# Creating a Community of Care for Seriously Emotionally Distressed Youth:

# The Mott Haven Initiative, A Systems of Care Experience

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I am because we are and because we are, therefore, I am.

African proverb

## Introduction

This chapter describes the Visiting Nurse Service of New York's Mobil Community Support Service's (MCSS) creation of a caring community for emotionally distressed youth based on recognizing that we are one; we are family. The MCSS is a component of Families Reaching In Ever New Directions, Inc. (F.R.I.E.N.D.S, Inc.). F.R.I.E.N.D.S, Inc. is a mental health agency located in Mott Haven, a part of the South Bronx, New York. The F.R.I.E.N.D.S agency was created by a federally funded grant for the express purpose of establishing a family driven system-of-care. In family driven programs, families are partners in all decisions; no treatment meetings are held without family members. Moreover, at F.R.I.E.N.D.S, Inc. family members comprise half of the agency's Board of Directors.

The MCSS service seeks to form what Madsen calls "appreciative alliances" (1999) with families. At F.R.I.E.N.D.S the MCSS staff and the rest of the caring adults, including the specialized caretakers, function as a youth's extended family. The term family is used in the sense described by a group of family members from the federal government's Comprehensive Community Mental Health Center for Children and Families Program. This group lead by Osher sought to establish the concept of family as including those who defined themselves as a family member. According to this team, "Families can include biological or adoptive parents and their partners, siblings, extended family members (called kinship caregivers), and friends who provide a significant level of support to the child or primary caregiver" (Osher et al., 1999).

The team is encouraged to think of the youngsters in the MCSS's care as "our youth" as this promotes a greater sensitivity to the concept of family and shared responsibility for meeting the needs of young people. The terms client, patient, delinquent and case are avoided. Families do not talk of cases, clients, patients or delinquents but of daughters, sons, sisters, brothers, aunts, uncles, nieces, nephews, and cousins. "What would you want for your child?" is a frequently asked question during supervision. So is "What would you want to hear if you were this youth's parent?"

In the same spirit, the term seriously emotionally distressed replaces the more traditional use of the term seriously emotionally disturbed. We believe the word distressed offers greater recognition that the family and youth are responding to multiple stressors. This stance suggests that the situation creating such stress needs changing as much if not more than the families or youth.

A related assumption driving the MCSS is that the stress our families and youth face is traumatic stress. Such stress can come from witnessing one act of violence directly or from dealing daily with abuse and other traumatizing events. We believe all living in Mott Haven have been traumatized in one way or another. For many, the traumas have been so embedded in their lives as to seem normal. More and more theorists are viewing such stress as a major contributor to mental illness. (Garbarino, 1999; Kessler, 2000; Perry, 2001; Seikkula, Alakare &Alltonen, 2001; Terr, 1983; van der Kolk and Fisler, 1995).

According to this theoretical perspective, the agency and community serve as the treatment medium, not just for the specific child dealing with serious emotional distress, but also for the child's entire family, for all the service providers serving the child, and for the community at large. Community-based clinical care cannot stop with one-on-one care or with the relationship between client and clinician. Adequate clinical care for those living in trauma filled communities must tend to the youth, the family and the community. The MCSS has translated the above perspective into action primarily through use of a Tri-level Intervention Model of Care.

The chapter will (1) briefly review the theoretical changes leading to the current emphasis on community based, family driven care; (2) describe key components of the Tri-level Intervention Model of

Care; (3) illustrate use of the model, discuss outcomes including difficulties as well as successes, and (4) review lessons learned.

## Theoretical Changes

Analytic theories, social-biological theories including genetic determinism, and learning theories, each hoping to scientifically explain human behavior, came of age in the same century (Bronfenbrenner, 1979; Germain 1991; Potkay & Allen 1986; Pinker 1997). Like siblings seeking parental love, these various mental health models have long competed with each other. Proponents of each theory have proclaimed effectiveness while loudly or subtly denigrating other theories (Miller, S. et al. 1997; Duncan, et al. 2000).

As efforts to effectively help the seriously emotionally distressed have grown, it has become increasingly clear that like the proverbial blind men grasping separate parts of the elephant, early practice theorists were correct in their theorizing for what was in their immediate grasp, but no one had the final answer. Fortunately, some have begun to see the whole and to take a "yes/and" approach rather than an "either/or" approach to understanding human behavior (Duncan et al. 2000; Gergen, 1994, 1999; Kagan, 1984; Morgan, 2000; Meyer, 1983). As Kagan notes "It is almost a general truth that the understanding of every complex phenomenon requires a simultaneous appreciation of complementary concepts."(1984 xii).

As some theorists have moved toward broader approaches, so have practitioners worked to discover better ways of helping. Since the 1960's the number of therapies has grown from 60 to over 250. Simultaneously, as recent evidenced based efforts have shown, no one approach was been found to be more effective than another. Some approaches might prove better in some situations, but no one approach works for all (Burns et al., 2002; Duncan et al., 2000; Henggler et al., 1998; Lambert & Bergin, 1994; Schoenwald & Rowland, 2002).

## Families as Partners

As mental health practitioners struggled to figure out how best to help, many began to partner with the very people they sought to help—consumers. In terms of children's mental health services this

has meant partnering with families. During the development of mental health services, parents have been blamed for creating the youth's problems or impeding his or her treatment. The child was the identified patient and symptom bearer for the family. The family's dysfunction caused the child's problems (Haley, 1997). Moreover, in spite of mounting evidence to the contrary; Schopler, 1971; Schriebman, 1988; Thomas & Chess, 1984), families continue to carry most of the blame for a youth's mental health problem.

This blaming and exclusion of caregivers from the treatment process runs counter to acceptable practices for a mildly physically ill or injured child. In such situations, caregiver knowledge, what the narrative therapists describe as "local knowledge" (Morgan 2000) is expected to suffice. (Miller & Diao, 1987 A child or adolescent suffering a minor sprain might never reach the attention of specialists. Experienced parents or caregivers familiar with life's every day injuries treat such injuries without benefit of professional advice. If the injury is such that local knowledge does not suffice, then the child is taken for medical care. This care might be provided through an office or if the injury is more serious, say a compound fracture of the leg requiring complicated surgery, through hospitalization where a system of specialized care can be called into action. If hospitalization is required, the goal, however, is always to return the child home as soon as possible. Unfortunately, long after it was realized physically ill children did better cared for at home when that was possible, the treatment of choice for seriously emotionally distressed youth has too often been removal from home, school, or community

## The Systems of Care Approach

Since at least the 1960s, government policy makers and others have raised concerns about the mental health treatment of children including the tendency to pursue placement and to exclude families from planning or participating in their child's treatment. (Duchinowski, Kutash & Friedman, 2002.; Knitzer, 1982; Koop, 1987; U.S. Department of Health and Human Services. 1999). As noted by the Joint Commission on Mental Health of Children, the services available in the 60's did not adequately serve youth in need. Specifically, the concern was that youth in need of mental health services were not being adequately served. Not only were the desired results lacking, but care was fragmented; various providers

competed, were often at odds, and failed to communicate with one another or with parents and caregivers. No continuum of care and no intermediate community-based treatments existed; youth with serious emotional distress were generally to be found in restrictive settings; other treatment choices were limited to outpatient care. (1969). These complaints were repeated again and again. (The Joint Commission on Mental Health of Children 1969; Kintzer 1982; Koop, 1987; The President's Commission on Mental Health 1978).

Fortunately, as the inadequacy of traditional approaches to treating seriously emotionally distressed youth has become more and more apparent, the willingness of families to be relegated to a back seat has eroded. Families began to challenge the experts and to exert a greater influence on policy makers. In 1979 the National Alliance of the Mentally Ill was established, and in 1989 the Federation of Families for Children's Mental Health was established. Such politically active family driven organizations have played an important role in shaping what has come to be known as the systems of care approach. Systems of care emphasize community-based-care, comprehensive and individualized services, extensive use of supports including the use of local and family identified supports, full participation of families, coordination among child-serving agencies and programs, and cultural competency. (Friesen & Stephens, 1998;Henggeler et al., 1998; Osher et al.,1998; Stroul & Friedman, 1994).

Discussion surrounding the need for this systems-of-care approach has existed since the Joint Commission on the Mental Health of Children in 1969. Movement toward meeting that need has been slow. A major step in that direction was taken when the Child and Adolescent Service System Program (CASSP) was initiated in the early 1980s. Initially, small capacity funding grants were issued, and finally in 1992 Congress created the Comprehensive Community Mental Health Services and Their Families Program. This legislation funded 67 large demonstration grants through the Center for Mental Health Services. In 1994, New York State received a 17 million dollar grant to develop a mental health based systems of care for the youth of Mott Haven, a section of the South Bronx, NY. The Mobile Community Support Service (MCSS) became one of the components of the Mott Haven systems of care projects. During the initial grant period, the other components included case management, family support, youth

leadership, and a respite and recreation program with local mental health clinics serving as part of the broader systems of care. A homework help program was added to the grant after three years of operation.

The core F.R.I.E.N.D.S, Inc. staff currently consists of an executive director, deputy director, an access coordinator, an office manager, a financial director, an administrative assistant, a director of family support, two parent consultants, a director of home work help, three home work help tutors, three youth leaders, a receptionist and file clerk. Three of the staff have advanced degrees. Half of the staff, including the executive director live in Mott Haven. As previously noted, one half of the Board of Directors is composed of family members. Since federal funding ended, primary financial support for F.R.I.E.N.D.S, Inc. has been provided by the New York State Office of Mental Health.

## Mott Haven

Mott Haven was selected for this grant because it was a triple jeopardy community and known for its high prevalence of mental illness, substance abuse and physical illness. Moreover, at the time of the grant, existing services were not adequate and competed with one another while mental health services for children were particularly lacking. Finally, the fact that it was the poorest community district in the United States also played a part. Kozol in his book *Amazing Grace* says this about Mott Haven:

> ...I walk for hours in the neighborhood, starting at Willis Avenue, crossing Brook, and then St.Ann's, going as far as Locust Avenue to look at the medical waste incinerator one more time, then back to Beekman Avenue. In cold of winter, as in summer's heat, a feeling of asphyxia seems to contain the neighborhood. The faces of some of the relatively young women with advanced cases of AIDS, their eyes so hollow, their jawbones so protruding, look like the faces of women in the House of the Dying run by the nuns within the poorest slum of Port-au-Prince [Haiti]. It's something that you don't forget. (1995, 8)

## Visiting Nurse Service of New York (VNSNY) Programs at F.R.I.E.N.D.S

VNSNY is funded to provide two services by F.R.I.E.N.D.S, Inc. One contract provides a specialized Respite and Recreational service (R&R). R&R provides recreational services to those

youngsters not able to utilize traditional recreational services. The primary goal of the service is to teach the youngsters the skills needed to make use of traditional services. R&R also provide respite care to F.R.I.E.N.D.S families in crisis. The R&R team consists of a respite coordinator and four respite workers who serve 50 youths a year in addition to providing twice monthly events for a larger number of youth and their families. The R&R service is not the focus of this paper; the MCSS is.

The MCSS provides consultation, clinical assessment, and crisis stabilization services for F.R.I.E.N.D.S, Inc. families and youth. The MCSS consists of a Program Director, a Program Coordinator, a half time Child Psychiatrist, a Community Mental Health Nurse, two team leaders, three bachelor level social workers, two parent advocates, two case aides, and an administrative assistant. The MCSS team serves 150 youth and families a year and provides 500 consultations to community residents and service providers a year.

The MCSS was initially designed to provide a traditional mobile crisis and Home Based Crisis Intervention (HBCI) service using the Homebuilder's model. (Kinney et al., 1991). The Homebuilder's model provides intensive crisis services in the home over a six to eight week period. Each service provider works with only two youngsters and their families at a time. Families are seen four to five times a week for an average of 4 to 5 hours per visit. Finally, service providers are on call 24/7. Skills teaching serves as the primary treatment modality. Since the early 1990s, VNSNY had run several successful HBCI programs and had participated in research involving those services. (Evans et al., 1997; Evans et al., 1999).

