eligible for early intervention services under the Individuals with Disabilities Education Act (IDEA). Lastly, we discuss a project being developed by researchers at the Regional Research Institute and Child Welfare Partnership at Portland State University. The goal of the project is to develop, implement, and measure the effectiveness of coordinated transition services to support the success of children who have emotional disabilities and their families as these children enter public school.

### Rationale

The transition into public school kindergarten marks an important rite of passage for children and their parents and plays a critical role in later school success. Some of the positive consequences of successful adjustment to school include development of positive peer relationships, cooperative relationships with teachers, and long-term social competence and academic achievement (Pianta & Cox, 1999). A number of studies show that individual school outcomes, especially academic achievement, remain very stable after the first two years of school (Alexander & Entwisle, 1988). These findings reinforce the premise that effective strategies are needed to ensure that a child's first year of public school is a positive, successful experience. The overarching goal is to develop positive relationships between children, parents, and caregivers during preschool and during the process of transition to public school settings.

Findings from studies of children who do not have special needs suggest that the emphasis on academic skills and the demands to interact with larger groups of diverse children are the most difficult aspects of their transition (Rimm-Kaufman & Pianta, 1997). Children who have social and emo-

tional problems in the child care or preschool setting may have even greater difficulty when they enter the unfamiliar and very different environment of public school kindergarten. The transition to kindergarten disrupts the routines and patterns of interaction developed in preschool. Continuity associated with friends and sense of belonging established in preschool is also interrupted (Fowler, Schwartz, & Atwater, 1991).

### Transition Models

The ecological approach to understanding child development posits interdependence among social systems at the parent, family, and community levels (Bronfenbrenner, 1979; Pianta & Walsh, 1996). Within this social ecology model, it is of little benefit to treat a problem in isolation, since any change that occurs will likely not be supported in the larger contexts of family and community environments. The context for the successful transition of children who have or are at risk of emotional disabilities is a model of support that takes place in the early stages of the pre-school years and evolves as children move from pre-school through the first months of kindergarten. The hallmark of the model of support is a

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strengths-based approach to supporting each child and family.

Effective transition models to support children included in the special education population organize strategies to address the roles of the child, family, and service providers in preparing, planning, implementing, and evaluating the effectiveness of the activities (Fowler, et al, 1991). For example, an individualized assessment of the match between the child's skills and the skills required of kindergarteners is considered essential during the preschool period. (Rosenkoetter, Hains, & Fowler, 1994; Rous, & Hallam, 2000). Such an assessment identifies the skill areas that will become the focus of teaching in preparation for transition. One role of the teacher is to actively encourage parent participation in planning and implementation during the preschool period. Prior to the transition, a team meeting takes place that includes the sending and receiving teachers, parents, school district special education coordinator, and any other formal or informal supports the parents consider key to developing the educational plan for kindergarten. Ideally, the parents and child visit the kindergarten classroom the child will attend and tour the school before the end of the school year and at the beginning of the year to orient the child and parent to the new environment. Considering the number of participants and range of activities considered important to effectively support one child and family, securing the means to coordinate a child's transition process becomes critical. Unfortunately, lack of time and funding to coordinate parents between-school arrangements often poses a barrier to implementing these practices.

Public Law 99-457, IDEA, and amendments to the legislation consistently identify transition as an integral component of the service delivery systems for young children with disabilities. However, only a small number of systematically designed transition approaches have been evaluated and findings disseminated. Two such efforts are summarized below.

### **The STEPS Model**

STEPS (Sequenced Transition to Education in Public Schools) was developed as a model demonstration project from 1984-1987 in Lexington, Kentucky through a grant from the Handicapped Children's Early Education Program (HCEEP) and expanded to the national level in the mid 1990s. The purpose of the project was to assist communities in building a system to facilitate the transition of children from one agency or program to another. The goals of the earlier projects were to (a) establish model sites across a state, (b) develop a statewide system of training and technical assistance, (c) include the STEPS' components in state policies and procedures, and (d) produce a replicable process. Goals of the current program are to (a) establish an administrative structure, (b) specify staff involvement and training needs, (c) establish options for family involvement, and (d) plan how child preparation and follow-up will occur (Rous, Hemmeter, & Schuster, 1999).

An evaluation of the model was conducted to ascertain the effects of the training and technical assistance provided to sites on the ability to develop community-wide transition systems (for additional information about the model and evaluation findings, see Rous, Hemmeter, & Schuster, 1994, 1999). Seven sites participated in the evaluation. Findings suggest that agreement must be reached among community team members regarding the combination of specific transition activities that will have the greatest impact on the successful coordination of transition services for children, within the limitations of professional and parent time. Moreover, the need for ongoing technical assistance to community teams who may not have the skills and knowledge to influence policy change must be provided if in fact the systems change goals are to come to fruition.

### **The TEEM Model**

The Transitioning into the Elementary Education Mainstream (TEEM) Project was developed and field-tested in Vermont, with federal funding from HCEEP. The goal of the project was

“to develop a model that enables parents and staff from ECSE [Early Childhood Special Education] and elementary school programs to collaboratively establish and implement a system-wide transition process for planning transitions” (Conn-Powers, Ross-Allen & Holburn 1990). Like STEPS, the model is not prescriptive, but rather provides school systems with information to assist in development of a system for providing transition services.

Evaluators measured professional and parent satisfaction with implementation of each best practice component and with the next placement decision for each child. There was a high degree of satisfaction regarding both transition activities and procedures and child educational placement decisions. However, it was beyond the scope of the evaluation to measure child adjustment and success in the next setting and to ascertain how the child and family were supported after the transition to public school took place. Again, the TEEM Model was designed to provide a framework for school districts and to develop and implement transition services for children identified as IDEA eligible.

### **A New Research Project**

A research team from the Regional Research Institute and Child Welfare Partnership at Portland State University is engaged in a project to examine transition supports for children with emotional disabilities and their families as they exit preschool and enter kindergarten settings. The research has been supported through the Center for the Study of Mental Health Policy and Services and is conceptualized as three progressive phases:

**Phase I.** Preliminary information was collected from parents in Oregon who volunteered to share their experiences of the transition of their children from preschool to kindergarten. Parents shared information about (a) their child's adjustment to kindergarten, (b) helpfulness of preschool and kindergarten teachers or other school personnel before, during, and after the transition, (c) challenges faced by the family and child, and (d) what was learned as a

result of the experiences.

**Phase II.** Six preschool settings will be selected to expand our knowledge of stakeholder perspectives and of site-specific transition support strategies. Three day-treatment programs and three Head Start programs will be selected. Twelve parents whose children transitioned from these settings during the previous school year, their children's sending and receiving teachers, and the disability specialists from each site will participate in the study. Data will be collected using semi-structured interviews. A comparison will be drawn between children receiving early intervention services (ECSE) and those not receiving those services.

**Phase III.** Using the data gathered in previous phases, we will work with families and other community stakeholders to design, implement, and evaluate a comprehensive transition model to support children who have emotional disabilities and their families as they make the important change from preschool to kindergarten.

### Preliminary Findings

We invited parents whose children with emotional or behavioral problems who had recently made the transition from preschool to kindergarten to share their experiences with us. The following information was provided by a very small number of parents (n = 6), and should not be viewed as representative of all parent perspectives. However, the parents we interviewed came from rural and urban areas of the state, single and two-parent households, and middle- and low-income families.

A content analysis of interview transcripts resulted in a number of common challenges faced by the parents who were interviewed. These were:

- Changes of environment and circumstances were generally difficult for their children.
- Four of the six parents were not able to find out prior to the week before school started who the kindergarten teacher would be.
- Parents stated that their children "missed" their preschool teachers.
- Teacher skills and attitudes toward their children were critical to child

adjustment and apparent level of enjoyment with school [parents thought that some teachers lacked the knowledge and skills to work positively with their children].

- Generally, parents were not aware of receiving systematic transition services as described in best practice literature for children in ECSE.
- Overall, parents perceived that professionals judged them unfavorably when they attempted to access information and make suggestions about how to prepare their children and themselves for the transition to public school.
- Two parents talked about experiencing difficulties in ensuring that their children received medication during the school day in the kindergarten classroom.

In the case of these six parents, there appeared to be little strategic planning and support provided to prepare their children for the transition to the kindergarten setting. In addition, these parents felt that some teachers were more prepared to positively support their children than others. Finally, parent-professional partnerships appeared to be fairly weak in terms of preparation, transition, and follow-up planning and support for their children.

### Conclusions

This article proposes a conceptual framework for developing effective transition strategies for children with emotional disabilities as they shift from preschool to kindergarten settings. There is a paucity of research and evaluation of transition support models for this population of children. Therefore, the initiation of studies that evaluate transition models designed specifically for this population of young children and examine short and long-term child outcomes is critical if we are to provide the types of support that will help children with emotional disabilities maintain gains made while in preschool and encourage their positive relationship with school and learning.

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Constance Lehman, Barbara Friesen, & Eileen Brennan, *Research and Training Center on Family Support and Children's Mental Health*





## SUPPORTING YOUNG CHILDREN WITH MENTAL HEALTH NEEDS

Imagine you are a parent with three children. Your middle child has tantrums that each last an hour at least four times a day. How would you manage this situation? Imagine you are a fourteen-year-old who has just given birth to a child. Where do you start to learn how to parent? Imagine you have a history of mental health problems, are working hard to move from welfare to work, but your son cannot maintain a day care placement for even two-weeks at a time because of his challenging behaviors. Where would you turn for help?

First of all, it is important to know that you are not alone. Statistics indicate that approximately 12% of children are in need of significant mental health services, and an even greater percentage of children are at-risk for developing significant mental health problems. However, only a very small percentage of young children are receiving any level of mental health service.

The challenges facing the family to access services are often overwhelming. Once the family has accessed services the challenges continue. One of these challenges is to successfully navigate through the multiple transitions associated with receiving services from an array of professionals and systems. As mental health professionals, we often

look on with wonder as we see families trying to respond to the multiple transitions and demands placed upon them by service providers. Each of these transitions has the potential to cause a great deal of difficulty for the children and their families.

This article highlights one agency's effort to assist families with this issue. Since 1971, Positive Education Program (PEP) has helped children and their families with multiple challenges build skills to grow and learn successfully. PEP's programming is grounded in the principles of *Re-EDucation* developed by Dr. Nicholas Hobbs, a psychologist and past president of the American Psychological Association. Although PEP operates many programs, we will focus on the continuum of early childhood services and how these programs support children and their families in search of help through the maze of services and transitions. PEP's Early Childhood continuum of services includes two Early Intervention Centers (EICs), PEP Early Start, and Day Care Plus.

### Early Intervention Centers

PEP's Early Intervention Centers serve families with young children by providing short-term educational and therapeutic services to the child and the

parent. It uses professional staff as consultants to families, believing that support for the adults in a child's environment will positively influence the child's ongoing development. The EIC program requires the parent/caregiver and "target" child under the age of six to attend a center-based program. All family members are welcome to come and the program is available weekdays, both days and evenings, as well as Saturday mornings. This flexible schedule accommodates most families' work or school schedules. The program operates year round, allowing for entry and exit at any time.

Families are assigned a professional staff member, who has at least a master's degree in special education, psychology, or related fields and has experience working with families in a strength-based philosophy. In addition, each family is assigned a session coach, a parent who has previously completed the program, thus helping to insure a credible and culturally compatible treatment partner. It also insures that this family can contact EIC staff for help with their child at any time during their child's school years.

