Chapter Three

Strengths and Family-Driven Services

A Typology and Narrative Illustration of Procedures for Following a Strengths-Based Approach in a Children's Community Mental Health System of Care

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Introduction

This paper types, explains, and illustrates techniques that direct service providers can use to follow a strengths-based approach with children and families enrolled in a children's mental health system of care. A major challenge in the human service field is identifying strengths and using them as interventions or change agents. A strengths-based approach assumes "people are already competent or… have the capacity to become competent" (Dunst, Trivette, and Deal, 1994a, p. 3), and focuses on personal development of the family's strengths rather than treatment of deficits. In this sense, then, this is an empowerment approach that supports people's ability to help themselves and to build on their competencies (Dunst, et al., 1994a; Dunst, Trivette, and Mott, 1994; Durrant and Kowalski, 1993).

In the strengths approach, language is transformed to transcend problems and to acknowledge wisdom, abilities, and resources through reframing an individual's personal narrative and identity from one of deficiency to one of capability, and of identification of existing sources of support in the person's natural environment (Bronfenbrenner, 1979; Saleebey, 1996). People practicing a strengths-based philosophy don't ignore problems; they assess the needs behind problems and focus on strengths as pathways to solutions. It's important to understand that system-of-care principles do not imply that problems and needs do not exist. In fact, child and family problems do exist and may never go away completely. What is suggested, however, is that there are alternative strategies to addressing needs, and one such strategy is to identify, develop, and use child, family, and team strengths and resources that may be able to meet the needs of the child and families.

Simply listing strengths can be a good assessment tool, but by itself, does not effectively address needs. Strengths assessments help teams find out what resources are available and what potential interventions can be used in a strengths-based plan. Rather than simply listing strengths, teams are most effective when they specifically tailor a strength to a family's plan, identifying those specifically relevant to a family's needs. Tying strengths to needs also ensures that the family and the team agree on what the actual needs really are, as a lack of consensus on needs is a source of family-team conflict (Dunst, et al., 1994a). Strengths used effectively give a child and family and their service providers hope (Davis, 2005).

The purpose of this research is to define functional ways a service provider can use strengths in treatment planning, and to provide case illustrations of each of those ways.

Method

This research is based on a longitudinal case study of one system of care, the Tampa Hillsborough Integrated Network for Kids "THINK" program, in Hillsborough County, Florida. The THINK program was funded by a grant from the Child and Family Branch of the Center for Mental Health Services (CMHS) in the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) to implement and enhance systems of care.

This paper analyzes the results of two separate sub-studies of the CMHS National Evaluation, a longitudinal study measuring outcomes of children and families enrolled in THINK-funded services. The first sub-study included in this research is called the Team Meeting Observation study. Families enrolled in the longitudinal study who were involved in child and family teams were invited to take part in this sub-study. This research involved a combination of a quantitative checklist adapted from the Wraparound

Observation Form (Epstein et al. 1998; Epstein et al. 2003), and a qualitative, ethnographic component in which one to two observers attended child and family team meetings and took detailed field notes on the meetings. Our research team observed 118 child and family team meetings. The meetings observed represent five different agencies providing team facilitation and leadership.

The second sub-study that informs this paper is called the THINK System of Care Practice Review (Hernandez, Gomez, Lipien, Greenbaum, Armstrong, & Gonzalez, 2001). This study used a case method of interviews and record reviews with 65 child and family teams across four different agencies to assess fidelity to system of care principles.

In order to identify types of strengths and to develop narrative illustrations of each type, field notes from the Team Meeting Observation study and open-ended interview responses from the System of Care Practice Review were analyzed. The analysis used a variation on the constructivist approach to a grounded theory (Charmaz, 2000; Glaser & Strauss, 1967; Strauss & Corbin, 1990), in which a targeted interpretive thematic analysis categorized themes related to strengths, based on observed patterns in the notes and interview responses (Bulmer, 1979; Stake, 1995). The data were examined for examples of strengths, and were coded for categories, which were collapsed into seven types of strengths. Each strength-type was substantiated by case stories derived from the interviews and observations.

Results

We identified seven key types of strengths that can be identified and used in assessment, planning, and intervention: child and family talents, child and family resilience, child and family possibilities, available family and team resources, borrowed strengths, past or historical strengths, and hidden strengths.

Talent Strengths or Competencies

Examples of talent strengths are musical and sports talents. Dunst, Trivette, Davis, and Cornwell (1994) call these "competencies." Focusing on family or child competencies reminds everyone that children and families are greater than their problems, and it gives the family a foundation on which to build goals and plans. This is the most straightforward and simple way to connect needs and goals to strengths. Talent strengths can be used in powerful ways. A talent can also be used to form or enhance a relationship. They give hope because they show the child or family is good at something that can be used to help them (Davis, 2005).

Resiliency Strengths

The next type of strength is a "resiliency" strength. Resiliency strengths would include: the ability to survive in the face of chronic stressful situations; having a sense of humor; a mother's desire to keep her family intact; a parent's persistence in obtaining help for her family; and having a strong spiritual or religious faith. Resiliencies tend to be thought of as personality traits that enable a child or family to have survived thus far in the face of difficult life circumstances (Dunst, et al., 1994; Richardson, 2002). Like talent strengths, resiliency strengths give hope because they remind everyone the situation is not all bad or bleak (Davis, 2005).

Possibility Strengths

"Possibility" strengths, also referred to as "solution talk" (Berg & DeShazer, 1993, Fanger, 1993), refer to goals or dreams set in the future toward which the family and team are working. These types of strengths use imagery to orient the family toward what they have to look forward to, or toward what they can accomplish (Fanger, 1993). Possibility strengths also move the family out of a present-time focus, which is often problem and deficit laden, into a future-time focus, which may be seen as a time of hope.

Tying possibility strengths to goals or needs moves the child, family, and team from the past and present to the future. This consists of answering the question, "What will it look like when things are better?" Possibility strengths focus the team away from problems or deficits and toward positive, concrete alternatives. They move families out of an "either/or" orientation that limits their options, to a "both/and" orientation that opens up options and solutions (Lipchik, 1994). Possibility strengths turn negatives into positives.

Resource Strengths

Resource strengths include financial, time, and knowledge resources available to help the family and team achieve their goals. Other types of resources include environmental, food/clothing, medical, vocational, transportation, educational, recreational, emotional, cultural, and social resources (Dunst, Trivette, and Deal, 1994b). Resource strengths are hopeful because they remind everyone working with the family they're not in this alone—there are resources they can all rely on for help.

Borrowed Strengths

Borrowed strengths can be taken from an exemplary other person, or by the strengths of the intervention or treatment itself, such as in medical treatments (Groopman, 2004). Strengths can be borrowed from a mentor, from another child or family who has overcome similar circumstances, or from the experience of a service provider. A teacher's intervention in a classroom could be borrowed from other work he or she had done in other schools, and a school staff's success in controlling a child's behavior could be borrowed from their experience with other children at their school. Borrowed strengths are hopeful because they also borrow hope—someone else could do this; this helped in another situation, therefore this will help here. Borrowed strengths are the experiences of other people's lives whether it is a success or a lesson learned from a failure or mistake.

Past or Historical Strengths

Past or historical strengths are actually borrowed from the family's own history. Past strengths are hopeful because they remind everyone the family accomplished something before, therefore they can do it again. In addition, past strengths help remind the family what they did to achieve their goals and successes, and these skills can generalize to the future.

Hidden Strengths[1]

Hidden strengths are strengths that are manifested, on the surface, through undesirable behaviors. For example, a youth belonging to a gang could be exhibiting several strengths: commitment, leadership, inclusiveness, interpersonal skills. The challenge is to identify these strengths and help the child channel them into more productive activities.

Conclusion

Fully adhering to a strengths-based approach in providing services for children and families is quite a challenge. In the "real world," attempts to do this are derailed by problem-saturated language, the seemingly innate need for people in the helping profession to jump quickly to solutions, and an inability to identify family strengths and resources that can address problems without calling in formal system assistance. The secret to moving beyond these challenges toward a system of care orientation is to continually reframe and model the desired behaviors. The difference made in the lives of the children and families is worthwhile.

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Is There a Theoretical and Empirical Basis for Strengths-Based Planning?

Chair & Discussant
Susan McCammon

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Susan McCammon et al.
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Introduction

Susan McCammon

The development and implementation of a strengths-based plan for providing services to children with a serious emotional disturbance and their families is recommended in system-of-care approaches. Panelists addressed the following questions: while a strength-based approach is conceptually appealing, what theory and guidelines exist for operationalizing such plans? Is there empirical research examining the degree to which service provision is strength-based and the impact of using that model? What further research is needed in this area?

Use of a strengths-based service plan is identified as an essential element of the wraparound approach to care planning, as recommended in the system of care (SOC) model for serving families with a child with serious emotional disorder (Pires, 2002). However, while strengths-based service provision is conceptually appealing, is there a theoretical framework for guiding the development and implementation of strengths-based plans? Further, in today's practice settings, there is a stated value of the use of empirically supported interventions, but is there a body of empirical study that evaluates the use of the strengths-based service model? What resources are available to support the model's implementation? Does its use result in improvements in mental health outcomes and functioning? What research needs to be done to address these questions? In this topical discussion a panel of university-based faculty and a parent who have been involved in SOC implementation and evaluation share the result of a literature review and their experience in addressing these questions.

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Theoretical Models that Provide Rationale and Approaches for Implementation of Strengths-Based Planning

Susan McCammon & Ryan P. Kilmer

Introduction

Traditionally, the field of mental health has been problem-focused, targeting pathology with after-the-fact treatment models, asking "goes wrong" and how do we "fix" it? (see for example, Cowen, 1994; 1999; Cowen & Kilmer, 2002). In recent decades, there has been growing recognition that this medical model approach is insufficient and has significant shortcomings and, in turn, there has been increased attention paid to approaches that focus on building or enhancing health and well-being, developing competence, preventing problems, and, importantly, emphasizing the positives, including strengths and growth. This shift in focus has taken a number of forms, including *positive psychology* (Seligman & Czikszentmihalyi, 2000), which builds on prior efforts in primary prevention, wellness enhancement, and competence enhancement, to name just a few.