In planning for the MCSS, family members soon made it clear they wanted something more than a traditional crisis team or Homebuilder's service. As one parent noted, "Crisis intervention is too late. If we are in a crisis, we know where to go for help. What we need is help before the crisis. We need help when things are starting to get tough or when our children begin to have trouble in school" (Levine, 1999).

Family members also made it clear they wanted more flexibility then traditional HBCI services provided. Over the course of the first year a number of changes were made that brought the MCSS into

better alignment with family desires. The first change involved the ability to see families in an office as well as in the home or school as long as safety did not require home visiting. Direct services are provided in the home or the office depending on what the family wants. This offers greater flexibility and more choice to both caregivers and youth. Another change has been in the frequency of services. MCSS visits are scheduled frequently, but only until safety is established. Thereafter, the family has greater input in determining the service plan, including how often visits should be made.

Another change involved the ability to stay involved with a family even if hospitalization or another placement proved necessary. Traditionally, HBCI services end if a youngster is hospitalized or placed. This lead to families and youth feeling abandoned by the team when most needed. The MCSS stays involved with hospitalized family and youth until the child is safely returned home and long-term services are in place or until long term placement becomes the discharge goal. Even if long-term placement becomes necessary, the MCSS will be available to help if the family desires whenever the youth returns home.

The final way the model was changed was the addition of support staff. MCSS added parent advocates and case aides who serve as mentors and youth advocates. The addition of support staff to the HBCI model led to an adjustment in how many cases a worker carried. Service load is now determined by number of hours spent on case management tasks and not just by the number of families served. Line staff is expected to provide 20 to 25 hours a week of service. Those hours can and do include trainings, case consultations, supervision, and travel time. Sometimes a worker will carry two cases, at other times three, four cases or more cases.

Services often begin with a consultation. If it appears the child needs more immediate care than can be provided by a community mental health agency or school, a clinical assessment including a psychiatric evaluation is completed. Based on this assessment, intensive services are provided as needed. If intensive services are not indicated, the family is referred to appropriate community providers. Since the program started, the MCSS has served over 800 seriously emotionally stressed youth, a third have

been provided with assessment services, the remaining families have been offered both assessment and crisis intervention. The MCSS has also provided over 5000 consultations. See Figure 1 for details.

## The Tri-Level Integrated Model of Care

The MCSS uses a Tri-Level Integrated Model of Care. See Figure 2. This model seeks to integrate various theories and treatment approaches in a flexible manner that involves partnering with families, other service providers, and systems of care. Although developed prior to the criteria for interventions that "change lives" discussed by Shorr in her book Common Purpose, the model meets many of her criteria. She calls for family and community based services that are flexible, responsive, comprehensive, and are staffed by people willing to go above and beyond traditional job requirements to help the people they serve because they have faith in what they are doing (1998).

Tri-Level Model was first used in the VNSNY HBCI programs. It was developed in response to the ever-growing knowledge about how to best treat traumatized youth. Van der Kolk et al., (1995) believe the treatment of PTSD must include controlling the physiological stress reaction, cognitively processing and accepting the traumatizing experience, maintaining or re-establishing safe social connections, and finally building interpersonal efficacy (1995). James echoes these beliefs when she notes that in children: "Trauma may assault the child physically, cognitively, emotionally, and spiritually, and therefore treatment strategies must deal with each of these areas (1989 p 14)."

The Tri-Level Model seeks to meet these treatment requirements by providing three levels of care—Support, Sharing Knowledge and Specialized Care. Each level consists of six tasks. The model can be used linearly, or tasks can be by-passed to be re-visited later or eliminated completely as safety and the needs and desires of the child and family dictate.

### Safety First and Last

Safety is the gateway into and out of the model's levels of service. This serves the purpose of emphasizing that safety cannot be jeopardized in the interests of providing family friendly services or avoiding hospitalization. Although it is recognized that many of the tasks from the model are involved in

establishing safety, using safety as a gateway instead of incorporating it into the first level stresses that safety issues can never be by-passed or ignored.

Staff is instructed to ask directly at the beginning of each contact, “Is everyone safe?” as well as to conduct traditional safety assessments throughout each session. Staff is also trained to repeat the question “Is everyone safe” and to ask “Is there something more I need to know before leaving?” at the end of each contact.

Another way safety is insured is through the use of beepers. Families are not on call 9 to 5; a crisis can occur morning, noon, or night. All team members are expected to be beeper available 24 hours a day, 7 days a week. Simultaneously each family member is trained to recognize the difference between a crisis and an emergency and to call 911 for immediate help during an emergency. An emergency is defined as a life-threatening situation necessitating immediate police or medical intervention—someone is locked in a room threatening suicide, someone has swallowed pills, someone has run to a roof top, someone is physically assaulting another person or threatening others with a weapon, someone is so out of touch with reality he or she cannot be safely left alone. A crisis involves a lower level of risk. Generally, it is assumed someone in a crisis can wait 24 hours for services. A child may be talking of suicide, even have a plan, but agrees not to act on the plan and to contact a responsible adult when suicidal thoughts intrude. A child may have done some tissue damage to another child during a fight, but the fight has been stopped and calm restored for the time being. A youth might be experiencing psychotic symptoms but not be in immediate danger. Finally, families are also assured that the MCSS staff would prefer to be beeped than to have the family worried about something.

While many of the tasks connected with the Tri-Level Model might be accomplished as safety is being established, if safety issues exist the model may need to be completely by-passed or jettisoned midway. For example, upon making an initial visit to a family, staff was shown a bottle of pills by a sibling and told that the client had recently taken all the pills. Ingesting pills, even being suspected of ingesting pills, demands an emergency response and staff immediately called 911 despite the primary care giver’s protestations and the youth’s denial she had taken any pills. The youth had taken a liver-

damaging doze of Tylenol. She was hospitalized for several weeks until she was no longer considered a serious suicidal risk. Once this youth was hospitalized, safety had been assured, the Tri-Level model was brought fully into play. By the time the youth returned home, many tasks at the model's first two levels had been accomplished.

In another case situation, progress through the levels was proceeding step by step. Then the youth revealed he was being sexually abused. Although efforts were made to hear everyone's story and remain supportive of the primary care taker, it rapidly became clear that for the youth's safety, protective services had to be brought in. The abuser, a relative of the mother, was arrested; the mother terminated services at that point. Efforts were made to re-engage the mother, but this did not prove possible. Ideally, if safety issues disrupt the flow through the Tri-Level Model, starting again at the Support Level allows service to continue. Unfortunately, in some situations that is not possible.

**The Support Level**

Once safety is established, formal use of the model begins. Most often this means starting with the Support Level. One of the goals of the Tri-Level model is to make certain support is seen as equal to other more traditional clinical services. Numerous studies and theorists support this idea. (Beardslee, 1986; Brown et al., 1986; Garbarino, J., 1995, 1998,1999; Garmezy, N. 1986; James, 1989; Madsen, 1999; Webster-Stratton. 1989). Garbarino emphasizes the importance of support when treating traumatized children and youth. For example, he believes one of the best hopes for troubled children lies in a connection to someone, either a member of the extended family, a teacher, a childcare worker, even someone the child only sees occasionally, but who has absolute faith in the child's ability to succeed. Clearly, the more caring people in our youths and our families' social circle, the more people assuming the role of extended family, the more support the family and child experiences. Moreover, the more supportive people in a child's environment, the greater chances a child will experience some measure of absolute faith in his or her positive abilities. This is why the concept of agency as extended family serves as the foundation for the Support Level of Care.

There are six tasks at the Support Level. The tasks primarily involve adding supportive relationships. While essential, such relationships are not the only support offered to families. Support Level tasks include Meeting Concrete Needs, Engaging Or Allying With All, Hearing All Stories, Affirming Strengths, Hearing All Change Ideas, and Adding Supports. The emphasis on “all” reminds staff that all family members and significant others involved in a youth’s life are part of the treatment medium.

Socializing together is one way the MCSS adds support. Extended families join together for festive occasions. Extended family members eat together and play together. These every day family experiences are not always available to families struggling with a seriously distressed youth. The VNSNY original HBCI team met in focus groups with family members regarding the needs of their seriously disturbed children and how services could be improved. Families identified a need to go out as a family. “We need to be able to relax. We don’t want to always worry about what other people think of our kids.” was how one family member described this need.

Through the efforts of several students and ultimately with the help of a number of other agencies, a “Family Fun Night” was established by the VNSNY. Held monthly at a local psychiatric hospital, all family members including siblings of the youth served by the HBCI team and other participating service providers gather for three hours of socializing. The night involves serving the families a light supper and after supper providing a choice of gym, crafts and a family support group The MCSS helped with the creation of a similar event at F.R.I.E.N.D.S, Inc. This event is held at a local school and is frequently mentioned by families in consumer satisfaction surveys as a valued F.R.I.E.N.D.S, Inc. service.

Other fun events, workshops and celebrations are also part of the F.R.I.E.N.D.S Inc. and Mobile Community Support Service’s culture of caring. Such events advance the idea that the team serves as part of an extended family and a caring community for our youth. Such events aid in promoting continuity of care. The events also ease the pain of abandonment families and youth feel when confronted with termination. Extended family members don’t say goodbye, so while a family or child’s involvement with

the MCSS can and sometimes is placed on an inactive status, the relationship is never terminated. Seeing staff at various F.R.I.E.N.D.S, Inc. events maintains a connectedness valued by families, youth and service providers.

In addition to reconnecting at various F.R.I.E.N.D.S Inc.'s events, families and youth know services can begin again simply by calling for an appointment or dropping by the office. One client calls regularly from Puerto Rico to touch base with her MCSS staff-family. Recently a drop-in Staying Strong meeting, combining aspects of 12 Step Meetings and Multi-Family groups (McFarlane 2002) was added to the MCSS service array. These meetings offer mutual problem solving in a support group consisting of other families, staff and youth. This group offers easy access to maintaining or re-establishing contact with various MCSS service providers.

**Sharing Knowledge**

Support Level tasks pave the way for the model's second level—Sharing Knowledge. The Sharing Knowledge tasks include: Name to Tame, Psycho-Education, Emotional Fitness Training®, Behavior Management, Communication Skills, and Meaning Making. As with Support Level tasks, the tasks at this level are interwoven.

Without the well-developed human capacity to share knowledge, civilization would not be. Moreover, there is growing recognition that as Lightburn and Black note:

> ….practitioners are engaged with clients in a learning relationship, often teaching without recognizing they are doing so, because their primary identification is that of therapists. Clinicians teach as psycho-educators, and are often mentors, guides, and coaches, whether or not they purposefully view or develop this aspect of their work (2001,15 ).

The Sharing Knowledge Level purposefully develops these aspects of the helping process. The first task is Name to Tame. Name to Tame involves naming, not only objects, but events, feelings, and behavior. According to ancient mythology one evil spirits be warded off calling their names. Myths are attempts to name and explain life.

Without shared knowledge, accumulated knowledge would be lost. As the movie *Miracle Worker* so movingly described, Helen Keller eventually came to understand that the repeated sensations Sullivan traced in her palm meant water. Once that connection had been made Keller had access not only to Sullivan's knowledge but to the accumulated wisdom of the ages. She was able to learn not just what she could gain from her own experiences, but from the experiences of those who came before her. She had begun to name and tame the confusion wrought by her handicaps.

Clearly, one better copes if one can name what is going on. One youth named the death of a younger sibling "The Day the Family Died." His parents had tried to protect him by not discussing the death. Both had assumed he needed no help and had tried to keep him from experiencing their pain. When he was able to name his pain so poignantly, his parents heard his anguish and the way was paved for this youngster to mourn this loss. His and his parent's goal became "Reviving the Family."

