

*Family Involvement  
& Perspectives*

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*Chapter 2*

## Chapter 2: Family Involvement & Perspectives

# *Family Service Coordination: What Constitutes Effective Support?*

## **Introduction**

Community-based systems of support for children and families rely on systematic service coordination to assist parents in navigating multiple providers. Service providers, policy makers, educators, and parents must understand factors that constitute effective service coordination so that this information can be used to improve services.

A one year research project was designed to explore the construct of service coordination in order to better understand the factors that affect the provision of effective service coordination to children who have emotional or behavioral disorders (EBD) and their families. Effective service coordination appeared to depend upon three primary factors: (a) personal characteristics of professionals, (b) characteristics of the organization in which the professional is employed (intra-organizational), and (c) characteristics of the larger community system (inter-organizational and community characteristics).

## **Method**

An in-depth examination of parent and professionals' perspectives is one way to understand what it takes to provide effective support for families. This focus also reflects the shift toward child-centered, family-focused service delivery. Qualitative or naturalistic inquiry allows for an in-depth examination of "insiders'" points of view. The qualitative research methods of data collection used in this study were (a) a focus group, (b) in-depth semi-structured interviews with a sample of parent and professional respondents, and (c) researcher reflexive notes.

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## ***Participants***

Purposive sampling procedures were employed to select parents for initial data collection from a sample of families who had participated in a survey of Oregon families. This previous study examined the types and helpfulness of support received by families who had children with EBD (Lehman, 1996). The respondent pool included families from the survey sample who had received two or more functions of service coordination and stated that they were able to access the help they needed. The final group consisted of 8 families that varied by head of household, geographic location, and socioeconomic factors. Family annual income ranged from less than \$10,000 to \$60,000, with 6 families earning \$20,000 or less. Single mothers headed five families. Four of the 5 worked full time outside of the home. Child ages ranged from 6 years to 18 years. There were 7 males and 1 female. All children had been involved with more than one service system. Seven of the 8 children had lived outside their home at least one time. Five had more than 2 out-of-home placements. Seven children had more than one disability classification. The 18-year-old carried nine labels. Six children had between four and six disability labels.

The second respondent group included professionals nominated by parents as helpful in providing service coordination. Six nominated professionals participated in the study. Three worked officially as service coordinators; one for a therapeutic foster care program, one for a system of care demonstration project, and one as a family support worker for a federally funded county system of care project. The later was also the parent of a child with EBD. A local juvenile department, county drug and alcohol treatment program, and state child welfare agency employed the other 3 professionals.

## ***Data Collection and Analysis***

One focus group, with parent representatives from the Oregon Family Support Network was conducted to ensure that the content of semi-structured interviews elicited all essential information. Focus group data were analyzed prior to conducting interviews. Findings were employed to finalize interview protocols.

Analysis of interview transcripts took place throughout the course of data collection. Analysis consisted of systematic coding and clustering of categories. Constant comparisons of statements and researcher experiences occurred as data collection and analysis progressed. These processes lead to the development of grounded theory. Data analysis and management were facilitated by utilizing the qualitative analysis software, ATLAS/ti.

Within the context of qualitative research, reliability of the data and validity of research findings are referred to as the extent to which findings are considered trustworthy. The strategy of triangulation (Rossman & Wilson, 1985) was employed to constantly test reliability and validity. Triangulation occurred across data sources (i.e., parents, professionals, and reflexive notes). Formal and informal member checks were conducted as a second method of ensuring trustworthiness.

## ***Results***

### ***Characteristics of Effective Service Coordination***

Three primary theme areas emerged, related to effective service coordination. These were (a) personal characteristics of professionals, (b) characteristics of organizations in which the professionals were employed (i.e., intra-organizational characteristics), and (c) characteristics of the larger community system (i.e., inter-organizational and community characteristics).

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### ***Personal characteristics of professionals.***

The following themes were identified as personal characteristics of effective service coordinators:

a) they were regarded by the parent as a resource, (b) they assumed the parent had the best interests of the child in mind, (c) they took a pragmatic approach (i.e., provided timely and practical assistance based on priorities set by the parent and child), (d) they were available when needed, either by phone or in person, (e) they genuinely cared about the child, parent(s), and family, (f) they visited the home and spent time with the family, i.e., understood what home life was like, and (g) they built and sustained a positive relationship with the child.

Personal characteristics of professionals that presented barriers to effective service coordination included: (a) they did not recognize and respond appropriately to early signs that the child had serious emotional or behavioral problems, (b) they told parent(s) she/he could not help because the parent(s) were already doing everything possible, (c) the parent(s) were not considered decision-makers even when they were included in team meetings, (d) they were not familiar with current information regarding specific disabilities and best practices, and (e) they blamed parent(s) for the child's problems.

***Common attitudes regarding effective service coordination.*** After the analysis of professionals' interview transcripts, three major themes emerged: (a) how they believed support should be provided, (b) concerns about the current system, and (c) approaches to providing services and support. The responses from these professionals revealed several similarities:

- Had a vision for how to support children from an early age.
- Were concerned about the children and parents.
- Were pragmatic and “did what needed to be done”, whether or not the task was expected as part of their job description.
- Consciously attended to not doing the work of other professionals.
- Searched for community resources that matched child and family needs.
- Identified the need for systems level changes.

***Intraorganizational and interorganizational factors.*** Analysis of interview transcripts and researcher reflexive notes revealed organizational factors that either contributed or presented barriers to effective service coordination. Contributing factors were: (a) programs designed to provide individualized service delivery (i.e., therapeutic foster care); (b) services in which the service coordinator role was clearly defined (based on the values and principles of Stroul and Friedman's System of Care (1986); and (c) agencies that provided staff with freedom to expand and modify their job to include activities they considered necessary to ensure effective support (usually dependent on supervisor attitudes).

Conversely, barriers to effective service coordination included: (a) support limited to the parent and child; (b) the child received services when she/he “fit the program”; (c) a lack of continuity of support when the child left a program or placement, for example, the family had to “start over”; (d) more services were received after a child's behavior had dramatically impacted the school or community, (e) categorical systems generally not proactive, support received was often “too little, too late.”; (f) a greater focus on classification of the child's problem than on responding in a timely and effective manner; (g) children were “placed” based upon availability of “slots/beds”; (h) no transition support, information about how to access adult services; and (I) inflexible categorical rules and procedures.

## Discussion

The shift toward child-centered and family-focused service delivery continues to evolve. Even though this study is limited in scope, results imply that within the current service delivery system, effective service coordination may be more a function of the personal characteristics and commitment of the individual direct service professional than of the infrastructure of the community service agencies. It does not appear that the community systems were integrated, or that community agencies were practicing principles of the system of care. In spite of these systems issues, the parents in this study appeared to hold in high regard the individuals who provided service coordination functions.

Professionals providing service coordination may be an important source of emotional support for parents coping with extreme stress as they address the pragmatic, day-to-day issues related to their child and family. Further, while community systems continue to evolve, it remains essential to provide families with at least one professional service provider (e.g., service coordinator, case manager) who has the characteristics of those identified in this study.

In terms of the status of community system development, this study suggests that children's mental health, juvenile justice, education, and child welfare continue to be program-centered and agency-focused rather than child-centered and family-focused. In contrast, the professionals in this study appeared to clearly understand how to effectively support children and families: showing respect while providing pragmatic support.