A focus on strengths in assessment and service planning is justified on multiple conceptual grounds. For instance, when assets and risks are both assessed, clients are more likely to experience the interaction

or situation as affirming or empowering (Cowger, 1994; Saleebey, 1996). Furthermore, a focus on strengths yields a more balanced view of the child and family, sending the message that the provider, the team, and the system recognize and acknowledge an individual's identity and competencies beyond his or her presenting concerns or diagnostic profile (e.g., Saleebey, 1996; Tedeschi & Kilmer, 2005). Similarly, as Tedeschi and Kilmer (2005) noted, attending to and working to build upon strengths can have relational benefits, such as creating a different, more positive set and, in turn, impacting rapport, influencing the client-professional power differential, and fostering supportiveness and trust. Identifying strengths, skills, and resources (as well as need areas) can also provide team members with direction in developing a given plan of care. Thus, rather than "fixing" a problem, the emphasis becomes one of enhancing or building upon a characteristic, asset, or skill set; this also facilitates the use of solution-focused approaches (Handron, Dosser, McCammon, & Powell, 1998; Harniss, Epstein, Ryser, & Pearson, 1999). In sum, numerous theorists have posited that it may be more fruitful in the long term, to work to establish means of building on clients' strengths and to harness and promote the development of empirically-identified factors associated with positive adjustment (Tedeschi & Kilmer, 2005). Indeed, such efforts may be the most efficacious way of enhancing wellness and reducing dysfunction (and the need for formal mental health services) in the future (Cowen & Kilmer, 2002; Tedeschi & Kilmer, 2005).

Positive Youth Development

The Positive Youth Development perspective notes that structured voluntary youth activities provide a fertile context for positive development, especially the development of initiative and the promotion of intrinsic motivation (Larson, 2000). The typical experiences of youth during their school day and unstructured leisure are not usually conducive to promoting the development of initiative. In contrast, such structured leisure activities as the arts, sports, hobbies, and organizations provide a context in which youth develop an operating language of initiative. In structured voluntary activities youth may become highly engaged and involved, and exert effort over time toward an outcome (e.g., skill development over the course of a season). They practice facing setbacks obstacles and challenges ("how to get 11 band members into a van when the insurance only covered 9 people," Larson, 2000, p. 177), and learn contingency thinking ("If we rent the band shell, will the city give us access to electric jacks and bathrooms?" Larson, 2000, p. 177). According to Larson, this learning of initiative is foundational for other elements of positive development: creativity, leadership, altruism, and civic engagement. Building on the interests of youth by including structured leisure activities into care plans offers a platform for the development of these important qualities.

Broaden and Build Model

Another theoretical basis for positive focus in serving youth is the Broaden and Build model, articulated by Fredrickson (2000). She notes that while negative emotions narrow one's thought-action repertoire (e.g., think of the narrow ranges of responses you might offer when angered by being cut off in traffic), experiencing positive emotions not only broadens people's habitual modes of thinking, but also builds their physical, intellectual and social resources. Fredrickson notes that the broadening effect of positive emotion "can increase an individual's receptiveness to subsequent pleasant or meaningful events, increasing the odds that the individual will find positive meaning in these subsequent events and experience additional positive emotions. This can in turn trigger an "upward spiral'" (Fredrickson, 2000, p. 16). Programming and care planning designed to increase positive emotions could include activities designed to help youth feel connected to others and cared about; have an opportunity to be distracted from everyday cares; feel a sense of achievement, pride, or self-esteem; feel hope or optimism; and receive affirmation or validation from others.

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Use of Applied Behavior Analysis in Strengths-Based Planning

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There is a growing interest in the use of strengths-based approaches, partly due to the rise in system of care service delivery frameworks. One challenge to this approach, besides changing the zeitgeist of problem-oriented approaches, has been the lack of validated measures that specifically tap strengths. However, with this increased interest, has come the development of validated approaches to assessments that focus specifically on strengths, such as the Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1997), or include strengths while assessing behavioral challenges, such as the Behavior Assessment System for Children, Second Edition (BASC-2: Flannagan, 1995), and PsyberCare-Youth (Toche-Manley, Nankin, & Dietzin, 2004). The increased options in strengths-based discovery/assessment have led to a growing research base of empirical approaches that translate these strengths into treatment planning, implementation and review (see http://cecp.air.org/interact/expertonline/strength/transition/1.asp).

Why use strengths-based approaches? Where is the empirical support?

- Focusing on strengths is *more motivating* (e.g., see Motivational Enhancement Therapy in substance abuse treatment; Center for Substance Abuse Treatment, 1999)
- Strengths are not just the absence or reverse of risks and research (such as the resiliency literature) strongly indicates the importance of considering both risk and *resilience or protective factors/processes in treatment* (e.g., Masten, 2001)
- A strengths focus can be used not only in treating serious emotional disturbance but also in *preventing problems* in youth at risk (e.g., Farmer et al., 2005); see also the extensive literature on Developmental Assets at http://www.search-institute.org/research/)
- Identifying strengths can produce important clues as to what needs to be done in treatment to: (a) *ensure that the treatment does not unwittingly undermine existing strengths* ("first do no harm;" may not be helpful to take away participation in sports if that's the only venue where the child is successful) and (b) identify those *triggers and payoffs that are maintaining strengths* even in the face of serious emotional disturbance. Two approaches that have research support lend themselves to this approach to treatment, as follows.

One is *solution-focused therapy* (SFT) which until recently had more of a clinician following than a research base of support but does have a growing literature demonstrating its effectiveness. SFT typically seeks to use existing coping strategies and amplify existing strengths, discovering ways in which the "solution" is already operating in the clients' life.

The other is *functional behavioral analysis*, but instead of applying it to understanding the triggers (antecedents) and payoffs (consequences) of a behavior that's targeted to be reduced or is problematic, one should *use the same tools to understand what sets up and maintains strengths*. This can be used in two ways. First, is to understand those antecedent conditions (e.g., time of day, person, activity) that give rise to the strength as well as those consequences that are truly rewarding (e.g., feeling efficacious, praise of a valued coach) so that strengths can be maintained. Second, it can be used to pinpoint a strength that directly competes with the expression of the problem behavior. Resources found at http://cecp.air.org/fba/default.asp can be helpful in conducting a functional behavioral analysis for strengths as well as problem behaviors.

A		B		C
Antecedent	⇨	Strength/Competing Behavior	⇨	Consequence
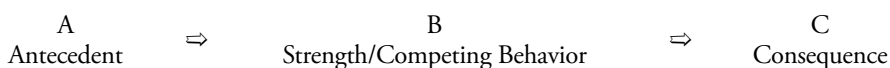
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Building on Cultural Strengths: Using Cultural Assessment Tools and Resources

Kathy Lazear

Introduction

What do we mean by "cultural strengths"? We use the term "cultural strengths" to refer to cultural characteristics or qualities of an individual that are associated with a set of ideas, behaviors, beliefs and values which are shared by a family, a community, or a group of people that may be considered and/or incorporated into the development of an individualized support plan or plan of care. While research indicates that caregivers think it is important that services are culturally appropriate (Walker, 2000), the importance of considering a family's and youth's culture in treatment and service intervention has also been documented at the national policy-making levels (U.S. Department of Health and Human Services, 2001; New Freedom Commission on Mental Health, 2003).

As system of care communities develop from a values-based framework that includes being family centered and youth focused, community-based and culturally competent (Stroul & Friedman, 1986), it has been a challenge to operationalize the principle of cultural competence and translate it into effective practice (Vinson, Brannan, Baughman, Wilce & Gawron, 2001; Brannan, Baughman, Reed & Katz-Leavy, 2002; Holden & Santiago, 2003). This paper focuses on operationalizing the value of culturally competent strengths focus, within a system of care, at the practice level.

Cultural Assessment Tools, Interventions and Resources

The National Wraparound Initiative model for developing individual service plans/care plans identifies four major phases of wraparound, a practice approach that is based on the system of care values and principles. These phases are: (1) Engagement and Team Preparation, (2) Initial Plan Development, (3) Plan Implementation, and (4) Transition (National Wraparound Initiative, 2005). During the Engagement and Team Preparation, a care coordinator or family support partner conducts an initial meeting with the family and youth. Screening, assessment and evaluation are among the most important areas for providing planning and services that are culturally strengths-based during this phase. A comprehensive base of information regarding cultural background and history will help the family and service providers to develop an effective plan of care. Several instruments and resources are available to

assist in conducing assessments that are culturally strengths-based. These tools and resources include the following:

- Strengths Discovery—Finding families' strengths: A multiple-choice test. Vandenberg, J. & Grealish, E.M., (1997) available at: http://cecp.air.org/wraparound/famstren.html
- Techniques for Assessing Social Supports (Armstrong, 2006). Components include: Eco-map; Social Network Map; EMQ Connectedness Model; Inventory of Socially Supportive Behaviors; and the Quality of Relationships Inventory.
- *Building on Strengths in Community Settings* (Focal Point, 2002).
- *A culturally receptive approach to community participation in system reform* (Guiterrez-Mayka, & Contreras-Neira, 1998).
- *EQUIPO: The Partnership Between Natural Helpers and Formal Service Providers to Support and Strengthen Families in Our Community* (Orrego, & Lazear, 2000).
- *Organizational and Individual Self-Assessment Tools to Enhance Cultural and Linguistic Competence.* (Georgetown University Center for Child and Human Development, http://gucchd.georgetown. edu/nccc)
- *Cultural Competence Self-Assessment Instruments.* Child Welfare League of America, http://www.cwla.org and http://www.cwla.org/pubs/pubdetails.asp?PUBID=8404)
- National Wraparound Initiative; www.rtc.pdx.edu/nwi

The next phase, Initial Plan Development, focuses on meeting the needs of the family and youth by selecting strategies to meet those needs. Below are several examples of how child and family teams have integrated culturally strengths-based planning into individualized service plans/care plans.

- Having bilingual staff and translation services available.
- Identifying specific provisions to maintain confidentiality about service provision, such as holding meetings after school, due to very strong stigma about mental health in the community.
- Recognizing that a family did not have a telephone or easy access to transportation, so phone contact was not part of the plan and the expectation for face-to-face contact was placed on the care manager to conduct more home visits, not for the family to come to the office or school.
- Recognizing that many families in the community have limited literacy, so all information and material is usually read out loud by care managers as regular practice.
- Establishing relationships with a number of groups who serve and support specific racial and ethnic populations.
- Switching traditional counseling to Christian counseling, on a trial basis, to meet the family's desire to work with someone from their church.
- Scheduling services and support activities based on the family's religious activity schedule.