In addition to providing common ground for discussing shared events, Name to Tame also involves thinking. Doing so uses the cortex—top-down processing. (Ogden & Minton, 2000; Perry, 2001). Top-down processing aids efforts to gain control of bodily sensations and feeling by adding reason to the decision making process. The middle and lower brains are controlled by emotion and reflex. Without top-down processing, less control is felt and less control is exercised. One youth struggled with owning a very considerable strength—her ability to problem solve for her friends. She also had difficulty calling on this strength for her own use. She eventually named this part of her self "Dear Abby Nicole." This Name to Tame act, a top down processing, strengthened her ability to call on this strength for herself; it put her cortex in control.

Separating Name to Tame from more traditional, medically based psycho-education tasks reminds all that there is specialized knowledge. Name to Tame uses local knowledge. Local knowledge serves important purposes. Spiritual advisors, either from traditional churches or healers connected with Espiritismo are important sources of local knowledge in Mott Haven. The streets are dotted with Botanicas. Shrines to various Espiritismo and Santeria saints are frequently seen in homes. If a family feels a spiritual cleansing of their home is needed, the MCSS will help them provide a cleansing.

Sometimes such a cleansing is carried out by a local Catholic priest, sometimes by another spiritual advisor. The thoughtful spiritual advisors know that lifting a curse or providing a spiritual cleansing is not enough to deal with psychosis or other serious emotional distress. In such cases, these require more specialized medical care. At the same time the power of the belief in a curse may be part of the psychotic process and then a spiritual cleansing aides the treatment. In a less dramatic and mundane example, local knowledge often suggests one can "just snap out of depression." Sometimes that works, when it doesn't, specialized knowledge is needed. It is then psycho-educational tasks are utilized.

The primary tools used by the MCSS in this sharing knowledge task are "What We Think" handouts. See Figure three. These are one page sheets listing in parent and youth friendly language the DSMIV symptoms for the disorder the team suspects is part of the youth's distress. The handouts are first introduced to the primary caregiver during the information gathering process as soon as staff has begun zeroing in a possible DSM IV diagnosis. The caregiver is asked to see if he or she agrees with our assessment and to rate the youth on the various symptoms. When appropriate, the same handouts are shared with youth. Most often, the care-givers and youth agree with the MCSS's assessment. If not, other possibilities are explored. These handouts also contain the MCSS's recommendations for dealing with the distress. When the family and staff agree on a diagnosis, those recommendations are explored and ultimately incorporated into the family's action plan. Use of these handouts adds the family and youth's knowledge to the team's specialized knowledge and generally strengthens the treatment process.

A consistent recommendation on the "What We Think" handout introduces the third Sharing Knowledge task. This recommendation suggests family and youth learn another type of specialized knowledge by taking one or another Emotional Fitness Training® (EFT) course. (Levine, 1997; Sunderland, 2001). EFT seeks to reduce the stigma attached to emotional distress and mental health problems. EFTprograms are based on the premise that just as most people are more or less physically fit, so most are more or less emotionally fit. Physical fitness training seeks to improve physical health; EFT seeks to improve emotional health (Goleman, 1995). Each EFT program teaches and reinforces skills such as feeling awareness, feeling measurement, self-soothing, thinking before acting on negative feelings, and

remembering what is important. Each skill represents a top-down approach to dealing with strong feelings.

All MCSS staff become Emotional Fitness Trainers. Three F.R.I.E.N.D.S, Inc. staff have also completed the training. Interested family and youth have recently been offered an opportunity to complete the licensing process, but none have yet completed the entire course. Part of the licensing process involves taking a Staying Strong Self Care course. Requiring potential trainers to personally apply the concepts underscores the core EFT belief that everyone struggles with life problems and everyone needs not only support, but a daily program to insure emotional fitness. (See Figure 3.)

An important aspect of each EFT program is the ability to break the curriculum down into individualized training modules based on youth and family needs and motivation. This fits in well with the Systems of Care principle of individualized care. The family and youth can pick and choose what aspects of EFT most appeal to their ideas of what is needed. For example, one youth was having difficulty controlling the impulse to run out of the school in an effort to reassure himself all was well with his mother who suffered from asthma. He was taught a self- soothing and calming self-talk exercise to use whenever “The Run Back Home Urge” visited. He was also given a picture of his Mom in which she wrote. “I’m taking care of me, you take care of school.” This helped him remember that staying in school was his goal.

Stressed youth are usually acting out youth. Acting out stresses caregivers. Stress erodes the ability to manage negative feelings. If you can’t control your feelings, you have a difficult time dealing with a youth’s difficult behavior. Caregivers are taught to apply Emotional Fitness Training skills as an essential ingredient when dealing with the next Sharing Knowledge task—Behavior Management.

Behavior problems are the most common reasons youth are referred to the MCSS. Service providers put a great deal of emphasis on communication skills and natural consequences (Farber & Malish, 1980; Gordon, 1975); these contrast with the tough love approach many parents feel helps youth survive life in a high crime area. As one mother put it “If my child doesn’t do exactly what he is told to do when he is confronted by a dealer or a cop, he’s in big trouble.” Hpwever, tough love parents are only

one part of the picture, for other parents have given up trying to control. Most frequently these are single parent mothers from cultures in which patriarchy is strong and sons have been encouraged to dominate. Both groups need behavior management tools.

The MCSS behavior management teaching takes a yes/and approach. We urge parents to catch their children doing the right thing; we use behavior charts to track and reward positive change, and we urge strong responses to unacceptable behaviors. We emphasize the difference between punishment and abuse. We make it clear abuse will lead to a referral for protective services.

Youth who are ruled at home with an iron fist have a particularly difficult time behaving at school. When asked, almost every child can tell you exactly when he or she had better do what a parent wants. “She stands up.” “He raises his voice.” “She goes for the switch.” “He gets very quiet. “His face gets red.” Youth is encouraged to use that knowledge aid in understanding when a teacher means business. A teacher might speak more softly then Mom or Dad, but the teacher’s “No” is every bit as important as a parental “No.” Parents are asked to reinforce that message.

The fifth Sharing Knowledge task involves improving communication skills. Such efforts usually refer to teaching people to use active listening and ”I messages.” (Farber & Mazlish, 1980; Gordon 1975). The MCSS does a great deal of this type of teaching, but also adds to this usual task improving communication by teaching the use of family meetings. In addition to serving as a tool to improve communication within the family; family meetings also help prepare youth and families for Child and Family Team Meetings. Child and Family Teams are a major strategy of most Systems of Care programs. Consisting of the family’s natural supports and the service providers the family finds supportive. These teams hold Child and Family Team meetings with other service providers to insure the family’s voice is heard, a strength-based approach is adhered to, and service planning is coordinated.

The goal during an intensive intervention is to hold three family meetings and three Child and Family Team Meetings. One Child and Family Team Meeting is held with the family and the referral source or child’s school at the beginning of the intervention; a second meeting is held to develop the

service plan after the evaluation process is completed; a final meeting is held when the MCSS ends its intervention and the family is transitioned to another service

Each of the above tasks paves the way toward the final Sharing Knowledge task—Meaning Making. Emphasis on meaning making relates to the MCSS' underlying belief that the majority of our youth's difficulties are trauma related. Trauma threatens meaning by shattering core beliefs and by destroying faith in the goodness of self and others as well as in the possibility of living a good and meaningful life. (Garbarino 1998; James 1989; Perry, 2001; van der Kolk et al., 1995). As Garbarino notes in describing the voices that help make sense of violence:

> There is a third voice I would call soul searching. This voice begins from the realization that human beings are not best understood as animals with complicated brains but as spiritual beings who have a physical experience in the world. Once this is recognized, we can see that the world of violent trauma is not so much an injury, but a spiritual challenge that has diverted us from the path of enlightenment. (1998 p 28.)

Meaning making as used by the MCSS focuses on two tasks. The first is on helping families provide children with meaningful explanations for the bad things that happen, particularly the bad things people do. A strong faith is useful and the emphasis is on life affirming explanations that lead toward hope and connection, not despair and revenge. The second task involves restoring a sense of meaning to those who have lost theirs through trauma.

Family meetings are often used to bring up the importance of having a life affirming explanation for why bad things happen. Most often the question comes up in relationship to traumatic experiences including the death or desertions of loved ones. Many of our youth have lost family to violence or premature death; many others have been abandoned by biological parents. One youngster fell prey to depression when his soccer ball was swept down into a storm drain. The ball symbolized the dead father he hardly knew. His one memory was of kicking a soccer ball with his father. By helping the boy construct a memory book (Levine, 1992 ) about his father, this youth was able to maintain a relationship important to his ongoing mental health. The team was able to procure a picture of his father as a boy, a

number of other pictures, including one of the father holding our youth; several family memories were gathered about the father that included his hopes for his son’s future. Creating the memory book not only helped the youngster maintain a meaningful relationship with his father, but also involved his paternal relatives more fully in his life, and helped him make sense of his loss.

**The Specialized Care Level**

When support doesn’t work, sharing knowledge might succeed; but when neither support nor sharing knowledge are sufficient more is needed. The time has come to utilize the Specialized Care Level. The tasks at this level may include: development of insight; medication; family therapy; having the child live with another family member or placed in an open settings such as therapeutic foster homes or group homes; placement in a controlled environment such as a psychiatric hospital, residential treatment centers or detention center; and finally, changing systems affecting the youth and his family—what the entire Systems of Care movement seeks to do. Specialized Care Level interventions involve use of broader systems of care, often involve people licensed or otherwise acknowledged as being able to provide special care or involve teams of people directed by a licensed professional.

Although the primary work at this level is not carried out by the MCSS team but through referral or collaboration, that work is augmented and integrated into each family’s action plan by the back and forward flow through the Tri-Level Model of Care. For example, when a youth needs an emergency placement in a controlled setting, the family is offered additional support through the crisis, the youth is supported as the placement occurs, and the team remains involved and ready to accept the youth back into care when the emergency passes.

## The Tri-Level Model and the Systems of Care Movement

Seeking to become part of a Systems of Care movement fit well with the Tri-Level Model of Care’s attempt to integrate various treatment approaches and theories into a more coherent whole for practitioners and families. In addition to guiding individual efforts, the Tri-Level Model of Care can be used to guide all change efforts.  Establishing alliances, hearing everyone’s story, affirming strengths, adding support are all steps to system as well as individual change.  Sharing knowledge is pivotal. Even

something as simple as labeling the inability to get required services (A Name to Tame intervention) as a system problem is useful. Having families facing such problems write letters of complaint to appropriate change agents, including legislators, empowers families and adds support and legitimacy to all efforts to improve systems. Some families can write such letters without help, others need help writing and some need the letters written for them. Finally, encouraging political action at all levels from inviting legislators to speak to families to helping register families to vote were an important part of the F.R.I.E.N.D.S, Inc. Systems of Care and MCSS action strategies.

**The Colon Family: A case example**

This is a family involving two youngsters. Jason who was eight years old at the time of referral and his half sister Lizette then thirteen years old. Jason was referred first. He lived and still lives with his mother Maria C, a 48 year old white woman, in a one-bedroom apartment in one of the more dangerous and semi-deserted areas of Mott Haven. Joseph H, Jason's 50-year-old Afro-American father, currently lives nearby. Both parents were thought to be former heroin addicts; this was not admitted by either. The marriage of these two was very much off again, on again and at the time of the referral, they had separated once again. Mr. H had moved from the Bronx. This separation was reported by the mother to be permanent as she had "had enough of the father's abuse." The mother was employed by a needle exchange program and has since had several similar jobs. The father is on disability and now helps with child care.

Care began when Jason was referred to the MCSS by his school. He suffers from a genetic disorder that makes him unusual in appearance and can cause severe hyperactivity. Jason was given to darting out of the classroom and school. More problematic, he was fascinated with electrical plugs and the teacher had to be constantly alert to the possibility he would be trying to put pencils and other objects into a classroom plug. He had already succeeded in shorting out the electricity at the school. According to his mother only one or two of the plugs in the apartment worked because he had also shorted them out also. or she had been forced to block them. Although considered dangerous to himself and others, he was not

deemed at immediate risk of placement in a psychiatric hospital. He was, however, considered at sufficient risk of removal from his home that an intensive intervention seemed appropriate.