Families often encounter a bewildering set of bureaucratic rules in obtaining services and managing smooth transitions as their child grows older and

needs change. EIC staff understands that an integral part of their role is to assist families with these transitions. The level of support varies with the knowledge, skills and abilities of the parent. For families overwhelmed by a child with emotional difficulties, support may range from providing information and coaching before transition-related meetings, to attending planning and reporting meetings with the parent, to advocating for the child and family at these meetings. Our goal is to empower families as soon as they are able to manage this role. However, for most meetings with medical personnel, schools, and the Department of Children and Families (DCFS), families typically require support. Initially, EIC staff make themselves available to attend these meetings at the family's request. Once families have developed important knowledge and confidence, they are able to self-advocate successfully.

### PEP Early Start

Unlike the EICs, which are center-based, PEP Early Start is a home visiting program serving families with children birth to three years of age who are at-risk for developmental delay, abuse, or neglect. PEP Early Start, borrowing from the EIC's parent-implemented model, is the only home visiting program in the county that utilizes EIC program parent coaches as paraprofessional home visitors. Families participating in Early Start are asked to deal with many transitions as a result of receiving services from multiple agencies and due to systems' demands requiring cross agency collaboration.

Working with both their home visitor and service coordinator, families develop an Individual Family Service Plan (IFSP) that outlines in detail how these transitions will be handled and what kind of assistance the home visitor and service coordinator will provide. Often, this assistance includes facilitating referral to other service providers, accessing health care, and coordinating services and benefits from the Department of Human Services. One of the primary functions of the family's service coordinator is to

streamline services and create a schedule with the family that is both appropriate and manageable. As a provider, PEP Early Start has achieved considerable success providing consistent transition support to families.

### Day Care Plus

The third member of the PEP Early Childhood continuum is Day Care Plus. The Day Care Plus Program was established to provide consultation and technical assistance services to child care providers, and support for families with children experiencing difficulties in the child care setting. The program's consultants work with staff, parents, and all agencies involved, working out a seamless and effective program for children experiencing emotional/behavioral difficulties.

The goal is to maintain children successfully in their child care placements. Often parents are forced to choose between child care and special services because special services traditionally have not extended into the child care setting. Economics and welfare reform too often force parents to forego special services due to the pressing need for child care. This situation sets up the child for failure and often places an unrealistic demand on the child care provider. As in the programs mentioned previously, Day Care Plus places a great deal of emphasis on minimal, smooth, and seamless transitions for children and their families.

For better than a quarter of a century, Positive Education Program has been working with families to provide the best possible mental health services for children. PEP's services are based on an ecological model. This model is holistic and asset-based. It incorporates the medical perspective, but that perspective is not its only driving force. PEP is always open to change and continually adapts its services to meet the needs of the families it serves.

The need for appropriate services for children with mental health needs is great. PEP will always be an active advocate for these children and their families and is committed to providing the best and most effective services.

The twelfth principle of Re-

Education states, "A child should know some joy in each day." PEP extends this principle to the child's family and believes they should also know joy in each day. That is why PEP's early childhood services focus both on the child and the child's family. We believe that is the only way to deliver effective services to young children in need.

*Laurie Albright, M.A., Program Coordinator, Early Intervention Center-East*  
*Sally Brown, M.Ed., Program Manager, Day Care Plus*  
*Darlene M. Kelly, M.Ed., Program Supervisor, PEP Early Start*

*Positive Education Program, 3100 Euclid Avenue, Cleveland, OH 44115, (216) 361-7600, Fax: (216) 361-8600*  
*E-mail: [infopep@pepcleve.org](mailto:infopep@pepcleve.org)*  
*Web: <http://www.pepcleve.org/>*

### Of Special Interest for Families

#### NAMI ANNUAL CONVENTION July 11-15, 2001 Washington Hilton & Towers Washington, DC

Featured topics include:

- **"Teachers as Allies"**
- **Family Opportunity Act.** Connie Garner, will guide us through the efforts to pass the most important legislation needed for families with children with special needs.
- **Medications, Children, and Schools.** Talk about controversy over providing psychotropic medication to students.
- **Forum: Screening Teens for Depression.** Ways to initiate effective community collaboration to identify youths with depression using computerized technology that makes screening far easier and less costly.
- **CABF's Family Reunion.**

**For more information on registration, scholarships and attendance please contact: Brenda Souto, [brenda@nami.org](mailto:brenda@nami.org)**

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## TRANSITION CONSIDERATIONS FOR FAMILIES ON THE MOVE

**T**he Technical Assistance Alliance for Parent Centers National Conference hosted a workshop entitled “Families on the Move—Serving Homeless Families” in January 2001 in Washington, D.C. The Alliance, based in Minneapolis, Minnesota, provides technical assistance to over one hundred parent centers serving families of children and adolescents with disabilities. The purpose of the workshop was to describe the multi-faceted needs of homeless families of disabled children and to provide approaches on how to reach out to homeless families in each state. The strategies included the knowledge and use of local, state, and national resources. The presentation was an outcome of the 1999 Policy Forum sponsored by the U.S. Department of Education Office of Special Education Programs and the National Association of State Directors of Special Education.

The moderator of the workshop was Marie Mayor, Education Program Specialist, Office of Special Education Programs at the Office of Special Education and Rehabilitative Services (OSERS) in Washington, D.C. She also headed the Office of Homeless Services

in Baltimore County, Maryland, before coming to Washington. Beatriz Mitchell, former Special Assistant to Assistant Secretary Judy Heumann at OSERS, began the presentation by reviewing the Office’s efforts to highlight the unique problems that homeless families of children with disabilities face in obtaining housing and services in this country.

Connie Hawkins, Executive Director of the state parent training and information center in North Carolina, described her attempts to incorporate the homeless families of children with disabilities as part of her center’s outreach activities. She talked about the many needs that the families presented to them. One obstacle included the lack of transportation to medical and social services, and to employment resources. A second obstacle the families face is having to move from shelter to shelter or apartment to apartment, thus crossing school jurisdictions and making it difficult for the children to be served appropriately in their “home” schools. Connie recommended that parent center staff identify the state and local homeless education representatives and utilize them in both recruiting the

homeless families to their centers’ training sessions and in advocating for services from state and local agencies. She also stressed the need to understand the laws that stipulate educational services for homeless children.

Ana Espada, the Director of Advocates for Children of New York, described the inherent difficulty that a transitory lifestyle presents to children with disabilities. Ana discussed the emotional disturbances that homeless children often develop because they frequently do not know where they will be sleeping the next night, and fear that they may not have food to eat when they return from school. That lack of security, as well as having to cope with stressors such as new school settings, peer relationships, poverty, and parental distress all contribute to disruptive behaviors and depression when the homeless child enters the classroom. Since assessments for these suspected problems are often thwarted when the child moves out of the school district that is assessing her, it is imperative that advocates convince the school districts to maintain the child in the same school and to transport her from the temporary housing as long as necessary.

Donald Lash, executive director of Sinergia in New York City, stressed the need for homeless advocates to formulate united, multi-faceted approaches in convincing the responsible social services, including the schools, to comply with their mandate to serve homeless children and their families. Sinergia runs shelters for homeless families, many of whom have children with disabilities. Their staff is diverse and speaks various languages, and their work is comprehensive and “flexible,” to accommodate the changing needs of the families whom they serve.

The workshop participants brought up vivid accounts of their encounters with the public institutions as they attempted to obtain assistance to home-



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less families of children with disabilities. An advocate from Texas described her ongoing efforts to maintain a child in his same school even though the child and his family had moved out of the school district. The child was receiving appropriate educational services in his school, and equally important, he had established a circle of friends there. The workshop presenters offered several suggestions, including the name and telephone number of the homeless liaison for that state, and encouraged all advocates to form a

working strategy with their state education liaisons for homeless services.

*Beatriz Mitchell, former special assistant to Judy Heumann, former Assistant Secretary for the Office of Special Education and Rehabilitative Services in the U.S. Department of Education can be contacted at [bmitch4809@aol.com](mailto:bmitch4809@aol.com)*

To contact the individual panelists:  
Connie Hawkins, Director ECAC, Inc.  
P.O. Box 16, Davidson, NC 28036  
704-892-1321 Fax: 704-892-5028  
NC only: 1-800-962-6817  
[ECAC1@aol.com](mailto:ECAC1@aol.com)  
[www.ecac-parentcenter.org/](http://www.ecac-parentcenter.org/)

Ana Espada, Director, Advocates for Children of New York, Inc.  
151 West 30th St, New York, NY 10001  
(212) 947-9779  
[info@advocatesforchildren.org](mailto:info@advocatesforchildren.org)

Donald Lash, Metropolitan Parent Center of Sinergia, 15 West 65th Street, New York, NY 10023  
212.496.1300 Fax: 212.496.5608

Marie Mayor, Office of Special Education Programs  
330 C Street SW, Mary E. Switzer Building, Washington, D.C. 20202  
Phone: 202.205.8688

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## CONTINUITY OF MENTAL HEALTH CARE FOR YOUNG ADULTS

The transition from youth to adulthood is stressful for almost everyone. It is not surprising that mental health and substance use problems intensify for people in this stage of life. However it is also during this time in life that people are least likely to have health insurance and most likely to experience residential changes. Therefore, young adults face added challenges to the lifelong task of finding and maintaining health care. Our primary goal was to study organizations that provide care for young adults with mental health concerns, and to understand their scope and collaborations. Our secondary goal was to provide information about services in our community.

According to leading epidemiologists, young adults ages 15-24 are more than twice as likely to suffer a psychiatric disorder as 45-54 year olds. At the same time, insurance coverage for young adults ages 18-25 is weaker and more tenuous than for all other age groups. Of over 40 million uninsured U.S. citizens, the rate is highest (30 %) among young adults. So young adults are at highest risk of mental health problems at an age when they are least insured against it. As a result, young adults get less care and are most vulnerable to experiencing interruptions in care.

We set out to study "Service Transi-

tion Points" (STP) through a research project in St. Louis. We contacted the major city and county organizations that provide care for young adults with mental disorders. We talked to representatives of mental health organizations, schools, substance abuse treatment centers, and child welfare and juvenile justice agencies. We identified 116 different organizations, which served young adults in St. Louis County and City. We designed a survey to ask a person representing each organization about its structure, its relationships with other agencies, and its work with people who had mental health problems. We did not collect private information about individual health consumers.

We interviewed organizational representatives who gave us permission to include them in our survey. To date, we have data from 89 organizations, 22% serving youth only, 25% serving adults, and 53% serving all ages. Most organizations are located within the specialty mental health, education, and substance abuse sectors. The juvenile justice and child welfare sectors are centralized and in the public domain, so these sectors include a few large agencies, rather than a large number of smaller ones.

The average organization in our sample has 78 full-time employees

(FTEs), including 34 people directly providing mental health services (social workers, psychologists, psychiatrists, etc.). The average organization had served about 4,000 people with mental health services in the preceding year, operating as a non-profit with both income and expenses of \$6 million. Schools and mental health care agencies saw clients an average of 18 times per year, for 30-50 minutes per session. Substance abuse centers saw clients more often, for a full hour.

Most organizations provided transition planning (82%) and routinely followed-up referrals (71%). A majority provided case management (63%) and/or long-term planning (54%). These indicators, along with others, showed that continuity of care was built into the system through multiple practices. The other most common types of services provided were counseling, family support, and therapeutic groups. About half of the sample provided emergency services, half provided transportation, and a third provided housing services.