With many formal services, such as individual or family therapy, attention to culturally strengths-based treatment intervention can also be challenging as professionals rely on the more traditional methods and approaches they learned in school. Examples of culturally strengths-based clinical interventions, where therapists have moved from strict traditional approaches, are included in Gibbs and Huang (2001), *Children of Color: Psychological interventions with culturally diverse youth.* The chapters highlight several approaches to consider for certain youth of color. For example, the chapter on American Indians references an intervention where traditional Indian techniques, such as sweat lodge and talking-circle ceremonies, are combined with more conventional group and social cognitive therapies. The chapter on Chinese Americans and Southwest Asian refugees identifies the concept of active exchange in collaboration with conventional individual and family therapy to counter the stigma of obligation in these cultures. For Puerto Rican youth, interventions that combine the established family therapy techniques with cultural reframe techniques are highlighted. And, the chapter on African-American adolescents highlights the need for treatment providers to consider blending interpersonal competence with an instrumental, task orientation to overcome the African-American youth's initial mistrust and internalized negative experiences with mainstream institutions.

Conclusion

In spite of the challenges of operationalizing the values and principles of providing service planning, interventions and services and supports that are culturally competent and strengths-based, there are examples of effective outcomes associated with culturally focused strengths-based systems of care. For example, there have been very encouraging outcomes in communities where a *broad range of services* are offered and *families are provided a choice*, such as: Wraparound Milwaukee (VanDenBerg & Grealish, 1996); The Dawn Project (Anderson, Wright, Kooreman, Mohr, & Russell, 2003); and the Massachusetts-Mental Health Services Program for Youth (Grimes &Mullin, 2006). In addition to an extensive array of services, these approaches include the incorporation of *individualized service planning* and the *inclusion of both clinical treatment services and natural supports* (Pires, 2002). As Kluckhohn and Murray (1956) observed, all people are in certain respects like all other people, like some other people, and like no other people.

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Evaluation of Strengths-Based Approaches: What Research is Needed?

James Cook & Ryan Kilmer

In addition to the key tools and resources discussed by Lazear, key needs include:

- Better ways of conceptualizing strengths. While service planning teams often merely "list" strengths, the types of strengths identified may be important. For instance, a distinction can be made between strengths as "personal characteristics or abilities" (e.g., good verbal ability, interpersonal skills) versus strengths as "interests" (e.g., likes basketball, likes to read). Does it matter if we focus on characteristics or interests, or some combination of the two?
- Better ways of measuring (a) factors reflecting the process of strengths-based planning (i.e., assessing the degree to which strengths are actually being identified and used in the planning process) and (b) outcomes (both child and family) related to this work.

Multi-method assessment approaches are warranted to best examine the degree to which child and family teams are functioning in a way that reflects 'best practice' of the wraparound approach to care planning (Burns & Goldman, 1999; VanDenBerg & Grealish, 1996), particularly in developing SOCs. Strategies can involve multiple forms of inputs and levels of assessment.

Process-Oriented Strategies: Assessing Implementation and Fidelity

1. *Child and Family Team Assessment*
   a. Participant Rating Forms – After each meeting, participants rate the meeting process, what happened, and what was accomplished.
   b. Observations of team meetings by trained observers (e.g., Wraparound Observation Form; Nordness & Epstein, 2003) – Attending to multiple key dimensions of SOC and the Wraparound approach.
2. *Assessment of Planning Process via Record Review* – i.e., to ensure that strengths have been identified and incorporated into a written plan of care.
3. *Assessment of Services Provided* – The Wraparound Fidelity Index (WFI: Bruns, Suter, Burchard, Force, & Leverentz-Brady, 2004) provides a broader assessment of process and services at, for example, 6-month intervals. Can be completed by caregivers, care coordinators/case managers, etc.
4. *System-level Assessment* – Part of the national evaluation includes site visitors who assess system, including utilization of strengths

Outcome-Oriented Strategies: Assessing the Impact of the Process on the Child(ren) and Family

1. *Child Outcomes: Sample Measures*
   - Caregiver-Completed Measures: Parent-Child Rating Scale, Behavior Assessment System for Children-2 (BERS-2; Buckley Ryser, Reid & Epstein, 2006).
   - Child-Completed Measures: Child Rating Scale (Hightower, Cowen, Spinell, & Lotyczewski, 1987).
   - Teacher-Completed Measures: Teacher-Child Rating Scale (Weissberg, et al., 1987); the Behavior Assessment System for Children-2 (BASC; Flanagan,1995).
   - Record Review – i.e., to what degree is child attaining goals of plan? Are services less restrictive?
2. *Family Outcomes: Sample Measures*
   - Family Functioning – e.g., Family Environment Scale (FES; Moos & Moos, 1994); Family Assessment Device (FAD; Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990).
   - Family Resources – Family Resource Scale (FRS; Brannan, Manteuffel, Holden & Heflinger, 2006).

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Conclusion

Susan McCammon

Strengths-based planning fits within the contemporary framework of Positive Psychology. The field of Positive Youth Development offers ideas about activities that promote youth development, and has begun to identify the developmental processes involved. The Broaden and Build Model and Applied Behavior Analysis offer rationales and ways to apply a positive focus in working with youth. Strength based planning is enriched by the use of cultural assessment and resources. Outcome-oriented evaluation strategies can assess the degree to which service planning goes beyond merely listing strengths of a child and family, and builds on them in care plans in meaningful ways.

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Strengths that Matter:
An Empirical Investigation
of Elementary School Student Success

Valerie B. Shapiro
Paul A. LeBuffe

Introduction

The use of the constructs of resilience and within-child strengths to guide the practice of assessment and intervention in education and child psychology is a relatively new approach. As a consequence, the literature discussing strength-based approaches at the practice level is sparse and often anecdotal. The lack of empirical direction for the practical use of resilience in educational and treatment planning exists despite the President's New Freedom Commission on Mental Health (2003) stating that the transformation of the mental health delivery system relies on our ability to focus on the consumer's "ability to cope with life's challenges, facilitate recovery, and build resilience" (p.5). The gap between mandate and practice was further emphasized when the strength-based perspective was incorporated into law when the Individuals with Disabilities Education Improvement Act (IDEIA) reauthorization regulations were adopted in July, 2005. The revision requires that strengths be considered in the development of an Individualized Education Plan (IEP) and that a greater emphasis be placed on prevention services (allowing school systems to use up to 15% of their federal money for early intervention instead of for traditional special education services or out of district placements). The spending of this early intervention money is required to be for scientifically based behavioral and academic interventions that make use of technologically sound assessments. The value of strength-based practice has been widely propagated, and by mandate, strength-based practices have been "adopted." But is the field ready to use individual strengths in a scientifically and technologically sound manner?

To initially investigate this hypothesized disparity, forty client files were randomly selected in March of 2003 from three different mental health service programs, including a wrap-around program for children with developmental disabilities, a special education day treatment program for children with social skills deficits and affective disorders, and a residential treatment setting for boys with oppositional defiant and conduct disorders. Upon reviewing each child's current and previous treatment plans, assessments, educational reviews, and individualized education plans, a total of 329 statements of strengths were found. Statements ranged from ones that seemed like potential assets to recovery (e.g., "likes to be around others," "enjoys drawing"), to those that seemed only indirectly relevant to his or her mental health (e.g., "well nourished," "motivated to have cyst treated") and then to those that actually seemed like potential concerns (e.g., "likes to be clean - 4 showers/day"). Other strength-statements seemed entirely inappropriate (e.g., "adjusts well to tranquil environment," "light-skinned"). These exploratory findings led to a thorough review of the literature and a series of focus groups with multi-disciplinary professional teams to determine what strengths are theorized to promote wellbeing. After generating a list of 765 uniquely phrased potential within-child protective factors, we collapsed similar content, operationalized the items, and devised an empirical study to determine the degree of clinical utility which exists for a final set of 156 hypothesized characteristics.

Method

To empirically investigate the relationship between the 156 theorized strengths and children's actual social and emotional well-being, a contrasted group study was designed. Parents and teachers provided ratings of the observed frequency of the positive behaviors in children who had either already been identified as having significant social and emotional problems ($n = 86$) or who had not been so identified ($n = 322$). The criteria used to determine an "identified" child/adolescent was the presence of one or more of the following: a referral to the school disciplinary office for aggressive or violent behavior during the academic year; a referral to a mental health professional for an evaluation regarding emotional/behavioral problems during this academic year; treatment by a mental health professional for emotional/behavioral problems during the academic year; a program or plan developed to manage his/her behavior problems; a psychiatric diagnosis; or special education services for emotional/behavioral problems.

Data were collected on 408 children in Kindergarten through 7th grade attending 35 schools and after school programs in 26 states. The children comprised a diverse sample and included Black (*n* = 67, 16%), Latino (*n* = 61, 14%), and socio-economically disadvantaged children (*n* = 68, 16%). Teachers provided 58% of all ratings, and parents or guardians provided the rest. The data collection form asked them to indicate on a 5-point Likert-type scale ranging from *never* to *very frequently* how often they had observed the 156 strengths in the past four weeks. Informants were also given the opportunity to indicate that the item was unclear, or that they felt the item did not apply to the child being rated.

Results

A multi-stage data analysis plan was used to reduce the initial pool of 156 potential strengths to a more manageable, useful, reliable, and valid list of strengths. As a first step in the analysis, those items that that were frequently marked as *unclear*, *does not apply*, or left blank, were eliminated. The items with the highest percentages of unclear ratings were, "look for deeper meaning in daily routines" (7%), and "delay gratification" (6%). A larger percentage of informants, especially teachers, indicated that certain items were not applicable. These items included, "participate in religious activities" (22%), "recycle or do something to help the environment" (12%), and "spend time on a hobby" (10%).

The next criterion applied to the potential strengths was the ability of the item to differentiate between the identified and non-identified samples. In addition to *t*-tests, effect sizes (*d*-ratios) were also examined. Those items where the mean scores differed significantly, and were separated by at least half a standard deviation ($d \geq .50$) were retained. Only 7 of the original 156 items did not differentiate significantly between the two groups. In addition, only 30 items had effect sizes of less than half a standard deviation. Examples of items that did not differentiate include, "participate in after school or community activities," "show talent in athletics, the arts, or in a technical/mechanical area," and "engage in cultural activities or traditions."

The third step was to examine the corrected item-total correlations. Very few items were eliminated on this basis. Fourth, item raw scores were correlated with the student's age, gender, and race. To avoid strengths that seemed biased across these dimensions, 10 additional items were eliminated. As a final step, redundant or very similar items were eliminated. These five steps winnowed the pool of potential strengths from 156 items to 81 items. Using a discriminate analysis function, these 81 strength-based items correctly classified children based on their referral status in 87.6% of all cases, suggesting that strength-based indicators can empirically predict well-being.

