Coordinator Resource Toolkit
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The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded through the voter-approved Mental Health Services Act (Prop 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.
Introduction

This toolkit accompanies the *Healthy Transitions Curriculum*. It is intended to be a resource guide to coordinators and instructors at California Community College sites who implement the curricula, so that you may better connect with and serve your students regarding mental health and wellness concerns.

The YESS Programs, and the CalMHSA-funded *Healthy Transitions*, are both aimed at providing training and peer-to-peer support for transition-aged foster youth (TAFY), but not direct services or treatment. The intention is to increase awareness and disseminate information among these youth about wellness and its importance as a key life skill. Other objectives of the program are to assist youth in developing peer connections, creating support among themselves, and to better connect them to local resources and services. It is inevitable that mental health problems and related concerns of some participants will be uncovered in the course of delivering these curricula. Site coordinators must be prepared to receive and communicate about these issues, and must be knowledgeable about resources and concepts important to mental health and wellness. Effective referrals will be critical to promoting mental health and well-being among participants.

This toolkit is designed with these needs in mind. It provides coordinators with additional curricula and classroom resources, tips to help you to work more effectively with youth who may be struggling with physical and mental health concerns, and strategies for making effective referrals and building local partnerships.
Part I: Additional Curricula and Classroom Resources

The resources in this section help to supplement the materials provided in the curriculum. It includes a wealth of resources, additional information, activities, and training modules on topics included in the curriculum—all at the ready when you need them.

Materials are organized as follows:

A. Comprehensive Curricula on Mental Health-Related Topics
This section lists names, links, and information about full curricula, both free and for purchase, which are most relevant to the curriculum. Some of these materials are necessary for implementing the curriculum and are referenced specifically in the slides, workbooks, and trainer guides. Others are simply supplemental and available at your discretion.

B. Other Health and Mental Health-Related Resources and Materials
This section includes additional resources are web portals for youth, addressing an array of topics and issues relevant to this curriculum. Many of these materials are free for educators to use or are sites youth can access directly.

C. Self-Advocacy Materials
This section is to supplement the resources and information about youth rights in health and mental health settings included in the Basic Curriculum workbook. We have listed several other resources here that instructors and coordinators can use to assist youth to self-advocate in California’s mental health and healthcare system.
Comprehensive Curricula on Mental Health Related Topics

Included as companions to the current curriculum:

- **TeenMentalHealth.org**: This website is home to the Mental Health & High School curriculum guide, the *Transitions: Student Reality Check* youth booklet, the Mental Health Guide to Action, and several other handouts, PowerPoints, and articles that we have directly suggested you include in various pieces of your curriculum. Additionally, their online classroom space is always being updated with new and innovative materials on mental health, all aimed at a youth audience. A license to utilize any and all of these materials (both hard copies and online) has been purchased for each site as an integral part of our curriculum, and the intention of TeenMentalHealth.org is that materials be free for educators to utilize as needed. As their website states: “The materials we have created are provided in a variety of mediums that include animations, face-to-face training programs, web-based training programs, and easy to understand guides and books designed specifically for youth, parents, educators, and health providers. Our knowledge dissemination work takes a variety of forms, from media interviews, to junior high parent chats, partnership with NGOs, institutions, government and work with partners in mental health and the arts. In addition, numerous global partners have been secured to further the dissemination of these important materials.”

- **KidsHealth and TeensHealth**: Many articles and handouts are included from these sites in the Basic Curriculum Youth Workbook provided as part of this curriculum. KidsHealth and TeensHealth are health and wellness websites with a plethora of resources for kids, teens, and adults. Though not quite a full curriculum, the materials here are extremely comprehensive.

- **Mental Health First Aid (MHFA)**: Several slides and concepts from this source have been included directly in your curriculum.

Additionally, the following links may be helpful:

- Find resources near you
- Become an instructor
- Instructor training courses by community
- Rural MHFA

Online presentations:

- Depression: How to help yourself or a loved one
- Understanding substance use disorders
- Understanding psychosis
- Understanding anxiety
- Understanding depression

- **Recipes for Life Cookbook**, by and for the youth of California Youth Connection. Youth completing the Healthy Transitions curriculum will receive an early, unpublished version of this book, which they can keep and use. They can also submit entries for the book, which will automatically be published on the *Recipes for Life*
The book and blog site contain recipes, nutrition information, and stories by and for youth currently in or transitioning out of foster care, about self-care, cooking, etc. The final first edition of the book will go to print in April 2014; youth will receive a copy of this book as well. Specific information about participation in this project provided to coordinators separately.

Sites are also recommended to purchase the following two books, which contain an additional variety of activities and materials that can be used to customize the course or in peer-to-peer groups:

- **Mind Over Mood**, by Dennis Greenberger, Ph.D. and Christine A. Padesky, PhD. This workbook: “...shows readers how to improve their lives using cognitive therapy. The book is designed to be used alone or in conjunction with professional treatment. Step-by-step worksheets teach specific skills that have helped hundreds of thousands people conquer depression, panic attacks, anxiety, anger, guilt, shame, low self-esteem, eating disorders, substance abuse, and relationship problems. Readers learn to use mood questionnaires to identify, rate, and track changes in feelings; change the thoughts that contribute to problems; follow step-by-step strategies to improve moods; and take action to improve daily living and relationships.”

- **Relaxation and Stress Reduction Workbook**, by Martha Davis, Elizabeth Robbins Eshelman, and Matthew McKay. This book provides coordinators with a variety of interactive and self-reflective exercises that can supplement those provided in the current curriculum; it can also support your own self-care process, given the difficult work you do with youth. Description excerpted from Google Books: “Widely recommended by therapists, nurses, and physicians, the ultimate stress reduction workbook offers a variety of techniques, a stress awareness test, and information about the sources of stress in professional and personal life.”

**Other curricula:**

- **[FREE!] Allies in Action Toolkit—Holistic Sexuality**: “The collective experiences and research of the Action Circle and its members suggest that many adults and youth have attitudes toward one another that serve to alienate and isolate each group from the other. Many adults have not had the opportunity to work collaboratively with young people for a common goal over an extended period of time. We have noted too that a great number of young people and adults have unhealthy attitudes about sex and sexuality. Sexuality is a term that encompasses every aspect of our being. At a time when sexuality is at the forefront of a person’s physical and psychological development, it is imperative that every opportunity is taken to encourage young people to make healthy and positive choices.”

- **[Free during beta testing!] BodiMojo**: “BodiMojo.com can be a great companion to your regular health curriculum. At BodiMojo, teens can become part of a fun, health-focused online community, and find teen-friendly tools to monitor their own health and wellness. On the site, they can create personal health profiles; set and track health goals; take health habits quizzes; use health tools such as a body mass index calculator; read teen-focused articles about nutrition, exercise, and positive body image; take health challenges with friends; or write their own articles or videos on health topics as a class assignment, then submit them to BodiMojo for potential publication on the site. Whether you are teaching a 4-, 6-, or 8-week curriculum, BodiMojo can help by offering kids an engaging place to think about health and wellness in their own way, on their own time, with a safe community of online friends. BodiMojo’s offerings are particularly timely in light of First Lady Michelle...”
Obama’s efforts to make obesity prevention a signature cause in 2010. And, beyond addressing issues about healthy eating and exercise, BodiMojo also covers a wide range of other topics of interest to teens, such as body image, relationships, stress, and social media. Below, check out additional ideas for ways to get your students thinking about their health and wellness. We’ve also listed links with useful classroom resources.

- **[For purchase] UrbanTech.com:** Coordinators can go here for additional sample curricula on a myriad of health and wellness topics as related to transitioning into adulthood ([sample curricula and list of modules](#)). Their mission statement: “The National Urban Technology Center (Urban Tech), a not-for-profit educational corporation, transforms lives through the power of technology by giving youth the capacity for positive behavior and academic success. Urban Tech achieves its mission by teaching students essential life skills, and by training and coaching parents and educators to support social and emotional learning.”

- **[For purchase] SocialLearning.com:** Curricula for purchase on a variety of topics related to youth development and special needs populations. “Our mission is to provide quality training products for foster, adoptive, and kinship care providers, agencies, and schools, backed by attentive customer service and a hassle-free return policy.”

**Other published participant workbooks available for purchase:**

- **Teening your Parent: Adolescent Development: A Primer for Teens,** by Courtney Heisler, Project Manager Sun Life Financial Chair in Adolescent Mental Health: a 26-page booklet for youth ($10 each or downloadable for free) on brain development, health and mental health concerns, what’s really going on with teenagers today, etc. Note: this book has a few Canada-specific references but overall seems relevant.

- **Med ED Booklet,** by Murphy, Gardner and Kutcher: a book for youth ($13 each) on tracking one’s mental health symptoms, psychoactive meds doses, etc., so youth can self-advocate when medicated.
Other Health and Mental Health-Related Resources and Materials

- **The Annenberg Foundation Trust at Sunnylands Adolescent Mental Health Initiative**: A mental health site for teens with articles, facts, and tips about mental illness and other mental health issues, including stress management and coping resources. Also includes a great and very extensive glossary of mental health terms and concepts.

- **Research and Training Center’s Pathways to Positive Futures**: “The Pathways Transition Training Collaborative is designed to enhance the skills of service providers working with young people with serious mental health conditions and to provide information and tools to young people and their family members, researchers, and policy makers involved in developing and implementing transition-focused interventions, policies, and research.”

- **FosterClub.org**: “FosterClub is the national network for young people in foster care... FosterClub helps open the way for these young people to transform their lives and provides a forum to raise their voice. Our members engage with peers and regain control over their situation through support, skill building, and healing opportunities. FosterClub’s young leaders achieve impressive levels of success as they demonstrate remarkable resilience. Here they have real life opportunities to become true heroes as they reach back to improve the foster care system for their younger peers.”

- **The YouthHood**: A site “where childhood meets adulthood”, with a wealth of resources and information for transition-aged youth (not specifically foster youth).

- **TeenInk.com**: A site where students can submit their creative writing (poetry, prose, short stories) for publication, which can be empowering for aspiring writers and poets. You can use this site for creative activities in the classroom and/or encourage individual students to submit work on their own.