Mrs. Colon made it clear when first contacted that she wanted Jason placed and was only seeking services to get a psychiatric evaluation to facilitate this. She was reluctant to invite the team to her home because of her shame at the damage created by Jason. The initial work involved hearing her story, honoring her desire to receive services in the office, affirming her strengths and hearing her ideas. (See Figure 4) Three team members were initially assigned to help, a nurse, a case aide and the parent advocate.

Following the Tri-Level Model, establishing safety became the first concern. The major strategy involved a behavioral management task dubbed the STOP plan. (Levine, 1997). The STOP plan is a technique to be used only when a child is involved in dangerous or hurtful to others behaviors in the parent's presence. The plan involves four steps based on the word STOP:

1. S = Saying the word stop loud and with a hint of anger
2. T = Telling the child what to stop
3. O = Offering an acceptable alternative behavior
4. P = Physically intervening if necessary to force compliance and then praising the compliance

The mother had given up trying to control Jason's behavior believing that efforts on her part were futile. Based on her relationship with the Parent Advocate who formed a strong alliance from the first interview, Ms. C. eventually agreed to permit team members to spend time at her apartment to demonstrate the STOP plan—a behavior management task. While the parent advocate took Jason and his mother out for breakfast; three team members gathered at the house to prepare for the demonstration. Having obtained Mrs. Colon's permission, the team moved the furniture and unblocked a number of plugs. Upon his return home, Jason spotted the changes and headed straight for a plug. The loudest staff person instantly commanded "Jason, STOP playing with that plug it's dangerous, play with the box." Jason stopped and looked up in surprise. He was instantly praised and then gently but forcible lead to "the box" a series of mechanical plugs, lights, and buzzers staff had devised hoping it would offer a safer

alternative to the electric plugs. The box served its purpose. As Jason played with the box, he was praised and told this was a safe way to exercise his curiosity in mechanical things. Anytime Jason returned to a plug, the STOP plan was repeated. Ms. Colon eventually took over as the STOP commander. By the end of the day, Ms. C felt confident in her ability to keep Jason from playing with plugs. The STOP plan was augmented by teaching Ms.C a number of other behavioral tools including catching and praising good behavior, use of behavior chart, and time out for unacceptable behavior.

The success of the STOP strategy made the MCSS team and Mrs. C partners. It was not long before Mrs. C shared with the team her concerns regarding Lisette her thirteen year old daughter. Initially, she had claimed Lisette had no problems. It was not unusual for the MCSS, once an alliance had been established with the family, to discover siblings of the child initially also suffered from severe emotional distress. Once an alliance forged between Mrs. C. and the team, Mrs. C. described Lizette as being irritable and argumentative. Of more concern was that Lizette had run out of the apartment on a number of occasions, each time threatening to kill herself. On those occasions, she fled to her paternal grandmother's house and stayed there for several days.

When team members talked with Lizette, she was found to be severely depressed. She was actively contemplating suicide by taking some of her mother's pills. She felt abandoned by her birth father, Mrs. C's first husband. Mr C. called sporadically, but never visited. She felt her mother cared only about Jason and wanted her daughter in the home only to baby-sit. Lizette was tearful during the initial interview but agreed to a safety contract and to see the team psychiatrist.

At the psychiatric evaluation Lizette's three wishes included spending time with her birth father, having a room of her own, and spending time with other girls her age. Mrs.C had told the team she thought the father was living in a flop house in lower Manhattan and involved in heroin addiction, however she was not sure. She did not want this information shared with her daughter. In helping Lizette make a different meaning of her father's absence, staff explained it sounded as if he just didn't have the strength to be the kind of father she wanted at the moment, nor was it clear why. She shared her idea he might be sick. The parent advocate agreed saying it might be a physical illness or some kind of mental

illness. Later on during an outing, the case aide was able to share that her own father had never been in her life, and she had finally decided it was her father's loss; she had to get on with her life without his support. The case aide's self disclosure brought tears to Lizette's eyes, but also marked the beginning of her ability to stop idealizing her absent father and fantasying his return.

Several possibilities for meeting her other two wishes were discussed including buying a screen to block off part of the living room, or buying a bunk bed in an effort to give her some private space. She liked the idea of the bunk bed and claimed the top bunk as her private retreat. Some shelves were placed high on the wall, and part of the bunk bed enclosed. This efforts delighted Lizette. She was also signed up for an art class she was interested in taking; she was taught a number of self -soothing skills; she was referred to F.R.I.E.N.D.S Youth Leadership program; finally, she was referred for ongoing therapy.

Helping this family involved tasks drawn from each of the Tri-Level Model's levels. In addition to those described above involving allying, hearing change ideas, affirming strengths, adding supports, self-soothing, and meaning making; psycho education information was provided both Jason's parents and his school, the parents also learned a number of EFT skills, Jason was placed on medication, the mother was helped to hold Family Meetings and Family and Child Team meetings; and Mrs. C and her daughter were referred for conjoint counseling.

As the MCSS intervention ended, the family was referred for ongoing Case Management, Jason to the F.R.I.E.N.D.S Homework Help Program, Youth Connection Programs and the mother continued to receive services from F.R.I.E.N.D.S Family Support. Lizette was referred to Youth Leadership. That was three years ago Jason is doing well, he is in a good special education program, properly medicated, attends the Youth Connection, Home Work Help, F.R.I.E.N.DS Connection, and various other special programs at F.R.I.E.N.D.S, Inc. He is accepted by the other youth served in the agency and although it is possible that because of his appearance, major difficulties lie ahead as he enters adolescence, he is stable and doing well within the protective circle of his special extended family. Hopefully, his strong connections at F.R.I.E.N.D.S will serve to buffer him from any difficulties he faces as an adolescent.

Lizette eventually moved in with her paternal grandmother but stays connected to the F.R.I.E.N.D.S Youth Leadership program and periodically comes to the F.R.I.E.N.D.S Family Connection. She and her mother are getting along better. She has been told about her father's many problems.

Mrs. C is working full time; she and her ex-husband have established a "friendly relationship" Both the father and the mother are involved in Sharing Knowledge workshops and attend the F.R.I.E.N.D.S Connection. Both have also become political active and have testified at a number of fact finding hearings. Mrs. C sees F.R.I.E.N.D.S and its various MCSS staff as part of her family. As she noted "This is our second home."

## Victories and Defeats

### F.R.I.E.N.D.S. outcomes

Starting new programs is difficult. tarting a new agency, combining five new programs, incorporating major changes in treatment approaches and governance while researching the whole process begs description. The fact that F.R.I.E.N.D.S, Inc. ultimately came to be and remains a growing force in Mott Haven speaks to its victory over its difficulties. The fact that the MCSS is and remains an important part of the F.R.I.E.N.D.S, Inc. systems of care speaks to the MCSS' success.

Success is always a process with times of forward movement and times of retreat. F.R.I.E.N.D.S, Inc. has experienced its share of problems. Established community agencies resented the idea that a new community mental health agency was being created and funded. Each felt the money would be better spent improving existing agencies. Because of these concerns, the Mott Haven Agenda for Children Tomorrow, an active political force for Mott Haven residents and service providers withdrew support from the project. Other community leaders joined forces to blocked referrals. The local school board was particularly active in this protest movement and school principals were told not to permit F.R.I.E.N.D.S, Inc. into the school for outreach and not to refer families to F.R.I.E.N.D.S, Inc.

Efforts to find adequate housing for the program bogged down because of a dispute between the landlord and the funder. For the initial 5 years of service, Case Management and Respite and Recreation were located in separate buildings while F.R.I.E.N.D.S and the MCSS operated out of inadequate quarters in a third floor walk up.

Leadership changes have been problematic. Some of those changes have involved changing leadership at the state level. As the program was starting up a new governor was elected, the various commissioners involved in developing the Mott Haven project moved on to new jobs; all those involved in creating the project, including the initial grant writers, research personnel, and proposed state level overseers, also moved to new jobs. Finally, after two and half years, the Director at F.R.I.E.N.D.S moved to a new job. It was nearly a year before another new Director was hired. Finally, difficulties existed in terms of the various service providers. The Case Management program had five changes of leadership during the six years of the demonstration project. The Family Support and Youth Leadership programs saw three leadership changes. Of the initial service providers only the VNS of NY had stable leadership and currently is the only service to remain under contract to F.R.I.E.N.D.S, Inc.

Despite these difficulties, F.R.I.E.N.D.S, Inc. exists, is now located conveniently and in an attractive space with rooms for community meetings and workshops as well as F.R.I.E.N.D.S, Inc.'s programs. Positive relationships have been established with the School Board; 52% of the referrals come from the local schools. The fact that 31% of referrals are made by families also speaks to F.R.I.E.N.D.S, Inc. success within the community.

Positive relationships have also been established with an important array of community service providers. The Executive Director of F.R.I.E.N.D.S, Inc. is a co-chair of the ACT Collaborative; the Director of Visiting Nurse Service Programs at F.R.I.E.N.D.S, Inc. Inc. chairs the ACT Collaborative Community Building Committee and is Co-Chair of the Bronx Borough Based Council. The council is one of similar councils established with consumers throughout New York State in an effort to further the development of systems of care approaches. Co-Chairs attend a City Wide Oversight Committee also attended by a variety of high-level city and state officials.

**MCSS outcomes**

To date the MCSS has served nearly 900 families and children. As measured by the follow-up surveys consumer satisfaction runs high; 91% of the families report being satisfied or very satisfied with the services. Improvement in symptoms related to the reason for referral was noted in 80% of the youth served. Other outcomes such as hospitalization and placement rates have also been positive, although a growing number of youngsters have been hospitalized during recent months. The increase is thought to be due to the willingness of referral sources to refer more disturbed youngsters to the MCSS. That may or may not be the case. Although many funders measure success by reduction in psychiatric hospitalization; the MCSS believes this ignores an important fact. Safety is risked if clinicians are being rated on hospitalization rates. Success should be determined by whether or not avoiding hospitalized is in the best interest of the child and whether it occurs as an un-planned or un-justified hospitalization.

**Systems of Care Outcomes**

Finally, the victories and defeats of the MCSS and F.R.I.E.N.D.S, Inc cannot be completely separated from the systems of care movement. According to the 1997 System of Care Annual Report to Congress, the overall Systems of Care outcomes have been mixed (US Department of Health and Human Services, 1997). Initial findings as measured by symptom and functional scales did not exceed care provided by more traditional services while functional outcomes have shown notable improvements. However, as English noted:

> Findings indicated notable improvements for children after one year of service, including (1) reductions in law enforcement contacts, (2) improved grades and fewer absences from school, (3) improved behavioral functioning, and (4) more stable living arrangements achieved. Furthermore, after 1 year in services 71% of the children's caregivers were "satisfied" or "very satisfied" with their children's progress. (2002)

Both F.R.I.E.N.D.S and the MCSS initial outcomes were included in the above findings. MCSS consumer satisfaction ratings have consistently been in the 90% rating for "satisfied" or "very satisfied."

**LESSONS LEARNED IN BUILDING COMMUNITY BASED CLINICAL PRACTICE**

**Lesson One: Use the start up period wisely.**

New programs are graced with a start up period. Time is needed to hire, train and bring staff on board with the program's vision and goals; develop and establish practice procedures, paper work and accountability documentation; find and furnish space and finally, do the social marketing necessary to gain referrals. Taking advantage of this time is vital. F.R.I.E.N.D.S, Inc. did not hit the ground running. The mission was not articulated, specific goals and objectives were not clearly communicated to service providers, accountability including paper work was not in place, and office space for the program had not been obtained.