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# *How Parents Balance Work and Family Responsibilities: A Qualitative Study*

## **Introduction**

Parents of a child with an emotional disorder must overcome formidable challenges to balance their work-family responsibilities. Recent empirical and theoretical scholarship has addressed the difficulties of balancing employment and family life (Barnett, 1997; Hochschild, 1997; Barnett & Rivers, 1996; Brennan & Rosenzweig, 1990). For working parents whose children have serious emotional disorders, a lack of support for their caregiving can make meeting the challenges of home and employment very stressful (Lechner & Ceedon, 1994; Roberts & Magrab, 1991; Friesen & Koroloff, 1990). Satisfactory employment can be crucial for sustaining the family, since financial stability, family support, and personal development can all depend upon a suitable work situation.

However, few studies have addressed the perceptions and strategies of employed parents of children with mental health concerns. To address the lack of literature and research in this area, an exploratory study was conducted using the qualitative research methodology of focus groups. The study was designed to answer the three following research questions: (a) What were the adaptations parents made to their work responsibilities due to their child having a serious emotional disorder? (b) What were the arrangements made by the parents to care for their children while they were at work? and (c) What resources are needed to help parents balance their work and family responsibilities?

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## Methods

Flyers were distributed to service provider organizations, parent support groups, family support conferences, and through personal contacts to recruit employed parents of children with serious emotional disorders. Five focus groups were formed; the 41 participants included couples and single parents employed in a wide range of occupations whose children varied in age. Participants completed demographic questionnaires, informed consent forms, and agreed to tape recording. The participants were offered refreshments and paid a stipend of \$15.00. Focus groups met for 90 minutes and the authors led discussion with five general questions.

Transcripts of the five tape-recorded sessions were prepared, and the text was entered into the qualitative software Ethnograph for analysis. Each transcript was coded by two of the investigators, with the third investigator checking for concordance. Coding began with simple descriptive categories. The coding schema was elaborated, and major themes emerged from the analysis.

## Results

Major themes relevant to the research questions were identified, as well as those themes illustrating stresses, challenges, and strategies experienced by employed parents whose children have serious emotional or behavioral disorders. While identification of these themes make a contribution to the understanding of work-family dynamics faced by these parents, their essential nature can be best communicated by sharing the voices of the parents. Toward that end, the themes related to each guiding question is identified and followed by representative direct quotes from focus group participants.

### *How has a child with a serious emotional or behavioral disorder changed your work life?*

**Work Adjustments: Employment Duties and Time at Work.** "I could have worked for a large international company in international sales because I know different foreign languages, and I unfortunately had to reject this opportunity, and I would have accepted the job if I did not have a disabled child...I feel that I could not work to my fullest potential intellectually or professionally because I just had to look for my son's welfare first."

**Work Flexibility Highly Desirable.** "Instead of working in the daytime like most people do, I will work and do the things that I need, absolutely have to do to keep my deadlines; and anything else I can put aside I do when they are asleep or in the early morning. I go in and work when the behavior, just everything is working...I manage my time based on their behavior."

**Diminished Concentration & Frequent Interruptions.** "...you know, it is very hard to focus on school or a job, if the school is constantly calling you saying, 'Your son is a problem. Your son hit somebody, beat somebody, destroyed something.' Here you are in the middle of a professional activity and you are getting all these messages and you sort of start shaking, you know."

**Co-workers: A source of support and worries over revealing too generally the child's disorder at work.** "I felt, for professional objective reasons, that the most important person in the unit I worked in needed to know because he had the most interaction with the world outside my work unit. So if there were questions...he could handle discreetly in explanation. Then at a more personal level, there was one other staff member who I felt...would always be there to remind me that it wasn't at times as bad as I felt it might be, that she saw progress or something like that...But I was very uncomfortable, on the other hand talking with anybody else besides these two

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people in a working environment that had 8 or 10 adults and anywhere from 20, 25, 30...young adults.”

### ***How is the child with the emotional or behavioral disorder cared for while you are at work?***

***Qualified care providers scarce.*** “Because it was so impossible for a one-on-one adult to handle this little girl, we also had a day care provider to take her from after school until 5:00. For an entire year... the only time that I was away from her, was when I was at work because the behavior was just so bizarre that we could only find this one day care person and they said they absolutely would not take her for more than that hour and a half.”

***Varied ingenious alternative sources of care developed.*** “...I have my friends from church who became her adopted grandparents...When I do need a weekend off, they will take her for the weekend, and occasionally during the week if I have an evening meeting...That helps but it is still an ongoing problem.”

***Nuclear family members provide the most care.*** “...he was the fourth child so I always had the older siblings watching. I have to explain over and over why he did these certain things. I was fortunate that way, that they were close knit enough to where they would watch out for him ...I took jobs that were really close to home, you know, like within a three-minute walk from my house, so that I could get home really quick.”

***Barriers to care were numerous and stressful.*** “I have a problem with having my son cared for. Mostly my teenage daughter takes care of him after school and definitely on the weekends. I work every single weekend; sometimes I work 7, 8, 9 days a week before I get one day off. I have to do this in order to support four kids. I can't afford to pay somebody to watch a special needs kid. Everyone that I sent him to, (cares for him) one time only, and

they won't do it again...too much...It is hard to find people that understand the child's disorder. I think it is very important that they understand the disorder before they try and take care of a kid with those disorders.”

### ***Barriers to Child Care***

***High cost of special care.*** “One of the (support group) mothers said that for \$8.00 per hour you can get students from...University who are willing and able and knowledgeable. The problem is that who can afford to pay \$8.00 per hour after-tax money? So if my (pay is) \$15 (per hour), and I pay \$5.00 in taxes, I have \$10.00. I give the student, who is in their twenties \$8.00 and I am in my forties and I get \$2.00.”

***Difficult to find care.*** “Summer is a very critical time for a parent who works and has children with disabilities because there is no school and they have the additional 6 hours on hand, and you really have to work and shift with your spouse, because otherwise you get financially ruined.”

***Transportation: school, care leisure.*** “...my older daughter...managed to get thrown off every bus system she was ever on. I rode the bus with her for a few weeks...and clearly she was a trouble-maker. I would be sitting right there beside her, and it was still a problem.”

***School problematic to child & working parent.*** “For my daughter who does most of the acting out, the crises...(always happened) at school. So for me it meant rearranging my work schedule and making the time to meet with school, teachers, principals, counselors. Sometimes there would be six or eight professionals in the room around the table trying to figure out what to do with this child and setting up a new IEP and figuring out how to monitor their behavior and control them, contain them within the school...So I had to drop things and be able to work with the school people quite intimately in dealing with it.”

**Couple distress from crisis care.** “Well if I’m lucky my wife is in a good disposition, stress levels and everything goes really well. But...I do whatever I can to keep my wife’s sanity going, so it relieves the stress on me so I can function in my job, because if she is wiped out because the stress is too much for her, even though I keep my cool and nobody knows that I’m suffering, it is affecting my ability to get my job done.”

**Professional relationships stress work-family balance.** “(Professional appointments) were always during the day. The school, when he was in regular school, did not want him leaving school for appointments because they didn’t want him to miss school...that left about maybe from 3:30 to 5:00 when we could schedule appointments if we were able to get them...It was like having this constant tension, always tension. Did I remember to go every place I was supposed to go, make all the phone calls, get to work, do my work, if I have to go home, what if he gets worse, what if we have to put him in the hospital, what’s going to happen when he’s in high school, what’s going to happen when he is an adult.”

**What external parent coping strategies helped to handle work-family balance?**

**Legal means with schools and institutions.** “...where I live camps is what all the kids do during the summer. If they don’t take him, I am going to sue them for discrimination.”