- **Youth4Health**: A health navigation curriculum guide with five modules for navigating health care. Guide is very focused on connecting youth to services in Ontario, Canada specifically, so not all is relevant to California foster care youth. But it includes resources, information, icebreakers, and ways of teaching the social determinants of health that could be useful when delivering the current curriculum.
Relationships and self-esteem resources:

- Building healthy relationships
- Dating Bill of Rights
- Consent
- Self-care
- Body image
- Affirmations for building self-esteem
- Comprehensive self esteem
Self-Advocacy Materials

- **“Your Right to Make Decisions about Medical Treatment.”** California Department of Social Services. This brochure explains your right to make health care decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future.

- **The Health Pages.** As a patient you need to assume your share of the effort towards your health. No doctor should be expected to do it all. The following offers some tips on how you can play that active, responsible role.

- **“Your Medical Record Rights in California (A Guide to Consumer Rights under HIPAA)”**. This guide describes how to get, amend, or correct medical records from California doctors, hospitals and other health care providers that have to follow the HIPAA Privacy Rule.

- **“Your Health Information Privacy Right”**: Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

- **“Are you in Recovery from Alcohol or Drug Problems? Know Your Rights”**: This brochure provides general guidance on the legal rights of individuals with alcohol and drug problems. It is not intended to serve as legal advice for any particular case involving or potentially involving discrimination. If you believe that you have been or are being subjected to illegal discrimination, you should immediately consult an attorney or seek assistance from the Federal agency responsible for addressing discrimination complaints or administering the program or benefits at issue.

- **“Rights for Individuals in Mental Health Facilities”**: If you are receiving, either voluntarily or involuntarily, mental health services in a mental health facility, you have the rights outlined in this handbook.

- **“Depression: Finding a Doctor or Therapist”**: Here are some answers to common questions about finding a doctor, psychologist or therapist. Here you’ll find a list of tips for how to prepare for your first appointment.

- **“When You Are in Therapy, What Your Doctor Needs to Know”**: Here are some answers to why it is important for doctors and therapists to communicate.
Part II: Working Effectively with Youth Facing Mental Health Challenges

This section contains tips and resources for working effectively with youth in regard to their personal wellness challenges and needs. It is organized as follows:

1. **Best Practices Resources and Links**
   Included here are two resources that provide best practices recommendations for working with and teaching youth with mental health issues:

   Additionally, there are two sources that address tips and strategies for effective prevention work with youth in or exiting foster care:
   - “Strategies for Effective Prevention Programs for Foster Youth,” excerpted from *Reaching Youth in Foster Care with Your Alcohol and Drug Prevention Efforts*. Dustianne North, M.S.W., Ph.D. and Leah Gold. Center for Applied Research Solutions, updated 2013.

   We then provide a list of “Key Links,” or sites with comprehensive and centralized information and resources for adults who work with mental health needs, for easy reference, followed by:
   - Prevention and Foster Youth: References and Resources by Dustianne North and Siobhan Stofka.

   In addition to these materials, we also recommend:
   - **Prevention Brief: Providing Effective Prevention Services to Youth in Foster Care, by Belinda Basca.** 4:2 (August 2009). Center for Applied Research Solutions. A practice brief with additional best practices information for prevention work with foster youth. Has similar information to the other documents provided here but also highlights the practices of the 2007-2010 California Safe and Drug Free Schools and Communities AOD Prevention grants recipient, who selected foster youth as their target populations.

Dealing with Difficult Issues with Youth: Effective Communication and Intervention

Included in this section is a set of handouts by Dustianne North and Jerry Sherk, which address how to communicate and act effectively when difficult issues arise in the lives of youth. Information includes philosophical approaches to building healthy relationships with youth, basic communication skills, and an exploration on a range of difficult issues and the appropriate responses. It also provides concrete tips for communicating effectively in difficult moments, detailed suggestions and guidelines for respecting confidentiality and managing disclosure of practitioners’ own personal information, and additional resources on the topic. We recommend reviewing and considering this information regularly. There is also a [recorded webinar](#) on this topic.

C. Respecting Culture: Foster Care Youth
Presented in this section are new state and federal guidelines for health and mental health professionals to help ensure culturally and linguistically appropriate services (CLAS), and a link to an array of related cultural information and research. Some concepts and a few slides, by Jerry Sherk and Dustianne North, are also provided, related to culture and the provision of culturally-appropriate services for youth in foster care. We recommend further study in these areas for all site coordinators.

D. Trauma and Recovery
Some recommendations from SAMSHA for “trauma-informed care” are provided, along with a few slides excerpted from *When Stakes are High: Research-Based Mentoring for Youth With Multiple Risk Factors*, by Dustianne North, M.S.W., Ph.D., Denise Johnston, M.D., and Brenda Ingram, L.C.S.W. (Center for Applied Research Solutions). This addresses trauma, development, and a developmental approach to intervention for traumatized youth. These materials provide a companion to the corresponding modules in the Basic and Supplemental Curricula, on topics of the brain, trauma, development, and recovery. Materials included here are intended to deepen your understanding of how these issues should inform the way you run your program and classes.

E. Grief and Loss
We have included an array of grief and loss materials in the Student Resource Guide and the peer-to-peer manual. Materials and links in this section focus on how adults can work effectively with youth who are grieving.

Grief and loss issues are difficult for all of us, but young people who have experienced multiple losses and failed relationships are more vulnerable to additional losses, no matter how much time has passed since those early experiences. They are also more likely to face further losses, not only in terms of deaths but each time they change placements or lose connections with their bio families and others they care about. We've included resources here that will assist adults in understanding how grief and loss can trigger responses that may seem to be out-of-proportion to the situation, as well as better ways to support these youth in experiencing and managing their grief.

Sources included here:
- **Excerpt from State of Wisconsin Foster Parent Handbook, Chapter 3: “Caring for Children in Foster Care.”** Wisconsin Dept. of Children and Families. 2008. Contains tips for assisting foster youth who are experiencing the grief of being removed from their families or changing placements.

In addition to these, we also recommend the following:
- **New York Life Foundation Bereavement Guide - After a Loved One Dies**
- **Childhood Traumatic Grief Educational Materials for Parents**
Successful Transition Models for Youth with Mental Health Needs

A Guide for Workforce Professionals

May 2009– Issue 23

This InfoBrief describes the systems’ service barriers faced by youth with mental health needs as they reach adulthood, while highlighting new models and strategies designed to break down those barriers and help them to transition successfully into the workplace.

The transition from adolescence to adulthood is a challenging time. It is a time in which the young person is called upon to make complex decisions about schooling, work, finances, and personal relationships. For the more than three million young adults (ages 18-26) diagnosed with serious mental health conditions, this phase of life poses even greater challenges.

Youth with mental health needs often face unemployment, underemployment, and discrimination when they enter the workforce. Statistics show that youth with mental health needs, diagnosed or undiagnosed, are over-represented in foster care, the juvenile justice system, and among school disciplinary cases and high school dropouts.

The absence of a coordinated system of service delivery also presents significant challenges for youth and young adults with mental health needs as they age out of youth services. They may be either shunted down an inappropriate service tunnel that does not address their specific needs, or they may “fall off a cliff” as they age out of youth services and have to navigate the complexities associated with the adult service system.

Through partnerships with service agencies and organizations in their communities youth service professionals can assist youth in preparing for the adult world without getting lost in a tunnel or falling off a cliff. They will need to make a concerted effort to:

- Learn what other systems may provide
- Make contacts within those systems
- Coordinate services.

This InfoBrief presents model programs and successful strategies to help youth and young adults with mental health needs successfully transition to employment and to lead independent, productive lives.

Service Tunnels

The service systems that may serve youth and young adults with mental health needs may include community-based organizations, foster care, juvenile justice, mental health, Social Security, special education, vocational rehabilitation, youth services funded by the Workforce Investment Act, and others. Staff working within each system often consider only those service options available within their system despite the fact that another system may offer services that may better address the youth’s needs. Understanding other service tunnels and how to access their services is often overwhelming for practitioners, which means youth may not gain the help they need.
Successful Transition Models for Youth with Mental Health Needs

To successfully transition to adult life. Fortunately, professionals and researchers are increasingly recognizing the importance of partnering to connect these multiple systems so that youth and young adults with mental health needs have access to the full array of services needed to maximize their potential.

**Transition Cliffs**

In addition to service tunnels, youth encounter a transition cliff when they age-out of youth systems and attempt to access adult services. Many youth services end at age 18 and others at age 22, which means a youth could simultaneously be a youth in one system and an adult in another. In addition, many young people lose health insurance under their parents’ plan when they reach age 19 or graduate from high school or college.

The adult systems of education, mental health, Social Security, vocational rehabilitation, and workforce development all have different terminology, eligibility requirements, and service options than those of corresponding youth systems. The lack of a seamless youth-to-adult system can cause young adults to lose services and fall behind in career planning.

The adult mental health care system also presents challenges. Millions of young adults face being going without services or paying for expensive private mental health care for several reasons: public adult mental health systems vary widely; provide services only to adults with severe and persistent mental illness; and frequently have long waiting lists.

**Avoiding Tunnels and Cliffs with Mental Health Recovery Models**

The following mental health recovery service delivery models offer promising ways to overcome the challenges of tunnels and cliffs and to provide an effective, integrated, self-directed system of care for young adults with mental health needs:

**Transition to Independence Process (TIP)**

The TIP approach is an evidence-based program model that stresses the importance of providing access to appropriate services, engaging young adults in their own future planning process, and utilizing services that focus on each individual’s strengths. The TIP system operates through the following seven guidelines that provide a framework for the program and a community system that supports that framework:

- Engaging young people through relationship development, person-centered planning, and a focus on their futures; providing tailored supports that are accessible, coordinated, and developmentally appropriate.
- Ensuring a safety net of support by involving a young person’s parents, family members, and other informal and formal key players; focusing on acknowledging and developing personal choice and social responsibility with young people;
  - Enhancing a person’s competencies;
  - Maintaining an outcome focus; and,
  - Involving young people, parents, and other community partners in the TIP system at the practice, program, and community levels.
Successful Transition Models for Youth with Mental Health Needs

Assertive Community Treatment (ACT)
This community-based, multi-disciplinary approach was developed in the 1980s to provide treatment, rehabilitation, and support services to persons with severe and persistent mental illness. Using the ACT approach, cases are managed by a multi-disciplinary team, providing services directly to an individual that are tailored to meet his or her specific needs. A team may include members from the field of psychiatry, nursing, psychology, social work, substance abuse, vocational rehabilitation, and community-based organizations. Team members collaborate to deliver integrated services to individuals in their “natural living” settings instead of hospitals and clinics.