Starting with practice procedures and accountability documentation in place would have been wiser. Then, when something was not working, collaboration and negotiation could have been brought into play to make needed changes. Such an approach would have been similar to the type of one text negotiation employed in hammering out the Camp David Accords. In that type of negotiation one party draws up the plan and then asks the other participants for revisions. The revisions are combined and used to developed a second one-text plan. The process is repeated until all agree (Fisher & Ury, 1983).

For example, one hope of the project was to pilot the use of a unified record—a record the family could have and that would follow the child from service to service. The hopes for such a record were to prevent duplication, to eliminate the need for families to tell their stories over and over again, and to reduce paper work for service providers. This project hope was never fulfilled. A unified record might exist now if during the start up period, a record had been put together that met various state regulations as well as the families' desires. Before the doors were opened to receive clients, service providers could have been told that this was the record of choice and given an opportunity to criticize and suggest change, but with the expectation that by the start-up of services this was the record that would be used by all. . Service providers were asked to create such a record only after services had begun. They never came to an agreement as to what should go in the record.

**Lesson Two: Market and sell services during the start-up period by stretching eligibility criteria**

A steady flow of consumers is essential for the success for any endeavor. In the human services field too many new programs fail to attract clients because of rigid adherence to eligibility criteria. It is particularly important during start up to figure out how to say "Yes" when a family or youth does not meet the eligibility criteria. For the MCSS this meant expanding the definition of risk during the start-up phase. Traditional definitions of risk generally referred to some one actively suicidal, homicidal, or dangerously psychotic. During the start up period, this definition of risk was expanded to deal with youngsters displaying lesser symptoms of psychosis, murderous intent, or suicide. The MCSS also accepted several four-year-olds into care during the start-up period.

A second way the MCSS stretched the eligibility requirement during the start up phase was to agree to work with some situations in which the problem was probably not the child's serious emotional distress, but a stressful family situation. In order to maintain research fidelity, stretching the eligibility criteria needs to be carefully monitored and seen as a start up strategy only. The MCSS was able to stop stretching eligibility criteria after five months.

**Lesson Three: Strategize to include silenced voices**

At the same time one is starting strong, it is equally important to privilege the quieter voices. This is particularly important when attempting to partner with families. Professional and expert voices are accustomed to dominating. Encouraging the setting aside of those voices so the family and youth voices could emerge challenged all. Adding to this challenge was the fact that all change ventures require certainty in order to gain acceptance. When new ways challenge old ways, most cling to the old ways. This plays into to the natural tendency to polarize and assume an either/or stance that too often leads to blaming others rather then seeking solutions.

Clinical staff worried about family's refusal to follow best practice guidelines. As one staff asked "Should we just let a child commit suicide because the parents don't think she is depressed?" or as another staff noted "So we let the child fail because Mom doesn't believe in medication when we know it is what make the difference?" The answer to both questions is "No". Collaboration does not mean submerging one voice at the expense of another. It means hearing all voices.

One way to strengthen the less heard voices is to hire staff, including clinicians, who have been there and done that. The MCSS sought to hire staff who were parents, lived in or near Mott Haven, grew up in Mott Haven, had a relative who lived in Mott Haven, had a relative who suffered from serious emotional distress, or who themselves had been involved in mental health treatment of one form or another. Such staff are generally more family friendly, and less likely to stigmatize serious emotional distress. Such staff also can join with families and youth with greater authenticity than someone who has not experienced such life stressors. While not essential, such experience, particularly in a climate of respect for families and the struggles facing those living with serious emotional stress, improves services. If a team member can say "My brother has been hospitalized" or "I've had therapy" or "I grew up around the corner" usually a door opens for families and youth to feel more comfortable entering the conversation.

Top down modeling was an essential ingredient in building staff comfort and disclosing how staff's personal experiences were in one way or another similar to those facing family and youth. When the Program Director causally dropped into a conversation how she had felt as a child when her family was evicted from their home, jaws dropped, but the director used this opportunity to open discussion on the importance of well-planned and thoughtful self-disclosures in building alliances.

Administration and clinical staff found it particularly difficult to let go of their knowledge in order to privilege family voices. Administration worried about diminished professionalism. Three strategies reduced these administrative worries. (1) The VNSNY had in place a generous reimbursement schedule for ongoing training. A number of MCSS employees have been able to move forward educationally because of these benefits. (2) Because of concern about maintaining clinical professionalism, the Director of Community Mental Health Services (CMHS) at the VNSNY established a CMHS University. All CMHS employees are required to complete its four days of training. The curriculum ranges from establishing safety, gaining familiarity with the DSMIV, to writing clinically effective reports. (3) Finally, maintaining a supervisory ratio of one clinically sound supervisor to no more then four staff also eased administrative concerns.

A number of other strategies also proved pivotal in allowing all voices to be heard. One was absolute transparency about when clinical knowledge would be privileged and when family wishes would predominate. Families and youth were told from day one that safety was the MCSS's primary concern and once we deemed all were safe, family and youth preferences took over. Teaching families what we considered a safety issue as well as the use of the What We Think Handouts helped with this task.

Yet another strategy for including parental voices was to use round-robin instead of pop-corn processing at every meeting. In pop-corn processing people speak at random; this often means the strongest voice dominates. Round-robin processing requires that each participant be asked to contribute. No one is forced to speak, passing is possible, but each person must be asked to contribute. Sometimes it might take a number of go-rounds before previously silenced voices choose to enter the conversation, but without round-robin processing such voices might never be heard.

**Lesson Four: Satisfy your customers**

The need to include silenced voices is also involved in the issue of consumer satisfaction. Quality work based on consumer satisfaction demands being clear about expectations, measuring performance, checking outcomes, and dealing with problems. This means speaking up and encouraging others—staff and consumers—to speak up rather then assuming all is well. People who don't speak up are on what management consultant Hersey calls a bus trip to Abilene—too many people going where they don't want to go because everyone keeps quiet for fear of offending one or another person. (1988)

VNSNY emphasizes pleasing customers. Customer means not only those thought of traditionally as patients or client, but funders, the people who supervise you, the people you supervise, referral sources and those who work with you. As part of this focus, VNSNY staff are trained to view all service requests the way a concierge at a hotel views a request for help. The customer must leave the hotel satisfied. For families and youth this means whether receiving a full array of services or a quick assessment and referral to another service, all parties, at the end of an intervention, need to feel the MCSS had done all that could be done to help. When dealing with a stigmatized service such as mental health services this is particularly important.

However, for oppressed minorities, speaking up to authority has always held dangers. Staff, as well as families and youth, when asked about satisfaction with services, preferred “Going along to get along” to being direct about what was working and what wasn’t. As one valued and trusted staff member noted during a VNSNY Code of Honor training which encourages reporting of wrong doing, “I don’t want to be responsible for getting someone fired. If I know someone is doing something wrong, I won’t report them. Administration has to catch them, not me.”

Realizing the power of such constraints doubled for families and youth was one reason the MCSS undertook to develop a consumer progress note. See Figure 5. The note was developed by the staff and used to record all face-to-face contacts with the primary caregiver. The note measures not only goal progress but also consumer satisfaction. The original note is placed in the chart and a copy given to the family. A parallel effort to encourage staff openness regarding the usefulness of supervision was instituted at the same time. Both notes served to encourage families and staff to become more open about complaints and succeeded in doing so.

Although initially reluctant, staff and managers ultimately found the use of such a note improved their ability to provide family sensitive services. Staff’s primary unhappiness with the note was that the consumer satisfaction components tended to become rote. At the same time, there was an immediate awareness of when a family was not satisfied. Benefits cited were:

"Forced me to listen more, and I knew if a family was not satisfied.”

"I got my recording done on time."

Administrative staff found the forms extremely useful in tracking staff time and accountability. Most important, families were pleased with this type of recording. Caregiver comments included:

“I could see how my child was doing visit by visit.”

“I could prove to my other worker (a child welfare staff person) that I was working hard to help my child get better.”

“I felt respected and like my ideas mattered.”

Following the demonstration project, staff and administration elected to continue using the note. In addition to using the consumer progress note, other accountability efforts kept the MCSS on target. These included focus groups, audits, and end of service consumer surveys.

**Lesson Five: Ethical behavior safeguards all family members**

Prevailing clinical wisdom often views seeing clients as family as an invitation to boundary violations. Families, youth and non-clinical staff had fewer difficulties with the idea of becoming part of a larger extended family than did clinical staff. MCSS management believed boundaries were not the issue, but that ethical behavior was. All families face boundary issues. All families deal with what is proper behavior in close and distant relationships. Healthy families know which lines are never to be crossed.

Nevertheless, for some, the concept "We are family" felt dangerous. Two strategies helped ease such concerns. One was transparency—the willingness to take an open stance about relationship expectations and about roles. Staff were family, but extended family, living apart. The roles were seen as that of a distant family member with specialized knowledge similar to a cousin who also happens to be a plumber and who can be relied on to fix a stopped drain when asked to by members of his extended family or to join the family again when invited to celebrate milestones or holidays. Such relatives come when invited, are delighted to be part of the family, enjoy helping, love celebrating, expect little beyond a thank you in return, never over stay their welcome, and live separate lives.

The second strategy was the use of thoughtful supervision regarding appropriate and ethical behavior. Because so much of the work done by all the VNS NY happens in people's homes, the agency is particularly attuned to the potential for taking advantage of service consumer's vulnerability and trust. Part of the VNS Code of Honor training involves a clear articulation of how to handle the ins and outs of being a guest in someone else's home. For example, staff are allowed to accept small gifts as tokens of appreciation, but are never to accept cash tips. Finally, the agency also offers sexual harassment training and this proved useful in discussing the importance of being attuned to inappropriately sexualized behavior between staff and clients. For example, in many cultures family members are greeted with a hug and a kiss on the cheek. Not accepting a hug when it is offered is seen as rejecting. Offering a hug, on

the other hand, is less appropriate. So is a kiss on the lips. Open discussion of such issues and permission to air concerns keeps all safe.

**Lesson Six: Attend to staff morale**

Because of the inherent difficulties in start-up programs and in working with the seriously emotionally distressed, attending to staff moral is essential. One of the benefits of requiring all MCSS staff to become licensed Emotional Fitness Trainers and to take the core Self Care Course has been the side benefit of maintaining MCSS staff morale. A core aspect of the Self Care Course is the practice of a daily Emotional Fitness Program which consists of 12 exercises (Levine 1997). Staff is encouraged to practice each of these exercises. See Figure 5.

Two exercises focus on what is working—Practice Gratitude and Review Your Things Done List. Five focus specifically on self- care—Be with Beauty, Move Your Body, Laugh, Indulge in a Healthy Pleasure. Finally, the remaining exercises focus on dealing with difficulty—Remembering What Is Important, Practicing Kindness, Remembering Someone Who Cared, Practicing Forgiveness of Others, Practicing Forgiveness of Self. To encourage practice of these various exercises Emotional fitness exercises are included in staff meetings, non-offensive jokes are posted on the bulletin board, and inspirational sayings posted around the office. Finally, staff and families are offered a variety of Emotional Fitness Outings including Move Your Body workshops featuring various physical fitness exercises and Be With Beauty Walks.

MCSS staff morale and loyalty have been continuously high. Staff sees themselves as family, turn over has been minimal and then only when better advancement opportunities or higher salaries were offered. Staff who have left maintain contact, work per diem, and when their new jobs permit attend staff events and celebrations as well as various F.R.I.E.N.D.S events.

**Lesson Seven: Work to reduce the stigma attached to serious emotional distress**

According to Kessler at one time or another 50% of the population suffers from one or another mental illness—a figure many dispute and find shocking. Kessler, however, believes that if he said 99.9% of the population had been physically ill at some time in their life no one would be shocked.

Therefore, it should not then be surprising that 50% of the population has been mentally ill at some time in their life. Kessler sees the reason for this as the investment of the word mentally ill with negative meaning. (Kessler 1994).