**Extended family crisis care.** “My parents who live 2,500 miles away have offered to step in...They say,... ‘You have a crisis. We are worried about you.’..They have offered ‘We’ll come out for a week and you go somewhere and rest.’ Indeed, things are much better now than when they made that offer, so it is not looming. But there is a commitment from my parents to step in.”

**Provision of information to school personnel & professionals to improve care.** “I kept very good records; I asked for copies of everything when I left every professional. If I was going to see another professional, I would take the packet of typewritten things that had already been from one counselor or another professional, or another diagnosis,...along with things that I would write about on a daily basis of what we had to deal with. So I didn’t have to keep telling the story over again. It became more believable.”

**Technology: information & communications.** “The other thing that really helps me is having a pager, so that I know that when my special needs children need me, I can always be reached anywhere...I can work flex hours and when I ask the psychiatrist to call me back regarding a med change, he can reach me 24 hours a day because I have a pager.”

**What internal parent coping strategies helped to handle work-family balance?**

**Reframe problem as external.** “The thing that got me through the rough years when he was a terrible two that he never grew out of, and he is 14 now, was that when he was asleep he was so angelic. I have all these pictures...So just looking at those pictures of him and remembering him asleep as a little angel got me through the rough times.”

**Encouraged by child progress.** “I find that when he is progressing, when I don’t feel impotent, when I don’t feel powerless, that I can keep doing this.”

**Adjusted standards of performance.** “One thing that works out with families is learning to make ...allowances. They can’t walk the same line as your average students because these kids have special needs. That’s what the whole thing about it is. So educating people, that is another thing that would help...Sort of drop those walls, make those allowances for these kids.”

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**Work as a coping resource.** “I guess that I am a naturally-born optimist, and I try to take time every day to do things that are as (low stress) as possible, and pleasurable for me. They are not necessarily things that people would always view as pleasurable, but for me it is work-type activities...I enjoy writing computer codes to help better my business. I enjoy using mental challenges to improve things in life or in my business, whether it be writing a computer program that automates a work process or thinking a process through.”

**Troubles as transitory & better future.** “Really what keeps me going in the middle of this house is that I’m always looking forward to something, and I am able to shut off my mind from the negatives and dream about my future projects which I really enjoy.”

**New treatments and therapies.** “This is the first year (my son’s behavior) was going in a positive way, although it is still pretty rough. It’s got a lot of ways to go, and I think there is a lot of hope there now, because I see some things that appear to be working for my son, if you have the energy level to implement them.”

**Promoting positive mental health of self and partner.** “I mean we have so many things that we need to work on, on our son, that what we’re trying to do is pick out the ones that are the most disturbing to us mentally...I guess our theory is if ...you go on an airline, they say when the oxygen mask comes down the first thing you do is you put your own on, and then your kids’... So we’re under the belief that if we are going to be the best, if we’re really interested in our son’s well-being, our best bet is to make sure that we’re mentally OK and physically OK as best we can, so that we can take care of our son. I tell you, it sounds good on paper, but damn it is hard.”

## Discussion

The results from the focus groups begin to identify critical stress points in the lives of employed parents of children with serious emotional and behavioral disorders. Significant adaptations in work situations were reported by the parents, including quitting jobs, derailing career paths, and lowering self-expectations of performance. Childcare resources traditionally used by employed parents, such as center care, individual day care providers, or “baby-sitters” often were not suitable for the children. Parents experienced a multitude of barriers to finding care for their children while they worked, frequently relying on an older siblings to provide care during after school hours because of the scarcity of trained providers and prohibitive costs. Frequently, parents received calls from school requiring them to immediately leave the job and intervene. Parents often perceived themselves as educating and training school personnel about their child’s disorder and related behavioral management skills. In spite of the stresses and challenges experienced by the parents, they reported remarkable resiliency and resourcefulness, envisioned a better future, and found hope in the smallest steps of their child’s progress.

The focus group findings will inform a model of work-family fit and design a survey to further study the stresses and needs in balancing work and family for parents of children with emotional disorders. The results of the survey and the focus groups will be used to develop interventions such as individualized family-centered care plans, which accommodate both the special needs of each child, and the requirements of employment held by the parents.

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# *Family Involvement in Therapeutic Foster Care: Multiple Perspectives*

## **Introduction**

Therapeutic foster care (TFC) is a form of community-based treatment used with children and adolescents with serious emotional disorders (SED). TFC models vary, but they share certain general characteristics: a child is placed with a family selected and trained to work effectively with children with special needs; typically, only one or two children are placed at one time; TFC program staff have small caseloads; and TFC parents receive a higher stipend than traditional foster parents (Rivera & Kutash, 1994; Hawkins, 1989; Stroul, 1989). While some TFC models described in the literature offer assistance to the biological parents, there has been little attention to family involvement in TFC (Grealish, Hawkins, Meadowcroft, & Lynch, 1990). Since most children in TFC return home eventually, Maluccio and Whittaker (1989) recommend preserving family ties as a major goal. This paper describes the preliminary findings of a qualitative study designed to examine the involvement of biological family members in TFC; and the effects of cultural diversity on relationships between biological parents of children in TFC, professionals and TFC providers.

## **Method**

Participants in this exploratory study were biological parents, TFC providers, and child welfare and mental health professionals in four Oregon counties. Child welfare staff identified cases for inclusion in the study where a child with a

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serious emotional disorder (SED) was placed in TFC, and there was at least some family involvement (the intent of the study was to identify practices related to family involvement). Parents with a child diagnosed as SED who was placed in TFC were invited by letter to participate in the study. Out of approximately 30 possible parent participants, ten parents agreed to participate. Parents choosing to participate were interviewed. This examination of preliminary findings is based on the responses of eight parents.

Next, researchers interviewed child welfare professionals and TFC providers. Each respondent participated in a semi-structured interview lasting approximately one and a half-hours. The questions focused on contact between biological parents and their children, communication between parents and providers, the quality of relationships, and the effects of cultural difference on relationships. Parents and TFC providers were paid \$25 for their participation. Changes in the child and family situations were identified in follow-up telephone calls after six months.

Interview data were recorded, transcribed, and analyzed with the assistance of The Ethnograph computer software program (Seidel, 1994). A constant comparative method based on the work of Glaser and Strauss (1967) and Lincoln and Guba (1985) was used to analyze the data. Major themes emerged from the data in a process of inductive analysis by three research team members who coded the data independently to ensure the trustworthiness of the findings. In this paper, preliminary themes developed from an analysis of findings from 28 interviews with 8 biological parents, 10 TFC providers, and 10 professionals are provided.

## **Results**

Major themes areas that emerged from the data included: professionals' and TFC providers' values related to family involvement and cultural beliefs; professionals' and TFC providers' attitudes toward biological parents; relationships between parents, professionals, and TFC providers; barriers to family involvement; elements of practice related to family involvement; and strategies to enhance family involvement.

**Values related to family involvement.** Child welfare professionals, TFC providers, and biological parents offered a range of values and attitudes about family involvement in TFC. Predominant positive themes related to beliefs that family involvement contributes to positive outcomes, and the importance of parent-child contact. There were also some negative perspectives offered by a small number of TFC providers.

Child welfare professionals and TFC providers saw family involvement as a way to help parents understand the goals and planning in the case, a vehicle for parent education, and an essential part of successful outcomes in TFC. Child welfare workers in this study said that they communicated information about the child's progress and promoted family involvement in decision making to ensure agreement in planning for the child's future. Parent-child contact was valued, because of the perception that family involvement contributes to successful treatment outcomes for children. There was a reported intent to support parent-child bonds even where family reunification had been ruled out.