Respondents all agreed that their organizations valued the cultural traditions of ethnic and racial minorities, but not all organizations incorporated these values in their practices. Fifty-seven percent matched African-Ameri-

can clients with African-American providers, and the same proportion matched Hispanic clients with Spanish-speaking staff. Forty-four percent rarely or never trained staff in principles of cultural competence, and 46% rarely or never monitored caseloads to ensure proportional racial and ethnic representation. Organizations providing continuity of care were more often those that practiced cultural competence as well.

When these representatives evaluated the quality of the regional system of services for young adults with mental health needs, they identified the availability of care as the most pressing problem, stating that the system was impeded by red tape, waiting lists, insurance restrictions, and delays getting appointments. Thirty-two percent thought the system rarely or never provide sufficient service to consumers with insurance. The system as a whole was better at providing accessible, personalized, trustworthy, and skilled care. However only 46% thought that the system frequently or always emphasized the strengths of consumers with mental illness.

Our respondents were experienced in the field of mental health care, working with these problems an average of 20 years. This survey found that non-profit organizations that worked to provide mental health services for young adults had collaborative relationships with some parts of the system, but that their view of the system was not always rosy.

In the upcoming months, we will complete our data collection and distribute a directory of services to survey participants. We are starting to compile statistics on many different aspects of the system of care for young adults, presenting our work to fellow scholars and at professional meetings. We hope that this study will encourage others to study where and how collaborations among organizations promote continuity of care and cultural competence. And we hope that families and providers recognize that young adults may require mental health care, and that they are disproportionately like to have little or no health insurance.

**Michael Polgar, Ph.D. & Leopoldo Cabassa, Washington University, St. Louis, Missouri. For further information please contact Michael Polgar at: [polgar@gwbmail.wustl.edu](mailto:polgar@gwbmail.wustl.edu)**

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**I am a sufferer of Obsessive Compulsive Disorder.** I have had this disorder from the first days of my childhood. When I was between the ages of about five and nine I washed my hands (for fear of germs) until they cracked and bled. I also had a difficult time performing daily tasks such as getting dressed, doing chores, and walking to school. That is when my parents first suspected I had a problem. I went to a psychiatrist and they told my parents that it was probably nothing and that little kids do weird things. They were wrong. During that period of time I possessed so much shame around the fact that there was something wrong with me that I could not admit this secret to anyone. This denial only added more difficulty to my daily routines because I had to focus on believing the lie that I was just like everyone else. This lie plagued my life until I was 16 when (with the help of my nighttime prayers to God to take this defect away from me) I finally mustered up the courage to tell my parents that I was well aware and had been of this continuing problem. It felt good to finally admit it.

From that point I began to tell my psychiatrist about this secret I had. It was very helpful to me when he assured me that many people have this disorder and that I didn't have to live this way. It was especially helpful when he let me know in no uncertain terms that I was not crazy.

I enjoyed the meetings with my psychiatrist because he made me feel genuinely cared for, not like an interesting case study. He validated my feelings about my disorder with hard textbook facts, but still encouraged me to be an individual. In other words, I felt less alone because a lot of my symptoms had been documented, but I still felt unique. Medication also provided me a little rest from my constant daily battle with my brain. It did not cure me, but it allowed me a choice between whether or not my compulsions were worth my time and energy.

Now that I am 24, I have a little more perspective on what worked for me as an adolescent. The most helpful things to me were a supportive family, a doctor who truly cared for me, medication, as well as a willingness to work with these resources. With supports like these, I don't believe one can go wrong.

What did *not* work for me was the attitudes of certain service providers. I felt that I was very lucky in finding people that really cared about helping people. As an adult, I can now see that there are a lot of service providers (psychiatrists, M.S.W.'s, etc.) who are selfish and look to children with mental health disorders as an opportunity to better their résumés. I have had experiences with mental health professionals who write you a prescription and send you on your way because they are so burned out that they have lost the ability to care. I have dealt with mental health professionals who believe all a mentally ill person can achieve is to become a member of society that does not draw attention to herself. That does not work for me.

I was very fortunate for the most part growing up with OCD. But I have also seen the stigma that is attached to people like me. I have seen us chastised and silenced by "professionals." That is why I am not signing my name. In my personal opinion, *I am a professional. I am a professional sufferer of O.C.D. I am not an animal. I am a person with family, friends, wants, needs, dreams, and the ability to carry them out. I am more than another case study. I deserve to be treated with respect and dignity.*

—Anonymous

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# SURVIVING TRANSITION TO HIGH SCHOOL

## *Understanding and Teamwork Go A Long Way To Help*

**W**hen I graduated middle school I was both excited and terrified. I knew I was going on to high school and even though I was overwhelmed with joy to be out of middle school, I was also intimidated by high school. On top of all that, I had just been diagnosed with Tourettes, Depression, Obsessive Compulsive Disorder, and Attention Deficit Disorder (and if that isn't enough I was also going through puberty).

While I was in middle school many of my problems went undetected and therefore untreated. This led to an endless saga of dismal progress reports and useless confrontations with my mother.

In the summer I became more and more anxious about high school as it drew closer. This was when I knew I needed help. Fortunately for me I found a perfect psychiatrist for my needs. In very little time I recognized that he was equally as challenged by a lack of organizational skill as I was! To overcome his own ADD he clung to his palm pilot like it was a security blanket. I discovered how important a quality, caring psychiatrist could be to someone with my types of challenges. For me, nothing compares to the kind of insight and understanding that my compassionate and reassuring psychiatrist provided.

Now my biggest challenge was high school. The first day was horrible. With knots in my stomach I quickly realized that there would be mountains of homework and social pressures that no one can really prepare you for. I realize everyone has to go through it, but that knowledge doesn't make the experience any easier (note to myself, remember this when I'm an adult!).

In no time the entire pattern emerged. I managed to have more outstanding as-



signments than completed in every one of my classes. I was convinced my gym teacher hated me (this may be a universal phenomenon). The best diagnostic indicator of my well-being was the state of my backpack. I hope that if you are reading this and your backpack is a disaster know you are not alone.

So back to my new friend and doctor I went. Once I told him about everything I was struggling with and had a good cry—which everyone can use from time to time—we agreed I would begin medication. I wish I could say that everything is just perfect now. It's not but there is good news.

My English teacher was immeasurably patient and understanding. One day I skipped school because I was afraid of taking a test I didn't feel prepared for and my mother couldn't find me. She flipped out. Not knowing what else to do she went and told my teacher. After that day, there were a number of meetings with the school counselor, my other teachers and the vice principal. Out of those meetings I got a revised schedule and an agreement about ac-

commodations for my disabilities, which isn't perfect but it is a basis upon which I'm figuring out what I really need.

The bottom line is this: there is no sufficient substitute for an understanding set of people in your corner. In my case I was fortunate. One of my other teachers told me that he had a son with similar issues. As the assistant wrestling coach he also encouraged me to participate on the team. I discovered I love wrestling.

I have a tutor outside of school who specializes in teaching children who are identified as gifted and ADD. He is great. We talk about everything under (and above)

the sun. I also enrolled in a class at the local university, which I just finished. I find that it is easier for me to be in a learning environment that is either one-on-one or with other adults. I realize that I'm very fortunate to be able to do these things. There are probably many youth who don't get the kind of individualized attention I get. Knowing how hard it is for me with the help I do have, I don't know how people manage with less.

So here is how I made my transition: with the help of a good tutor, Zoloft and Concerta, a revised class schedule, a lot of accommodations written into a 504 plan and a wonderful English teacher who loves science fiction like me. I think I'm going to make it through. The key to all of this was finding a good doctor who was able to help me understand that although maybe I can't take away my challenges there are things that I can do for myself to make life a little better every day.

Joseph Caplan, Lincoln High School, Portland, OR [yehoshuabinyomin@yahoo.com](mailto:yehoshuabinyomin@yahoo.com)

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# BEST PRACTICES IN TRANSITION PROGRAMS FOR YOUTH WITH EMOTIONAL AND BEHAVIORAL DIFFICULTIES

**A**lthough the Individuals Education Act (IDEA, 1990; 1997) has provided a national mandate to help high school students with disabilities grow into independent adults, youth with emotional and behavioral difficulties continue to experience considerable problems transitioning into adulthood. Their adjustment into socially acceptable adult roles has been examined in a number of follow-up and follow-along studies. These studies consistently show that many of these young people achieve only a few of the critical post-school outcomes identified in the research literature:

- **High school completion.** In numerous studies, students who have experienced emotional and/or behavioral difficulties have been found to have the highest high school dropout rates among all exceptionalities (Brown, 1995; Wagner, 1995).
- **Postsecondary or vocational education.** Only seven to twenty-six percent of the youth who do graduate go on to enter postsecondary education and training (Blackorby & Wagner, 1996).
- **Employment.** Mirroring the high school dropout rate, the employment status of these young people after leaving school is also very poor. Indeed, these youth are more likely to be unemployed, under-employed, or employed in lower-skilled jobs than any other groups of the same age (Blackorby & Wagner, 1996). The earnings of these young people are slightly more than minimum wage and often in less than full-time employment, placing them in poverty (Davis & Vander Stoep, 1997).
- **Independent living.** Without employment, benefits, and adequate income, many of these young adults are unable to attain a level of financial self-sufficiency necessary to live indepen-

dently. Therefore, they are at great risk of homelessness and dependency on public assistance once they leave the school system (Doren, Bullis, & Benz, 1996; Davis & Vander Stoep, 1997; Way et al., 1997).

- **Social adjustment.** Finally, youth with emotional and behavioral difficulties are more likely to demonstrate substance abuse, unplanned adolescent pregnancy, involvement with the criminal justice system, psychiatric disorders, and poor work, marital and occupational adjustment than other groups (Doren et al., 1996; Vander Stoep, Davis & Collins, 2000; Way et al., 1997). These youth are more than twice as likely as youth with other disabilities to be living in a correctional facility, a halfway house, drug treatment center, or “on the street” as they transition to adulthood.

The complex challenges of the transition process of these young people and their unique needs pose a major challenge to parents, practitioners, administrators, and policy makers. It also presents a compelling argument for designing transition systems around a solid framework of promising strategies that facilitate the vocational, social, and community transition of these young people.

## BEST PRACTICES IN MODEL TRANSITION PROGRAMS

To identify the best practices in transition programs for youth with emotional and behavioral difficulties, Clark and Stewart (1992) conducted a survey of more than 250 transition programs across North America, visiting some of them in order to examine their values and practices. Although the transition programs studied presented a wide range of supports and services, common crucial features were identi-

fied leading to the development of six guidelines which seem to drive the development and operation of quality transition systems (Clark & Foster-Johnson, 1996; Clark, Deschênes & Jones, 2000).

## Transition to Independence Process (TIP) system guidelines

### 1. Person-centered planning is driven by the young person's interests, strengths, and cultural and familial values

Improved community outcomes for young people in transition stem from an informal and flexible planning process driven by the young person's interests, strengths, and cultural and familial values, allowing for the formulation of the individual's goals. In model programs, staff encourages youth to take an active role in planning their transition to work and adult community life and allows them to make decisions regarding their futures. For example, young people served by these programs often determined who would participate in their transition processes. Family members, friends, co-workers, therapists, church-members, and others were invited to come together to create a circle of friends to help these young people reach their goals. In addition, the young person's skills, strengths, preferences, cultural values, limitations, and personal goals were used to guide students to educational opportunities as well as pre-employment experiences, and employment. This focus clearly increased the interest, involvement, and self-determination for the young people.