Items were then conceptually categorized in a way that would most readily support prevention and treatment efforts. Through this alternative approach, items were grouped together logically based on the framework suggested by the Collaborative for Academic, Social, and Emotional Learning (CASEL). The study was replicated with the 81 items across a nationally representative sample of 2,500 subjects, which resulted in a data-based decision to remove nine additional items, including a scale of Optimism, and divide two of the five CASEL scales into independent parts, creating eight scales with very high internal consistency. These results are displayed in Table 1.

Discussion and Conclusions

This study advances our knowledge of within-child strengths in many ways. First, it provides a comprehensive review of our existing knowledge about within-child strengths. Second, it investigates which of these 156 operationalized potential strengths have contextual validity to both parents and teachers. Third, it explores which of these strengths differentiate between students already identified with significant emotional and behavioral disorders and those without. Interestingly, some of the strengths that are widely recognized in the literature as protective were not validated through this study. This was most strikingly the case for items related to religion/spirituality.

Table 1
Internal Reliability (Alpha) Estimates for DESSA Scales Based on CASEL Framework

Scale (Number of Items)	Alpha	Example Item
Self-Awareness (7)	.87	Describe how he/she was feeling
Social Awareness (9)	.89	Resolve a disagreement
Self Management		
Management of Emotions (11)	.90	Adjust well to changes in plans
Goal-Directed Behavior (10)	.92	Take steps to achieve goals
Responsible Decision-Making		
Responsibility (10)	.90	Handle his/her belongings with care
Problem solving (8)	.90	Seek advice
Relationship Skills (10)	.93	Compliment or congratulate somebody
Optimism (7)	.87	Say good things about him/herself

This study identifies of a robust set of student strengths that are related to social and emotional development. The field will benefit from an empirically based measure to assess student strengths and resilience known as the Devereux Elementary Student Strengths Assessment (DESSA). Further studies will scrutinize this 72 item-set to explore issues of reliability, validity, and how the strengths lend themselves to intervention planning and progress monitoring. Such findings will help identify students at risk for social and emotional dysfunction and to support the healthy social and emotional development of all children.

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Application of Appreciative Inquiry to Evaluating Family Satisfaction in Two Publicly-Funded Behavioral Health Systems

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Introduction

The Family Satisfaction Team (FST) employs caregivers who have children who have received services in the behavioral healthcare system to conduct evaluations of family satisfaction with publicly-funded behavioral health services. After developing and using traditional tools to measure satisfaction, the FST decided to develop tools using the Appreciative Inquiry approach (AI; Hammond, 1996). AI is based on a positive, strength-based format to facilitate change, progress and quality improvement where all stakeholders benefit.

Application of AI to obtain youth and family evaluations of behavioral health services is a promising approach for advancing program evaluation and quality improvement efforts. Although it is now accepted that family members should be included in program evaluation efforts, publicly-funded behavioral health services are still typically evaluated using traditional consumer and family satisfaction tools. Typical satisfaction surveys emphasize a problem-finding approach.

Additionally, it has been well documented that traditional satisfaction surveys are of limited utility because respondents tend to report fairly high levels of satisfaction even in services known to be rife with problems (Lebow, 1982). Traditional satisfaction surveys have also yielded less impact on service system improvements than possible because of failures to adequately incorporate the results into dynamic continuous quality improvement processes. One of the impediments to doing so is that the problem-focused approach of typical quality improvement methods can elicit defensiveness, leading stakeholders to emphasize typically high overall satisfaction rates and fall short of addressing problems.
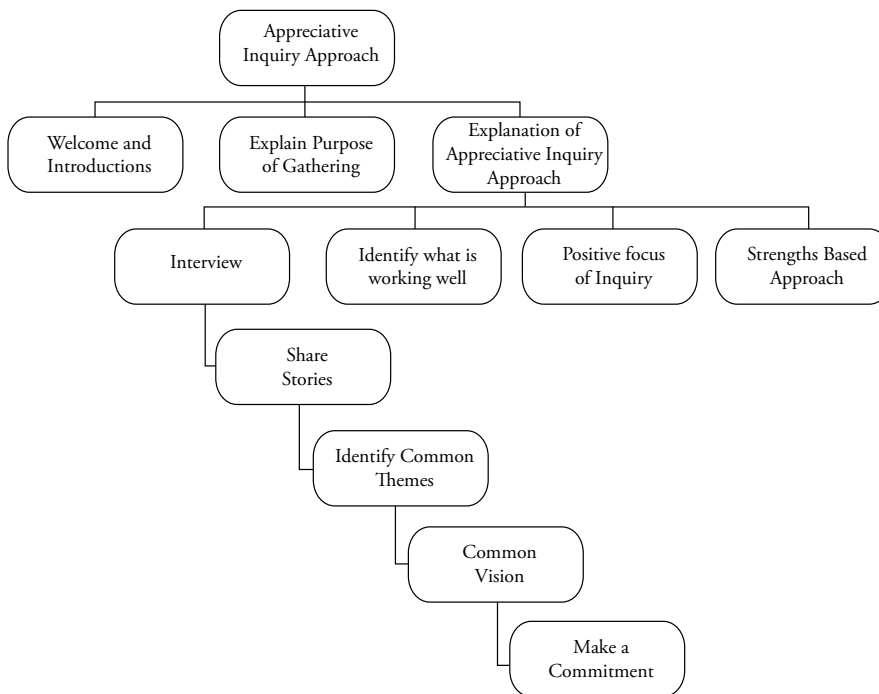
One reason that traditional satisfaction surveys have proven problematic for evaluations of service packages or systems' performance is because respondents are often directed to focus on a particular service provider or service aspect in order to give opinions about accessibility, effectiveness, and quality. We adopted an AI approach that gives a wider view of the experiences of families receiving services while still allowing empirical rating of specific aspects of service delivery that are useful in directing goal-focused quality improvement efforts. AI has been used extensively in other areas of organizational development (e.g. Cooperrider & Srivastva, 1987) because of its ability to rejuvenate quality improvement efforts.

Method

The Family Satisfaction Team employed the AI process (e.g. Cooperrider, 1996) to measure family satisfaction with family-based services in the public system of behavioral health care. The AI approach ensures that one obtains information about what works well and builds on strengths rather than focusing on deficits or problems. Previously, we would usually look for issues to resolve, problems to fix, barriers to overcome. Instead, we decided to try something different, to look at "what is working," and try to do more of it, model it, and in this way improve behavioral health services. Appreciative Inquiry was developed by David Cooperrider of Case Western Reserve University. Appreciative Inquiry utilizes a 4-stage process focusing on: (1) *Discover*: The identification of organizational processes that work well. (2) *Dream*: The envisioning of processes that would work well in the future. (3) *Design*: Planning and prioritizing processes that would work well. (4) *Destiny* (or Deliver): The implementation(execution) of the proposed design. See Figure 1.

The Parents Involved Network/Family Satisfaction Team (PIN/FST), the Mental Health Association of Southeastern Pennsylvania (MHASP), Behavioral Health Administrators and Family Based Providers collaborated on the family satisfaction project by holding focus groups specific to family based services to determine what was working well within the service.

Figure 1
Evaluating Family-Based Services Using an AI Framework

```
                    ┌─────────────────┐
                    │  Appreciative   │
                    │ Inquiry Approach│
                    └─────────────────┘
         ┌───────────────┼───────────────────┐
┌────────────┐   ┌───────────────┐   ┌─────────────────┐
│ Welcome and│   │Explain Purpose│   │ Explanation of  │
│Introductions│  │  of Gathering │   │  Appreciative   │
└────────────┘   └───────────────┘   │ Inquiry Approach│
                                      └─────────────────┘
      ┌──────────────┬──────────────────┬──────────────┐
┌──────────┐  ┌───────────────┐  ┌──────────────┐  ┌───────────────┐
│Interview │  │Identify what is│  │Positive focus│  │Strengths Based│
└──────────┘  │ working well   │  │  of Inquiry  │  │   Approach    │
              └───────────────┘  └──────────────┘  └───────────────┘
       ┌──────────┐
       │  Share   │
       │ Stories  │
       └──────────┘
            ┌────────────────┐
            │Identify Common │
            │    Themes      │
            └────────────────┘
                 ┌──────────┐
                 │ Common   │
                 │  Vision  │
                 └──────────┘
                      ┌──────────────┐
                      │   Make a     │
                      │ Commitment   │
                      └──────────────┘
```

The FST facilitated focus groups utilizing an AI approach. The focus groups consisted of parents/caregivers of children and adolescents who receive publicly-funded behavioral health services and specifically asked what was working well within the services. The questions asked were: Tell me about a time when services worked really well for your child and family. How did things change? What do you think contributed to the change?

Results

In November and December of 2005, several dozen family members were invited to participate in focus groups. Four family members agreed to participate, 3 in person and 1 by telephone. This was an initial small pilot (trial run) incorporating the Appreciative Inquiry Approach. The focus groups were scheduled during the winter holiday season which many families said made it difficult to attend. Family members cited already scheduled family based services, medication checks and family activities as conflicting with the scheduled focus groups. Recommendations were based on responses from the family members that the FST contacted through letters of invitation, follow up phone calls, and other outreach efforts. Recommendations came from participants in a focus group or an interview format who were receiving family based services at the time or had received family based services.

Family members made some of the following statements about times when family based services worked exceptionally well:

"The make-up of the team"
"Team created the opportunity for their child to open up"
"Learned to advocate"
"Team includes family as part of the team"
"Able to see how services effect change"

"Realistic environment in real time"
"Empowering the parent"
"Encouragement"

Additionally, participants reported that the treatment team is important to providing exceptional family based services; and that the makeup of the team can create success. The focus group was helpful and enabled families to provide feedback. The teams provided support, encouragement, and tools (approaches, methods) for the family, and the families welcomed creativity and physical movement outside of the home.

The information the FST obtained from the focus group evaluation form suggested that the family participants found the focus group helpful, liked the small group format and liked that the positives were stressed. The families who participated in the Family Based focus groups also wanted to be involved in creating more positive family-based experiences. They stated that they intend to demonstrate this by being active participants of the family and team and by being committed to the Family Based therapy. The families also stated that they will give positive feedback to the team when they are doing a good job.