Even though family involvement had been conceptualized as a key element in planning the TFC programs, a few therapeutic foster (TF) parents believed that contact with biological parents was not helpful to the child nor part of their role.

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**Values related to cultural awareness and beliefs.** In general, child welfare workers believed that recognizing family values, culture and beliefs during placement planning was important. However, due to the limited availability of placements, the TF parents' capacity to treat the child's specific emotional or behavioral disorder was of primary concern. Therefore, there was little or no matching based on cultural issues or family beliefs.

Biological parents described varied experiences related to their beliefs and values being taken into account in placement planning and the extent to which they felt that this was important. One mother of a bi-racial child appreciated her son's placement in a bi-racial home with bi-racial children and with TFC providers who shared many of her values. In contrast, several biological parents stated emphatically that there had been no effort to take their values into account in placement planning. Foster parents described ways in which they honored families' values, but worked to change specific behaviors, for example by limiting children's access to TV, or providing a structured routine. Some biological parents appreciated the positive changes in their children, while others were resentful, because they were excluded from the planning process.

**Attitudes toward parents in TFC.** Even where there were general values favoring family involvement, professionals' and foster parents' attitudes toward specific biological parents contributed to actual practice. The most frequently encountered negative attitudes incorporated elements of skepticism about parents' capacity to keep their word, dislike and disapproval, and fear. In contrast, several child welfare workers and TF parents demonstrated tremendous respect for biological parents. There were two main themes: empathy with birth parents and appreciation of their courage and strengths; and respect that parents earned by complying with requirements.

**Relationships in TFC.** Relationships between biological parents, child welfare and mental health professionals, and TFC providers varied considerably. The range was from close and personal to distant and hostile. Biological parents appreciated when workers were honest and trustworthy, and when they supported and advocated for them. Relationships were enhanced: (a) when parents' strengths and efforts to comply with requirements were appreciated; and (b) when professionals and TFC providers shared information and facilitated contact with children.

Positive relationships were related to foster parents' willingness to get to know parents, to discuss their treatment goals and strategies, and to negotiate with parents. Biological parents appreciated the love and care TFC providers gave to their children. One TFC couple explicitly shared parenting roles with biological parents. Through modeling and teaching, they helped parents manage their children's behavioral difficulties, leading to early family reunification.

In contrast to these positive relationships, there were cases where the TF parents did not like biological parents and refused contact, and where there was a lack of trust on both sides. In these cases, the biological parents verbalized anger and resentment.

**Barriers to family involvement.** Large caseloads were described as a barrier to family involvement. In one county, work with biological families was contracted out. Biological parents' discouragement, lack of skills or lack of supportive services were mentioned by professionals as barriers to family participation. There were also barriers to parent-child contact, such as professionals' negative attitudes and bureaucratic "red tape". The latter was best illustrated in a case where the biological mother had to "jump through many bureaucratic hoops" in the process of reunification, even though the caseworker was supportive.

***Practice related to family involvement.***

Emerging themes related to effective practices associated with parent involvement were open communication with biological parents; contact between parents and children; and parent involvement in decision-making and meetings. Communication between biological parents and professionals emerged as a key factor in family involvement. Several parents felt that their suggestions about their child's treatment were received respectfully and acted upon. In other cases, biological parents said that professionals failed to listen, distorted what they said, or "made you feel like they were God". Generally, professionals observed positive effects of biological parent contact with children.

Parent involvement in decision-making varied widely from none to a lot. Several parents described professionals' efforts to reach compromise arrangements where there were differences in opinion. While some biological parents were pleased with their involvement in decision making at formal meetings, others were not even invited. Biological parents who participated in meetings reported that they felt empowered to make decisions and remain involved in the child's care. Reasons for excluding parents from formal meetings were related to differences in philosophy and difficulties in scheduling meetings.

In many cases, the amount of contact between TFC providers and biological parents was determined by foster parent preferences and related to their general life experiences, rather than specific training. Preliminary training for TF parents did not address skills in working with biological parents, but this topic was the focus of ongoing discussions and training in weekly team meetings, and professionals recommended explicit training on this topic.

***Discussion***

Preliminary analysis of the findings suggests that the participating biological parents of children with SED who were placed with TFC providers desired contact with and involvement in making decisions about their children. Likewise, child welfare professionals who participated in this study expressed values that were supportive of family involvement and parent-child contact. While some TFC providers valued family involvement, others did not think that contact with families was part of their work.

Professionals' and TFC providers' attitudes regarding specific parents were varied. Several professionals described their efforts to promote family involvement and parent-child contact and the efforts of TFC providers to work with parents. Some parents appreciated the professionals' and TFC providers' work to share information with them, to involve them in decision making, and to promote contact with their children. In other cases, parents who did not receive information and were excluded from decision making were resentful and hostile. Barriers to family involvement identified by child welfare staff were mainly related to bureaucratic constraints and large caseloads. TFC providers' willingness to work with parents seemed to be related to their previous life experiences, rather than training they had received. Further research is needed to more fully understand the dimensions of family involvement in TFC and the conditions that promote and impede involvement. In addition, future studies will increase understanding of the relationship between family involvement and child and family outcomes in TFC.

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# *Part of the Picture: Family Outcomes Using a Wraparound Approach*

## **Introduction**

In the past fifteen years, innovative paradigms, such as systems of care (Stroul and Friedman, 1986), have started to reshape ideas about service delivery and its concomitant infrastructure development for children with complex and enduring mental health needs and their families. Beginning with initiatives such as the Child and Adolescent Service System Program (CASSP) to the Robert Wood Johnson Mental Health Services Program for Youth (MHSPY) through the Center for Mental Health Services (CMHS) demonstration projects, communities have received funding to implement this paradigm shift. At the center of these programs has been a commitment to provide family-driven, culturally contextualized, community-based services.

Funded by CMHS in 1994, the Community Wraparound Initiative (CWI) serves Illinois' Riverside, Lyons, and Proviso townships. The Initiative has focused on changing the ways in which cross-agency services are delivered to children and their families. Emphasizing a wraparound approach, services are planned and organized by family teams facilitated by wrap coordinators, education staff, family members, and/or mental health providers. Families also have access to a family resource developer (FRD), a family member who provides support and linkages to services. The purpose of the teams and the FRDs is to provide a forum for family input and ensure that a family's needs drive the planning process. Through the wrap process,

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CWI implements core principles of systems of care. It seeks to assure accountability with these principles and values through the implementation of a comprehensive evaluation, which links the wrap process to the achievement of specific, measurable child and family outcomes.

This study examines the effect of wraparound services for 48 families in three communities outside Chicago, Illinois. Specifically, it seeks to identify changes in family empowerment, needs, support systems, adaptability, and cohesion during the first six months of involvement in a wrap-around process. A secondary purpose of the study is to assess the strengths and challenges of the current service delivery model, the assumption being that the outcomes can serve as a quality assurance mechanism.

## **Method**

### **Instruments**

**The Family Empowerment Scale (FES)** is a 34-item scale developed at the Research and Training Center on Family Support and Children's Mental Health at Portland State University by Koren, DeChillo, & Friesen (1992). The scale has 34 items, and responses are rated on a Likert-type scale of 1 to 5. Items focus on a family's perceptions of their ability to act on their own behalf.

**The Family Needs Profile** is an adapted version of the instrument developed by Dunst, Deal, and Trivette (1988). The profile is a 32-item scale that examines what needs are or are not currently being met. Items are rated on a Likert-type scale (1 = *not a need*, to 5 = *a very high need*).