For example, at one of the programs we visited, José, a 17-year-old, strong, tall, Hispanic young man, had not been in school since he was arrested three months before. José had been in and out of a variety of out-of-home place-

ments since he was eight years old. Released to a foster home in his hometown of San Antonio, José had been mandated by the judge to return to school and keep out of trouble. Throughout his multiple placements and incarcerations, José had always managed to keep a ten-speed bicycle he had purchased three years ago with money given to him by his Aunt Rosie. José had maintained his bicycle in excellent condition despite the miles he had put on it.

A transition facilitator at José's new school worked with him on identifying his interests and skills and on expressing them during his transition planning meeting. His team was very supportive of his interest in mechanics. With the team's encouragement, José joined a school-to-work program that taught him skills in small engines repair. The transition facilitator also helped him find an after-school job opportunity that required these new skills and helped him prepare for the interview. Now, along with his school activities, José works at a bicycle shop in his neighborhood.

## **2. Services and supports must be tailored for each youth individually and must encompass all transition domains**

An array of individualized services and supports is essential during the transition from school to the world of employment and independent community living. The supports and services provided by the model programs visited were comprehensive in scope, encompassing the four different transition domains of employment, educational opportunities, living situation, and community-life adjustment. A comprehensive array of community-based service and support options within each of these domains was provided to accommodate the strengths, needs, and life circumstances of each young person.

For example, in the employment domain, the model programs accessed a range of work opportunities with varying levels of support, including practicum and paid work experience, transitional employment, supported employment, and competitive employ-

ment (e.g. employment in a large hotel or in a park with a co-worker identified as a training mentor). Similarly, in the domain of community-life adjustment, various supportive individuals, including the youth's natural support system, provided supports and services in different settings. For example, a live-in aunt taught her nephew how to cook at home; a teacher helped her students establish an Internet users' group; and a case manager helped a young person obtain the necessary financial means to move into an apartment. These supports and services were most effective when they were flexible, individualized, and reflected the changing needs of the young person.

## **3. Services and supports need to be coordinated to provide continuity from the young person's perspective**

Continuity of supports across child and adult systems is essential during the transition to adult living, especially when a young person turns 18 and must begin to access adult services. To ensure access to required community resources and the creation of opportunities across all of the transition domains, collaborative linkages must be established at the young person's level and at the system level. For example, in some programs that were visited, transition facilitators or case man-

agers assigned to transitional youth were employed half time in children's mental health and half time in adult mental health services, giving them the authority to work in both arenas. In other communities, regional and state-level interdepartmental teams were formed to coordinate available resources and to resolve issues related to specific individuals (e.g., eligibility criteria).

Continuity is, however, best achieved from the young person's perspective when the program focuses on establishing the young person as his or her own "life manager" teaching self-advocacy and related skills that allow him or her to function as independently as possible. In conjunction to this focus is the development of reliable natural support systems. In many cases, these supports are found to be the only ones that continued after managed care had pulled its funding.

## **4. A safety net of support is provided by the young person's team**

Another crucial feature identified in some of the model programs was their unconditional safety net of support. Kaleidoscope, a youth development program in Chicago, was one such program that exemplified this no eject/no reject policy. The program service providers offered an unconditional commitment to transitional youth by ac-





cepting referrals based on the community's determination of who was to be admitted, and by unfailingly adjusting services and supports based on the current and future changing needs of each individual. They never denied services to these youth and never rejected them under any circumstances. Kaleidoscope did not punitively discharge any of the youth involved in their transitional program. Although a few youth did decide to leave the program on their own, and others left due to contingencies such as criminal convictions that involved prison terms, administrators and staff at Kaleidoscope "stuck with" the youth they served, "no matter what." This commitment is a powerful expression by staff of their hopefulness and a positive affirmation of the young person's worth and merit.

#### **5. Achieving greater independence requires the enhancement of the young person's competencies**

Although vocational training and career development often predominate in transition programs, other community life skills are necessary to successfully transition into independent adult living. Such skills, including problem solving, communication, daily living, money management, personal hygiene, housekeeping, emotional/behavioral self-management, recreational and social development, are integrated into numerous curricula on the market, offering models and strategies for teaching these relevant and meaningful life skills. These approaches, however, often do not account for the diversity of individual needs of transitional youth. To avoid this deficit, model programs provided youth with concrete actions and practice opportunities in real-life community environments, such as integrated work-sites, apartments, and shopping malls, to teach these important skills most effectively and functionally.

Effective transitions to the world of



work and adult community life were clearly enhanced in programs that helped youth acquire community-relevant skills. It was important for these youth to learn how to function in the mainstream of the community alongside regular students, community members, and co-workers. In the model programs visited, such environments included practicum experiences in a competitive work environment, school-sponsored work experiences, community-based instruction, apartment living, and after-work social activities with co-workers. In several of the model programs visited, transition facilitators actually helped transitional youth establish themselves in the community. They helped them select the apartment, furnish it, and obtain necessary kitchen appliances, hygiene supplies and cleaning materials. As the young person moved into the apartment, the transition facilitators taught and reinforced such skills as budgeting, shopping, cooking, cleaning, and getting along with neighbors.

Community businesses and industries were tremendous partners in the transition programs when youth were ready to enter the labor market. Often the businesses' unique needs were met by these interested young people. For example, at the Marriott Foundation for people with disabilities, a school-

to-work program, employer representatives worked closely with youth who had experienced difficulties in order to place and support them in corporate-sponsored internships. Such internships provided the young people with work experiences that helped them gain the skills and experience necessary to seek competitive employment later in life.

This approach to teaching relevant and meaningful community living skills is very important for these students who often have had poor experiences related to traditional classroom instruction (Knitzer, Steinberg, & Fleisch, 1990; Wehman, 1997). Students involved in these activities

also appreciate being able to earn high school credits toward graduation while acquiring these relevant community-based experiences.

#### **6. The TIP system must be outcome driven**

Finally, all of the programs visited exhibited an outcome orientation that emphasized three features: youth outcomes, system responsiveness, and system effectiveness. Limited resources, new legislative mandates, and changing views about the needs for ongoing services for youth during transition all indicate the need for increased evaluation of programs and youth outcomes. Service providers who were interested in and responsive to such evaluation data seemed to be more effective than those who were not involved in monitoring outcomes.

For example, the school attended by José, the young man previously described in this article, went the extra mile to track outcomes. Not only did this program monitor José's outcomes closely (he only partially met his academic goals), but he was also successful in achieving each of his employment and independent living goals. The program also aggregated such outcome data on a regular basis to determine how the program was doing overall. These data on goal

completion were tracked across all four transition domains.

### Conclusion

To “make it” as adults is particularly difficult for youth with emotional and behavioral challenges (Vander Stoep, Davis, & Collins, 2000). Many of these youth encounter economic hardship, instability, and dependence when they leave school to enter the world of employment and independent living. The consequences of being set adrift during this transition can be tragic if these young people are left without social or independent living skills and community support. To be effective, professionals and community members must continue to address the complex, multiple, and interrelated needs of this population across the four transition domains of employment, educational opportunities, living situation, and community-life adjustment.

Transition systems based on the six TIP guidelines identified above will clearly be more effective in addressing these youths’ needs than those that are not. However, adopting best practices alone may not be enough to ensure successful transitions. Greater collaboration among all required supportive resources and services also needs to occur (Clark & Foster-Johnson, 1996). Finally, research and development efforts must continue to be undertaken in order to address critical issues faced by youth and young adults in their crucial transitions from school to adult living. These systemic developments, in conjunction with best practices, may be what are required to ensure more successful transitions of these young people.

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**Nicole Deschenes** is a Research Faculty member at the Department of Child and Family Studies, University of South Florida, in Tampa, Florida. She is presently serving as coordinator for the Transition to Independence Process (TIP) system project funded by the Florida Department of Education. She can be reached at: (813) 974-4493, fax (813) 974-6257, or e-mail: [deschene@mirage.fmhi.usf.edu](mailto:deschene@mirage.fmhi.usf.edu).

**Hewitt B. Clark** is a Professor in the Department of Child and Family Studies at the University of South Florida. Dr. Clark can be reached at: (813) 974-6409, fax (813) 974-6257, or e-mail: [clark@mirage.fmhi.usf.edu](mailto:clark@mirage.fmhi.usf.edu).

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## TRANSITIONING FROM RESIDENTIAL TREATMENT: FAMILY INVOLVEMENT & HELPFUL SUPPORTS

Residential care for children and adolescents with severe emotional and behavioral challenges is often a last resort for families who have exhausted community resources and exhausted themselves in efforts to care for their children at home. Young people are also placed in residential care “through a number of public avenues: through child protective agencies; through the public mental health agencies, frequently after state hospital stays; by juvenile justice authorities as an alternative to incarceration; and with increasing frequency, by school districts, when the school [was] unable to educate and maintain the student within the school community” (Hoagwood & Cunningham, 1992). In addition to struggling with serious emotional disturbance or mental illness, children and adolescents in residential treatment may be dealing with issues related to child abuse and neglect, substance and alcohol abuse/addiction, delinquent behaviors, family violence, learning dis-

abilities, mental retardation, and handicaps (McNair & Rush 1991).

In most cases, the goal of residential treatment is to return the young person to family-centered community living. However, making a successful transition back to family and community is a process with many challenges, especially given that a young person’s relationships with family members are often further stressed and disrupted during the period of residential treatment. Common sense and research both suggest that supporting, enhancing and maintaining family relationships during the period of residential care will increase the probability of successful transition; however, many families find that contact with their children and participation in service and transition planning is limited and/or discouraged by policies at residential treatment centers (*see the article by Friesen et al. in this issue, page 20*).

Residential treatment programs conceptualize and prioritize family involve-

ment in treatment and in discharge and transition planning using very divergent theoretical foundations. The spectrum of involvement practices ranges from the exclusion of parental and family involvement, to limited family involvement as directed by the program staff, to the ongoing maintenance of parent and family involvement in all aspects of the treatment milieu from start to discharge with extensive family follow-up services, or to the rare family residential program at the far end of the continuum where parents and children are placed in residential treatment together. Many residential programs vacillate across this continuum in time and across components of the treatment program. Societal values and priorities also influence the emphasis placed on families by residential and community-based treatment and service options.

Roles for parents have included everything from being a topic in the therapy of children, to being clients

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along with their children, or to being an equal expert partner in the treatment and planning processes. While parents generally value family therapy, parent skills training, and a variety of family support groups as part of both residential and community-based interventions, respectful consideration of parental priorities is the best guide to the selection of services and supports.

Residential staff have struggled with issues that infringe upon their ability to support parents' desire to participate in treatment and/or the planning process. Concerns include a fear that involved parents who visit more will criticize the program, a lack of understanding by staff as to why parents placed children in residential care, and a fear that parents once supportive of residential treatment will prefer community-based services and denigrate residential programming (McDonald, Owen & McDonald, 1993). "Parental guilt about any placement, professional notions of 'saving' children from 'bad' home environments, and milieu therapy approaches which emphasize regulation of outside (family) influences on the identified patient have conspired against active involvement of parents" (Mitchell, 1982). Residential treatment programs traditionally explained away parents as resistant or unworkable thus erecting further barriers to their participation.

In a break with then-prevailing attitudes, Finkelstein (1980) proposed, based upon the experience of Parsons Child and Family Center in Albany, NY, that residential treatment programs be structured from inception upon the plan for discharge with priority given to a return to the family. Focusing treatment on the needs of the family, not just on needs of the child, altered the approaches traditionally utilized in residential treatment. This past research may have led to a change in staff attitudes towards family and parental involvement in treatment and in discharge planning: a more recent study showed that residential staff members were very supportive of greater family involvement, although they showed more support for families in the role of service recipients than as

decision makers (Baker, Heller, Blacher & Pfeiffer, 1995).