Discussion

Interestingly enough, there was a great deal of excitement generated by using this approach. The families who participated in the interviews enjoyed the process, though at first they were doubtful. When we explained to the providers what we intended to do, we met with a great deal of support and interest. All stakeholders were engaged, excited, and enthusiastic, as well as very intrigued. There was strong collaboration on everyone's part from County administrators to managed care organizations to providers and families. There is rich, qualitative information generated from the interviews being done in an AI way and there is commitment from all stakeholders to create more of "what works."

The FST will be applying the AI approach in all our endeavors to ascertain family satisfaction with children's behavioral healthcare services. FST will reframe the question of satisfaction, whenever appropriate, to ask what is working and to inquire how success can be replicated. We feel that this approach can yield new information and fresh insight into satisfaction levels while still capturing informants' primary concerns regarding services provided.

This is a study in progress and worth pursuing as an innovative approach to evaluating family satisfaction with behavioral health services. Our goal is to elicit information, housed in a positive inquiry framework that promotes change, gives ownership to all stakeholders such that the quality of services for children and adolescents and their families is enhanced. The methodology used to gather the information is multi-modal and multi-informant. Multi-modal uses both qualitative and quantitative methods. Multi-informant gathers information from family members; youth, when appropriate; and providers of service (see Table 1).

Table 1
Mental Health Association of Southeastern PA
Approach to Youth & Family Evaluations of Services/Systems of Care
within an Appreciative Inquiry Framework

Multi-Informant	*Multi-Method**
• Parents/Caregivers	• Semi-Structured Peer Interviews (Quantitative & Qualitative)
• Youth ages 14+	• Structured survey (Quantitative)
• Direct Service Providers— "front line," e.g., TSS, MT, BSC	• Participatory Dialogues & Focus Groups (Qualitative)
• Behavioral Health System Policy Makers & Administrators (County Authority, MCO	• Unstructured Interviews, e.g. PIN (Qualitative)
• Behavioral Health Provider Administrators	
• Other child-serving systems stakeholders	

* All methods can be done via different modalities—face-to-face, written, phone, web/chat. High preference is given to convenience for participants.

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Parents as Navigators: How Caregivers of Children with Mental Health Difficulties Find Supports in the Workplace

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Introduction

For some parents, the gap between the demands of work and family and the resources they have available to meet these responsibilities is too great, particularly for employed parents of children with emotional or behavioral disorders (Brennan & Brannan, 2005). While responding to the increasing demands of the workplace for dedicated performance and significant face-time, parents must also arrange for their children's treatment, see that their educational needs are met, and provide enrichment opportunities in the community (Huang et al., 2005). Despite challenges, these parents have used creative approaches to "cobble together" flexible arrangements that work for both their families and employers (Rosenzweig, Brennan, & Ogilvie 2002). We report the results of six focus groups of employed parents of children with mental health difficulties. This research was conducted as part of a federally funded five-year research project investigating work-life integration for this group of families. Two major research questions guided our analyses of focus group transcripts:

1. What are the employment-based strategies used by family members of children who have emotional disorders that increase work-life integration and reduce workplace barriers?
2. How do family members collaborate with supervisors and human resources professionals in their workplace to combat barriers, and to secure the resources and benefits they need?

Method

Purposive sampling (Patton, 1990) was used with the goal of reaching employed family members from different employment settings and with varied experience. Participants were recruited through parent support and advocacy networks, and through the Research and Training Center on Family Support and Children's Mental Health website. Information was distributed with an invitation to contact the research team with questions and to sign up for the study.

Twenty-eight female family members, with a mean age of 41.5 years (SD = 9.1), and a median family income between $30,000 and $39,000, participated in the research. Family members cared for a total of 59 dependents, of whom 43 (75%) had emotional or behavioral disorders. Approximately half (54%) shared parenting duties with another adult. Participants were generally European American (68%), and had a high school diploma as their highest level of education (57%). Other ethnic groups represented were African-Americans (15%), and Hispanics (7%). Parents reported spending between 5 and 83 hours per week in care activities, and between 7 and 60 hours in paid work. Of those who reported a job with benefits (68%), most had flexibility (79%), sick leave (75%), vacation time (71%), medical leave (64%), and health insurance (61%).

The selection of topics for discussion in the focus group was informed by the results of the project team's previous research, and a review of the literature. Topics addressed were availability and use of formal and informal workplace support, dealing with crises related to their child during work hours, communication in the workplace about family needs, and suggestions to improve work-based support for parents.

A focus group script prepared in consultation with project advisors, was used to guide the discussion in each of the six groups that were held in the same city in the Pacific Northwest. Researchers welcomed participants, introduced the study, addressed participant questions, and followed procedures for informed consent. Prior to the focus group discussion, participants completed a short questionnaire to collect demographic, job-related, and caregiving information. During the 60-minute audio-recorded focus

groups, participants were encouraged to share their individual experience and to build on the discussion of the other family members. The focus group moderators supported the discussion and used probes to clarify responses as appropriate (Krueger, 1998).

Transcripts were prepared from the taped focus group discussions, and the text was entered into NUD*IST (Qualitative Solutions and Research Pty. Ltd., 1993) to manage the qualitative coding and analysis. Qualitative data were coded systematically using an iterative approach, beginning with a careful reading of each transcript by two or more researchers working independently. The identification of preliminary codes was followed by meetings of the research team to discuss and compare interpretations of the first level of data coding, and to develop more substantive coding based on themes.

Results

Five major themes emerged from our analysis of focus group transcripts: (a) communicating at the boundaries of work and family, (b) managing flexible work arrangements, (c) developing and carrying out crisis plans, (d) attaining informal workplace supports, and (e) navigating the formal benefit system.

A primary issue for participants was how much they should communicate to their supervisors and co-workers regarding their children's mental health difficulties. Some decided on full disclosure, even in the initial job interview, so their need for flexible work arrangements would be well known. Other participants practiced self-censorship, disclosing only what supervisors or co-workers needed to know at a particular time. "*I try to limit what I tell people in the workplace, mostly for self-preservation.*" Repeatedly, parents spoke of the stigma they encountered in the workplace, reporting worries about the workplace chill that could result from full disclosure, and their fear of negative evaluations.

Parents discussed disclosing enough about their situation to obtain workplace flexibility: "*being able to take the time off to do whatever it is I am needing to do for my child.*" They reported flexible work scheduling, working from home, telecommuting, and shifting job duties. For some flexibility came with a price: exhaustion after working for extended hours to compensate for work interruptions the previous day, being taken advantage of by school personnel who called on them to manage their children's problems, and reducing work hours to the point that they lost benefits.

Flexibility was made necessary for many of the participants by the crises brought about by their children's acute emotional or behavioral difficulties in childcare or school settings. "*That…was the most difficult thing, because when a crisis does come up, it is hard to leave* [work]." Crisis plans involved: having school personnel lined up to step in when other staff could not manage, having the other parent respond if the participant could not leave work, and obtaining coverage from co-workers so that the parent could take care of the child's immediate needs.

Informal workplace supports made it possible for some to hold paid employment. Understanding co-workers gave moral support, covered for each other in times of greatest need, and even let the parent bring the child to work. Supervisors also provided support through flexibility, arranging coverage, and allowing the parent to respond to crises. "[My boss said]…*Any time you need to take time off, we understand.*" In a few cases, participants mentioned that they faced backlash from co-workers who resented providing coverage.

Finally, the parents discussed their search for formal supports, sometimes through human resources professionals. They took advantage of sick leave to care for children with short-term problems, the Family Medical Leave Act to assist their children in extended crises, and when acute episodes went on for a period of months, used intermittent leave. Employee Assistance Programs were used for counseling or referrals, and insurance was used to provide access to treatment for their child for a limited time. Participants spoke about their gratitude to other parents who helped them use formal work supports to their greatest advantage, and one mother labeled this assistance as "*peer advocacy for navigation.*"

Conclusion

The results of this research make an important contribution to our understanding of parents' experiences of work-life integration when they care for children with mental health needs. These data indicate that the stigma associated with mental illness in the family (Hinshaw, 2005) has a profound effect on the experiences of employed family members. Stigma leads to communication barriers and reduced access to resources and support. It is clear that in addition to redesigning workplace supports to meet dynamic needs of families, other changes are necessary. Stigma reduction efforts are required to increase understanding of how children's mental health affects family and work life. It is also important to examine ways in which schools and employers might collaborate to create more supportive arrangements for families, and new ways in which service providers in systems of care can support families in their efforts to engage in paid employment.

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Family Voice in the Mental Health Services Program for Youth (MHSPY)

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Introduction

Family "voice and choice" is a key Child and Adolescent Services System Program (CASSP) principle (Stroul & Friedman, 1986) and a major design element of the Mental Health Services Program for Youth (MHSPY). Recognizing that traditional child psychiatric approaches have historically failed to recognize the power of family-driven care (McKay, Stoewe, McCadam, & Gonzales, 1998), MHSPY actively engages and relies on the family voice to help create effective change. Based on eight years of experience in the Boston area, this unique program model, which integrates traditional and non-traditional services for families whose children have serious emotional disorders (Grimes & Mullin, 2006), not only seeks to improve the care of individual children, but to help families create sustainable community-based systems of care. This summary describes how MHSPY seeks to integrate family voice at every level of the program to create a family-driven service delivery system.

Method

From the beginning design phase, the MHSPY program has included parents and family members in a collaborative model. Despite the genuine interest across stakeholder groups in hearing from families, standard operating procedures within state agencies and health care settings are rarely "family friendly" and it is easy for professionals to begin to take over the conversation, even if unintentionally. In order to provide counter pressure against business as usual, MHSPY has worked with family members to build multiple mechanisms for participatory governance into the model (see Figure 1). By creating reinforcing layers of system influence at the state agency leadership level (Steering Committee), the local community resources level (Regional Steering Committee), the program level (the Family Leadership Council and the Parent Support Group) and the child and family team level (Care Planning Team), the family voice can be heard and integrated throughout the MHSPY process.

Care Planning Team Process

Building on strengths. From the perspective of a family referred to the program, the first step is for parent/caregivers to sit down with their MHSPY Care Manager (a Master's level clinician with experience in child and family service delivery) and identify what their needs and strengths are and whom they want on their child and family team. The Care Planning Team then hammers out a "mission" for themselves and the child. The Care Planning Team identifies goals to support the mission, and strength based services and necessary interventions are assigned to each goal.