The MCSS joined in a number of efforts to reduce the stigma attached to mental illness. The use of Emotional Fitness Training® Programs helped with this task in a number of ways. One was the emphasis on the idea that emotional health impacts physical health; physical health impacts emotional health. Similarly, the linking of Emotional Fitness Training to the idea of physical fitness training further normalized emotional problems. Finally, the fact that everyone involved with the child including MCSS staff, family members, class mates, and teachers learned the core EFT skills normalized the idea everyone needs to strengthen the ability to manage stress and other negative feelings.

This idea was further emphasized during consultations. Many consultations consisted of Self Care Workshops directed toward staff of various providers within the community as well as foster parents, child care staff and teachers. Particularly popular were appreciation sessions involving self soothing skills including aroma therapy.

Another way serious emotional distress was normalized was having staff at a consultation site involved in programs offered youth. In one, successful intervention in a school two youngsters involved in bullying were matched with less troubled youngsters in a workshop called Young Ladies of Strong Feelings. The school social worker co-led the group, two teachers participated with the youth and MCSS staff as people with strong feelings. The six-week workshop helped not only the bullies, but according to the involved teachers, changed the atmosphere in the school.

**Lesson Eight: Work to change conditions creating serious emotional distress**

Mott Haven's high level of crime, unhealthy air, overcrowding and lack of green space contribute to our families and youths' distress. Although many families manage to stay healthy and to raise healthy children in such communities, those continuously bombarded by one trauma after another do not fare so well. The more the stress of a community impacts on a family, the greater the likelihood, one or another

family member will suffer from symptoms of serious emotional distress. All our work is in vain if we do not also work to change the conditions that stress our families and our youth.

Both VNSNY programs at F.R.I.E.N.D.S Inc. have been active in community efforts to reduce the level of crime and violence through the Camino de Paz/Peace Walks Labyrinth project. A labyrinth is similar to a maze, but has no blind turns or dead ends. See figure 6. Following a labyrinth's path takes you to the center and back. (Curry, 2000).

The Camino de Paz project originated as an outgrowth the R&R team's efforts to teach some of the children a walking meditation. A portable labyrinth was created and then taken by various VNSNY programs to a number of street fairs. The project now has a larger canvas labyrinth and three permanent outdoor labyrinths. Most have been built with community help and in-put by the families and youth the VNS of NY have served at F.R.I.E.N.D.S, Inc. Three more will be completed by the end of the 2003. The project also provides conflict resolution workshops. These are run by the MCSS consultation teams. The workshops are held at the labyrinths and in local schools.

Ultimately, this project lent support to other community efforts to transform Mott Haven's image from one of violence. Community leaders sought to attract visitors from outside of Mott Haven. As labyrinths are often a tourist attraction the Camino de Paz project has served to attract some visitors to the area. The Labyrinths have been used by community leaders as one focus for special community events.

<2>Lesson Nine: Expensive programs work, but costs are high and sustainability difficult.

As indicated previously, the MCSS program is successful. Families believe so, staff believes so, referral sources believe so; youth and family stress decrease; youth's symptoms decrease, family and youth functioning improves. The cost of this success is high. The annual budget for both VNSNY programs at F.R.I.E.N.D.S, Inc. is $851.157.82. Of that $29,655.44 goes directly to families as wraparound dollars. Salaries for both programs add up to $548, 811.86. The cost of the psychiatrist and nurse combined are $160, 417.14. Even with what seems like generous budget, the MCSS salaries are lower than comparable city and state salaries. Recruiting staff is difficult because of salary differentials, program location, the nature of the work, and the need to hire Spanish-speaking staff. The upside is that

staff that does come aboard is committed to the work and staff commitment is an important ingredient in the MCSS successes. Currently, all costs, except for involvement in the Camino de Paz project which is supported by private donations, are funded through F.R.I.E.N.D.S Inc. by the New State Office of Mental Health (NYSOMH). The contract for continuing the services comes up for renewal yearly. The NYSOMH is eager to find others to share the funding. Whether or not that happens will determine if the successes achieved by F.R.I.E.N.D.S, Inc. and the VNSNY programs at F.R.I.E.N.D.S, Inc will be sustained. Hopefully the successes will be built on and not lost.

In achieving sustainability one must serve the designated population and serve it well. One must also prove one serves the designated population well. The MCSS has served the youth it was intended to serve. As indicated by consumer satisfaction and other measures of success, not only has the MCSS served the designated population, but it has served them well. Unfortunately, the successes do not meet evidenced based practice criteria which involves control groups and replication.

Meeting evidenced based practice would require on going research funding which is not currently available. Data is being collected but not systematically analyzed. In addition to attempting to include consumer voices in the treatment process, the Consumer Progress Note was specifically designed with the hope they would provide a consumer and service provider friendly research tool. The Consumer Progress Notes are data rich. Staff uses the information to guide services, but the ability to systematically analyzing the data requires more time and more research specific knowledge than is currently available at either F.R.I.E.N.D.S. or VNSNY.

The difficulty of systematically analyzing data is not an uncommon one for most service providers. As one participant in the Chinesegut Out Retreat at the University of South Florida reported: "Service information is there. I mean, it's in the child's record. Now, how you do you extract it? What do you do with it? A lot of it depends on your staff." (Hernandez et al 2001, p.16.)

A lot also depends on finding sources of funding for on going research efforts. Once federal funds are withdrawn from a grant site, research capabilities are also withdrawn. As a result fidelity to the original model begins to fade; equally important, the opportunity for long term follow up is lost. The

MCSI has watched its youth mature and age. Some of our youth have been part of the F.R.I.E.N.D.S. extended family since we opened. Some of these have only moved beyond their problems as they have moved into their twenties. Some of the youth helped when six or seven now need intensive help getting through adolescence. Becoming all you can become is a process that takes far longer than the few years involved in systems of grant funding for outcome research.

Finally, sustainability also depends on maintaining positive relationships with funders. The Tri Level Models Support and Sharing Knowledge Levels are useful strategic guides when apply to funders. The most important strategy has always been to provide gold standard services to the population the funders want served. Other strategies include sharing knowledge by giving presentations at various national, state, and local sites; information sharing through monthly reports discussing both successes and concerns; and finally offering support to the funders in the form of serving on various committees, providing training to other programs, and recruiting family members to tell their stories to legislators. Hopefully, this will be sufficient to sustain this valuable community based clinical service in a way that meets the needs of the Mott Haven community, its families and youth.

**Lesson Ten: Change is possible.**

Change comes slowly and the broader the changes sought, the slower the progress. Nevertheless, the more good people of good intent work together, the more inevitable the positive progress. Caring works. When the caring extends to the community, its effectiveness multiplies.

When we step out of our offices and walk the streets leading to a family's home, we see more. When we enter a home to visit one of our families, we know more. When we are with our families for more then a fifty-minute hour, we understand more. The more we understand, the more we can help others understand. Our work cannot stop with our families, for we must then carry our knowledge back to the world of politicians and policy makers, we must hear their stories, and support their efforts. As we reach out into the community and back to the power brokers, our connection grows and we better understand we are all of the same family. We see that our differences are small when measured against

the sameness of desires, hopes and experiences.  The stronger our connections, the deeper our desire to help one another, the broader our capacity to do so.

References

Beardslee, W.R. *The Need for the Study of Adaptation in the Children of Parents with Affective Disorders.* In Depression in Young People: Developmental and Clincial Perspectives. New York: The Guildford Press. 1986. p 189-204,

Brown, G.W., T.O., Harris, A., Bifulco. Long-Term Effects of Early Loss of Parent. In Depression in Young People: Developmental and Clinical Perspectives. New York: The Guildford Press. 1986. pp 251-296.

Burns, B., S. Compton, E. Egger Farmer, E. Robertson. "An Annotated Review of the Evidence Base for Psychosocial and Psychopharmacological Interventions for Children with Selected Disorders." In *Community Treatment for Youth*, ed.B. Burns and K. Hoagwood. New York: Oxford University Press, 2002.

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Curry, H. *The Way of the Labyrinth*. New York: Penquin Compass. 2000.

Duncan, B., Miller, S., & Sparks, J. (2000). *The Heroic Client: Doing Client-Directed, Outcome-Informed Therapy*. San Francisco, CA: Jossey-Bass. 2000.

Evans. M., R. Boothroyd, & M. Armstrong. (1997) *Outcomes of three children's psychiatric emergency programss.* Journal of Emotional and Behavioral Disorders, 5, 93-105.

Evans. M., R Boothroyd, & M. Armstrong. (1999) *Outcomes Of An Experimental Study Of The Effectiveness Of Intensive In-Home Crisis Services For Children And Their Families*: Final Report. Tampa, FL: Center for Nursing Research, University of South Florida. 1997.

Farber, A. & E. Mazlish, *How to Talk So Kids Will Listen*. New York. Avon Books. 1980.

Fisher, R. & W. Ury, *Getting to Yes: Negotiating Agreement Without Giving* New York: A Penquin Book. 1983.

Fresen, B.J., & N.M.Koroloff, 1990; Family Centered Services Implications for Mental Health Administration and Research. *Journal of Mental Health Administrations*, 17, 13-25

Garbarino, J. *Raising Children in a Socially Toxic Environment*. San Francisco, CA: Jossey-Bass. 1995

Garbarino, J. Finding Meaning in a Socially Toxic Environment. *Reaching Today's Children.* Bloomington, IN: National Education Service. 2, 2. pages 27-30. 1998.

Garbarino, J. *Lost Boys: Why Our Sons Turn Violent and How We Can Save Them.* New York: The Free Press. 1999.

Garmezy, N. Developmental Aspects of Children's Responses to the Stress of Separation and Loss. *In Depression in Young People: Developmental and Clinical Perspectives.* New York: The Guildford Press. 1986. pp 297-323.

Gergen, K. *An Invitation to Social Construction.* London. Sage, 1999.

Gergen, K. *Realities and relationships: Soundings in Social Construction.* Cambridge. MA: Harvard University Press, 1994.

Germain, C. *Human Behavior in the Social Environment: An Ecological View.* New York. Columbia University Press, 1991.

Goleman, D. *Emotional Intelligence*. New York: Bantum Books, 1995.

Gordon, T. *Parent Effectiveness Training.* New York. NAL Dutton. 1975.

Haley, J. *Leaving Home: The Therapy of Disturbed Young People.* 2nd edition. New York: Taylor & Francis, 1997

Henggeler, S., Schoenwald, S., Borduin, C., Rowland, D. Cunningham, P. (Eds.), (1998) *Multistemic Treatment of Antisoical Behavior in Children and Adolescents.* New York, Guilford Press.

Hersey, J. *The Abilene Paradox and Other Meditations on Management.* New York: John Wiley & Sons. 1988.

Ireys, H., Devet, K., & Sakwa, D. Family Support and Education. In Burns, B.J. & Hoagwood K., *Community Treatment For Youth.* New York: Oxford Press. (155-175)

James, B. *Treating Traumatized Children: New Insights and Creative Interventions*. New York: Lexington Books: 1989.

Joint Commission on Mental Health of Children. (1969). *Crisis in Child Mental Health: Challenge for the 1970s.* New York. Harper & Row.

Kagan, J. *The Nature of the Child*. New York: Basic Books. 1984

Kessler, R. "Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States—results from the National Co-morbidity Study," *Archives of General . Psychiatry*. Vol. 51[1]:8-19, Jan. 1994.

Kessler, Ronald C. Posttraumatic Stress Disorder: The Burden to the Individual and to Society *Journal of Clinical Psychiatry* 2000;61 [suppl 5]:4-12)

Kinney, J., D. Haapala, and C. Booth. (1991). *Keeping Families Together: The Homebuilders Model*. Hawthorne, NY: Aldine de Gruyter.

Knitzer J.1982; *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services.* Washington, D.C. The Children's Defense Fund.

Koop, C.E. *Surgeon General's Report: Children with Special Health Care Needs.* Washington, D.C.: U.S. Department of Health and Human Services. 1987.

Kozol, J. *Amazing Grace*. New York: Harper Collins. 1995.