**The Family Support Scale** was also adapted from an instrument developed by Dunst, Deal, and Trivette (1988). The scale evaluates the helpfulness of 20 people or groups (e.g., parents, spouse or

partner, and school or daycare center). Respondents answer on a five point Likert scale (1 = *not helpful* to 5 = *very helpful*).

**The Family Adaptability and Cohesiveness Scale II (FACES II)** was developed by Olsen, Bell, and Porter (Olsen et al., 1982). The 30-item scale contains 16 cohesion items and 14 adaptability items. Family cohesion is defined as the emotional bonding that family members have towards one another. Family adaptability is defined as the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress (Olsen et al., 1982).

### **Participants**

Participating families started receiving wrap-around services in Lyons, Riverside, and Proviso Townships between June 1995 and June 1997. Families ( $N=48$ ) completed instruments at intake (Time 1) and at six months after entry (Time 2).

### **Procedure**

Families enrolled in services completed questionnaires as part of an evaluation packet for the Initiative. A Wrap Facilitator reviewed all four self-report instruments with the family member prior to completion. Each Wrap Facilitator had been trained by an evaluation team member on the content of the evaluation packet and how to help family members to complete their portion of the evaluation packet.

## **Results**

Paired  $t$ -tests were conducted item by item on the FES, the Family Needs Profile, and the Family Support Scale. Three items on the FES increased significantly between Time 1 and Time 2. These items included "I feel my family life is under control,"  $t(81)=-2.47, p<.05$ ; "I have ideas about the ideal service system for my children,"  $t(38)=-2.16, p<.05$ ;

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and “I know what the rights of parents and children are under the special education laws,”  $t(36)=-2.34$ ,  $p<.05$ . One item decreased significantly, “I believe that other parents and I can have an influence on services for our children,”  $t(38)=3.94$ ,  $p<.001$ .

Between Time 1 and Time 2, nine needs identified on the Family Needs Profiles decreased significantly. These items included “getting information that can tell us about our child’s disability (diagnosis and assessment),”  $t(48)=2.55$ ,  $p<.05$ ; “getting information about the services available for our child,”  $t(47)=3.05$ ,  $p<.01$ ; “getting information on how to care for our child,”  $t(48)=4.85$ ,  $p<.001$ ; “getting financial assistance from government agencies (SSI, AFDC, Medicaid),”  $t(48)=3.78$ ,  $p<.001$ ; “getting counseling or psychotherapy for our child,”  $t(48)=2.34$ ,  $p<.05$ ; “getting someone to come into our house and provide care for our child for short periods of time (running errands),”  $t(48)=2.06$ ,  $p<.05$ ; “getting someone to come into our house and provide care for our child for long periods of time (evenings, weekends, vacations),”  $t(47)=2.20$ ,  $p<.05$ ; “finding time to complete household chores and routines,”  $t(46)=2.56$ ,  $p<.05$ ; and “getting counseling for myself or other family members,”  $t(47)=3.87$ ,  $p<.001$ . There were no significant increases.

On the Family Support Scale, one item increased significantly between Time 1 and Time 2. Professional agencies were identified as significantly more helpful at six months than at intake,  $t(39) = -2.61$ ,  $p < .05$ . No other items changed significantly.

Finally, a paired  $t$ -test was conducted on the FACES-II to detect changes from Time 1 to Time 2 in the adaptability or cohesiveness of the families. No significant changes were found.

## Discussion

Results from these instruments show mixed outcomes for families. Many items, particularly on the Family Support Scale and FACES-II, show no change from Time 1 to Time 2. The reason for the lack of change is unknown. Possible explanations are (1) the items do not change as a result of the implementation of the service delivery system; (2) the items being examined take more than six months to change; or (3) the measures themselves do not capture the kinds of changes experienced in the first six months by the families in the study. Further research is needed to confirm or deny these hypotheses.

Clearly, there are positive changes. Families’ knowledge about services and about their rights increased significantly during the six months. Also, families’ needs (particularly those related to information, counseling, and respite) decreased dramatically. These are not minor issues, since in separate studies families have reflected on the primary importance of information in influencing their satisfaction with services (McCormack, 1998) and since the reduction of families needs (assuming they are being met) is a goal of the Initiative. There is, however, amidst these positive changes, an apparent disconnection between information, reduction of need, and the felt need to act, or at least be persuasive, since families also report an inability to influence services for their children. This concurrent increase in knowledge and experience of powerlessness appear contradictory but may, in fact, yield important insights into the limitations of the instruments used and the services being provided, while serving as a guide for probing how the wraparound process is currently being implemented within CWI. Another possible explanation for this finding is that increased knowledge of the service system may lead to decreased perception of power.

In response to questions about the type of information that the instruments reveal, the research team held focus groups with the families enrolled in the study. The purpose of the focus groups was to give the data back to families and simultaneously invite their interpretation of the results. In examining the data, families reported their hesitancy about answering the questionnaires accurately because of fears of loss of services and/or the withdrawal of grant funding and lack of confidentiality. Moving past these barriers, families stated that the instruments do not necessarily speak to their concerns or achievements. These focus groups have led the research team to strategize about alternate data collection strategies such as intensive interviewing with a smaller sample. Similarly, these findings have suggested the need for a closer examination of how the wrap teams function, a clearer definition of how the wraparound process serves as an intervention and a broader categorization of outcomes.

In conclusion, after six months in the wrap-around process, families in the study are reporting that they feel their lives are more under control, a decreased need for information (related to the child and families' needs and the service system), decreased counseling needs, and decreased needs for respite activities. However, families also report that they feel less able to influence the services for their children. Further research is needed to identify the specific causes for these outcomes.

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# *Comprehensive Evaluation of the Hawaii Healthy Start Program: Effects on Maternal Mental Health, Substance Use and Social Support at One Year*

## **Introduction**

Many children are born into families whose circumstances put them at risk for sub-optimal health, developmental delay, and abuse and neglect. It has been argued that a comprehensive, coordinated, family-centered system of primary care and support services focusing on prevention and early intervention can reduce the occurrence of these adverse outcomes (Brewer, McPherson, Magrab & Hutchins, 1989; U.S. General Accounting Office, 1990).

Hawaii's Healthy Start Program (HSP) aims to provide this type of coordinated care for at-risk families of newborns. HSP is a well-established program, consisting of: (1) population-based neonatal assessment to identify at-risk families, and (2) home visiting by trained paraprofessionals in the child's first three years of life to provide direct support services and parenting education, to assure access to pediatric primary care, and to coordinate primary care with other needed community resources. The program's goals are to improve parent functioning, child health and development, and to prevent child abuse and neglect.

The HSP is administered centrally by the Hawaii Department of Health (HDOH), with seven agencies statewide operating 13 program sites. Presently, because of funding limitations, the State is able to finance services for only about half of eligible families. This funding shortage has implications for the way agencies allocate program resources. All of the programs operate at full capacity. Home visitors must balance

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their time between outreach to new families and providing services to active families.

The agencies' philosophies regarding treatment provision are reflected in the way they focus their time. Two of the agencies on Oahu (Agency A and Agency B) view the at-risk child as their target client and see breaking through barriers (i.e., parent reluctance to participate) as a key aspect of their role. To this end, the agencies employ extensive outreach in engaging families in the program. The third agency (Agency C) identifies itself as 'family-centered,' and focuses its resources on families who initially are more receptive to services.