Involvement of family members as service recipients was further supported in research employing a records review of 130 adolescents served in residential treatment. Researchers looked for predictors of discharge status, examining variables related to demographics, victimization, family dysfunction, prior antisocial behaviors, and therapies (Stage, 1999). "The results showed that the odds were 8:1 that residents who received family therapy were discharged to less restrictive settings" (Stage, 1999). Findings such as these support early and continued involvement of family members in their child's services.

It remains important that the family and service community work together during planning for discharge and transitioning back into family care. "Aftercare is a distinct and necessary intervention for children leaving residential treatment...[a time] when child and family face critical tasks" (VanHagen, 1982). Family involvement and contact, and/or resolution of issues surrounding biological families' parenting, represent crucial issues demanding attention when returning children to less restrictive environments while supporting treatment gains post discharge. Parents "were unable to rear the children themselves because of a host of problems, and...these problems ...[need to be] confronted to enable the parents to resume care" (Tam & Ho 1996). Family therapy appears to be an important component in attaining this goal (Stage, 1999).

Since the majority of children eventually return to family-centered community living, service values have shifted toward supporting the child and family. In fact, "the degree of environmental support following discharge tended to be a stronger predictor of success and improvement than [the] clinical treatments received during placement (Durkin & Durkin, 1975)" as cited in Hoagwood & Cunningham, 1992. Environmental supports include family, school, community, peer group, and professional helpers. These same supports make it more likely that posi-

tive treatment gains achieved will be maintained: "The gains of the treatment experience were not maintained if supports were not in place when the child returned home (Whitaker & Pecora, 1984)" as cited in Hoagwood & Cunningham, 1992. In addition, Hoagwood & Cunningham cite a study that found:

*"[O]ver two thirds of the respondents stated that the availability of community-based services for the student and family would have prevented residential placement. The availability of community-based services with which to transition a student from residential placement back into the community was the single most likely reason...for positive discharge. Specifically mentioned were services that included day treatment, respite care, intensive in-home family support, and crisis stabilization"*

Current research also questions the effectiveness of residential treatment as compared to community-based alternatives. The recent report by the Surgeon General (U.S. Department of Health and Human Services, 1999) summarized its discussion on residential treatment centers by noting that the proposed justifications for residential treatment (such community protection, child protection, and benefits of residential treatment per se) have not stood up to research scrutiny. Further, residential treatment is expensive: a study comparing adjudicated juvenile delinquents in residential treatment to those in intensive day treatment found that the "post treatment measures support an interpretation of the similar effectiveness of the two types of treatment ...[with intensive day treatment] approximately half the cost of residential treatment" (Velasquez & Lyle, 1985). Perhaps the best answer to the problems associated with transitioning out of residential care is, at least for some children, not to leave their homes and communities in the first place.

Research shares the responsibility to provide reliable information upon which parents and children can make decisions. When and for whom will

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residential treatment be most appropriate? How can outcomes be adequately documented, families be supported, and quality program components be assured? What environmental elements do individuals, families, and communities need to maintain gains and support prevention efforts? Promising and exemplary interventions and support services require ongoing collaborative study by teams of consumers, family members, practitioners, researchers, and educators to strengthen families who take on the difficult task of raising healthy, competent, happy, and productive future citizens.

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Myrth Ogilvie is an Assistant Professor of Social Work at the University of Washington, Tacoma. [amo452@u.washington.edu](mailto:amo452@u.washington.edu)

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## STRAINING THE TIES THAT BIND

### *Limits on Parent-Child Contact in Out-Of-Home Care*

Current policy and practice in children's mental health recommends family centered, community-based systems of care that keep children with their families while receiving mental health treatment, rather than removing them from the natural contexts of their family, community, and cultural group. System of care principles also feature individualized services and models of service delivery that wrap services around families as well as a view of family members as partners actively participating in decision-making about their children's treatment.

Despite these advances in community-based services, there are still significant numbers of children who are placed out-of-home to receive treatment. In out-of-home treatment, the principles of family-centered services may be less central and parents may find it difficult to maintain active participation in their children's treatment. For example, residential programs of-

ten use points and levels systems as a therapeutic technique. Under such systems, the acquisition of privileges is conditioned on positive behavior. Parent-child contact may be considered as one of these "privileges", with the result that contact may be denied at any time.

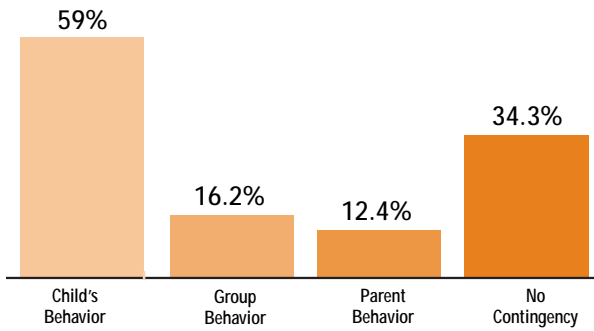
In 1996 and 1997, we conducted a series of focus groups with family members and residential treatment providers. Family members reported that in many residential treatment centers, group homes, and residential facilities, their contact with their children was limited by program policies and staff practices. For example, many parents reported that they were not allowed to have contact for an initial period (frequently 1-4 weeks) after admission to allow the child to "adjust" to the new environment. Even after this settling-in period, parents reported that agency policy limited visits at the facility, day visits, and home visits as well as tele-

phone contact with their children. Residential program staff confirmed that these practices were common in the facilities they represented.

Such limitations on parent-child contact are a concern in the light of research findings related to attachment theory and the importance of preserving children's attachments as a foundation for the capacity to form caring relationships throughout life (Bowlby, 1988). Further, there is some evidence that maintaining parent-child relationships during out-of-home care facilitates child well-being and more rapid family reunification (Davis, Landsverk, Newton, & Ganger, 1996).

These emergent themes were used as a framework for the development of a larger survey designed to examine the experiences of families participating in their children's mental health treatment, particularly those receiving services out-of-home. A sample of 105 parents with children receiving mental

Graph 1. Contingencies for Parent-Child Contact



health treatment in residential care facilities, group homes, and psychiatric hospitals or units responded to our survey about their experiences with limitations on parent-child contact. Fifty-seven percent of respondents said that when their child first entered the out-of-home placement, contact was limited for an initial period of adjustment. Fifty-three percent of respondents reported that contact with their children was governed by a levels system. Levels systems were used across treatment settings. Parents whose children were in placements that had a levels system were significantly more likely to have contact limited for an initial period of adjustment, but initial contact was also limited in programs that did not have a levels program. Most families reported that contact was predicated on the child's behavior (59%), but facilities also used unit or group behav-

ior (16.2%) and parental behavior (12.4%) as criteria (see graph 1). For instance, one caregiver reported that she was unable to visit her child because: *[The] group [was] on lockdown... they cancelled my visit that afternoon after [the] hotel was confirmed and paid.*

Parents were also asked if, after an initial adjustment period, there were restrictions on various types of contact. These respondents reported restrictions on telephone calls, visits at the facility and away from the facility, as well as home visits (graph 2).

According to VanderVen (1995) the withholding of activities that are at the core of treatment (such as caregiver contact and visitation) "is probably the most frequent—and the most misinformed—misuse of points and levels [systems]" (p. 356). Withholding contact is destructive to the child's relationships with and commitment to caregivers and agency staff. The practice of withholding contact may stem from underlying agency beliefs that caregivers are the cause of their child's problems, beliefs that often divide caregiver, agency, and child. One respondent to our survey wrote,

*She needed time to "adjust"...they used the time to teach her that I*

*had caused her problems...*

Another wrote, *Do not underestimate the power of the bond between child and family even when it appears dysfunctional. Do not restrict contact between family and child when [the] child is diagnosed [with] Attachment Disorder—I felt I was "pathologized" as "enmeshed" when I protested [after] 2 months total [of] no contact.*"

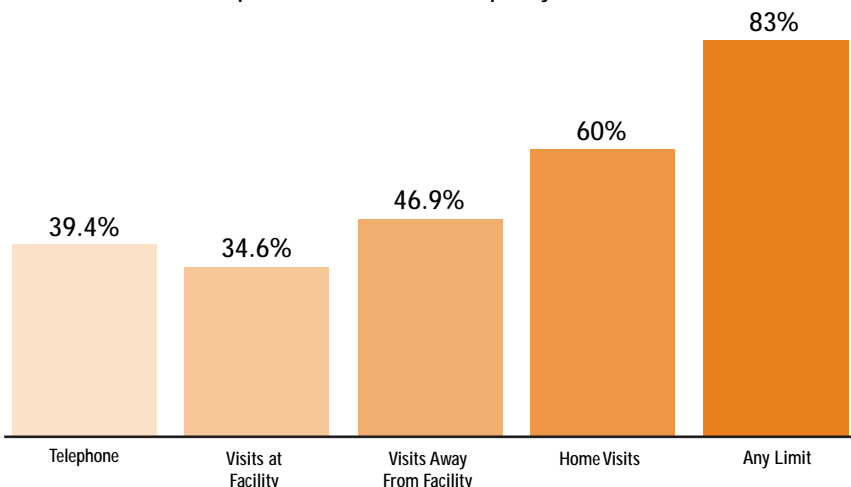
In contrast to practices that limit parent-child contact, a large body of research has shown that ongoing contact with caregivers is related to positive behavior of children in care, the child's ability to adapt to care, and more rapid family reunification in foster care (Davis, Landsverk, Newton, & Ganger, 1996; Noble & Gibson, 1994; Tam & Ho, 1996). Logically, if the ultimate goal of residential treatment is to return the child to the family, then ongoing contact is necessary (Thomlison et al., 1996).

In addition, restrictions are different for children hospitalized for the treatment of mental illnesses than for those hospitalized for the treatment of physical illnesses. Today, most hospitals not only allow, but encourage parental contact with a child who is to have her appendix removed, but our results show that many hospitals, residential treatment centers, and group homes have rigid rules regarding contact with a child who is receiving mental health treatment.

From our focus groups and survey, it is clear that parents routinely experience limitations in contact with their children. Caregivers' words indicate that there is much work to be done to make out-of-home treatment family-centered, to reduce the stigma associated with placing a child out of home, to build specific supports for increasing parent participation, and to value the critical significance of parent-child contact. Caregivers' words say it best.

- Caregivers want to feel respected: *"Honor the parents who suffer chronic grief and stress over the loss of their child."*
- Caregivers ask for specific help with contact:

Graph 2. Restrictions on Frequency of Contact



“Treatment facilities need to be flexible in scheduling, especially when parents work and/or live out of town.”

- And finally, parents emphasize the value of contact with their child: “Parents should be allowed to be as involved in their child’s care in the same way as parents of physically ill children.”  
“Frequent contact with the child, program staff, program psychiatrist, clinician, caseworker is a must”. Remember that nobody knows your child as well as you and that subtle changes can be picked up more quickly by the parent and not always by the staff.”