Systems of Care (SOC)
The SOC approach is characterized by multi-agency sharing of resources and responsibilities and by the full participation of professionals, families, and youth as active partners in planning, funding, implementing, and evaluating services and system outcomes. The SOC approach facilitates cross-agency coordination of services, regardless of where or how children and families enter the system. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. SOC is characterized by multi-agency sharing of resources and responsibilities and by the full participation of professionals, families, and youth as active partners in planning, funding, implementing, and evaluating services.

Case Studies of Integrated Care Focused on Career Preparation
In 2007, the Office of Disability Employment Policy at the United States Department of Labor, through its technical assistance center, the National Collaborative on Workforce and Disability for Youth (NCWD/Youth), conducted a study to examine successful strategies to help youth with mental health needs successfully transition to employment and lead independent, productive lives. The study, which included a national review of programs with a dual focus on youth and young adults with mental health needs and on career preparation, work-based experiences, employment, and related services, identified the following five youth service delivery programs as exemplary:

- The Village Integrated Service Agency’s Transitional Age Youth Program in Long Beach, California
- Options in Vancouver, Washington (Clark County Department of Community Services)
- Our Town Integrated Service Agency in Indianapolis, Indiana (Marion County Mental Health Association, in partnership with the Community Health Network’s Gallahue Mental Health Services)
- The Transitional Community Treatment Team in Columbus, Ohio (North Central Mental Health Service)
- YouthSource, King County Work Training Program in Renton, Washington (Work Training Program/King County Department of Community and Human Services, contracted by the Workforce Development Council of Seattle-King County)

Design Features of Successful Programs
The 2007 study, conducted by Lindsey Woolsey and Judith Katz-Leavy, determined that the following six design features were critical to the success of these programs:

- **A Place to Call Their Own:** A distinct program identity, including a separate physical location away from adult mental health services, helps to promote attachment and engagement of youth.
• **Staffing Choices that Maximize Engagement:** Professional development of all staff is essential and should include gaining knowledge of community resources that youth need to become successful adults. Staffing choices should reflect:
  - A blend of knowledge of mental health and work development strategies that are appropriate to different ages and developmental stages;
  - A balance between the expertise and guidance that adults can provide with the peer support and sense of youth ownership that youth can provide.

• **Mental Health Intervention Without the Stigma:** On-site mental health services which utilize non-traditional treatment approaches as well as outreach and follow-up to keep the youth engaged or to re-engage them are important to success. These approaches should incorporate the building of a trusting relationship between the professional and the client, and “anywhere, anytime” treatment that allows counseling to be integrated into daily activities, such as talking over coffee or lunch, at the grocery store, or while playing pool.

• **Assessment and Service Planning Processes that Build on Individual Strengths:** Utilization of a specific assessment and service planning process assists clients in addressing their current status and may be used to develop individualized person-centered service plans that are rooted in the individual’s strengths and interests.

• **Employment:** Preparing for it, Finding it, Keeping it: Individualized exposure to work and employment pathways is critical for all youth, regardless of the severity of their condition. A “place and train” as opposed to “train and place” philosophy is imperative. All individuals must set career goals, design a plan to get there, and have opportunities for work-based learning. Meeting youth “where they are at” increases the likelihood of success. Supporting employers by providing a “win-win” situation for their participation by offering incentives such as subsidized wages during the youth’s training is also important.

• **Housing is a Critical Part of the Service Mix for Older Youth:** Housing is an important part of the service mix for older youth. Given the shortage of suitable and affordable transitional housing for this population, three of the programs preferred to operate their own transitional housing units. Other options include establishing partnerships in the community for the use of transitional housing units and to use Federal or other grants to subsidize the expense.

**Systems Factors that Affect a Program’s Success**

A program’s- and its client’s- success are affected by several system-wide factors. All five programs emphasized cross-systems collaboration and used multiple mechanisms to achieve it, including advisory boards, memoranda of understanding, and use of unique funding sources. Three dimensions of cross-system collaboration are highlighted below:

• **Local Collaboration and Service Alignment Creates Networks of Care:** The five programs used several approaches to create networks of care through cross-systems alignment including advisory boards, formal agreements, and resource-mapping of programs, state policies, and regulations.

• **Identifying, Accessing, and Leveraging Funding Streams:** Programs do best if they strategically leverage multiple funding streams at the same time. Four of the five programs rely heavily on Medicaid, and all rely on in-kind services through community partnerships. Some use the Chafee Independence Program, HUD’s Shelter-Plus-Care grants, or maximize Medicaid options by using waivers, which are a powerful tool for overcoming “eligibility cliffs.”

• **State Capacity for Systems Change:** States have the authority to improve services to transition-age youth with mental health needs through a variety of mechanisms, including: state legislation; Medicaid waivers; amendments to state Medicaid plans; and State Incentive Grants (SIGS).
Summary
Youth and young adults with mental health needs face major barriers as they attempt to make their way in the adult world. Those barriers include a confusing maze of services that often fail to meet their needs, inappropriate service tunnels, transition cliffs, and ineffective, uncoordinated service delivery. Through thoughtful systems change at the local and state levels, and the adoption of promising new program models promoting collaborative networks of care, more youth and young adults with mental health needs can become self-sufficient adults who experience personal and employment success.

References
- National Association of Social Workers; NASW Practice Snapshot: The Mental Health Recovery Model (Feb. 2006)
- Hewitt B. ‘Rusty’ Clark & Nicole Deschenes; TIP Model Overview, TIP WEBSITE
Tips for Teaching to Youth with Mental Health Issues

By Lee Majewski

This brief blog gives some lessons learned by a yoga instructor, including looking beyond, not judging, being patient, setting up structure, and loving them.

Active listening
- Hear the words
- Consider body language
- Listen to what's beneath the words

Via elephant journal on Jan 27, 2012

In September 2009, during my first class, I was facing 12 young people, 16-24 years old, a combination of males and females, not knowing what to expect.

Some looked at me with curiosity, some avoided eye contact, some were laughing to themselves, some were dozing off, some were staring at the wall with blank expressions on their faces and some couldn't sit still– almost bouncing off the mat.

Two years later I look back at my beginnings and I try to define what made yoga classes such a success for these young people. Here are the keys that I think made a difference.

1. Look beyond
At the end of the class we sat in a circle holding hands. Before we started the chant I asked them to set their wish for the day. A girl, still fidgeting said, “I wish I didn’t have schizophrenia; I wish I didn’t hear voices.” There was an aspect of her that knew that her illness controlled part of her body and mind as she was watching it helplessly. Some deep part of her was not involved in the illness but was witnessing what was happening to her and wished that it didn’t, that it would go away.

You as a teacher need to look beyond the uncommon behaviors your students may exhibit and not be affected by them. They may have tics, may be drowsy, may be talking or laughing to themselves, or may be very anxious and agitated. Your success with them will depend on your ability to disregard behavior and see the person behind it—to find a way to connect to that part of them, which is watching the illness. Do it with every student.

2. Do not judge
Understand their conditions and side effects of the medications they use. Sometimes they are heavily medicated. Sometimes they have adverse reactions to meds they are taking (see the info on my website Medications and Side Effects). These may be varied like dizziness, drowsiness, dry mouth, fatigue, blurry vision, weight gain, tremors, shaking, stiffness or abnormal movements, just to name a few.
Often psychiatrists change the meds or adjust the doses. This creates the change in their behaviors. They may suddenly start bouncing off the walls or start falling asleep in the class. Behind these symptoms is a young, confused person struggling to make sense of their mental condition and life. You as a yoga teacher need to hold the space by treating them always with the same degree of care and kindness no matter what they do.

One of the students– with bipolar disease– was either falling asleep or bouncing off the walls. Sometimes he was troublesome. I was doing my best to not be affected by it and always address him with kindness although sometimes he would really stretch my patience. One day he came earlier to the class and wanted to talk. At the end he said, “You know, I really feel I can talk with you in a safe way. I feel closer to you than to my worker here.” I couldn’t ask for a better payoff!

It is also crucial for you to be aware of each diagnosis. You also need to be in constant contact with their counselors. I have a weekly meeting with staff during which we discuss the kids and their state.

3. Be patient

Do not be discouraged by lack of contact with them or if a class does not go well. It will take time for you to get to know them. It will also take time for them to trust you.

One of my students sat there during the class and did everything to the best of his ability but his eyes were always on the floor. He would never openly share but would answer if asked a question directly. It took him 3 months to make his first eye contact with me. It took another month before I saw the shadow of a smile on his face.

Most students feel confused and completely disempowered by the medical system. Show them that they have the power to make themselves feel better using yoga. Give them tools to cope with emotions like anger, anxiety, stress or discomfort. Teach them pranayama for specific situations; teach them mantras and mudras they can use when in need. Empower them so that they can manage their own reactions and become independent. This will help you earn their trust.

4. Set up class structure

Find a class structure that works for you and your kids. It may take some trial and error but always ask them for their feedback. My kids respond well to routine and structure but I do need to remain flexible to their behaviors on any particular day.

In addition to asana I use pranayama, mudras, chanting, meditation and relaxation with visualization. Sometimes, when they are down, I will have them free dance to the music, encouraging them to move every part of their body.

5. Love them!

Finally, the most important thing you can do is simply love them. Once, a 19-year-old student with anxiety and depression was waiting for me in the class. It was apparent that he was depressed– he sat on the floor in the corner with a sad face. He looked at me as I entered 15 minutes before class and said shyly, “I know I can be tough but sometimes even I need a hug. Can I get a hug from you?”
Love Performs Miracles!