### **Study Objective**

The purpose of the Comprehensive Evaluation of the Hawaii Healthy Start Program is to assess the program's success in meeting its objectives for families. The ongoing evaluation is a five-year randomized clinical trial (RCT), focusing on the three agencies operating Oahu's six program sites. The aims are to determine how closely program implementation mirrors program design; how effective the program is in achieving its intended benefits; how program impact is influenced by fidelity of program implementation; and how benefits compare to direct and indirect program costs.

The objectives of this report are to: (1) describe program effects in the first year on specific aspects of parent functioning, namely, maternal mental health, substance use and social support, and (2) illustrate how family engagement and service intensity influence these outcomes.

## **Methods**

### **Design and Sample**

The evaluation employs a longitudinal experimental design with random assignment of families to HSP and control groups. Measurement is blinded and independent of the program.

Recruitment of the baseline sample was conducted from November 1994 through December 1995. A total of 684 mother-child pairs were enrolled. Participating families were randomized into three groups: the HSP group ( $n = 373$ ), the main control group ( $n = 270$ ), and a testing control group ( $n = 41$ ). HSP group families were referred to Healthy Start; control group families were given a

## Hawaii Healthy Start Program: One-Year Maternal Outcomes

list of community resources. Families in the HSP group and the main control group receive annual assessments from birth until the children reach three years of age. The testing control group is assessed at baseline and when the children turn three. The testing control group was included to identify effects of the evaluation, i.e., changes in behavior that might result from repeated assessment. This report is based on the HSP and main control groups. Henceforth, references to the control group refer to the main control group. Comparison of the two groups at baseline revealed no significant differences in demographic characteristics (see Table 1).

One-year follow-up assessments were completed with 88 percent of the sample. The participation rate was the same in both the HSP

and control groups. Non-participants did not differ from participants in age, ethnicity, initial risk score, baseline substance use or domestic violence. Study group comparability was maintained at follow-up.

Two self-report measures of maternal mental health were used: the Mental Health Inventory Five-item Scale (MHI-5: McHorney & Ware, 1995) and the Center for Epidemiological Studies Depression Scale (CES-D: Radloff, 1977). The MHI-5 measures general mental health, focusing on anxiety and depression. It does not measure clinical anxiety or depression, but may indicate mood disturbances. The CES-D measures clinical depression.

We investigated program effects on *problem* alcohol use and *any* drug use in the one-year follow-up period. Problem alcohol use was defined as having a positive CAGE score *and* drinking during the past year. The CAGE is a four-item measure of alcohol problems which asks respondents if they ever: (1) tried to *Cut-down* on their alcohol use, (2) felt *Annoyed* by criticism of their drinking, (3) felt *Guilty* about their alcohol use, or (4) had an *Eye-opener*, or drink first thing in the morning. A positive CAGE score requires an affirmative response to two or more of these items.

There were not enough cases of problem drug use for a meaningful analysis. Therefore, we compared *any* drug use. The most commonly used drugs were marijuana and methamphetamine.

Social support was measured using the Maternal Social Support Index (MSSI: Pascoe, Ialongo, Horn, & Reinhardt, 1988). The MSSI assesses a mother's frequency of and satisfaction with interactions

**Table 1**  
**Baseline Sample Characteristics**

	HSP <i>n</i> = 373	Main Control <i>n</i> = 270	<i>p</i> value
Mother's age in years (average)	24	24	.34
Mother's ethnicity			
Native Hawaiian	21%	19%	.36
Pacific Islander	13%	14%	
Asian	10%	7%	
Filipino	18%	20%	
Caucasian	11%	13%	
Multiracial or unknown	28%	26%	
Parent's relationship			
None	10%	13%	.43
Friends/going together	35%	37%	
Living together	30%	29%	
Married	26%	21%	
Very high risk*			
Mother	23%	25%	.35
Father	35%	40%	.20
Lifetime alcohol use	72%	75%	.49
Lifetime drug use	49%	49%	.99

\*Kempe's Family Stress Checklist (Kempe, 1976) is the screening tool used to determine eligibility for Healthy Start services. Families are referred to Healthy Start if either parent scores 25 or more on the checklist. A score of 45 or more is considered by the program to be 'very high risk'.

with her family, friends and partner; the degree to which she has assistance with child and household responsibilities; and her involvement in group activities.

### Analysis

Multiple logistic regression was used to calculate odds ratios for the study groups on each of outcome measures. Baseline characteristics that might confound the results were tested statistically. Those resulting in a significant reduction in the model deviance were retained. Variables considered for model inclusion were: agency, age, ethnicity, education, income, mental health, substance use, and violence between mother and partner. For each of the outcomes, we tested for subgroup effects by including interaction terms for study group and subgroups defined by demographic and risk characteristics (e.g., agency, age, ethnicity, education, baseline mental health, substance use and domestic violence).

## Results

### Outcomes

**Maternal Mental Health.** Significantly fewer HSP mothers had poor general mental health compared to control group mothers (33% versus 47%). The adjusted odds ratio was .67 (95% CI: .46, .97). This difference was attributable primarily to a reduction in symptoms of anxiety. Subgroup analyses revealed that the program effect varied by agency and was limited to mothers who had poor general mental health at baseline. Among this subgroup of mothers, the adjusted odds ratio was .44 (95% CI: .26, .74). Agency-specific results are in Table 2.

The home visited and control mothers were similar in terms of reported depressive symptoms, with nearly a third scoring positive for moderate to severe depression. While the results were in the desired direction, i.e., fewer HSP mothers were depressed (27% versus 31%), the overall difference was not statistically significant (odds ratio = .89; 95% CI: .60, 1.32). The results approached statistical significance at Agency C (odds ratio = .57; 95% CI: .28, 1.19). There was no other subgroup effects on depression.

**Table 2**  
Agency-specific Results of Process and Outcome Assessments

	% Active at 12 months	Process Measures		Outcome Measures <sup>a</sup>	
		All families	Active families	Poor general Mental Health <sup>b</sup>	Depression
Total	49%	13±1	22±1	0.44 (0.26, 0.74)	0.89 (0.60, 1.32)
Agency					
A	51%	11±1	19±1	0.60 (0.26, 1.41)	1.21 (0.60, 2.42)
B	60%	16±1	22±1	0.23 (0.09, 0.62)	0.69 (0.33, 1.41)
C	35%	12±1	28±1	0.44 (0.15, 1.26)	0.57 (0.28, 1.19)

<sup>a</sup>Results are reported as odds ratios with 95% confidence intervals (CI) in parentheses. CIs not containing one are statistically significant.

<sup>b</sup>Results are based on mothers who reported poor general mental health at baseline.

## Hawaii Healthy Start Program: One-Year Maternal Outcomes

**Substance Use.** There were no group differences in reports of problem alcohol use or drug use in the overall sample or in any particular population subgroup.

**Social Support.** Program effects on social support were mixed. In the overall sample, there were no group differences, however, there was subgroup variation. Among teenage mothers (age 19 and younger), there was no program effect. Teenagers tended to have higher social support than adult mothers do. Many of them lived at home with their parents who provided a natural support system. Among adult mothers, the group effect varied by baseline mental health status, measured by the MHI-5. There was an improvement in social support among adult mothers who had good mental health at baseline (plus one point on a 39-point scale). However, there was a negative program effect among adult mothers with poor baseline general mental health (minus two points on a 39-point scale). Effects for both of the subgroups were small, but statistically significant. Aspects of social support that were worse for adult mothers with poor baseline general mental health were: reduced participation in groups, greater likelihood of having sole responsibility for household tasks, and having friends who could be counted on. Our interpretation of this apparent negative effect is that mothers in this subgroup spend more time managing family responsibilities and less time socializing outside the home.