Meeting the need. The parent/caregiver is "CEO" of the process, with the Care Manager acting as "consultant." The larger system of care goal being addressed is for sustainability of the process in the community after MHSPY. The first order of business is to determine who else the family wants on their team. The Care Planning Team starts with the family, then with existing providers and natural supports. A Family Support Specialist (parent professional) may be invited onto the team. Many times MHSPY Care Managers and Family Support Specialists encounter providers who may have "known" the family for years but little progress has been made. Frequently, the family does not realize they can pick someone else or a different treatment option. Unlike other models, where a clinician might only be able to "coordinate" services from elsewhere (case manager model) or provide temporary direct support (family stabilization team model) the MHSPY Care Manager authorizes (i.e. contracts, pays for and manages) all services, traditional mental health, medical and wraparound resources.

Shifting perceptions. Through this structural authority, the family has the power to say: "I don't want to work with that person" or, "can I try acupuncture for my son?" and that plan can be implemented.

Figure 1
Family Voice in MHSPY
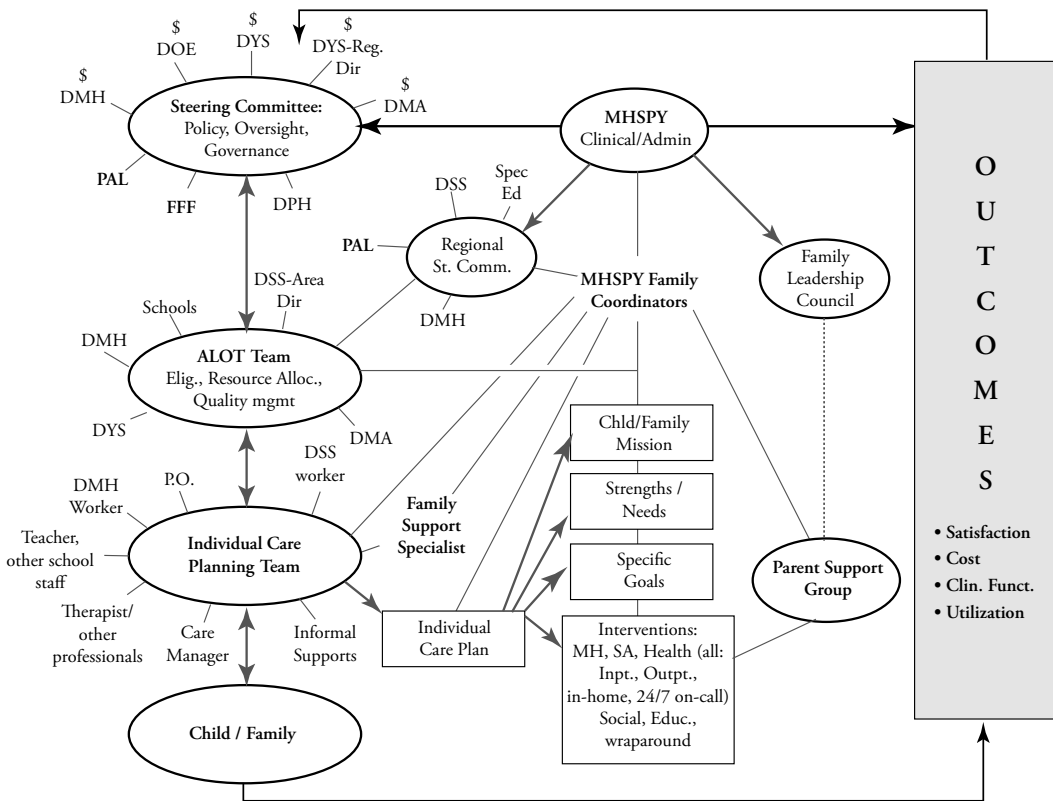
The MHSPY Care Manager can locate individualized providers and add them to the "network" so they can be paid. These providers might just work with one family or go on to work with several. This applies to both standard clinical services (e.g., therapists), and non-traditional resources (e.g., karate lessons with a clinically trained sensei). The family increasingly perceives that they are being heard by their team and that their opinions matter.

Ownership. MHSPY has incorporated structures that ensure that the focus remains on family preferences and continuous improvement. This service system's governance included the Family Leadership Council that provides program wide advice and guidance from involved parents, and a Parent Support Group which offers family-to-family connections and support. In this way, MHSPY is different from many home-based models; there is no standard service package, such as a family stabilization team, that is imposed, with a set time frame and intrinsically determined therapists. Instead, MHSPY care planning offers and individualized process of engagement, ownership, empowerment and change that "takes as long as it takes."

Discussion

There are challenges to this approach, in that these collaborations are relatively new and unfamiliar to clinicians and agency personnel. Therefore staff and families simultaneously work together to help individual children while also creating new models of parent/professional partnership. There are also challenges for professionals across agencies in defining and sustaining new roles within family teams.

At the same time, qualitative evaluations of both parents and professionals, using standardized interview tools, such as the Family Centered Behavior Scale (Allen, Petr & Brown, 1995) and agency satisfaction surveys, indicate multiple rewards from family-focused work in an intensively coordinated, multidimensional system of care.

Parent professionals associated with the MHSPY program identify, respect and understand the real life experiences of families with children that have mental health needs as the foundations for a successful system of care. They note that systemic progress for families can be seen when they encounter mental health professionals who listen to their needs and build solutions using their strengths and the strengths of their child. Voices recorded in a filmed meeting of the Parent Support Group report that receiving support through their communities and in their schools assists families with the challenges they experience daily and gives them hope.

Conclusions

MHSPY relies on the active preferences of the family voice to facilitate engagement. Successful engagement of multiple challenged caregivers is a key outcome of the MHSPY model and a necessary step in creating partnerships for change. Interviews of families, youth and public agency staff suggest that this unique approach to family driven care, with its emphasis on multiple opportunities for family voice, offers tangible rewards for children, families, providers and communities.

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First Findings from the Family-Driven Study of Family Involvement in Systems of Care

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Pat Baker

Introduction

The national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program (Holden, Friedman, & Santiago, 2001) provides information about the impact of systems of care using a standard approach and instrument package. Special studies have been conducted to examine unique issues and to explore the potential of less traditional approaches for evaluation. This paper will present the first findings from the Family-Driven Study of Family Involvement in Systems of Care. The study, designed and conducted by a team of diverse family members, examines the experiences and views of family members in three communities.

The second goal of Achieving the Promise (New Freedom Commission, 2003) is that mental health care will be consumer and family driven. Funded by SAMHSA, the Family-Driven Study of Family Involvement in Systems of Care puts this rhetoric into action. The study was conducted by the Federation of Families for Children's Mental Health in collaboration with the Georgia Parent Support Network and ORC Macro for three reasons. First was to conduct a study of a question of interest to families in a rigorous manner that was simultaneously consistent with the family values of systems of care. Second was to allow families to take the lead in all aspects of designing and conducting a study with highly qualified researchers playing a supportive role and providing technical assistance. Third was to document the experience, process and lessons learned from making the paradigm shift (Osher & Osher, 2002) to doing research in this manner. This paper focuses primarily on the first two reasons for the study.

Family members, practitioners, policy makers, administrators, and researchers all can benefit from the findings of the study itself and the lessons learned by actually doing the study. As this is arguably the first study of its kind to be so well documented, the authors believe the potential for impacting the field of children's mental health research is significant.

To help focus the broad goal of studying something of interest to families, the team conducted a modified Delphi process, a technique to build consensus using a series of written questionnaires with cycles of feedback rather than face-to-face discussions. The team identified 100 experts in family involvement in children's mental health to receive the questionnaires. The first wave generated a wide range of topics that could be studied. The team compiled and categorized these to generate more specific questions for the second round of responses from the same 100 individuals. These results were supplemented with information gathered from focus groups and interviews with key informants. The questions were:

1. How are families engaged in systems of care?
2. What supports or inhibits family engagement in systems of care?
3. Is there a relationship between family engagement and child and family outcomes?

In the course of developing the research questions, it became apparent that there were many different perspectives on what constitutes family involvement. The research team was interested in examining active and purposeful roles for families, beyond simply being present at a meeting or event. The team labeled this active role "engagement" and developed the following definition to insure a common understanding of the term.

> *Engagement is the act of doing something for your child, your self, or your family, that determines or derives from a care plan or supports the delivery of services and supports. Engagement is also participation of families and youth in governance, management or evaluation activities with the intention of improving or enhancing service planning and delivery of treatment, services, supports, or care for children in the community as a whole.*

Families may engage in different ways and intensity as their child's and family's needs change or as opportunities to become engaged in their child's care or in the system vary. Other terms used to refer to these acts have been involvement, participation, advocating, seeking, facilitating, and evaluating.

Method

The study used three methods to gather data: (1) a survey, (2) focus groups, and (3) extracting data from another evaluation in which the participants were involved. Site evaluators and family contacts assisted in recruiting family members whose children were enrolled in the longitudinal study of the national evaluation of the Comprehensive Community Mental Health for Children and Their Families Programs. Families from three communities who had received services in the past year were invited to participate in the study. Those indicating interest were sent a short questionnaire consisting of both closed and open-ended questions. Five focus groups of seven to nine individuals who had responded to the survey were held to supplement the survey data. With participant permission, child and family descriptive and outcome data were extracted from the national longitudinal data set and integrated with results from the survey for quantitative analysis.

The family driven study team reviewed existing instruments used for the national evaluation and looked for other instruments that assessed family engagement. Most items they found assessed a family's satisfaction with services or providers or their accessibility. These were not appropriate for this study.

The family driven study team was interested in the family's own perceptions about their engagement with the system of care. It was very important that the family be given the opportunity to describe how they engaged (specific activities or actions) how engaged they felt (level or intensity), and what impact they felt their engagement had on their child and family (outcomes). A new instrument was needed to answer these questions.

The team began by creating a question bank of their own. They then held three focus groups of family members to get reaction to their definition of engagement and some of the items in the question bank, as well as their preferences for different methods for collecting information and offering incentives for their participation.

The focus groups yielded support for some questions, provided clarity on others, and generated some novel ideas. Mixed opinions regarding methodology for collecting data led the team to a mixed-methods approach for the final study.

The team was committed to a minimalist approach to data collection, only asking for items that were really needed and could not be obtained elsewhere. Hence the effort to link survey responses to the national evaluation's longitudinal study. The result was a two page survey. There were field tests after each of three revisions of the instrument.

The team developed the moderator's guide and protocol for the focus groups after the they had completed the survey and received training on focus group methodology. The moderator's guide was designed to explore the same themes as the survey but in more depth. The survey questionnaire and the moderator's guide and focus group protocol were approved by the Office of Management and Budget (OMB).