Most of them are coming from abusive homes and that’s where they will return. Some of them live with foster parents, some in-group homes, and some have trouble with the law. All of them have had a shortage of love in their life and all of them respond well to love.

One of the boys told me, “You know, when I go back I have only 2 choices--it’s either gang or jail.” He didn’t see any other choices in his life. However, after 8 months of yoga and at the end of his integrative program he came to the class and proudly announced, “I will be a construction worker”.

An engineer and musician by education, I spent over two decades in a successful career within the corporate business world. Simultaneously I was inspired to study various healing arts, and became a part-time holistic practitioner in 1989. Currently I am member of International Kundalini Yoga Teachers Association, Toronto Kundalini Yoga Association and the International Association of Yoga Therapists. I teach therapeutic yoga in Toronto, Canada, and travel internationally teaching various programs and workshops. You can contact me via e-mail: lee@mentalhealthyoga.com.

Prepared by Yoga Editor, Tanya Lee Markul.
Preventing Substance Abuse Among Youth in Foster Care

By Belinda Basca and Dustianne North

I went to live with my aunt and uncle when I was 6. The police had taken custody of me and my six siblings because...there were too many reports about my mom and stepdad being abusive and fighting. My aunt took me and one of my sisters.

...when I was 15, I started with weed, and then I tried speed and crack. At school when I was mad because I had been arguing with my aunt and uncle, I'd go to the bathroom to do drugs, which got my anger out and made me forget about everything...things were going so badly, I wished I could start my life over with my mom. I missed how she would spend time with me, which made me feel like she cared about me.

Finally my aunt told a social worker she couldn't control me anymore and put me in a group home. I was devastated. I felt like she was giving up on me. I was losing another person in my life, another mom. I didn't realize it at the time, but if it wasn't for her, I'd still be doing drugs and probably be involved in a gang.

By Joel M., 18 years old

Many youth who experience the foster care system struggle with substance use and abuse. When a child is removed from the home, multiple organizations and people become involved in caring for that child and addressing his or her needs. By understanding these complex needs and underscoring the context in which services are provided, substance abuse prevention providers can adapt their service models to effectively address the needs of foster youth. This Prevention Tactic addresses how to tailor prevention-focused, substance abuse strategies to foster youth.

Youth in Foster Care: Why and Where

Most children become a part of the child welfare system because of confirmed child abuse or neglect, commonly referred to as maltreatment. Within that system, foster care refers to the care of minors who, for safety reasons, have been placed in an out-of-home living situation. Minors may be removed from their home due to severe maltreatment defined as neglect, physical abuse, sexual abuse, and emotional abuse. Child maltreatment can also include harm that a caregiver allows to happen or does not prevent from happening to a child. Youth may also be placed out-of-home due to the parent’s inability to address their child’s delinquent and/or high risk behavior. Foster care is meant to be temporary with the goal of returning children to a rehabilitated and safe living environment. Nationwide, 86% of all children exiting foster care were discharged to a permanent home (reunification with family, adoption, or guardianship), with the other 14% being emancipated or having their cases transferred to another jurisdiction.

Prevention Tactic

Tactic (Tak’tiks) n. 1. a plan for promoting a desired end. 2. the art of the possible.
Youth who initially enter the child welfare system may be placed in emergency care, a licensed shelter, transitional living program, juvenile detention (when a child has committed a crime), or a licensed Community Treatment Facility (when mental health and/or substance abuse treatment is necessary). If a juvenile dependency court determines it is not safe for a child to remain in or return to their home, minors are placed in foster care, which includes placement in a licensed foster home, with a relative (“kinship placement”), or in a group home. Nearly a quarter of youth in foster care are placed with kin (grandparents, other extended family, single individuals).

Explaining Foster Youths’ Increased Risk for Substance Abuse

Substance abuse is a factor in at least three quarters of all foster care placements. Foster youth exhibit higher rates of illegal drug use than youth who have never been in foster care (34% vs. 22%) and recent studies indicate high rates of lifetime substance use and substance use disorders for youth in the foster care system.

Implications of parental substance abuse

Often times, the alcohol and other drug (AOD) issues faced by foster youth can be traced to a family history of substance abuse and dependence. Parental addiction, both prenatally and during child rearing, is a significant factor in child abuse and neglect cases and can be a contributing factor in the removal of a child. These predisposing factors are multifaceted with research showing hereditary links, the influence of social norms, and the use of alcohol and other drugs as a learned coping mechanism. Studies suggest 40% to 80% of families in the child welfare system are affected by alcohol and drug dependence.

Emotional harm and substance abuse

When maltreatment occurs in the home, even when substance abuse is not a contributing factor, it can still leave a child more vulnerable to substance abuse in adolescence. One of the most common coping strategies used by youth who are suffering emotionally is self medication through alcohol and other drugs, which can lead to further victimization, mental health problems, addiction, and lack of self-care. In the most extreme cases of child maltreatment, where exposure to abuse is repeated and/or severe, research shows there can be changes in brain physiology that, in practical terms, impact how children think, feel, and act. Such changes can leave these children at higher risk for a variety of mental health problems and addictions. Nationally, 50% of children and youth in the child welfare system have mental health problems.

A lack of permanence in multiple settings

Youth in foster care often experience multiple placements in homes and schools. Children experiencing numerous placement changes are affected emotionally, cognitively, and physically—contributing to both the internalizing and externalizing of negative behavior. In addition, placement and school changes impact access to activities and programs, including student assistance programs (SAP) and substance abuse prevention services.
According to the California Foster Youth Education Task Force, for every change in school setting, foster youth fall three to six months further behind their classmates, creating a downward spiral. Consequences include alienation from teachers and peers who are doing well; a loss of self-efficacy (the feeling of success); detachment from school; and the acquisition of friends who are also alienated. As a result of poor attendance and low academic achievement, these youth may be transferred to continuation or community day schools. Survey data show that community school students are more likely to use drugs and alcohol with higher frequency and in higher amounts than their non-continuation school peers. This reveals the need to embed substance abuse prevention services into both mainstream and continuation schools.

When foster care ends

Typically, youth leave the foster care system when they reach the age of maturity, at age eighteen in California. Some youth, however, emancipate early and live independently as young as age sixteen. According to the U.S. Census Bureau, of the approximately 500,000 children in the foster care system nationwide, an estimated 24,000 “age out” of care each year and live independently.

These youth face challenges establishing a safe and secure living environment. One study reports a 50% homeless rate for youth who have been in foster care or probation. There is also a small, but vulnerable population of youth who leave their placements before age eighteen. Many of these youth live in marginal or homeless conditions, which presents a risk for substance abuse. An analysis of three national surveys found that youth living on the streets had markedly higher rates of drug abuse and were involved in more serious drug use than either youth in shelters or living at home.

Fortunately, there have been state and federal efforts to ensure the availability of support services and independent living programs (ILP) that continue until age 21. For these youth to receive services as “non-minor dependents,” they have to be working on a plan for self sufficiency through school, GED, or vocational education. The important distinction is that “ILP services” until age 21 are different than “remaining in foster care” beyond age 18; foster care involves a much higher level of support than ILP services.

Substance Abuse Prevention: Selecting Service Models for Youth in Foster Care

While many substance abuse prevention programs are tailored for youth, most do not specifically address foster youth. More broadly focused foster youth prevention programs address mental and behavioral health, with some including substance use (see diagram). As AOD prevention providers look to integrate their services into existing programs or look for programs that specifically address foster youth, they might consider evidence based programs, such as:

- **Strengthening Families Program (SFP)** is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children three to sixteen years of age. SFP comprises three life-skills courses delivered in weekly sessions and includes a parenting skills component.
• **Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students)** is designed to prevent and reduce substance use among students ages twelve to eighteen. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse.

• **Project ALERT** is a school-based AOD prevention program for middle/junior high school students and is based on the social influence model of prevention. It seeks to prevent adolescent nonusers from experimenting with drugs, and to prevent youth who are already experimenting from becoming more regular users or abusers.

• **The Comprehensive Student Assistance in Residential Settings Project** addresses foster youth who have been placed in group residential facilities and uses highly trained staff to provide culturally sensitive AOD prevention services.

• **Functional Family Therapy (FFT)** is a family-based prevention and intervention program that has been applied successfully in a variety of contexts to address a range of high-risk behaviors, including substance use.

• **Multidimensional Treatment Foster Care (MTFC)** is designed for foster youth who display chronic disruptive behavior, which may include problems associated with substance use. Its purpose is to avoid institutional placements by having youth live with families who are recruited, trained, and closely supervised to provide support services and intensive supervision at home, in school, and in the community.

• **One-to-One Mentoring Programs** match volunteers with youth, with some focusing on foster youth. The benefits of foster youth mentoring programs align with those of mentoring programs in general, and include decreased substance abuse.

• **Self-Motivation Group (SM Group)** is designed specifically for child welfare involved parents/caregivers of children through age twelve and consists of short-term orientation sessions that help parents recognize problems and build intervention skills.

**Meeting the Special Needs of Foster Youth: Program Content and Service Delivery**

Following are four suggested strategies for substance abuse prevention programs:

1. **Promote permanency**: Foster youth who endure multiple living situations and school placements may have fewer interactions with prevention programs, making it harder for them to gain the intended benefits. On the other hand, prevention programs that provide supportive and stable environments may help ameliorate some of these problems. Programs that continue to serve youth when their placements change are especially valuable and may be more effective.

“There’s a perception that . . . these foster kids . . . if they’re not with their mother or father, that means no one wants them, and no one wants them for a reason, so I think they’re almost seen as a lost cause.”

-Jelani, former foster youth.

*Source-Foster Care: Voices from the Inside (2003)*
**Tips:**

- Provide consistency, unconditional positive regard, and predictability in services.

- Encourage connections with caring adults in the community who will stay connected with youth regardless of their path through the system (mentors, volunteer therapists, ILP workers, and other professionals).

- Ensure that case workers and new placement families are aware of services.

- Offer services in multiple locations on the same schedule, so that mobile children can “enter” a new location without disruption. Or, integrate existing AOD prevention services into a broader program that has the potential to reach and sustain connections with foster youth.