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Barbara J. Friesen, Ph.D., Co-Principal Investigator, Jean M. Kruzich, Ph.D., Co-Principal Investigator, Adjoa Robinson, M.S.W., Pauline Jivanjee, Ph.D., Michael Pullmann, M.S., Caroline Bowles

### The National Center on Education, Disability, and Juvenile Justice: A Resource for Families, Educators, and Advocates

The National Center on Education, Disability, and Juvenile Justice (EDJJ) is a project designed to develop and promote more effective responses for youth with disabilities involved in the juvenile justice system, and those at-risk for delinquency. EDJJ, funded by the U. S. Department of Education and the U. S. Department of Justice, represents a major federal commitment to addressing the overrepresentation of youth with disabilities in the juvenile justice system—a long-standing and complex problem.

Youth with disabilities are three to five times more likely than their non-disabled peers to be incarcerated in a juvenile correctional facility. Nationally, about 10 percent of students are identified by the public schools as needing special education. In contrast, most researchers find that 30 to 60 percent of youth in the juvenile justice system have disabilities and require special education services.

The majority of youth with disabilities involved in the juvenile justice system are classified as having emotional or behavioral disorders, learning disabilities, mental retardation, and attention deficit disorders. Other disabilities, such as speech and language disorders and traumatic brain injury, are identified less frequently among this population.

#### WHY ARE YOUTH WITH DISABILITIES OVER-REPRESENTED IN THE JUVENILE JUSTICE SYSTEM?

Disability does not cause delinquency, but research consistently identifies a strong relationship between negative school outcomes and delinquent behavior among youth with disabilities. Various theories have been advanced to explain this link:

- *School failure* and *susceptibility* theories suggest that disability-related characteristics increase the likelihood that youth will demonstrate delinquent behavior.
- *Differential treatment* theory suggests that youth with disabilities are more likely than their non-disabled peers to

be labeled as delinquent, referred to the courts, and subject to punitive treatment at every stage of their involvement with the juvenile justice system.

These theories differ in their emphasis on the relative importance of personal characteristics (e.g., deficits such as language impairment or behavioral problems) and contextual factors (e.g., access to appropriate services in school and in the community). However, school failure plays a consistently prominent role in explanations of the development of delinquency.

#### FOCUS AREAS

EDJJ is developing and disseminating strategies to help youth stay in school and out of the juvenile justice system. A sizeable number of youth entering correctional settings have experienced course failure, suspension, expulsion, and school drop out. While a wide range of academic skills can be found among at-risk and delinquent youth, typically these students have marginal academic skills. Because higher levels of literacy are associated with lower rates of recidivism, education programs for incarcerated youth provide an invaluable opportunity to provide intense instructional services. EDJJ is carrying out research, policy analysis, training, and technical assistance activities in three broad focus areas: preventing delinquency, providing quality education programs for incarcerated youth, and ensuring transition supports as youth re-enter their schools and communities.

#### HOW TO CONTACT EDJJ

The EDJJ staff encourages input from families, educators, school and correctional administrators, and advocates. Your comments can help identify topics for regional conferences and other professional development activities. Resources available through EDJJ are on the web-site: [www.edjj.org](http://www.edjj.org).

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# TRANSITION SERVICES FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM

The passage of recent legislation, including the 1997 Amendments to the Individuals with Disabilities Education Act, has played a major role in focusing added attention on the transition of juvenile offenders from correctional facilities to appropriate school, work, and community settings. Historically, few transition programs have proven successful for adjudicated youth. However recent research and practical experience have yielded evidence regarding best practices in this area, and have highlighted the need for a comprehensive approach to transition services for youth within the juvenile justice system.

Transition, from a correctional education perspective, is a process which promotes the successful passage of a juvenile offender from the community to a *correctional facility and back again*. This article begins by outlining some of the challenges facing correctional employees and educators in providing transition services to youth, and particularly to youth with disabilities, within the juvenile justice system. A successful transition program in Arizona is then described, and the article concludes with a listing of promising practices.

## Transition Challenges

Although there is a consensus in the literature that education programs containing effective transition components aid in the post-release success of both juvenile and adult offenders, it is a challenge to provide these services within a correctional setting. Correctional organizations and the people within them frequently have different philosophies about incarceration, education, and transition which shape the ways in which individuals view troubled youth and the interventions developed to help them (Leone, Walter, & Edgar, 1990).

There are three types of theories or philosophies on delinquent youth (Leone et al., 1990). "Micro" theories focus on the behavior of the individual, and states that the responsibility for change resides

with that individual. "Systems" theories shift the attention from the individual to the relationship between the individual and his/her environment. Finally, "macro" or "ecological" theories examine the institutions, culture, and other social forces active in the environment of a youth.

A knowledge of these theories is essential in understanding why different education and transition programs exist within the same field. Leone points out that "an understanding of how professional roles and institutional forces support or inhibit successful transition of youth to community settings can suggest how to remove institutional barriers that interfere with successful transitioning." For example, the most important aspect of transition for a parole officer may be a reduction in the amount of delinquent or criminal behavior, while the most important aspect of transition for an educator may be the academic or vocational transition of the student.

In addition to dealing with competing theories, there are several other challenges facing correctional employees and educators in successfully providing transition services to youth within the juvenile justice system. For example, some have argued that the amount of time covered by transition is arbitrary. It is not clear when the regular public school district's responsibility to provide services has ended and when the correctional facility's services have begun. Still others maintain that the successful transition of a student in one area, such as employment, is not correlated with success in other areas like education. Furthermore, the agency responsible for correctional education differs across states, making it difficult to enact standard guidelines and responsibilities. Finally, there is often no clear consensus on who should provide transition services.

Providing transition services to youth with disabilities in the juvenile justice system is even more difficult. For example, although the delivery of appro-

priate transition services to special needs youth is mandated by law, the role of special education programming in corrections has only recently been recognized (Rutherford, Griller-Clark, & Anderson, 2001). In 1985, it was reported that less than 10% of all state departments of juvenile and adult corrections were in compliance with relevant regulations (Rutherford, Nelson, & Wolford, 1985); and although programming for special needs juvenile offenders has since increased in both quality and quantity, transition programming continues to be critically neglected for incarcerated youth with disabilities. This continued lack of services may be due to several factors. First, youth with special needs have greater social, emotional, and learning needs than their peers (Pollard, Pollard, & Meers, 1994). Second, special needs youth do not receive the transition services they need (Kochhar & West, 1995; Taymans, Corbey, & Dodge, 1995). Third, there is great diversity in the types of transition services and interventions delivered (Halloran & Simon, 1995; Kochhar & West, 1995; Taymans et al., 1995). Finally, a continuum of care, including partnerships between schools, families, communities, and businesses has not been fully established (Halloran & Simon, 1995).

## Arizona's Transition Program

In 1996 the Arizona Department of Juvenile Corrections Education System began providing extensive transition services to youth. Initially, all correctional education teachers provided transition services one day per week to youth that had been released from their program and were now in the community. Although this delivery system was successful in increasing the number of youth employed and in school post-release, it was redesigned for a number of reasons (Griller, 1996). One of the problems identified with the system was that there were too many individuals involved in the outreach to schools and the community.



As a result, each teacher was required to have a working knowledge of the all school districts, employers, and community programs in the Phoenix area.

Since 1996, the concept of a transition specialist has evolved into Arizona's present practice, in which full-time transition specialists have been hired and function as the educational component

of a broader transition team housed at each parole office. The Transition Specialist is responsible for meeting with the youth within the first thirty days of incarceration, assisting in developing an Individualized Vocational Transition Education Plan (IVTEP), attending a transition staffing thirty days prior to release, and finding appropriate educa-

tional or vocational programs for the youth upon release.

### Promising Practices for the Transition of Juvenile Offenders

Despite an increase in compliance with federal mandates, the need for effective implementation of transition programming for youth with and without disabilities in the juvenile justice system continues to be at the forefront of much discussion. As a response to this need, the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP) produced a body of research in 1994 entitled *Documented Effective Practices in the Education of At-risk and Delinquent Youth* (Coffey & Gemignani, 1994). This research outlines fifteen effective practices in the area of transition that have proven to be pragmatic through research or practical application. These effective practices have been reviewed, expanded, and classified into promising practices for long-term and short-term correctional facilities by The National Center on Education, Disability, and Juvenile Justice (Rutherford, Mathur, & Griller-Clark, 2001). While the successful transition of juvenile offenders back to the community is not easily accomplished, we can now have some confidence that correctional education programs containing these effective elements will increase the post-release success of juvenile offenders.

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### Promising Practices for Youth in Juvenile Justice System Long-Term Correctional Facilities

- Staff awareness of all county, state, local, and private programs that receive and/or send youth to/from long-term correctional facilities.\*
- Individualized pre-placement planning prior to the transfer of youth from jails, detention centers, or other programs to long-term correctional facilities should exist.
- The immediate transfer of youth's educational records from jails, detention centers, or other programs to long-term correctional facilities.\*
- A variety of specific educational programs are provided including: academics, vocational and job related skills, social skills, independent living skills, and law-related education.
- A variety of support services are provided including: work experience and placement, alcohol and drug abuse counseling, anger management, vocational counseling, health education, and training for parenthood.
- External resources such as speakers, tutors, mentors, vocational trainers, substance abuse counselors, employers, volunteers, and job counselors.
- Students in long-term correctional facilities should have access to a resource center, which contains a variety of materials related to transition and support.\*
- Special funds are earmarked for transition and support services.\*
- Interagency meetings, cooperative inservice training activities, and crossover correctional and community school visits are held regularly to ensure awareness of youth and agency transition needs.
- A process exists for the immediate identification, evaluation, and placement of youth with disabilities.\*
- An individualized education program is developed for each student with disabilities that includes a transition plan.\*
- An individual transition plan is developed with all students which includes the student's educational and vocational interests, abilities, and preferences.\*
- A transition planning team is formed upon student entry into a long-term correctional facility to design and implement the individual transition plan.
- The immediate transfer of youth's educational records from long-term correctional facilities to community schools or other programs.\*
- Coordination with parole to ensure a continuum of services and care is provided in the community.\*
- Coordination with public and private school educational program personnel to ensure that they advocate for these youth, cultivate family involvement, maintain communications with other agencies, and place students in classes with supportive teachers.\*
- A community based transition system exists for maintaining student placement and communication after release from a long-term correctional.
- The existence of a system for periodic evaluations of the transition program and all of its components.\*

\*indicates items also appearing on the list of promising practices for youth in short term jails and detention centers. The complete list is available at

[www.edjj.org](http://www.edjj.org).

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Heather Griller-Clark, is a research associate at The National Center on Education, Disability, and Juvenile Justice, Arizona State University. [griller@asu.edu](mailto:griller@asu.edu)

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## THE HUMAN FACE OF FOSTER CARE IN AMERICA

### Foster Care in the US

In the autumn of 1999 a young woman in her early twenties, Terry Harrak, testified before the Senate Finance Subcommittee on Health Care. She explained to the legislators that she had been in foster care since the age of 15. Her father and stepmother, who were raising ten girls and one boy, had abused, neglected and eventually abandoned her. Because her mother was now terminally ill and unable to care for any of her children, Harrak had few choices available to her.

In her testimony before the Senate, she described her abandonment:

*One day I came home from school and my father told me that he had lost his job and that we were going to have to move. I was to stay with an older sister temporarily until he found a place, and he was going to go stay with some friends. I went to stay with my sister and I never heard from my father again. My sister called the police, and the police called back and said they found my father. The police took me to his new house and my father opened the door and refused to talk to me—he slammed the door in my face.*

What followed for Harrak is common to many of the approximately half million children in foster care across the country, 41 % of them older chil-

dren and adolescents (ages 11 through 19 or older). Well into her adolescence, Harrak was bounced around from placement to placement. She lived first with a sympathetic high school teacher, then at a group home for teenagers and finally, in a “mentor home” that served as an “independent living placement” designed to help children learn to live on their own after “aging-out” of adoption.