Lambert M. and A.Bergin. The Effectiveness of Psychotherapy. *Handbook of Psychotherapy & Behavior Change* (4-h ed.) 141-150 Bergin A & Garfield S (eds). New York: John Wiley & Sons, 1994.

Levine, K. *Parents are People Too: An Emotional Fitness Program for Parents.* New York: Penquin Books, 1993a.

Levine, K Memory Books: Helping Children Cope with Loss. *Caring Magazine.* National Association for Home Care. Washington, D.C. 7, 12 pg 71.

Levine, K. "F.R.I.E.N.D.S, Inc. Mobile Community Support Service: Building Bridges Parents and Schools." National Resource Network for Child and Family Mental Health Services at the Washington Business Group on Health. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume VII*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research, 1999.

Lightburn, A. and Black, R. *The Client As Learner And the Clinician as Teacher: Working With An Educational Lens*Smith College Studies in Social Work, Vol 72:1, 15-33.

Madsen, W. 1999. *Collaborative Therapy With Multi-Stressed Families: From Old Problems To New Futures.* Guilford Press.

McFarlane, W. 1987. *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*, New York: Guilford Press. 2002.

Meyer, C. H. 1983. The Search For Coherence. In C.H.Meyer (Ed), *Clinical Social Work In The Eco-Systems Perspective*. (pp.5-34). New York: Columbia University Press.

Miller, M & Diao, J. (1987.) Family Friends: New Resources for Psychosocial Care of Chronically Ill Children IN Families. *Children's Health Care*. 15, 259-264.

Miller, S., Duncan, B. & Hubble, M. (1997). *Escape from Babel*. New York: Norton.

Morgan, A. *What Is Narrative Therapy? An Easy To Read Introduction.* Dulwich Center Publications. Adelaide, Australia, 2000.

Ogden, M and K. Minton. Sensorimotor Psychotherapy: One Method for Processing Traumatic Memory. *Traumatology* Volume VI, Issue 3, Article 3, 2000.

Osher, T., E. deFur, C. Nava, S. Spencer, & D.Toth-Dennis. (1999) New Roles for Families in *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series*,

Patterson, G.R., J.B. Reid, & T.J. Dishion. *A Social Learning Approach: IV. Antisocial Boys.* Ugenen, OR: Castalia. 1992

Perry, B.D. (2001). The Neurodevelopmental Impact Of Violence In Childhood. In Schetky D & Benedek, E. (Eds.) *Textbook Of Child And Adolescent Forensic Psychiatry.* Washington, D.C.: American Psychiatric Press, Inc. (221-238)

Pinker, S. *How the Mind Works*. New York. W.W. Norton, 1997.

Potkay & Allen. Personality: *Theory, Research, and Applications*. Monterey, California:.Brooks Cole. 1986.

Schopler, E. Parents of psychotic children as scapegoats. *Journal of Contemporary Psychotherapy*, *4,* 17-22.

Schor, L. *Common Purpose: Strengthening Families and Neighborhoods to Rebuild America* . New York: Doubleday. 1995.

Schriebman, L. *Autism.* Newbury Park, CA: Sage.

Seikkula, J, Alakare, B. & Aaltonen,J. Open Dialogue in Psychosis I: An Introduction and Case Illustration. *Journal of Constructivist Psychology*, 14:247-166, 2001.

Stroul, B. & Friendman, R. (1994). *A System Of Care For Children And Youth With Severe Emotional Disturbance*, (Revised Edition). Washington , DC: Georgetown University Children Development Center, CASSP Technical Assistance Center.

Sunderland, J. Fit To Go. (2002). *New Therapist*. Dorpsruit, South Africa. 17, 28-29.

Terr, L. (1990). *Too Scared to Cry.* New York: Basic Books.1990.

The President's Commission on Mental Health. *Report Of The Sub-Task Panel On Infants, Children, And Adolescents.* Washington, D.C. Author. XXXX 1978.

Thomas, A., & Chess, S. (1984). Genesis And Evolution Of Behavioral Disorders: From Infancy To Early Adult Life. *American Journal of Psychiatry, 141*, 1-9.

U.S. Department of Health and Human Services. (1997).*Annual report to Congress on the evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program.* 1997. Atlanta GA: Macro International.

U.S. Department of Health and Human Services. (1999). *Mental health, A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health , National Institute of Mental Health.

Van der Kolk , B & Fisler, R (1995) Dissociation and the Fragmentary Nature of Traumatic Memories: Overview and Exploratory Study. *Journal of Traumatic Stress,* 1995, 8(4), 505-525.

Van der Kolk, B., Van der Hart, O. & Burbridge, J. (1995) *Approaches to the Treatment of PTSD. Volume I,* Washington, D.C. Center for Effective Collaboration and Practice, American Institute for Research

Figure 1. Overview of MCSS

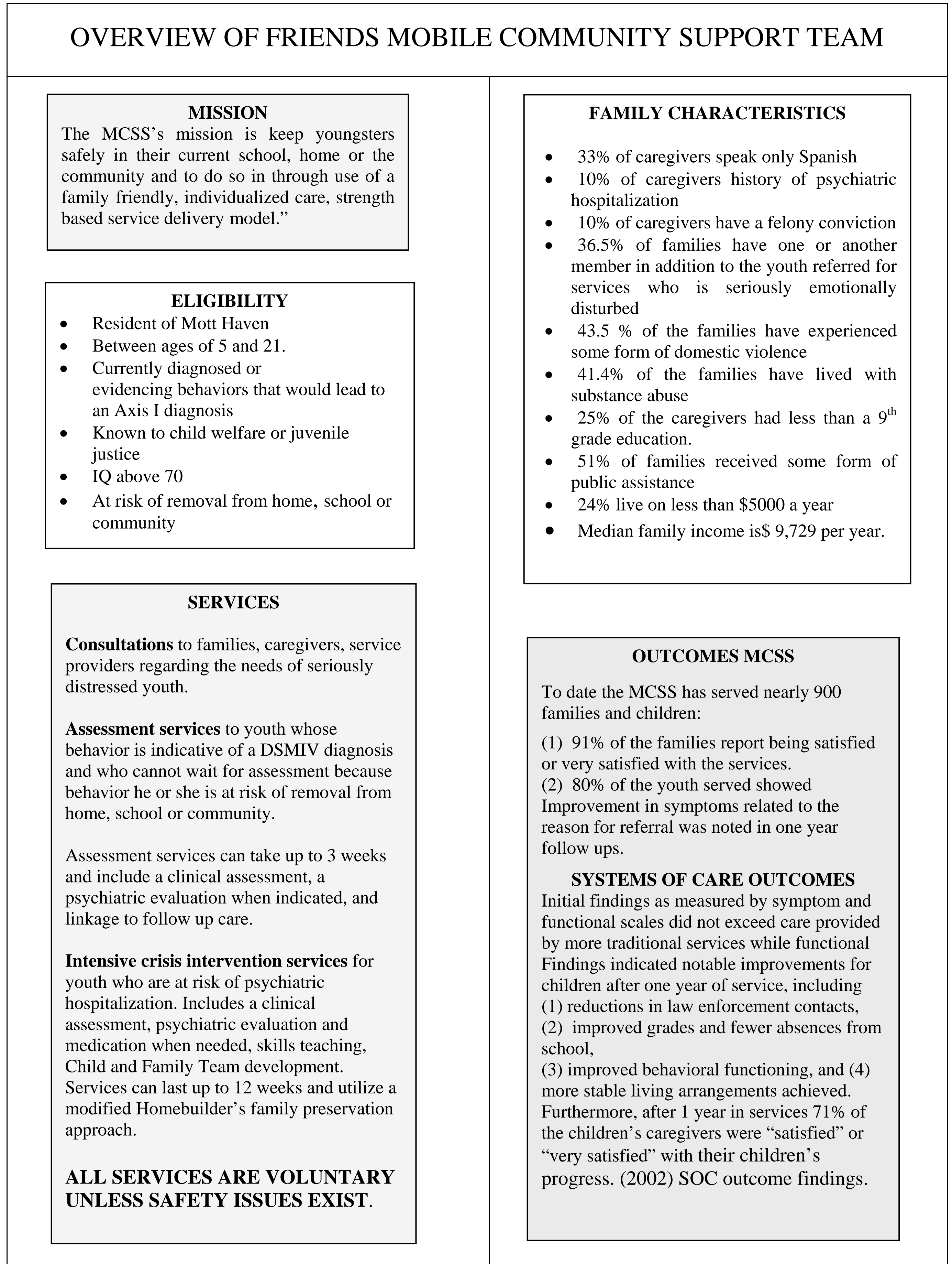

**Figure 2 TRI-LEVEL INTEGRATED TREATMENT MODEL**

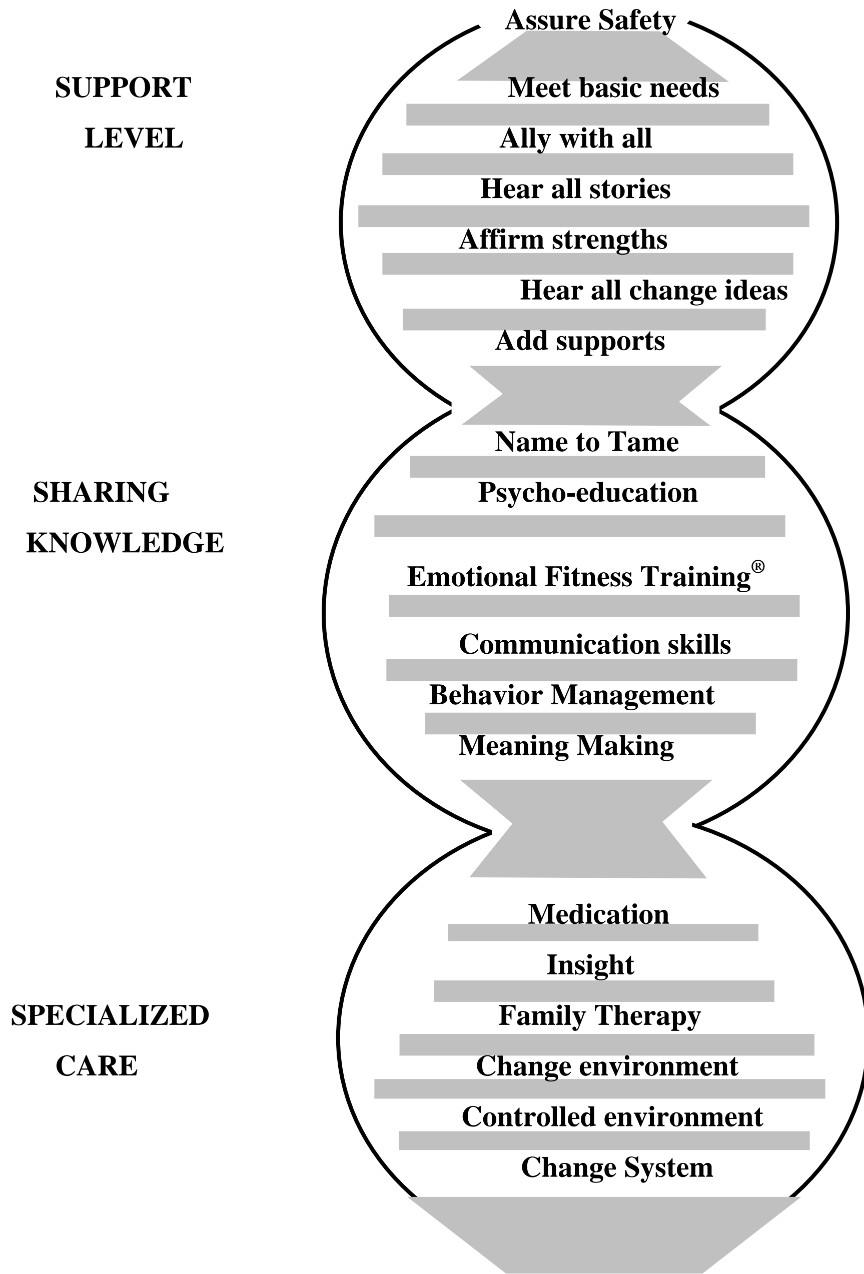


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Figure 4 Sample We Think is Going On,