- Plan to make confidential check-in call(s) when services end; in particular with foster youth.

- Connect older youth to available services within California County offices that provide emancipation and ILP services (including financial and other assistance).

- Coordinate and collaborate with the school district and county office of education, social and/or case worker(s), ILP coordinators, school administrators, guardians, and other service providers to ensure continuity of services.

**2. Provide staff training and support:**

Reluctance to discuss feelings, to form secure attachments, to rely on others, or to let down their guard—these are some of the coping mechanisms foster youth employ. These strategies can hinder their ability to fully participate in prevention programming. To build up youths’ inherent resiliency, staff and volunteers must be well trained, supervised, and supported to work with youth from a strength-based approach. Careful management, clinical supervision, or other support may be necessary for staff with personal experience of foster care issues. Finally, staff may need training and support to reach across organizations and systems and work collaboratively with other professionals.

**Tips:**

- Discover whether staff have faced similar issues as those faced by foster youth, and provide an opportunity to discuss, if needed.

- Determine protocols and appropriateness for sharing personal information with those served.

- Plan appropriate procedures and protocols for situations in which youth disclose personal information. Also make staff aware of mandated reporting rules regarding abuse and neglect.

- Train staff to work actively with other systems serving foster youth (departments of child welfare, juvenile justice, mental health, and substance abuse).

3. **Understand shifting family dynamics:** A typical youth in foster care undergoes stressful and emotionally taxing changes during their time in foster care. They often experience strong feelings of fear, shame, guilt, anger and confusion over their parent’s circumstances. Many foster youth maintain a relationship and/or have supervised visits with their parent(s) of origin. Foster youth become part of a second family system, which may include foster
parents, siblings, and other foster relatives, as well as their own biological siblings or relatives. In group placements, there is a “household” of youth and staff who must co-exist. Prevention providers can understand and appreciate these unique relationship dynamics and anticipate that a range of feelings and accompanying behaviors may be expressed by youth.

**Tips:**

- Ensure that outreach and service activities are welcoming and respectful of the placement situation of the youth.
- Avoid using only stereotypical examples of living situations such as the stable nuclear family in printed materials and programming.
- Be careful not to make assumptions about parental involvement in the lives of youth.
- Consider the constraints and particularities of each placement and biological family.
- Remember that resources such as transportation and other supports may not be as easily available for youth in foster care.

4. **Outreach to foster youth, but avoid stigmas and labeling:** Foster youth often feel stigmatized for being part of the child welfare system and desperately seek to avoid being “found out.” Special attention to service design is needed to strike a balance between assuring that the unique needs of foster care youth are addressed, without the identification of foster youth in a way that perpetuates stigma.

**Tips:**

- Review all printed materials and messaging to ensure that it is not stigmatizing.
- Ensure outreach strategies are neutral for the general population served.
- Avoid publicly identifying youth in your program as being in foster care or system-involved.

**Conclusion**

The California Health Kids Survey data reveals that many of our state's youth experiment with alcohol and other drugs. Foster youth do so at an even higher rate and with a broader range of more serious drugs, yet they feel less peer disapproval for this behavior. This emphasizes the importance of reaching out to foster youth and providing them with substance abuse prevention and early intervention strategies. When AOD prevention providers outreach to this population they must do so in a way that preserves an individual foster youth's anonymity. They must train staff to better understand the unique situations and pressures that can influence behavior choices and create more emotional pressure on foster youth. Meeting foster youths’ unique needs also calls for special attention to service designs and referral procedures that take into consideration foster youths’ altered living arrangements and adjustments to new schools, with an added focus on helping youth stay connected and grounded.
11 The California Healthy Kids Survey aggregate data for 2005-2007 shows, for example, that 85% of continuation and community day high school students report “Any AOD use,“ compared to 67% of 11th grade students across CA. www.wested.org/chks/pdf/CA_Agg_Upper_0507_tr.pdf
12 In October 2005, SB 1633 was signed into law, which extends foster care benefits to youth who are seeking a high school equivalency certificate up until their 19th birthday. In addition, some counties are choosing to extend benefits. For example, Los Angeles County pays foster care benefits for youth to stay in care until age 21 if they are working towards a high school diploma or a non-traditional high school proficiency certificate such as the GED or CHSPE (http://www.bassc.net/html/pdfs/FINALAgingOutOfFosterCare.pdf).
16 SAMHSA supports a searchable database of interventions for the prevention and treatment of mental and substance use disorders at www.nrepp.samhsa.gov/
17 A comprehensive guide to structuring mentoring services for foster youth is available online at: http://www.emt.org/userfiles/FosterYouthSeries5.pdf
**Handout: Strategies**

1. **Promote stability in the lives of youth**
   - **Help to prevent placement changes**
     - Preventing or slowing substance abuse can alone do this!
     - Offer strong support to youth and foster care providers when AOD use does occur, and encourage providers to remain committed to youth
   - **Make your program a haven of emotional stability**
     - Provide consistency, unconditional positive regard, and predictability.
     - Treat foster youth in your program as if they will be there for the duration, and not as transient participants
     - Make a confidential check-in call when services end, especially with foster youth.
   - **Connect youth to informal connections and resources/services in the community**
     - Whenever possible, engage extended family members (maternal and paternal)
     - Encourage connections with caring adults who will stay connected regardless of youth’s paths through system: family members and friends, mentors, volunteer therapists, etc.
     - Ask youth which adults are important to them, past and present, and strive to support those connections
     - Connect older youth to county offices that provide emancipation and ILP services.
   - **Strive to keep youth in your program or a related program, even when their placements change**
     - Coordinate and collaborate with other agencies to ensure continuity of services: School district, County office of education, Social/case workers, ILP coordinators, Guardians
     - Ensure that case workers and new placement families are aware of your program, so that youth continue to receive services.
     - Offer programs in multiple locations on the same schedule, so that youth can “enter” a new program without disruption.
     - Integrate existing services into a broader program with potential to sustain connections with youth in foster care.

2. **Raise staff awareness of foster youth issues**
   - **Involve staff and volunteers with expertise and experience working with youth in placement**
     - Look for language and ethnic diversity in staff
     - Invite alumni and current foster youth to lend a constituent voice
   - **Provide training in specific needs and strategies**
     - Make staff aware of mandated reporting law for abuse and neglect.
     - Educate staff about the unique emotional needs children in foster care may have.
     - Train staff in communication skills with these youths.
   - **Train staff to work actively with other systems serving youth in foster care: Child welfare department, juvenile justice, mental health, substance abuse**
   - **Offer cultural sensitivity/competency training for all adults who will work with youth**
   - **Address biases and personal issues in staff which may hinder their ability to effectively serve:**
     - Address staff and volunteer biases and misconceptions regarding race, class, and gender—especially those who have little experience with youth of different backgrounds
     - Monitor staff and volunteers to address how they might react to what youth share about abuse, neglect, and other negative family dynamics.
Also discover whether staff members have faced similar issues as those faced by youth in foster care, and explore how these experiences may affect their practice.

- Determine protocols and appropriateness for sharing personal information with those served.
- Plan appropriate procedures and protocols for situations in which youth disclose personal information.

3. Be friendly and accessible to nonconventional families
   - Avoid stigmatizing
     - Avoid using stereotypical examples of living situations, such as a stable nuclear family.
     - Review printed materials to make sure that these examples are not the norm.
     - Ensure that outreach and service activities are welcoming and respectful of the placement situation of the youth.
   - Consider the constraints and particularities of each placement and biological family (including fathers and extended paternal family).
     - Be careful not to make assumptions about parental involvement in the lives of youth.
     - Individualize the program’s expectations of capability of the caregivers (in kinship situations).
     - Remember that resources such as transportation and other supports may not be easily available for youth in foster care.

4. Respect the whole person’s unique interests and experiences
   - Build cultural competency in your staff and program
     - Address all aspects of cultural competency/sensitivity relevant to youth in placement:
       - Ethnicity
       - Class
       - Gender
       - Culture of foster care and stigmatization of foster youth
       - Culture within each placement/biological family
       - Mixed ethnic and class experiences from changing placements
       - Reach out without labeling or stigmatizing
   - Review all materials and messaging to ensure that they are not stigmatizing.
   - Ensure that outreach strategies are neutral for the general population served.
   - Avoid publicly identifying youth in your program as being in foster care or system-involved.
   - Make written materials and staff interaction respectful and accessible to the ethnic, language, and class characteristics of families served.
     - Address biases of foster care providers and authorities- be aware of them, educate beyond them, safeguard and advocate for youth and families
     - Individualize services based upon all cultural factors
     - Offer culture-specific programming:
   - Help youth connect back to their own culture, especially if they have been separated from it via placement
   - Help youth and adults learn about and respect each other’s cultures
   - Utilize a strengths-based approach
     - Recognize the heightened risks these youth face, but also learn to turn these challenges to assets
     - Assess the risks and resiliencies of EACH youth individually
     - Encourage strengths rather than dwelling on risks or deficits
- Encourage youth to take healthy risks and test their strengths
- Empower youth and respect their self-determination
  - Actively engage youth in your program and put their suggestions to measurable use.
  - Offer leadership development opportunities for youth in your program.
  - Collaborate with existing foster youth empowerment and advocacy groups in your area to involve youth in your program with opportunities to have a voice in policies that affect them.
  - Consider hiring individuals with this background or former youth in your program.
  - Allow youth to make their own decisions: offer support and information, not advice.
Key Links

[Website] Youth Mental Health: FindYouthInfo.gov is the U.S. government website that helps to create, maintain, and strengthen effective youth programs. Included are youth facts, funding information, and tools to help you assess community assets, generate maps of local and federal resources, search for evidence-based youth programs, and keep up-to-date on the latest youth-related news. Several Youth Briefs can be found at this home page, including Coordinating Systems to Support Transition Age Youth with Mental Health Needs and How Trained Service Professionals and Self-Advocacy Makes a Difference for Youth with Mental Health, Substance Abuse, or Co-occurring Issues. Links are also available to more information about protective and risk factors, contextual variables that promote or hinder the process that allow youth to grow and reach their developmental competencies; warning signs; co-occurring disorders; and treatment options.