### **Relationship Between Process and Outcomes**

**Agency Differences.** Our process assessment revealed substantial variation among agencies in family retention rates and frequency of home visiting (see Table 2). Overall, half of families still were active in the HSP at one year. Retention rates varied significantly by agency, from 35 percent to 61 percent. While some families discontinued services because they moved or returned to work

or school, the primary reason for termination was refusal of services. In terms of the intensity of services, the frequency of home visitation was substantially lower than the program standard of weekly home visits, even among families active at one year. The pattern of visitation was reflective of the agencies' philosophies described in the introduction. While Agency B made significantly more home visits overall, Agency C made more visits with families that remained active. The program effect on mental health was attributable primarily to Agency B, the agency that came closest to meeting program process standards.

### **Discussion**

This report described HSP impact on maternal mental health, substance use and social support at one year and investigated the influence of program fidelity on outcomes. The program had a positive effect on maternal general mental health among mothers who had poor general mental health at baseline. The difference was accounted for primarily by reductions in anxiety. Differences in depression or substance use were not evident. The model appears to reduce maternal anxiety, which is important for managing personal, social and parental responsibilities. However, it does not appear to affect depression or problem substance use.

Program effects on social support were mixed. Adult mothers with *good* baseline general mental health had improved social support and adult mothers with *poor* baseline mental health had worse social support. This negative program effect appeared to be due to this subgroup of mothers being more likely to have sole responsibility for household tasks. However, differences in both subgroups were small and might be spurious.

For the *mental health outcomes*, program fidelity was positively related to program effectiveness. The agency coming closest to meeting standards for program delivery had the strongest impact on

mental health. To date, other outcomes have not been compared in terms of program process. Without a more careful examination of the relationship between process and outcomes (e.g., program outcomes at varying levels of program implementation), a causal relationship can not be established. An alternative explanation for these results is that programs focus treatment differently. For example, one agency may focus treatment on helping the mother with interpersonal problems, while another agency may focus its attention on the child, e.g., obtaining adequate primary care, identifying developmental problems. Future analyses will explore these and other agency differences.

These results have implications for service planning and services research. The first concerns replicating treatment models. Even in the context of this well-established program, different agencies apply the same model differently, with varying success in family engagement. Caution should be used in replicating a model, regardless of its success in other settings or as implemented by other agencies. Adherence to the model must be assessed carefully.

Additionally, program integrity must be accounted for in evaluation of outcomes. Even within the same program, individual agencies differ in their adherence to program standards. Without examination of how closely the services delivered are to the stated plan, reports of outcomes will be inconclusive. It is important not only to describe the standards of treatment, but also to delineate how closely the program standards are followed.

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# *The Impact of Parental Depression upon the Utilization of Pediatric Services*

## **Introduction**

Researchers have documented the effects of maternal depression upon young children in the family (Gelfand & Teti, 1990). Empirical studies have recorded more flat affect in facial expressions; (Field, 1984); less stimulation of children; less time looking at and touching their babies; and less affectionate touching. (Fleming, Ruble, Flett & Shaul, 1988). The mother's behavior lacks the contingent responsiveness indicative of sensitive mothering (Field, 1984). There is evidence that both cognitive and emotional domains of child development are adversely affected by parental depression (McGee, Silva & Williams, 1984).

These findings have led a number of authors to recommend that primary care physicians who care for adults should routinely screen for depression (Murphy, 1987). Additionally, primary care pediatricians have been advised that a large number of children with psychosocial problems are not recognized within the framework of routine medical care (Costello, 1986). However, these recommendations left unanswered the question of the degree to which parental depression overlaps with psychosocial problems in children. Our central research

question relates to the potential misapplied pediatric services in relation to parental depression. This study sought to examine prevalence of parental depression in a population of parents who are bringing their child to a pediatrics medical appointment for routine care; the prevalence of child psychoso-

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cial problems and incidence of chronic illness for these children; and the frequency and economic impact of using pediatric services at large Northern California HMO, for this sample, as compared to children whose parents who are negative for symptoms of depression.

## Method

### Subjects/Sites

The study was conducted in six sites within the Northern California region of a large non-profit HMO. The project collected data consecutively on 300 patients from each facility that registered for routine and urgent pediatric health visits, were between the ages of 2 through 18, and were accompanied by a parent. A total of 1800 patients and their parent were sampled. The sample consisted of nearly equal numbers of boys and girls. A random sample method was employed to select patients. Informed consent was obtained from all parents at the start of questionnaire completion.

### Measurement Instruments

**Beck Depression Inventory**, (BDI: Beck, Ward, Mendelson & Ersbaugh, 1961). The BDI is a 21 item inventory that is valid and highly reliable, with each item scored on a four-point scale indicating the presence and severity of depressed feelings, behaviors and symptoms. In accord with other investigator use of this instrument as a research tool, the parents who receive a score greater than 17 are classified as *depressed* and parents scoring less than nine are classified as *non depressed*.

**Pediatric Symptom Checklist** (PSC: Jellinek, Murphy & Burns, 1986). The PSC is a 35-item questionnaire that is normed for children 2 through 18 years of age. This is a well-validated parent completed questionnaire, which consists of 35 items that are rated as never, sometimes or often present. Item scores are summed and the total score is recoded into a dichotomous variable

indicating psychosocial impairment. For children 6 through 16 the cut-off score is 28 or higher. For younger children the cut off is 24 or higher. The PSC has been validated for minority and economically disadvantaged populations (Murphy, Reede, Jellinek & Bishop, 1992). Parents routinely complete it while in a waiting room during a pediatric office visit. The PSC is designed to be completed and scored in less than five minutes and to yield a single cutoff score that is clinically relevant. Additionally principal component factor analysis was conducted using pairwise deletions and Varimax rotations on the items of the PSC and these revealed two factors: internalizing, externalizing. Test-retest reliability over a four year period was  $r=0.86$ . There was a 79% agreement between PSC scores and psychologists ratings of dysfunction.

### Analysis

Mean scores were analyzed utilizing chi-square with all tests performed under the assumption of unequal variance. Principal component factor analysis was conducted using pairwise deletions and Varimax rotations on the items of the PSC and these revealed two factors: internalizing, externalizing. Medical utilization data were extracted from the automated systems, which record all registrations. Cost information from the general ledger was allocated using the Cost Management Information System

### Results

Five percent of the total sample of parents was above cut-off for severe depressive symptomatology. Children of depressed parents were older ( $t=.02$ ) by an average of one year of age, but no other significant gender or demographic differences were found (see Table 1). The children of BDI positive parents had higher PSC scores than the children of BDI negative parents, as the mean PSC scores reveal in Table 2 ( $t = 6.68, p < .02$ ).

## Parental Depression & Pediatric Service Utilization

When evaluating the PSC scores of just the children whose parents were BDI positive, the chronically ill children had higher PSC scores than their non-chronically ill counterparts. The difference in average PSC scores was statistically significant,  $T= 2.62$ ,  $p < 0.02$  (see Table 3).

The principal component factor analysis revealed two factors within the PSC, (internalizing and externalizing). For those children of BDI positive parents who had PSC positive scores total ( $N= 241$ ), 157 (65.1%) children had externalizing symptoms, while 84 (34.9%) children had internalizing symptoms.

The association of the parent's level of depression as measured by the BDI, to a positive response to the question as to a desire for additional services for their child was not statistically significant. Thus, parents do not indicate a desire for additional medical or psychiatric services. However, when evaluating all medical visits for each child and parent within the Northern California medical region, including regularly scheduled appointments, urgent appointment, emergency room visits and hospitalization, there was a .9 visit increase if the child was chronically ill for each additional upward point above the clinical cut-off score on the Beck Depression Inventory of the parent.