**WHAT WE THINK IS GOING ON**: After speaking with you and your child, we believe he or she is suffering from a stress or trauma reaction commonly known as Post Traumatic Stress Disorder. This means something very scary, very painful or very frightening has happened to him or her. Witnessing violence, being beaten, being in an automobile or other type of accident, having a serious asthma attack are all things that could have lead to this disorder. Sometimes the youth doesn't even remember what happened. Sometimes others don't think the event was upsetting or traumatic for the youth. Often the youth tries to avoid the event or anything that recalls the event, even talking about the event. Unfortunately, anything connected with the event triggers flashbacks (feelings, thoughts, behavior that make it seem like the traumatic event is happening all over again.) Having this disorder means the youth:

| SYMPTOM OR SIGN | Describes my child | | Severity scale | Strengths and comments |
|---|---|---|---|---|
| | Yes | No | 1=never; 3 = weekly; 5 = daily | |
| Has frequent flashbacks (see definition above) | | | 1 2 3 4 5 | |
| Has difficulty sleeping | | | 1 2 3 4 5 | |
| May have nightmares | | | 1 2 3 4 5 | |
| Experiences danger everywhere | | | 1 2 3 4 5 | |
| Has intense fears | | | 1 2 3 4 5 | |
| Is irritable, has angry outbursts | | | 1 2 3 4 5 | |
| Is sad | | | 1 2 3 4 5 | |
| Doesn't trust others | | | 1 2 3 4 5 | |
| Is often numb—cannot feel love or happiness | | | 1 2 3 4 5 | |
| Feels or fears being crazy | | | 1 2 3 4 5 | |
| Physical complaints including low energy, stomach problems, faintness | | | 1 2 3 4 5 | |
| Does not expect to live long or have a happy life | | | 1 2 3 4 5 | |

**HOW TO HELP** Youth with this disorder can be successfully treated. Here are some guidelines The primary goal of treatment is to help youth gain control of behaviors and feelings, to see the traumatic event as unusual and not likely to reoccur; and to develop a way of making sense of the bad things that happen, and why people do bad things. If youth is continuously exposed to domestic violence, bullying, other forms of violence treatment may not be effective. (1) Keep youth as safe as possible. (2) Make sure youth knows what happened was traumatic and makes it harder to control feelings and behavior, but that control is possible. (3) Make sure youth know is his or her symptoms are normal responses to an abnormal situation and not a sign s/he is going "crazy." (4) Teach youth and those involved in his or her care self-soothing skills. (4) Youth and those involved in his or her care may need help learning some anger management skills. (5) If youth is experiencing unusual fears or isolating, he or she may need a cognitive behavioral program to help face fear. (6) Talk therapy is often helpful, but make certain the therapist is skilled at maintaining emotional safety when discussing traumatic events. Revisiting the feelings surrounding the trauma is not always helpful at least until the child has gained control when fear and anger visit. (7) Anti-anxiety medications are often useful.

**This is a disorder that can be successfully treated.**

Figure % The Daily Emotional Fitness Program

**Staying Strong** **PRACTICING A DAILY EMOTIONAL FITNESS TRAINING® PROGRAM KEEPS YOU EMOTIONALLY STRONG. Here is a brief description of the 12 exercises Emotional Fitness Training® suggests practicing daily.**

1. **Practice gratitude first thing every day. Be grateful for all you have been given—Life, love, others to love, this world, and all things beautiful.**
2. **Remember your mission—Think about the kind of person you want to be: kind, caring, just. You cannot be emotionally fit if you are cruel. You cannot be emotionally fit if you are filled with anger, hate or thoughts of revenge.**
3. **Be kind to another—Being kind brings its own reward. Give a hug and get a hug. Smile and feel your spirits lift.**
4. **Move your body—15 minutes brisk exercise daily improves not only your body, but your emotional fitness.**
5. **Be with beauty—Take time to look into a flower or to listen to beautiful music or to watch a bird soar.**
6. **Recall someone who cared—Too often we focus on past hurts. Remember instead another's kind act.**
7. **Laugh— Laugh with, not at. Practice laughter. Share a joke. Watch a funny movie, have a silly face feud.**
8. **Make something—Bake some special bread, plant flowers, crochet, carve, knit, paint, make music, write.**
9. **Indulge in a healthy pleasure—A candy kiss, a bubble bath, listening to your favorite music, a cup of tea.**
10. **Forgive yourself. Accept that people, you included, are human and none of us is perfect. Stop behaviors that harm others and make amends for wrongs you have done, then let go of guilt.**
11. **Forgive another—Forgiveness is not forgetting; it is not letting another hurt or abuse you. Forgiveness, as practiced here, refers to the forgiveness suggested by Bishop Tutu. This means stopping the circle of hurt by refusing to hurt those who have hurt you. In the long run revenge is neither healthy nor helpful.**
12. **Be grateful yet again. Every night before you fall asleep, remember and be grateful for all the good things in your life.**

**Practice each of these exercises daily and you will find you feel calmer, more in control, and more able to work for peace in your heart, at home, in the world.**

***…to appreciate beauty and find the best in others; to leave the world a bit better…to know even one life has breathed easier because you have lived—this is to have succeeded.***

***Ralph Waldo Emerson***

**Visit our Web Page at www.eft.org**

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Figure 4: Tri-level Integrated Model of Care Demonstrated.

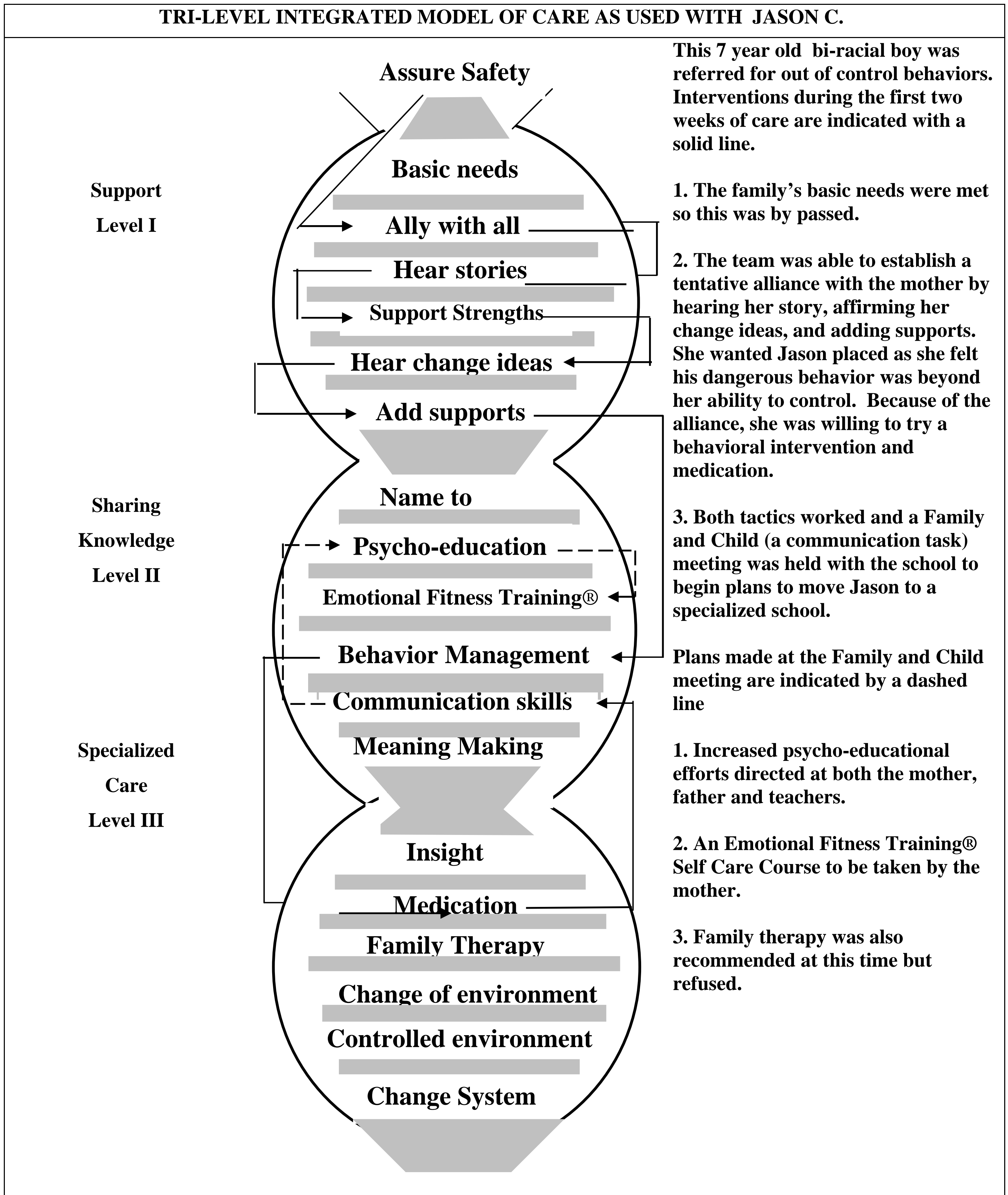

Figure 5

The Consumer Progress Note

**F.R.I.E.N.D.S** **Primary Caregiver'sProgress Note**

Youth's name ***Jason C*** Primary Care givers name *Marta C* ID# *F292*
Date 5/***22/2001*** Length ***1.5*** Location ***Home*** Wrap funds: *12.50 for purschase of snacks*
Reason for referral: Dangerous and out of control behavior Occurred 10 ***Xs*** a day Occurs ***10 a day n***

Check number you feel is closest to the truth: 5 is true, 3 is true some of the time, 1 is not true at all.
(1) My child got along well at home. 1 2 3 x 4 5 (4) My child was happy. 1 2 3x 4 5
(2) My child did well in school. 1 2 3 4 x 5 (5) My child is doing better. 1 2 3 4 x 5
(3) My child stayed calm. 1 2 3 4 5x (6) I worked on my goals. 1 2 3 4 x 5

**Current goal(s)** *Stop Jason's playing with electric plugs. Such behavior occurs at least ten times a day and when Mother forcibly stops him, Jason has a temper tantrum lasting 10 minutes. Today's goal demonstrate use of the STOP plan.*

**What did during session:** *Mom, parent advocate and Jason went to MacDonald's. Rest of team stayed by and moved the furniture blocking plugs. When family returned demonstrated, use of STOP PLAN and repeated it until Mom took over. Mom implemented plan 3xs and stated. "I can't believe this worked." Reminded to use it only with the behavior related to electric plugs as over use makes it less effective.*

*Talked briefly about holding a family meeting to begin preparations for a Family and Child Meeting with the School.*

**Next steps** Mo*m will continue to use the STOP plan. Team will return on Friday and will hold a family meeting. Mother will invite father and daughter to attend this meeting. Case aid will visit Thursday to reinforce STOP Plan with Jason. Mom needs someone to help her with Jason's medical appointment. Parent advocate will accompany her. Case Manager will schedule meetingn with school.*

Consumer Feedback Rating scales Circle number you feel is closest to the truth: 5 is true, 3 is true some time, 1 is not true.
(1) I was listened to 1 2 3 4 5X (3) My strengths were recognized 1 2 3 4 5X
(2) I could talk about my concerns 1 2 3 4 5X (4) I helped decide what to do 1 2 3 4 5X

Consumer signature Read by consumer __X_ Read to consumer___
Staff signature/Title Supervisor signature Date

Staff Safety /Risk of Removal Rating: Circle number you feel is closest to the truth: 5 is high risk, 3 is some risk, 1 is no risk.
Self 1 2 3 4 X 5 Others 1 2 3 X 4 5 Home 1 2 X 3 4 5 School 1 2 3 4 X 5

Figure 6 7 labyrinth