[InfoBrief] Successful Transition Models for Youth with Mental Health Needs: A Guide for Workforce Professionals. May 2009– Issue 23. U.S. Department of Labor: This InfoBrief describes the systems’ service barriers faced by youth with mental health needs as they reach adulthood, while highlighting new models and strategies designed to break down those barriers and help them to transition successfully into the workplace. Through partnerships with service agencies and organizations in their communities, youth service professionals can assist youth in preparing for the adult world without getting lost in a tunnel or falling off a cliff. They will need to make a concerted effort to learn what other systems may provide, make contacts within those systems, and coordinate services. This InfoBrief presents model programs and successful strategies to help youth and young adults with mental health needs successfully transition to employment and to lead independent, productive lives.

[InfoBrief] Helping Youth with Mental Health Needs Avoid Transition Cliffs: Lessons from Pioneering Transition Programs. National Collaborative on Workforce and Disability: This InfoBrief discusses challenges faced by youth and young adults with mental health needs during their transition to adulthood and describes strategies used by youth service professionals to avoid age-related transition cliffs and prevent service interruptions during this critical stage of development. This InfoBrief is based on a rich body of research about transition-age youth with mental health needs published in four separate reports in the last two years, including two produced by the National Collaborative on Workforce & Disability for Youth (NCWD-Youth).

[Article] Tips for Teaching to Youth with Mental Health Issues: Lee Majewski, Elephant Journal. January 27, 2012. This brief blog gives some lessons learned by a yoga instructor, including looking beyond, not judging, being patient, setting up structure, and loving them.

[Website] Foster Parent College: Online training resource for parents and educators.

[Website] Foster Club (resources for adults here; see Part I for a description of their resources for youth) Foster Club’s library is a collection of research papers, reports, articles, and book excerpts collected from leading child welfare resources. Courses are available on bio families, the court system, education, mental health (with a focus on helping children and adolescents cope with violence and disasters), special needs children, and youth transition to adulthood.
[Website] **Research and Training Center’s Pathways to Positive Future:** “The Pathways Transition Training Collaborative is designed to enhance the skills of service providers working with young people with serious mental health conditions and to provide information and tools to young people and their family members, researchers, and policy makers involved in developing and implementing transition-focused interventions, policies, and research.”

[Curriculum] **Reaching Youth in Foster Care with Your Alcohol and Drug Prevention Efforts** (Updated 2013) by Dustianne North, M.S.W., Ph.D. and Leah Gold, Center for Applied Research Solutions. Provided to coordinators in separate PDF file, this curriculum offers in-depth training for youth prevention providers to support foster youth in their programs, including best practices recommendations and incorporating the perspectives, voices, and stories of youth in foster care.

[Curriculum] **When Stakes are High: Research-Based Mentoring for Youth With Multiple Risk Factors** (updated 2013) by Dustianne North M.S.W., Ph.D, Denise Johnston M.D., and Brenda Ingram, L.C.S.W., Center for Applied Research Solutions. Provided to coordinators in separate PDF file, this comprehensive curriculum offers a research-based understanding of effective mentoring with youth who have been classified as “high-risk”. These youth require effective mentoring programs that are specially designed to address their issues. Programs tend to have greater staff to mentors ratios, structured activities, supervision to mentors, parent programming, intensive mentor training structures, clinical support, and require more collaboration with other community-based agencies and governmental systems.

[Webinar] **Prevention: A Key to Permanency for Youth in Foster Care**, by Dustianne North M.S.W., Ph.D. Center for Applied Research Solutions. 2011. “This webinar examines linkage among child maltreatment, foster care, permanency, stability, substance abuse, other risky behaviors, and it explores effective strategies for prevention and mitigation. Providers will learn to be effective partners with youth in foster care, as these youth transition into adulthood, striving to establish and maintain behaviors and relationships representative of a healthy, fulfilled life.” Register with the site for free.

[Website] **Disability Rights Education and Defense Fund Clearinghouse on Foster Youth and Transition:** This Clearinghouse offers a variety of selected resources to help foster parents, kincare providers, child welfare workers, educators, Court Appointed Special Advocates (CASAs), and other professionals to provide effective services and support for children with disabilities in foster care.
Prevention and Foster Youth

References and Resources, including abstracts
By Dustianne North and Siobhan Stofka

Handouts, Articles, and Broadcasts from the Field

- Lucile Packard Foundation for Children’s Health (2012): Foster Care Data
- Community Prevention Initiative. (2012) Prevention: A Key to Permanency for Foster Youth [Recorded webinar]
  - There’s No Place Like Home, A Guide to Permanency Options for Foster Youth
  - Youth Involvement in Case Plans, Court Hearings and Administrative Reviews
- The California Report. San Francisco, CA. KQED.

Government Resources and Reports

- The Adoption and Foster Care Reporting and Analysis System (AFCARS)
- California Department of Education, 2010 Report to the Legislature and the Governor for the Foster Youth Services Program [Microsoft Word document]
- California Department of Social Services, California Blue Ribbon Commission on Children in Foster Care May 2009
- For information about the Blue Ribbon Commission on Children and Foster Care, please visit: http://www.courts.ca.gov/brc.htm
- CWS/CMS Dynamic Reporting System (2009)
- National Survey on Drug Use and Health (NSDUH) Substance Abuse and Mental Health Services Administration (SAMHSA), (2005). The NSDUH Report: Substance Use and Need for Treatment Among Youths Who Have Been in Foster Care
- San Francisco Unified School District (SFUSD). Foster Youth Services– Student Support Services Department
Summary: Seventy-five percent of California foster youth perform below grade level standards, and by third grade 83 percent of foster youth have had to repeat a grade. We believe the state and local programs must reprioritize the way existing funds are spent in order to improve educational opportunities for foster youth. We recommend changing guidelines to provide certain services to all current and recent foster youth, expanding programs to include academic counseling and completion of education passports, and consolidating programs at County Offices of Educations. We also suggest convening a workgroup to address the transportation needs of K-12 and postsecondary foster youth.

Reports by Service Providers and Advocacy Groups

- Omni Youth Programs. Omni Youth Programs: Drug and Gang Prevention
- National Center for Lesbian Rights. Has some information about GBTLQ youth in foster care.
- National Center for the Prevention of Youth Suicide (2012). Preventing Suicidal Behavior among youth in foster care
- Boonstra, H. (2011). Teen Pregnancy Among Young Women In Foster Care: A Primer
- SPRC: Suicide Prevention Resource Center (2010). The role of foster parents in preventing suicide
Scholarly Articles
With abstracts when available


Abstract
Two-year follow-up data (from inner-city, minority adolescents) were collected to test the effectiveness of 2 skills-based substance abuse prevention programs and were compared both with a control condition and with each other. Students were originally recruited from 6 New York City public schools while in 7th grade. Schools were matched and assigned to receive a generic skills training prevention approach, a culturally focused prevention approach, or an information-only control. Students in both prevention approaches had less current alcohol use and had lower intentions to engage in future alcohol use relative to students in the control group. Students in the culturally focused group also engaged less in current alcohol behavior and had lower intentions to drink beer or wine than those in the generic skills group. Both prevention programs influenced several mediating variables in a direction consistent with nondrug use, and these variables also mediated alcohol use.


Abstract
Background: Universal school-based prevention programs for alcohol, tobacco, and other drug use are typically designed for all students within a particular school setting. However, it is unclear whether such broad-based programs are effective for youth at high risk for substance use initiation. METHOD: The effectiveness of a universal drug abuse preventive intervention was examined among youth from 29 inner-city middle schools participating in a randomized, controlled prevention trial. A subsample of youth (21% of full sample) was identified as being at high risk for substance use initiation based on exposure to substance-using peers and poor academic performance in school. The prevention program taught drug refusal skills, antidrug norms, personal self-management skills, and general social skills.

Results: Findings indicated that youth at high risk who received the program (n = 426) reported less smoking, drinking, inhalant use, and polydrug use at the one-year follow-up assessment compared to youth at high risk in the control condition that did not receive the intervention (n = 332). Results indicate that a universal drug abuse prevention program is effective for minority, economically disadvantaged, inner-city youth who are at higher than average risk for substance use initiation.

Conclusions: Findings suggest that universal prevention programs can be effective for a range of youth along a continuum of risk.
Abstract

Background: This paper describes a prevention study focused on the drug use scenarios encountered by Native Hawaiian youth. Priorities from communities on the Big Island of Hawaii helped to shape the qualitative data collection and analysis of middle school students participating in the study.

Method: Forty-seven youth from five different schools were interviewed in small, gender-specific focus groups during lunch hour or after school.

Results: The findings indicated that youth were exposed to drug offers that were direct–relational or indirect–contextual in nature. Direct–relational offers were didactic exchanges where drugs or alcohol were offered from one individual to another (e.g., “Do you want some beer?”). Indirect–contextual offers reflected complex exchanges among individuals, where drugs or alcohol were involved, but not offered directly (e.g., “Do you want to hang out with us?”).

Conclusions: Implications are discussed regarding drug prevention research and programs that highlight indirect–contextual drug offers that are place based and culturally grounded.


Abstract

This article reviews major risk factors for cigarette smoking, alcohol, and other drug abuse and promising community-based approaches to primary prevention. In a longitudinal experimental study, 8 representative Kansas City communities were assigned randomly to program (school, parent, mass media, and community organization) and control (mass media and community organization only) conditions. Programs were delivered at either 6th or 7th grade, and panels were followed through Grade 9 or 10. The primary findings were (a) significant reductions at 3 years in tobacco and marijuana use and (b) equivalent reductions for youth at different levels of risk. This study provides evidence that a comprehensive community program-based approach can prevent the onset of substance abuse and that the benefits are experienced equally by youth at high and low risk.

5. Narendorf, Sarah Carter & McMillen, J. Curtis (2009). Substance use and substance abuse disorders as foster youth transition to adulthood. [PDF file Copyright © 2010 Elsevier Ltd. All rights reserved.]