Qualitative analysis was conducted on the responses to open-ended items on the survey and transcripts from focus groups. Team members, working in pairs, conducted thematic coding of these data, looking for patterns, similarities, and differences. Each pair reviewed a printout of all the responses to one question at a time. Separately, each member of the pair identified themes for the same item. They did the same for a focus group transcript. The pairs compared their results and reached consensus to develop a common language about the themes in the data they had reviewed.

The full family driven study team reviewed and discussed all the themes for all the questions and transcripts to decide on a set of overarching categories so there would be consistency across the final analyses. The pairs then reassigned each item on their list of open-ended responses and their focus group transcript using the overarching categories.

The demographic profile of the 82 families that completed the survey was similar to that of the other 1,872 families receiving services from the systems of care communities in Jackson, Mississippi, Indianapolis, and rural Minnesota. However, since respondents were self-selecting and many were already engaged with the family organization that assisted in supporting their participation in the study, they may have been inclined to higher levels of engagement than families who chose not to respond.

Results

Thematic analysis of the responses to open-ended questions provided insight into how families describe their own engagement in systems of care, and what supports or inhibits engagement as defined by the study team. There were 82 respondents to the survey. For each of the open-ended questions, respondents were allowed to give up to two responses. Thus, the number of responses to each question varied.

The predominant themes regarding support for family engagement were support services and information, as well as opportunities for personal growth leading to empowerment and advocacy roles (104 responses). Representative responses included "being respected by professionals for their intelligence and involvement," and "having a better understanding of where to access information."

Over half of the responses (56% of the 64 responses) about what inhibits family involvement identified issues that impacted access to services. Specific issues mentioned were time constraints, lack of resources close to home, "revolving therapists," and waiting lists.

Seventy-two responses were provided to open-ended questions about the positive changes respondents had seen in their child and family. Personal growth or self-awareness, including empowerment, were endorsed in about 40% of the responses, and changes in their child's behavior or functioning in about one-third. "We are more apt and quicker to tell a treatment provider *thanks, but no thanks*," was a typical response.

Families provided 107 responses addressing what they believe contributed to the positive changes they see. Empowerment and their own participation in services were the most common themes endorsed by families. Their comments specified having trust in the case manager or therapist, and the knowledge necessary to interact with school personnel. Of the 107 responses, about one-third endorsed services as contributing to change, 15% supports, and 13% information.

Analysis of the survey data revealed a statistically significant positive relationship between family perception of the level of their engagement and their perception of positive outcomes for their child and family, ß = 0.482, *p* = .000 (see Figure 1).

Figure 1
Relationship Between Engagement and Perceived Improvement
in Outcomes Due to Engagement
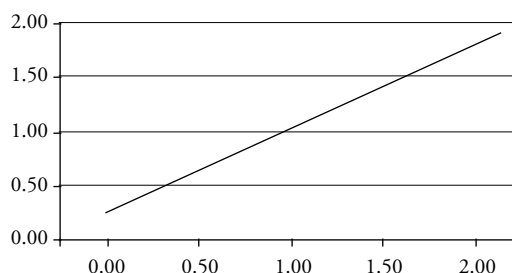
To investigate the relationship between family engagement and child and family outcomes, respondents were divided into high and low engagement groups. Various analysis strategies (General Linear Modeling and Loglinear Modeling) were applied to discern relationships between the family's level of engagement and child's outcomes in the data from the national longitudinal outcome study. The dependent variables used included functional and clinical outcomes (from intake to 18-month follow-up), with family engagement serving as the predictor variable. Results indicated that there were no significant differences between high and low engagement groups in terms of change in outcomes. However, there was some indication that the children of more highly engaged families were less likely to experience detention in school or expulsion from school, $Z = 2.522$, $p = 0.012$.

Demographic analysis of the high and low engagement groups did not reveal any statistically significant differences between the two groups. However, raw data from the survey did show some differences in how families of different racial groups characterized their level of engagement. White families reported much higher levels of engagement (80% say *a lot*; 0% say *none*) than Black or African American families (22% say *a lot*; 11% say *none*). Further research is needed to determine the extent of these differences, and whether they are related to differences in opportunity to be engaged, cultural values, family perceptions of what is needed and helpful, or some other factors.

Discussion

The Family-Driven Study team concludes that families of children enrolled in systems of care believe that their own engagement in those systems of care does have an impact on outcomes. Support services and relationships with peers and professionals (rather than clinical services) and activities that enhance their knowledge and skills so they can be effective advocates for their child seem to be most valued by families. Functional (rather than clinical) outcomes also seem to be most valued by families. The kinds of engagement and the outcomes families report have implications for the field and merit further study. Tools used by the national evaluation may not capture all aspects of engagement or the outcomes considered relevant by families.

This study opens the door for much further research. This includes further study of the survey instrument itself to determine its usefulness as a means of assessing how families describe and feel about their involvement in their child's care. The themes from the qualitative analysis suggest topics for further investigations into what supports and what inhibits family involvement in their child's care. Finally, the differences in perception of engagement reported by families from different racial groups merits further investigation.

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The Role, Impact and Effectiveness of Family Organizations in Developing Family Voice in Systems of Care

Symposium Introduction

Katherine J. Lazear

This symposium is built on the theoretical framework that there are certain system implementation factors which, when put into practice within communities, contribute to establishing well-functioning systems of care for children with serious emotional disorders and their families. This symposium examines how one of these factors—a strong family voice—contributes to the implementation of effective systems of care.

Chair
Katherine J. Lazear

Discussant
Lisa Conlon

Authors
Susan Hickcox
Connie Wells
Laura Weber

First, in Maricopa County, Arizona, a Managed Care Organization contracts with a family-run organization, the Family Involvement Center (FIC), to ensure the County's mental health system is family driven. The next summary addresses how the Florida Institute for Family Involvement/Florida Federation of Families for Children's Mental Health has championed strategic planning methods that guide policymakers to better understand the perceptions and real needs of families. The third overview addresses efforts to assess the current status of the literature on family organizations, in the interest of framing lessons learned in North Carolina. The family organization movement has grown significantly over the past 20 years, yet is a dearth of literature that details the journey of developing, running and sustaining family-led organizations. Together, these projects suggest an emerging methodology for bringing family voice to the center of service delivery reform.

Bringing the Family Voice to Practice Improvement by Pairing Professionals with Parents to Interview Families Receiving Services through the Child and Team Process

Susan Hickcox

Introduction

In 2001 a historic settlement to improve mental health and substance abuse services for children in Arizona's State Medicaid Program resolved a 10-year-old lawsuit. The settlement set forth a set of 12 principles that emphasized partnering with families and youth, interagency collaboration, and a child-and-family team approach for coordinating, designing and delivering individualized services. In Maricopa County, Value Options, the managed care organization (MCO), funded the development of a family-run organization, the Family Involvement Center (FIC) to hire family members to work on child and family teams. Other system building partnerships included the formation of a Maricopa County Collaborative, which brought together Maricopa County families and the following child-serving agencies including the Arizona Department of Health Services, the Department of Economic Security, the Arizona Health Care Cost Containment System (AHCCCS; State Medicaid), the Department of Education, and the juvenile probation and corrections systems. Under this Collaborative, the Assessments and Outcomes Sub-committee implemented a Child & Family Team (CFT) Interview process. These interviews were distributed in three formats: Family, Family Support Partner, and Facilitator. Interview questions were designed to represent issues associated with the 12 principles and the four Functional Outcomes: (1) engagement and relationship with child and family, (2) identify strengths culture, and needs of child and family, (3) create an Indivdualized Service Plan, and (4) implement, monitor and modify the plan toward a successful outcome for the child and family.

This initial interview process has taken on many different forms over the years, but the family voice has always been at the core of this practice improvement process. This summary describes how families have been actively involved in quality improvement processes, in evaluating system performance, in helping to recruit and select interviewers, and in training activities.

Methodology

Getting a full picture of how families were doing in the CFT process was important to the Assessment and Outcomes Committee. In June 2005 it was decided that pairing professionals and family members to work together, reviewing and interviewing, would provide the most complete picture of how to improve practice in Maricopa County. Value Options and the Family Involvement Center collaborated in managing the process as follows: Value Options requested a random "pull" of active CFTs (the CFTs had to be in place for 90 days or more). Once that process had been completed, information about the CFTs was "sifted" by demographics predetermined by the Assessments and Outcomes Committee. It was determined that each Comprehensive Service Planner (CSP) would have between 10 and 12 cases reviewed by the team. Professional reviewers were selected and put on a scheduling spreadsheet. Once the final CFTs for review were selected, the Family Interview Coordinator at the Family Involvement Center scheduled the interviews, placing the family interviewers with the professional interviewers.

Ten agencies were reviewed over four days, Monday through Thursday, with a debriefing on Friday for each of the agencies. Each interview team reviewed the files, interviewed the case manager (facilitator), the family and the child. Child Protective Services staff members were included in interviews when they were involved with the child and family. Each team completed a family interview each day, and scored the activities of the CFT across four domains:

1. Engagement and establishing a trusting relationship with the child and family
2. Clearly knows the family and has identified the strengths, culture and needs of the child and family
3. Has created an Individualized Service Plan that meets the needs of the child and family
4. Has implemented, monitored and modified the plan toward a successful outcome for the child and family

Scores were based on a one-to-four scale with the following measures: 1 = *a substantially unacceptable performance*; 2 = *a partially unacceptable performance,* 3 = *a minimally acceptable performance*; and 4 = *a substantially acceptable performance.*

The Practice Improvement Tool included questions addressing each of the four domains. Each question was answered with *yes*, *no*, or *n/a*, with additional space provided to record respondents' comments as they elaborated on their answers. Following the interview questions, sections were included to capture recommendations, needs, and a summary. Once the team finished each section of the interview they discussed their scoring and arrived at a score they both agreed upon. During the training we left the option open for team members to agree to disagree and to leave a particular item unmarked if they could not come to a consensus. There were no unmarked questions.

Results and Discussion

A two-day training on the Practice Improvement Tool and a hands-on demonstration of a family interview were created and implemented by Value Options and the Family Involvement Center. The unique element of implementing the review process was the pairing of the professional with a family member on review teams. As a result of this process, professionals who were involved in policy making (but never were on the "front lines" of service provision) partnered with a family member on review teams, interviewed families, and visited families' homes; thus, professionals and family members were able to share perspectives as peers, with the common goal of improving the system.