At no time did Harrak receive any counseling to help her deal with what had happened to her family. She had fallen behind in school and was having other problems in the group home for teen-agers, and by the time she had reached the mentor program she felt she had “lost everything that was familiar and comfortable” to her. Holidays and birthdays were spent without family in the group home and by the time she reached the mentor program, Harrak had learned she could depend only on herself:

*The mentor home placement was with an older woman who was a dog therapist. I knew it was supposed to be an independent living placement, but I didn't learn any independent living skills other than those I taught myself by shopping for food and budgeting for transportation and school expenses.*

Terry Herrak learned she would have to teach herself much more when, a

month before her eighteenth birthday, her social worker notified her she would have to leave her placement and foster care. “There had been no planning or preparation for this event,” Harrak testified before the Senate Subcommittee, “and I had no idea what I was going to do out on my own.” After an arrangement with a friend had fallen through for financial reasons, Harrak “found [herself] homeless, sleeping at the homes of friends and teachers or in metro stations and hospital emergency rooms.”

Terry's is one face of foster care in the United States. Approximately 20,000 children age out of foster care each year. For a variety of reasons, these children have been involved in the child welfare system on average for 7 years with 3 to 4 placements. It is unknown, exactly, how many of these young adults find themselves homeless. No tracking system exists which monitors their whereabouts after leaving the system. They are on their own and expected to transition, unaided, into the world of work and independent living.

Many, including President Bush, propose moves designed to promote adoption and returning children to their biological families, if they are considered safe by a judge. As a candidate, Governor Bush proposed \$1 billion over five years to return children to their families of origin. President Bush is also

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proposing to raise the adoption tax credit from \$5,000 to \$7,500, amounting to an additional \$1 billion over five years. Bush's proposal provides up to a \$5,000 allowance per former foster care child to be used on further education or vocational training.

But despite the bi-partisan good faith and recent victories, problems remain for children caught in the process. For example, there remains some disincentive to families who cannot afford health coverage. One foster father said it would be "irresponsible" of him to adopt if that meant his son would lose his Medicaid coverage for all of his special needs. More planning is needed to make sure all children are covered in both foster and adoptive families.

More troubling is the fact that 40,000 children who are eligible remain unadopted every year. It was for children like Terry HARRAK, that the Foster Care Independence Act of 1999, "the Chafee Bill," was designed.

### **The Chafee Bill**

On December 14, 1999, roughly two months after HARRAK's testimony, President Clinton signed into law the Foster Care Independence Act of 1999 (P.L. 106-169). In memory of the late Senator John H. Chafee, the bill replaces the former Independent Living Programs (ILP) with the John H. Chafee Independence Program (FCIP), giving states more flexibility to create programs that will better serve older foster children in their transition to adulthood. The bill also doubles the amount of federal money available to FCIPs from \$70 million to \$140 million. States may also use up to 30% of their funds for room and board and are given the option to allow the use of Medicaid money for former foster care children up to the age of twenty.

Lori Rubiner is currently serving as Vice President of Program and Public Policy for the National Partnership for Women and Families. Prior to this position she served as staff for Senator John Chafee who had a career-long commitment to child welfare in the United States. In 1997 the Child Welfare System underwent a series of vital reforms. Key legislation passed to speed

up adoption and parental rights, setting the stage for the key reform discussed in this article: helping youth transition from foster care to independence without duress. Prior to the passage of the Chafee Bill, youth whose foster care terminated lost their subsidies, were put out into the world with little formal support, lost their Medicaid, and were at serious risk for a number of adverse outcomes.

According to Lori Rubiner, the biggest obstacle to getting this legislation passed was the lack of understanding among elected officials concerning child welfare issues. The population of children affected by this legislation averages 20,000 per year. Many will suffer adverse outcomes. The risks for teenage pregnancy, substance abuse, poverty and adverse mental health are alarmingly high.

The passage of the bill, which bears Senator Chafee's name, is truly a fitting tribute to his legacy. After the Senator died Ms. Rubiner took the bill to Senator Nichols from Oklahoma and asked for his assistance in completing its passage. The bill was passed on the last day, during the final hours of the legislative session. The Clintons held a special signing event and Senator Lincoln Chafee (R-RI), following in his father's footsteps, attended the ceremony.

### **What else can be done?**

Links between child welfare, special education and community colleges are needed to secure education opportunities for those in, or formerly in foster care. The next steps are to launch the connection of housing and health care at the state level. Among other federal monies President Bush's budget calls for a \$5000 education allowance for foster youth as a set aside within the Chafee program.

Since this bill requires a lot of state-level statutory changes to be passed and implemented in the next two years, there are many opportunities to advocate at the state level. Part of the legislation called for the creation of an advisory committee of former foster youth. This is a significant symbol in terms of youth development and validation of the expertise of youth regard-

ing what is most needed by other youth.

### **Conclusion**

The Chafee bill had bipartisan support and assistance from people like Hillary Clinton, but the chief activist was Terry HARRAK, a woman whose own experiences served as the motivating testimony that ensured this bill's passage. Although she herself will not be the beneficiary, other young people who bravely transition from the child welfare system to independence every year will see its effects.

Terry HARRAK eventually found a youth transitional housing group, designed for homeless teens that want to get off the streets. She now works on child welfare issues at the National Youth Law Center in Washington, DC. As she testified before the Senate Finance Subcommittee, however, there were only two of these programs in the state HARRAK was living in and only 77 across the country. The Chafee Bill is a hopeful starting point in the process to create a better environment for children transitioning from foster care.

During a private meeting, shortly before her Senate Subcommittee testimony, one of the attendees asked HARRAK if she was forced to pick between housing, healthcare and education which would she choose? "Why should I have to choose?" she asked. "Without a home I will likely become ill, without an education I won't find suitable housing. So I suppose if I had to choose, housing would be my priority."

It will be up to continued bipartisan efforts—like the one between Senator Chafee and Senator Rockefeller that lead to the Chafee Bill's signing—and individual efforts like Ms. HARRAK's to ensure that no other children will be faced with these same slim choices on their eighteenth birthday.

*Terry HARRAK can be reached at National Youth Law Center, 1325 G Street NW, Suite 770, Washington, DC.*

*Shane Ama and Elizabeth Haran Caplan of the Research and Training Center on Family Support and Children's Mental Health wish to express their gratitude to Lori Rubiner and Barbara Pryor for their assistance in producing this article.*

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# POWERHOUSE: EMPOWERING YOUNG ADULTS AS THEY TRANSITION FROM FOSTER CARE

**P**owerhouse is a collaborative project of Casey Family Programs, Multnomah County's Independent Living Program, and Oregon's child welfare agency (SCF), with developmental contributions from the Sisters of the Holy Names and the Housing Authority of Portland. The mission of Powerhouse is to provide housing, networks of community support and resources to young adults transitioning from foster care to independent living.

Most young people in foster care leave these settings at age 18 when they are no longer eligible to receive state financial support. Many return to their birth families, others attempt to make it on their own, with little or no support from family, friends or communities. Without housing, the help of supportive adults, education, job readiness and retention skills, they are destined for serious situations—homelessness, poverty, drug and alcohol addiction, untreated mental health disorders, and incarceration. One study showed that 25 to 40 percent of these youth become homeless within 12-18 months after being discharged from foster care (*Children's Monitor*, 1999). Many of these individuals need specialized support to deal with emotional or behavioral difficulties. Research indicates that there are a large number of abused or neglected youth who also have mental health problems (Davis & Vander Stoep, 1997).

Prompted by concern, a small group consisting of SCF staff, foster parents, members of faith-based communities and community advocates made a commitment to find support and resources for these young people "aging out" of the foster care system. This group was the visioning force behind Powerhouse. The Powerhouse model uses a holistic approach to address the needs of young people who transition from foster care to independent living. This article presents the history, design, implementa-

tion, and evaluation of the program.

## PROGRAM COMPONENTS

Powerhouse seeks to leverage resources as well as identify additional sources of funding by bringing together agencies already serving this population of young people with the goal of developing a collaborative partnership. Public, private and faith-based organizations provide funding and administration of programs, program guidance, in-kind contributions such as office space, supplies, and administrative services, and vital links for establishing other public/private partnerships in the local community.

Our direct service partners (SCF, CFP, and The Inn) provide assistance with coordination of services that include housing, education, career development and training, employment, health and mental health, and community connections. The Independent Living Program (ILP) provides classes on basic independent living skills, social skills and other areas such as financial aid for college, employment and career development. A Youth Advisory Committee assists with program and policy development.

Powerhouse has developed a housing program to include a continuum of housing options that addresses the individual needs of the young adults served. For example, the program leases a home that accommodates five young adults. This house provides a live-in resource assistant who guides the young adults in independent living skill development. The residents work together to develop rules, balance the internal house budget, and create a sense of community.

Powerhouse also supports young adults in renting rooms in homes, obtaining apartments, and paying application fees, deposits and utility bills. A housing specialist seeks housing options for young adults, ensures their

understanding of rental agreements and landlord-tenant laws, and helps locate affordable housing. The housing specialist also works with property managers to develop sustainable relationships within the community for current and future program participants. Eligibility for ongoing financial assistance requires participants to set goals and maintain employment and/or school attendance equivalent to a 40-hour workweek.

Adult volunteers serve as mentors, trainers, and resource persons and provide a strong, supportive community links. Volunteers commit 8 to 10 hours per month for at least one year. After screening, Powerhouse volunteers receive initial orientation and on-going training and support in the areas of communication, foster parenting, mentoring, and program policies and procedures. Volunteers are matched with a young adult for mentoring based on similar interests, skills, and needs.

## EVALUATION

The Child Welfare Partnership (CWP), part of the Graduate School of Social Work at Portland State University, evaluates Powerhouse. CWP will assess the impact of the Powerhouse model on outcomes for youth and describe the process of developing, implementing, and sustaining this collaborative effort. Should the program prove effective, evaluation findings may help determine the feasibility of replicating the model in other communities.

The impact evaluation compares the transition outcomes for Powerhouse youth to those for a comparison group of youth receiving typical Independent Living Program services only. Key outcomes include (a) high school or GED completion, (b) participation in post-secondary education or training, (c) stable housing, (d) stable employment, (e) acquisition of life skills, and (f) establishment of social support networks.

## Child Care Leadership Forum

On March 6, 2001 over two hundred leaders in child care, children's mental health, family support, and disabilities services met in Arlington, VA to discuss collaboration on behalf of the nation's families and children. Co-sponsored by the Child Care Bureau, the Maternal and Child Health Bureau, and the Substance Abuse and Mental Health Services Administration, the leadership forum was convened to consider the current state of child care for families having children with mental health challenges and to devise action steps to improve services to those children and families.

Stephanie Fanjul, the Acting Associate Commissioner of the Child Care Bureau spoke of her years of experience in which she saw the "raw fear" of families enrolling children in child care, concerned about the ways in which their children's mental health issues would be handled. For years, child care providers encountered these families with a feeling of hopelessness and confusion, since they had not been trained to deal with emotional or behavioral issues of children, according to Fanjul. However, the forum gave evidence that hopelessness and confusion have been replaced by new approaches to the care of children with mental health challenges.

Promising approaches to the day-to-day promotion of social and emotional wellness were highlighted. An exemplary program, Brook Grove Children's Center in Olney, MD was discussed by parent Lisa Ohlheiser, teacher Roberta Borine, and mental health consultant, Vicki Zaitz. For the past five years, the center has provided free mental health consultation to parents and teachers, with the goal of helping children have a positive experience in the center, and have behavior that allows them to receive care there. Program participants emphasized the key role of family members in the collaborative team formed to support the children.