A .01 increase in medical visits for the child occurred for each point above the clinical cut-off score on the Beck Depression Inventory of the depressed parent. ( $F=3.54$ ,  $P > .01$ ). Every positive point on the BDI above the clinical cut-off added an additional \$24 in psychiatric service costs for the adult. It is of interest to note that the pediatricians only identified 14 (57%) out of the 241 children from the Beck positive group as needing additional services (see Table 4).

## Discussion

The high prevalence of psychosocial problems in children who score in the positive range of the BDI demands that health providers use techniques that allow the identification of those children who are in need of additional psychiatric treatment. This study indicated that an assessment can be easily administered in busy outpatient settings and is accepted by staff and parents as a routine adjunct to the pediatric visit.

The understanding of clinical morbidity and economic outcomes in health care is increased by the results of this study. The development of a centralized clinical data tracking system to measure the economic burden of undetected mental health morbidity is an important step.

**Table 1**  
Descriptive Characteristics of High Depressive Symptomatology and Low Depressive Symptomatology

Characteristic	+Beck		-Beck		<i>p</i>
	Mean	S.D.	Mean	S.D.	
Child Age Years, Range = 2 -18	9.48	4.35	8.1	4.32	0.5
Parental Age in Years	38.70	7.17	37.58	7.96	n.s
<b>Race/Ethnicity</b>	<i>N</i>		<i>N</i>		
African American	16		186		
Caucasian	27		777		
Spanish American	11		263		
Oriental	8		208		
Other (dual racial)	4		50		
<b>Educational level</b>	<i>N</i>		<i>N</i>		
< high school	11		80		
high school graduate	15		304		
< college	35		637		
college graduate	15		421		
post graduate	6		264		
<b>Marital Status</b>	<i>N</i>		<i>N</i>		
Married	48		1280		
Remarried	3		68		
Widowed	4		15		
Separated	5		70		
Divorced	15		157		
Never Married	8		125		

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**Table 2**  
Mean PSC Score of Child by BDI Positive Parent

	N	Mean	SD	F
BDI positive parent	70	24.8	1.6	0.02
BDI negative parent	1511	14.0	0.2	—

**Table 3**  
Mean PSC Scores of Child by BDI Positive Parent Among Chronically Ill Children

	N	Mean	SD	F
BDI positive parent	15	34.3	4.4	.02
BDI negative parent	55	22.2	1.5	

**Table 4**  
Comparison of Mean Health and Psychiatric Care Utilization/Costs for Parents with Depression and Total Sample of Parents for One Year Previous to Screening

	Mean Number of Health Care Visits	Mean Health Care -Costs	Mean Psychiatric Costs
<b>Total Sample</b>	4.6	\$626	\$32
<b>Depressed Parents</b>	+.2 per BDI point***	+\$24 per BDI point***	+\$12 per BDI point***
<b>With Chronically Ill Child</b>	6.0**	\$787*	\$65

\* $p < .01$

\*\* $p < .001$

\*\*\*Each point positive above the Beck Depression Inventory cutoff resulted in a mean \$24 increase in health care costs,  $p < .001$  and a mean \$12 increase in psychiatric costs.

# *Non-Married Parents and Post Traumatic Stress Symptomatology*

## **Introduction**

Recently, nonmarried parents have emerged as a population of interest distinct from single parents in general. However, little is known about them and how they may differ from separated, widowed and divorced parents. This is an important population to study when we realize that the number of never-married households increased from 4.2% to 34.6% from 1960 to 1995 (Committee on Ways and Means, 1996). In terms of income, a substantial percent (41.2%) of women whose income is below the poverty level are never married (Current Population Survey, 1992). Consistent with a lower rate of income, the level of education of never married mothers is also significantly lower than mothers in a two-parent household (Current Population Survey, 1992).

Research regarding these “fragile families” (families consisting of children born outside of marriage to two disadvantaged parents) has been fragmented— often focused only on mothers, only father, or only on adolescent parents (Mincy, 1994). Hence, the purpose of this study is to try and understand mental health issues, specifically post-traumatic stress symptomatology (PTSX), with this burgeoning at-risk population. Researchers have studied single mothers and depression, but PTSX has not been addressed, which we see as a gap in the literature. Additionally since the mothers are pregnant, effective parenting in the context of mental health issues is the next step to forwarding research with this population. Research has been conducted on the effects of depressive symptoms in mothers on their children—specifically impacting cognitive development. However, the relationship of PTSX and effective parenting has not yet been adequately addressed.

## **Methodology**

Ninety in-depth, in-person interviews were conducted using a structured survey format with a non-marital parent sample recruited through a pre-natal clinic in a major hospital in an urban area in the Midwest. The survey contained 164 questions and was completed in approximately one hour by trained graduate students.

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Of ninety interviews, 61 were with mothers and 29 were with fathers. Of the 61 mothers interviewed, 29 mothers had partners that were also interviewed. Eighty-two percent of the respondents to our survey reported their race as Black; 18% were Caucasian.

The survey utilized questions from the Youth Services Project (YSP: Williams, Stiffman, & O'Neal, 1998) instrument developed by McLanahan and Garfinkel for a national study of non-marital parents as well as additional questions from the National Longitudinal Study of Youth (NLSY) and the National Study of Families and Households (NSFH). Univariate and bivariate analyses were conducted using SAS data analysis software.

The PTSD scale was obtained from the Revised Diagnostic Interview Schedule (DIS-R). Experiences scored for this instrument included: experiencing a serious accident; being physically attacked or beaten; being sexually assaulted or raped; being in a natural disaster; seeking a person killed or seriously hurt; causing someone's death or injury; narrowly escaping serious danger; forced separation from your home; family member or friend dying; family member of friend attempting suicide or committing suicide; and being arrested or jailed.

The symptoms scored included: remembering the trauma when they did not want to; having nightmares of felt like you were reliving the trauma; had difficulty experiencing normal feelings such as love or affection for others; been jumpy and easily startled by small things; had trouble sleeping; had trouble concentrating; felt ashamed of still being alive; and avoiding doing or seeing anything that would remind you of the trauma.

## Results

Fifty-two percent of the parents interviewed met criteria for Post-Traumatic Stress Disorder (PTSD) at the 3+ symptom level. No significant differences were found between men and women. Significant differences, however, were found when PTSD symptomatology was examined by parent status (i.e. *mothers only*, *fathers only*, and *mothers for whom the father was also interviewed*). Sixty percent (60%) of fathers who were interviewed met criteria for symptomatology, and 58% of mothers whose partners were interviewed also met criteria for symptomatology. However, only 35% of

mothers whose partner was not interviewed met criteria for diagnosable PTSD. The difference was statistically significant at the .03 level.

This statistically significant finding indicates a need for further investigation, especially given the small sample size. However, we do know that mothers for whom the father of the baby was NOT interviewed have a higher level of education and correspondingly higher level of income. It may be that these women are a more advantaged group than the mothers for whom the fathers were interviewed. Again, this is an area for further study.

## Discussion

Given the growth of this family grouping and the propensity for family members to live at or below the poverty level, to receive less than a high school education, and to experience high rates of post-traumatic stress symptomatology we believe that further research is needed to guide policy and services as well as practice that involves this disenfranchised population. Furthermore, now that we have an idea of the extremely high incidence rate of PTSX in this population, we can begin to look at predictive variables, vis-à-vis PTSX and possible comorbid depression.

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