Family interviewers and families and children benefited from sharing the family perspective and interacting with policy makers, clinical supervisors and executive staff.

Family voice has been at the core of this recent practice improvement work in Maricopa County. The impact of the collaboration of system partners and the active involvement of families in quality improvement processes, evaluation of system performance, recruitment and selection of interviewers, and in training activities continues to be systematically monitored.

Using Family Perceptions to Guide System of Care Development

Conni Wells

Introduction

This summary describes how data collected on encounters with families over a period of several years have informed organizations, programs, and resource and policy development to ensure that efforts are built upon the voice and needs of families, as *they* perceive them. Through strategic planning that responds to the perceptions of families, the Florida Institute for Family Involvement/Federation of Families for Children's Mental Health has helped policymakers to better understand the real needs of families. The processes described here have also assisted in identifying and developing targeted information, resources, and training to enhance the capacity of families and providers to navigate the system of care.

Method

Methods used to collect data were aligned with the populations served and their level of communication comfort[1]:

- *Encounter data.* This included information regarding the family, their needs, and the purpose of the encounter. These data also outline which system of care issues were interfering with families' ability to access necessary services.
- *Family View Points Survey.* This survey was designed by and for families of children and youth with special health care needs and mental health care needs. The survey is based upon questions used in the State and Local Area Integrated Telephone Survey (SLAITS, n.d.); a population-based survey developed by the Centers for Disease Control and Prevention to measure and monitor changes in health, health care, and well-being at state and local levels to enable a comparison between results, national geographic areas, and as a reliability check.
- *Family/Youth Forums and Focus Groups.* Forums and groups conducted structured but informal conversations with families and youth to identify and explore their perceptions of the system.
- *Family Story Bank.* This is a searchable database with family stories detailing their experiences interacting with the system of care.

Findings

We found that professionals are looking for simple to understand, accessible information at a level almost equal to families. We also discovered that system gaps have created major obstacles for families as they seek a medical home and culturally competent care for their child. From the data, it appears that financing issues are the major barrier to the access to appropriate mental health services. Yet families have answers for system failures, and we can learn much from them.

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[1]*Surveys and tools are available upon request from the author.*

Conclusion

Families are reputable historians of system encounters when approached in a family-centered, culturally competent manner. Their ability to identify what they need, along with the barriers that interfere with their navigation of the system, are dependent upon the approach, style, and their perception of how the information will be used. Information gathered from families can be used for the following operations in system of care:

- Program Development
- Program Evaluation
- Provider Selection
- Contract Management
- System Advocacy
- Reality Check

Of critical importance is the use of "authentic" family voice to drive the system transformation. An authentic voice is one that represents the perception of families of children served by the system and results in views that are not coerced or shaped by anyone other than the families themselves.

Gathering, sharing, and using the perception of families carries risks with associated consequences because not all stakeholders are in a position to justify their actions or inactions. Further, the reality of the family experience can be a threat to leadership, and not all systems representatives are committed to a family driven transformation.

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What the Literature Says about Family-Run Organizations and Lessons Learned from the Field: Family-Run Organizations within a System of Care in North Carolina

Laura Weber

Introduction

The system of care (SOC) philosophy is a framework for improving child mental health outcomes and is changing the relationships between families and the service system at every level. Family voice and partnership is the thread that links together successful programs, policies and practices. As professionals continue to recognize the importance of family voice, mandates and funding have followed. This trend is a major impetus for the increase in independent family led networks, organizations and groups. It is these groups, started around a kitchen table or in a spare bedroom, that are the nucleus of the movement. However, little is known about the development and evolution of these groups and even less is known about how best to sustain these groups. As family involvement is increasingly seen as best practice, it is essential to understand the variety of models and structures of family groups, the activities that increase parent voice and involvement in systems reform, and the conditions necessary for their sustainability. This literature review provides a backdrop of family involvement within a SOC, the efforts in North Carolina (NC), and what is known about the necessary conditions for sustaining family-run groups.

Findings and Discussion

Family involvement in SOC had its roots in the fertile grounds of the peer support, self-help and consumer rights movements of the 1970s as evidenced by the development of national non-profit groups such as the National Alliance for the Mentally Ill. This early work gained further momentum and

recognition through federal legislation such as the 1984 Child and Adolescent Service System Program that provided support for the development of statewide family organizations (Briggs, 1996). In 1988, programming that mandated family participation in children's mental health began (Stroul & Friedman, 1986) supported later by the Surgeon General's Report (US Department of Health and Human Services, 1999) and the President's New Freedom Commission on Mental Health (2003).

As a result of these influences, family involvement is a more common part of the professional lexicon. This is evident in the values and guiding principles of SOC (Stroul & Friedman, 1986), which have been adopted as key elements in the reform of NC mental services. For example, the 2001 State Mental Health Plan makes provisions for family and consumer advisory committees for advisement on all aspects of local system development. These developments were supported by NC's four SAMHSA/ Children's Mental Health Services (CMHS) SOC grants. One way increased family involvement can be accomplished is through the development of family led support and advocacy groups. Currently in NC, there is a statewide family network and at least 18 family-run groups that were started in response to children's mental health concerns. Despite the commonality of their roots and influences, there is considerable diversity among these statewide and local groups in their structure, point of origin, staffing, funding, activities, and longevity.

When one examines the research base for what makes for successful development and sustainability of a family organization, there is a paucity of scholarly literature; however, slightly more information is available in the technical assistance documents produced by university-based research centers and national organizations, including foundations. Drawing on this literature and the related arenas of statewide family network development, community development, and organizational development, some insights can be drawn about the necessary conditions for the successful development and sustainability of family led groups.

Community development and neighborhood revitalization are fields with close ties to family run groups in the mental health field. The premise of all these groups is that fundamental change comes when those directly impacted are part of the change process. But how to ensure that they are part of the change process is less clear. The few studies that are available highlight a fairly consistent set of skills, such as leadership, and activism, advocacy, and organization (Joseph et al., 2001) that are needed in order for families to participate in full governance. Among the most frequently mentioned skills are leadership and leadership development (Koroloff & Briggs, 1996; Annie E. Casey, n.d.). Joseph and colleagues (2001), in a final project report for the Annie E. Casey Mental Health Initiative for Urban Children, adds that in addition to skills and experience with activism, advocacy and organization, individuals need skills and knowledge in areas of mental health policy and system reform, financing, management information systems and working in partnership with state and local governments. Furthermore, early and ongoing technical assistance supporting the further development of these skills is needed (Cornerstone Consulting Group, 2002).

Few sources speak directly to what is needed to sustain family led organizations. One organization, the Mary Reynolds Babcock Foundation (MRBF), began the Organizational Development Program in 1995 with community-based organizations. Through this work, the MRBF created a list of 13 areas of focus for sustainability. They, too, agree that much has been published about organizational theory and management, but this literature does not cross over to small grassroots community based organizations. What little information that is available comes from technical assistance providers. For example, the Federation of Families for Children's Mental Health Tip Sheet on Sustainability (2004) lists the following as areas of focus for sustainability: (a) developmental process, (b) building relationships, (c) cultural competence and diversity, (d) independence and autonomy, (e) communication networks, (f) running a business, and (g) funding and accountability.

Similarly, Weber (2004), after reviewing the literature and observing the development of family led organizations in NC, describes the following as necessary conditions for the sustainability of newly emerging family led organizations in a SOC: (a) strong family leadership, (b) sufficient paid staff, (c)

adequate and stable source of funding, (d) adequate infrastructure, (e) organizational commitment, (f) fiscal sponsors, and (g) early and ongoing technical assistance and training.

Conlan (2005), another technical assistance provider, presented consistent findings indicating that (a) planning and leadership, (b) organizational culture, (c) relationships and partnerships, (d) organizational relevance, (e) education and services, (f) fund/resource development and (g) volunteer capacity must be attended to for family led groups to be sustained.

Based upon the available limited research, the following areas are highlighted for continued exploration:

- *Family experience.* More information is needed from the families themselves, that is, from those who have tried to start groups and succeeded, and from those who have not succeeded. Researchers need to partner with families to describe and detail, from the family perspective, the necessary conditions for sustainability.
- *Original design.* How does the design, the target population, the issues and age ranges addressed affect the ability to sustain the work? What was the original purpose and funding for the group? From what source was the group initiated?
- **Funding.** Money often complicates the picture and efforts should be made to understand its impact. Important issues such as the source and recipient of the funds, how much money is enough, and what is the critical threshold of funds for a given group in a given area need exploring. Who controls the funds is also an important issue.
- *Leadership.* This topic was mentioned in a significant amount of the literature but rarely expounded upon. How are family leaders chosen and by whom? What are the qualities of leadership that support organization sustainability? What does leadership development look like for family led organizations? What needs to be included and how should it be implemented?
- *Technical assistance and training.* It becomes important to identify some of the specific competencies and skills needed by family leaders and to address which modalities are best for increasing competencies. For example, who should provide the technical assistance and training and what is the nature and duration important to sustainability?
- *Organizational model.* As family led organizations grow, there becomes an expectation either implicit or explicit that they will obtain a formal structure and incorporate as a nonprofit organization. Little work has been done to research other useful models for sustainability such as different methods of fiscal sponsorship or the development of a consortium model.

In 1996, Briggs suggested that the literature is lacking because national, state, and local family organizations have only started within the last 10 years, and that family support programs in children's mental health are also relatively new. However, 10 years later, the importance, role and benefit of family involvement in human service delivery systems is well documented. The on-the-ground experience of partnering with families is beginning to drive funders and researchers to develop strategies to gain a deeper understanding of the necessary conditions for sustainable family led organizations. Assessing the Role of Family Organizations in Developing Family Voice in Systems of Care, a current study by the Research and Training Center for Children's Mental Health at the University of South Florida, will research the factors that support or impede developing and sustaining family organizations within the context of SOC. This research will lay the foundation for new knowledge that will support the development and sustainability for family led groups, thereby ensuring the continuation of family voice and participation in SOCs.

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Symposium Discussion

Lisa Conlon

The three papers presented in this symposium highlight a number of developmental characteristics of family organization, including promising approaches to growth and sustainability, as well as longstanding organizational challenges. The field must continue systematic examination of family organizations focused on their external and internal characteristics, and the influence on and from system of care partners. Research needs to identify measurable factors that facilitate the active and influential inclusion of family voices in systems of care activities so that necessary transformation of the system can occur.

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