Also discussed at the forum was a community model, the Day Care Plus Program of Cuyahoga County, OH. A three-year early childhood initiative, Day Care Plus was founded to maintain children in their current child care centers according to Ann Bowdish, the Director of the Positive Education Program, the sponsoring organization. The program currently provides services to over 200 children whose challenging behaviors put them at risk of being asked to leave their centers. Services include intensive consultation, wrap around planning, and work with child care centers to obtain behavioral aides and reduce staff/child ratios.

The effectiveness of such innovative approaches was underscored in the keynote address delivered by Deborah Phillips, co-editor of the groundbreaking book, *From neurons to neighborhoods: The science of early childhood development*. Phillips emphasized the importance of child care centers as a nurturing environment for children, and also the first place that mental health issues can be identified and remediated. Calling child care a "powerful influence," on child development and mental health, Phillips appealed for collaborative research on child care and children's mental health.

The second focus of the leadership forum was on the development of action steps in five areas:

- Cross-system and interagency collaboration in child care and mental health
- Funding a new system of services
- Establishing developmental screening, assessment, and classification
- Training and sustaining a cadre of child care mental health consultants
- Engaging and supporting parents and providers through a continuum of children's mental health services: promotion, prevention, early intervention, and treatment.

To find out more about the conference and programs of the Child Care Bureau, visit their website at: [www.acf.dhhs.gov/programs/ccb](http://www.acf.dhhs.gov/programs/ccb)

Intermediate outcomes such as engagement with a pro-social peer group and participation in substance abuse treatment are early indications that participants are progressing toward successful transition to independence.

Powerhouse grew out of a grass roots effort to address the housing and community support needs of young people transitioning from foster care to independent living. It has developed into a collaboration of private and public agencies committed to providing individualized and holistic support for these young people. The Powerhouse program, like the life of any young adult in transition, is a work in progress. Our success will be ultimately measured by the lives of the young adults we serve. One young woman participating in Powerhouse stated, "[Powerhouse] is helping me out a lot with being pregnant and helping me be able to get all of my stuff ready to go out on my own. It's helping me with that [transition] step." Another young woman stated, "I hope to graduate from a university. I know that it is hard, but I know that I can do it. Powerhouse is a good help."

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Kirstin O'Dell, Lorea Alba, Constance Lehman, Judith Mayer, and Maria Hein, Faculty Child Welfare Partnership, Portland State University, P.O. Box 751, Portland, OR 97207-0751



## PARTNERSHIP NEWS

### CREATING MENTALLY HEALTHY SCHOOLS

September 20th – October 6th, 2001

*An On-line School Mental Health Conference, Fair, and Distance Learning Event*

**Purpose:** To share information about accomplishments; to present tools to address problems in the school mental health community; and to provide an accessible forum for diverse stakeholders to collaboratively address ongoing and anticipated challenges.

**Event Description:** On September 20th, CECP and Partner Organizations will kick off the Event with keynote speeches at the annual conference of the Center for School Mental Health Assistance. For two weeks, participants from diverse stakeholder groups will interact through multiple accessible media including live video streaming, chat groups, facilitated discussion groups, virtual libraries, and others to be announced and developed throughout the Event. The focus will be on linking diverse participants from across the country so they can discuss shared challenges and effective tools to address those challenges. The formats employed will enable increased access among all stakeholder groups and serve as a model for integrating high technology, community building, and learning. On October 6th, the Event will close with keynote speeches at the Annual Meeting of the Council for Children with Behavior Disorders.

**Expectations:** Project leaders and sponsors have made it clear that there are high expectations for this Event. This will not be a conventional paper and speaker conference—on the web.

This Event will take advantage of increased access such as that afforded under the distance-learning approach. However, beyond the traditional distance-learning approach, participants will take the next steps together and build a learning environment that targets their own needs and those of the students they seek to help. These next steps will be scaffolded by cutting edge technology and recent research about community building. For example, researchers at M.I.T. and elsewhere have begun to reevaluate the potential for technology to support community development and social program implementation. From this perspective, the Event should allow participants to build as much of their Event as possible.

Given this expectation, the format and substance of the Event will provide a forum for interaction among and between participants, conceptual anchors (papers), access to additional information, and organizational technology to facilitate the creation of virtual (and real) communities.

*Registration for the conference is free!*

**Contact:** Chad Rodi at [crodi@air.org](mailto:crodi@air.org) for more details on registration and participation. **The Caring for Every Child's Mental Health Campaign, part of the Comprehensive Com-**

**munity Mental Health Services for Children and Their Families Program**

### New Audiences Targeted for Coloring Book: *How Do You Feel?*

The enormously popular children's coloring and activity book—*How do You Feel?*—released in the summer of 2000 has been adapted for Hispanic/Latino and Native American/Alaska Native children. Intended to help first-to-third graders understand and recognize feelings as part of emotional well being, the new releases will help reduce stigma surrounding poor mental health among Spanish-speaking and Native American/Alaska Native children. The books will be released this summer and will be available free from the Center for Mental Health Services Knowledge Exchange Network (KEN) at 1.800.789.2647. Visitors to [www.mentalhealth.org/child](http://www.mentalhealth.org/child) will also have free access to downloadable versions.

### Communications Academy 2001

Nashville, Tennessee is the site of Communications Academy 2001, the second in a series of communications learning events sponsored by the *Caring for Every Child's Mental Health Campaign*, part of the Comprehensive Community Mental Health Services for Children and Their Families Program. Up to 100 grantee representatives will be invited to participate in the two-day program. The curriculum will be family-focused and will mix intensive, hands-on training in interview and public speaking skills with supplemental workshops that enhance overall spokesperson and grantee performance in public communications. Planned supplemental training includes sessions on message development, working with editorial boards, improving internal communication, maximizing media coverage, speechwriting and spokesperson placement. Dates for the training are July 30–August 1 and August 1–3, 2001.

### The Research and Training Center on Family Support and Children's Mental Health 2001 mentees include:

Jeffrey Chan is working on the Learning Community project, and Olivia Warfield is contributing to the research in the Models of Inclusive Childcare project.

Our year 2000 Mentorship program was a great success. Marià Garcìa, continues at the Center on the Guidance for Program Design and Promising Practices projects. After completing his menteeship last spring, Farzhad Sharafi matriculated at Oxford University for semester of special studies.

Teresa Espinoza (2000) is now pursuing a graduate degree in psychology and plans to complete her thesis on children's mental health. The Center has benefited immensely from the diverse contributions of everyone mentioned. We look forward to sustaining this program and tracking the achievements of our mentees.



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### *Research and Training Center Publications*

■ **CAREGIVERS SPEAK ABOUT THE CULTURALLY APPROPRIATENESS OF SERVICES FOR CHILDREN WITH EMOTIONAL AND BEHAVIORAL DISABILITIES** by Janet Walker

In non-technical language, this report presents the results of a study of nearly 300 caregivers' descriptions of ways in which their cultural beliefs and values were, or were not respected and/or accommodated in the services provided to their children with emotional and behavioral disabilities.

### *Research and Training Center Conference Proceedings*

■ **1999 BUILDING ON FAMILY STRENGTHS CONFERENCE PROCEEDINGS.** Keynoter Beth Harry, "Building reciprocal relationship with families: Culture in special education"

■ **2000 BUILDING ON FAMILY STRENGTHS CONFERENCE PROCEEDINGS.** Keynoter Nirbhay Singh, "Holistic approaches to working with strengths: A goodness-of-fit wellness model"

### *Articles and Book Chapters published by other sources*

■ **POLICIES THAT FACILITATE THE TRANSITION PROCESS** by Nancy Koroloff, Constance Lehman, and Matthew T. Lee. In H. B. Clark & M. Davis (Eds.), *Transition to adulthood: A resource for assisting young people with emotional or behavioral difficulties*. Baltimore, MD: Paul H. Brookes.

■ **POINTS OF TENSION: MENTAL HEALTH ADMINISTRATION IN A MANAGED CARE ENVIRONMENT** by Barbara Friesen. In R. Patti (Ed.), *The handbook of social welfare management* (461-480). Thousand Oaks, CA: Sage

### *Focal Point: A National Bulletin on Family Support & Children's Mental Health*

■ Back issues of FOCAL POINT, are available upon request! See listing on our web site, [www.rtc.pdx.edu](http://www.rtc.pdx.edu), call (503) 725-4175, or e-mail [rtcpubs@pdx.edu](mailto:rtcpubs@pdx.edu)

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□ **AN INTRODUCTION TO CULTURAL COMPETENCE PRINCIPLES AND ELEMENTS: AN ANNOTATED BIBLIOGRAPHY.** 1995. Describes articles & books that exemplify aspects of the CASSP cultural competence model. \$6.50

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□ **BROTHERS AND SISTERS OF CHILDREN WITH DISABILITIES. AN ANNOTATED BIBLIOGRAPHY.** 1990. Reviews of literature from 1979-1989 covering topics relevant to siblings of children with emotional disabilities. Includes personal sharing and fiction, effects of children with disabilities on their siblings, relationships between children and their siblings, services and education for family members, and siblings as interveners. \$5.00

□ **BUILDING A CONCEPTUAL MODEL OF FAMILY RESPONSE TO A CHILD'S CHRONIC ILLNESS OR DISABILITY.** 1992. Proposes comprehensive model of family caregiving based on literature review. Causal antecedents, mediating processes and adaptational outcomes of family coping considered. \$5.50.

□ **BUILDING ON FAMILY STRENGTHS: RESEARCH, ADVOCACY, AND PARTNERSHIP IN SUPPORT OF CHILDREN AND THEIR FAMILIES.** 1994 CONFERENCE

PROCEEDINGS. Transcripts of plenaries including keynoter Lee Gutkind, and summaries of paper and panel presentations. \$8.00.

□ **BUILDING ON FAMILY STRENGTHS: RESEARCH AND PROGRAMS IN SUPPORT OF CHILDREN AND THEIR FAMILIES.** 1995 CONFERENCE PROCEEDINGS. Transcripts of plenaries including keynoter Karl Dennis and summaries of paper and panel presentations. \$8.00.

□ **BUILDING ON FAMILY STRENGTHS: RESEARCH AND PROGRAMS IN SUPPORT OF CHILDREN AND THEIR FAMILIES.** 1996 CONFERENCE PROCEEDINGS. Transcripts of plenaries including keynoter Judge Glenda Hatchett and summaries of paper and panel presentations. \$8.00.

□ **BUILDING ON FAMILY STRENGTHS: RESEARCH AND PROGRAMS IN SUPPORT OF CHILDREN AND THEIR FAMILIES.** 1997 CONFERENCE PROCEEDINGS. Transcripts of plenaries including keynoter Carl Bell and summaries of paper and panel presentations. \$11.00.

□ **BUILDING ON FAMILY STRENGTHS: RESEARCH AND SERVICES IN SUPPORT OF CHILDREN AND THEIR FAMILIES.** 1998 CONFERENCE PROCEEDINGS. 2000. Transcripts of plenaries including keynoter Robert Naseef and summaries of paper and panel presentations. \$12.00

□ **NEW! BUILDING ON FAMILY STRENGTHS: RESEARCH AND SERVICES IN SUPPORT OF CHILDREN AND THEIR FAMILIES.** 1999 CONFERENCE PROCEED-

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