Abstract

Little research has previously examined substance use and substance use disorders as youth age out of foster care. This study examined rates of getting drunk, marijuana use, and substance use disorders over time for a cohort of 325 older youth in foster care in Missouri. Rates of past month marijuana use increased from 9%
at age 17 to 20% at age 19. Rates of getting drunk in past year increased from 18% at age 18 to 31% at age 19. Compared to the general population, older foster youth had lower rates of substance use but higher rates of substance use disorders (SUD), with 15% of youth meeting criteria for a SUD at age 19. Youth who had left the custody of the state had significantly higher rates of alcohol and marijuana use at ages 18 and 19. Transitions out of residential care and into independent living situations were associated with use of substances at age 18. Different risk factors were associated with substance use at ages 18 and age 19 while risk factors for SUDs were more stable over time. Findings highlight the need to screen and provide treatment for SUDs before youth leave state custody and to consider substance abuse treatment in decisions to extend care beyond age 18.


**Abstract**

This article compares two groups of foster care alumni residing in transitional living programs in San Francisco, California. One group of youth was served in programs geared specifically towards youth aging out of foster care who were referred through a transition planning process. A second group of youth was served in similar transitional housing programs that were not exclusively for foster care alumni but instead served homeless youth in general. Comparisons between these two groups reveal that youth in the population-specific programs have less acute initial presentations than foster care alumni in homelessness intervention programs, who had faced more unemployment, school attrition, substance use, and mental health concerns prior to program admission than their peers in the programs specifically for foster care alumni. The research also shows that youth in the homelessness intervention programs had faced more instability during their years in foster care when compared to youth in the population-specific programs for foster care alumni. The research highlights the need for better understanding of the referral process for youth aging out of foster care so that transitional housing programs for young adult foster care alumni can better serve a diversity of youth with different service needs.


**Abstract**

Adolescents in foster care are at risk for unplanned pregnancy and sexually transmitted infections, including HIV infection. A study using a qualitative method was conducted to describe how and where foster youth receive reproductive health and risk reduction information to prevent pregnancy and sexually transmitted infections. Participants also were asked to describe their relationship with their primary health care provider while they were in foster care. Nineteen young adults, recently emancipated from foster care, participated in individual interviews. Using grounded theory as the method of analysis, three thematic categories were generated: discomfort visiting and disclosing, receiving and not receiving the bare essentials, and learning prevention from community others. Recommendations include primary health care providers providing a confidential space for foster youth to disclose sexual activity and more opportunities for foster youth to receive reproductive and risk prevention information in the school setting.
Excerpt
The Midwest Evaluation of the Adult Functioning of Former Foster Youth (Midwest Study) is a longitudinal study that has been following a sample of young people from Iowa, Wisconsin, and Illinois as they transition out of foster care into adulthood. It is a collaborative effort involving Chapin Hall at the University of Chicago; The University of Wisconsin Survey Center; and the public child welfare agencies in Illinois, Iowa, and Wisconsin. The Midwest Study provides a comprehensive picture of how foster youth are faring during this transition since the Foster Care Independence Act of 1999 became law. Foster youth in Iowa, Wisconsin, and Illinois were eligible to participate in the study if they had entered care before their 16th birthday, were still in care at age 17, and had been removed from home for reasons other than delinquency. Baseline survey data were collected from 732 study participants when they were 17 or 18 years old. Study participants were re-interviewed at ages 19 (n = 603), 21 (n = 591), 23 or 24 (n = 602), and 26 (n = 596).
Dealing with Difficult Issues with Youth

Effective Communication and Intervention

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Dustianne North, M.S.W., Ph.D.
Jerry Sherk, M.A.
Roadblocks to Effective Communication


1. **Ordering, directing, commanding**
   Telling the youth to do something; giving the youth an order or command:
   - “Stop complaining!”

2. **Moralizing, preaching, shoulds and oughts**
   Invoking vague outside authority as accepted truth:
   - “You shouldn’t act like that.”
   - “You ought to do . . . “
   - “Children are supposed to respect their elders.”

3. **Teaching, lecturing, giving logical arguments**
   Trying to influence the youth with facts, counter-arguments, logic, information, or your own opinion:
   - “College can be the most wonderful experience you’ll ever have.”
   - “Children must learn to get along with one another.”
   - “Let’s look at the facts about college graduates.”
   - “If kids learn to take responsibility around the house, they’ll grow up to be responsible adults.”
   - “When I was your age, I had twice as much to do as you.”

4. **Judging, criticizing, disagreeing, blaming**
   Making a negative judgment or evaluation of the child:
   - “You’re not thinking clearly.”
   - “That’s an immature point of view.”
   - “You’re very wrong about that.”
   - “I couldn’t disagree with you more.”

5. **Withdrawing, distracting, sarcasm, humoring, diverting**
   Trying to get the youth away from the problem, withdrawing from the problem yourself, distracting the youth, kidding the youth out of it, and pushing the problem aside:
   - “Just forget it.”
   - “Let’s not talk about this at the table.”
   - “Come on– let’s talk about something more pleasant.”
   - “Why don’t you try burning the school building down?”
Using a Non-Directive Approach with Youth

Real motivation comes from within. People have to be given the freedom to succeed or fail.
-Gordon Forward, CEO Chaparral Steel

In the non-directive approach, you do a great deal of listening and asking questions, and you spend minimal time giving advice.

Remember that a successful helper places the growth and development of the child above helping them to solve a particular problem. If you continually tell the young person what to do, you are failing to create an environment where he or she can feel empowered.

The Problem of Being Too Direct
When you make decisions for people (by giving them advice or direction), two major types of outcomes might occur. If the advice works, from the child’s perspective: “Yes, it worked out, but I wasn’t the one that made the right decision. It was the adult helping me, therefore, I still don’t know how to solve these kinds problems.” If the advice does not work, the dynamics could be: “What I tried didn’t work, but it wasn’t really my choice, that adult told me to do that.”

Strong advice and direction can result in young people not fully celebrating their successes, nor owning their failures. The adult helper must have faith that the young person will eventually make the right decision, even though the “right” answers to a problem may not be immediately apparent.

The communication tools listed below (active listening, open questions, paraphrasing) are ways of not directing youths, but these tools serve to:
1. Help you to more fully understand his or her problem or situation;
2. Help the child to more fully explore and understand his or her situation, and;
3. Subtly lead or suggest to the child what you perceive to be a good course of action.

To Be, or Not to Be, Directive
Having said this, at times the adult can be somewhat more directive, especially in crisis situations. If you perceive that there are safety issues, you can give direct advice.

A non-directive approach relies upon solid basic communication skills.
Basic Communication Skills

1. Active listening

Active listening means that you make a special effort to genuinely hear what the youth is saying. This requires a great deal of effort on the part of the listener. You will know that you are acquiring active listening skills when you feel tired after listening and attending to others for a long period of time. Active listening requires a great deal of effort and energy. The goal of active listening is to allow the person who is speaking to come away from the interaction with a feeling they have been completely heard. It is not necessary that you agree with them; however, it is essential that you provide a non-judgmental environment that promotes freedom of expression.

Active listening skills

- Avoid distractions - choose a comfortable and quiet place for your meeting
- Avoid time pressure for your meeting - whenever possible
- Don't jump into a conversation too soon– let the youth finish what s/he is saying
- Pause a few seconds before feedback– you both need time to think
- Listen for feeling as well as content– read between the lines
- Don't confuse content and delivery– assume the youth has something to say even if s/he is having trouble saying it.
- Cultivate empathy– try to put yourself in the young person’s place
- Give the young person time to correct a mistake– this shows respect
- Use simple gestures and phrases– to show you are listening
- Ask questions beginning with ‘What’ or ‘How’– avoid questions which force ‘Yes’ or ‘No’ answers
- Pay attention to verbal and non-verbal cues
- Maintain good eye contact
- Face youth head on
- Keep an open posture– don't cross arms and legs
- Lean toward the person– show involvement in what he/she is saying
- Be aware your bodies’ language

Results of active listening

- Encourages honesty
- Reduces fear: people become less afraid of negative feelings
- Builds respect and affection
- Increase acceptance: promotes a feeling of understanding
- The first step towards problem solving

Three techniques for active listening:

Receive rather than transmit

A good listener usually receives (listens) before they transmit (talks). Remember that the situation is about the youth, not the adult. The first rule of active listening is that when you are talking you can't be listening. Do not be
like the narcissistic character that Bette Midler played in the movie Beaches, who only slowed down enough to say to her friend, “That’s enough about me. What do you think about me?”

**Bring your full attention to the conversation**
Good listeners are able to bring themselves fully to the moment. Of course, sometimes you will be having a rough day. It could be a fight with the spouse, bills to pay, a lack of sleep, or other problems that can prevent you from being able to fully focus on the youth’s concerns. If you are having a bad day, the best thing to do is to attempt to temporarily switch your frame of mind for the time you are with a youth.

**Pay attention to the little things**
The adult should try to discern if there is anything unusual in the conversation. Pay attention to the nonverbal aspects of the youth’s communication as well as the spoken word. Is the youth’s voice tense? Is breathing erratic? Does he or she use words out of context that might give you a clue as to what is going on with them? Does the youth keep coming back to a specific issue, even though in your mind it does not seem that significant? Does he or she seem happy or depressed? Is the youth focused, or going off on tangents?

2. **Paraphrasing**
Paraphrasing is the process of repeating what you just heard the child say, but in a little different wording. Paraphrasing focuses on listening first and then reflecting the two parts of the speaker’s message—**fact** and **feeling**—back to the speaker. Often, the fact is clearly stated, but a good listener is “listening between the lines” for the “feeling” part of the communication. Using this skill is a way to “check out” what you heard for accuracy—did you interpret what a young person said correctly? This is particularly helpful when working with youth. Youth culture/language is constantly changing. Often words which meant one thing when adults were youth could have an entirely different meaning for youth today.

**Format**

**Examples for FACT:**
- “So you’re saying that . . .”
- ”And that made you feel . . .“
- “You believe that . . .”
- ”Your reaction is . . .“
- ”The problem is . . .“
- “It seems to me…”

**Examples for FEELING:**
- “It sounds like…”
- “You feel that . . .”
- “I wonder if what you’re saying is…”
- “Correct me if I’m wrong, but…”
Note: Paraphrases are not a time to respond by evaluating, sympathizing, giving our opinion, offering advice, analyzing, or questioning.

Results
Using active listening skills will enable you to gather the information and then be able to simply report back what you heard in the message -- the facts and the attitudes/feelings that were expressed. This lets the other person know that you hear, understand, and care about his/her thoughts and feelings. The act of paraphrasing is also a demonstration of your respect: it shows the youth that you are taking the time and effort to understand exactly what they are trying to get across.

Examples
- “It sounds like what you are saying is that trouble seems to find you on the playground.”
- “Correct me if I’m wrong, but what I think I’m hearing you say is the teachers come down on you every day, no matter how you act?”

3. Open-Ended Questions
Open-ended questions are intended to collect information by exploring feelings, attitudes, and how the other person views a situation. Open-ended questions are extremely helpful when dealing with young people. Youth, teenagers especially, tend to answer questions with the least amount of words as possible. In order to maintain an active dialogue without interrogating, try to ask questions which cannot be answered with a “yes,” “no,” “I don’t know,” or a grunt.

Examples
- “How do you see this situation?”
- “What are your reasons for . . . ?”
- “Can you give me an example?”
- “How does this affect you?”
- “How did you decide that?”
- “What would you like to do about it?”
- “What part did you play?”

Note: Using the question, “why did you do that?” may sometimes yield a defensive response rather than a clarifying response.

Results
Since open-ended questions require a bit more time than closed-ended questions (questions that can be answered by “yes,” “no,” or a brief phrase), they give the person a chance to explain. Open-ended questions yield significant information which can in turn be used to problem solve.

Open questions have nice soft beginnings and they help youth to respond without having to be defensive. Using a style that encourages youth to speak freely helps in generating ideas, as well as in building the relationship. Using open questions is also a good way to get young people to talk and (sometimes) subtly direct them to consider issues or options. By virtue of the way they are phrased, open-ended questions require elaboration to answer.
Closed questions
The opposite of an open question is a closed, often painfully direct question that can be answered simply by the youth providing a response without further elaboration. Closed-ended questions often feel harsh and judgmental on the receiving end, even when they are not intended in that manner.

For example:
- Closed: “Do you want to get to school on time?”
- Open: “What might you do to make it to school on time?
- Closed: “You didn’t stay out of trouble on the playground this week, did you?”
- Open: “Please help me understand your ideas about what happened on the playground today.”
- Closed: “Do you think that sitting in the counseling office every day will help you to be successful?”
- Open: “Looking back, what are your thoughts about why you were called into the counseling office?”

4. “I” Messages
“I” messages provide an opportunity to keep the focus on you and explain your feelings in response to someone else’s behavior. Because “I” messages do not accuse, point fingers at the other person, or place blame, they avoid judging and help keep the communication open. At the same time, “I” messages continue to advance a situation to a problem-solving stage.

“I” Messages
- Avoid judging
- Keep lines of communication open

For example
“I was really sad when you didn’t show up for our meeting last week. I look forward to our meetings and was disappointed not to see you. In the future, I would appreciate it if you could call me and let me know if you will not be able to make it.”

Avoid
“You didn’t show up, and I waited for one hour. You could have at least called me and let me know that you wouldn’t be there. You are irresponsible.”

Pay attention to
- Body language: slouching, turning away, pointing a finger
- Timing: speaking too fast or too slow
- Facial expressing: smiling, squirming, raising eyebrows, gritting teeth
- Tone of voice: shouting, whispering, sneering, whining
- Choice of words: biting, accusative, pretentious, emotionally laden
Results

“I” messages only present perspective. Allowing the other person to actually “have” a point of view and hearing it does not mean that s/he is right. “I” messages communicate both information and respect for each position. Again, this skill moves both parties along to the problem solving stage.

Dealing with Difficult Issues: Guiding Philosophies

- The importance of self-determination, empowerment
- Collaborative rather than prescriptive
- Problem-solving vs. advice giving
- Confidentiality
- Caution with self-disclosure

Multi-level Considerations

- Immediate Emotional Needs
- Physical and Psychological Safety
- Problem-Solving

Consider where to begin: if there is immediate danger (during the actual conversation only!), consider safety first. Otherwise, meeting the emotional needs of the youth IN THE MOMENT the youth comes to you should take first precedence. Most often, problem-solving comes last!
The Range of Difficult Issues
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Delicate Topics
“Delicate topics” are simply topics that can be difficult to discuss, but do not necessarily represent a crisis in the life of the youth (“Kids at school are starting to talk about sex,” as an example).

- Sex
- Peer pressure
- Hygiene
- Behavior
- School performance
- Self-image/personal insecurities
- Class/cultural identity
- Others: _________________________________

Guidelines for Response
The topics listed here are likely to come up during discussions between adults and youth; however, caution needs to be taken since these topics can be touchy and strongly affect the relationship. Whenever possible, delicate topics should be discussed only when initiated by the young person, and confidentiality takes on greater importance. Adults who work with youth are encouraged to seek support and feedback from supervisors and peers when these issues come up. Keeping notes of ongoing issues may also be advisable.

Crises Requiring Intervention
“Crises” requiring immediate intervention include situations which pose direct and acute danger to the young person in question, or to someone else.

- Child abuse and neglect
- Abusive relationships
- Chemical dependency
- Depression/suicide
- Mental illness
- Other trauma
- Others: _________________________________

Guidelines for Response
The crises listed here are of grave concern and may require direct and immediate intervention. Some, like child abuse and neglect, are mandated by law to be reported to county authorities, such as law enforcement and/or children’s services. Regardless, these issues require a referral or a direct intervention. Many of these situations will require collaboration with families of youth, which should be preferably be handled by program professionals with clinical or relationship expertise.
Issues of Concern

“Issues of concern” are troubles facing youth that may be difficult and may present risk, but may not require or be approachable with a direct intervention. One example is “fist fighting.” A youth may have gotten in trouble for fighting at school, and the adult in whom they confide may be very concerned about this behavior. The youth, however, may have had a problem with fighting at school since the first grade, and so this is a long-standing behavior for which a direct “intervention” may or may not work.

- Unsafe sex
- Fist fighting
- Delinquent behavior
- Gang affiliation
- Drug and alcohol use
- Others: _______________________________

Because these issues are likely to have significant negative impact on the life of the youth, adults working with youth may need immediate and direct support from more experienced adults and professionals (and sometimes peer helpers) when these issues arise. However, adults must strive to accept these aspects of the lives of youth they serve without judgment. It is also important that adults do not focus too heavily on changing behavior in these regards. They should be aware of the challenges, and over time they may be able help youth to ameliorate them.

Assessing the Level of Particular Issues

These categories are fluid, and there can be many variables involved. For instance, how you approach the situation may depend on:

- Your training, expertise and comfort level
- The expectations regarding your role
- The quality and immediacy of support and supervision provided by your organization
- How well you know the youth (including length of time you have worked with him or her)
- The frequency that the issue/challenge occurs

Transforming the Relationship

Ask yourself, “If I were in this young person’s shoes, what would I want from an adult? What will appropriately strengthen the relationship?”

Times of crisis, big and small, represent a special opportunity for “teachable moments.” So though they may be times of great stress, and certainly can have a negative influence on relationships, they can also (when handled well) be times of self-learning and trust building for everyone. Training and ongoing guidance from staff are essential to these processes.
Putting Youth at Ease

Telling an adult about a difficult issue can feel like a very risky thing for a child or youth. The adult’s ability to help the young person feel safe in sharing personal information is key to both the development of trust in the relationship and to offering the best possible support for a youth in his/her situation. As the primary role of the adult is to build a trusting relationship with their youth, these concerns should take precedence over attempts to change the young person’s behavior or to influence their decisions.

Tips

• Stay calm.
• Use body language to communicate attentiveness—maintain eye contact, sit at same level, etc.
• Avoid judgmental statements like “Why would you do something like that?” or “I think you know better…”
• Be honest if you are getting emotional or upset, but never accuse or berate!
• Let the youth know that you are glad he or she came to you.
• Reassure youth that his/her confidentiality will be honored whenever possible.
• Use tact but be honest.
• Allow youth to talk at his/her own pace—don’t force an issue.
• Don’t pry—allow youth to bring up topics with which they are comfortable.

Honoring the Right to Self-Determination

What is Self-Determination?

Self-determination is the right that every human should have to make decisions for themselves. Of course this concept becomes tricky and confusing when youth are involved since many decisions are made for minors with or without their consent—youth are not seen as old enough to be trusted with such decisions. Without the opportunity to exercise decision-making, decision-making skills may be limited. It is the job of a supportive adult to help youth develop these skills and learn to make their own choices. You can do this by helping young people process the implications of any particular course of action, and by helping them to discover what is truly important to them. This is important to the mutual relationship, as it communicates respect and trust, and these concerns should take precedence over a focus on changing behavior or influencing the youth’s course of action.

Tips:

• Focus on his/her feelings and needs rather than jumping to problem-solving.
• When issue has been talked about, ask, “What do you think you would like to do about this situation?” and “How would you like for me to help?”
• If you are not comfortable with what (s)he wants to do, ask yourself why before you decide whether to say so.
• If what (s)he wants to do is not possible, explain so gently and apologize.
• Ask what alternative solutions would make him/her comfortable.
• If you must take an action which is uncomfortable for a young person (such as reporting abuse), offer him or her as much choice and autonomy as possible.
• Encourage critical thinking through questions and reflections.
• Use the words, “I don’t know—what do you think?”
• Other thoughts:

**Problem-Solving and Resources**

**Problem-Solving, not Advice-Giving**

Once the adult has successfully addressed the youth's feelings, and has processed with them in a way that honors the youth's need for self-determination, the adult can now further assist the young person in locating resources and options. It is important at this stage that the agency is prepared for any interventions that are needed. Ideally, this should be a team effort, a team of which the young person his or herself is the key player. Any adults who are relevant to the youth's life or situation should ideally work together, so that the young person has the best support available. This way, youth and adults can together solve problems, rather than the adult “advising” the youth about what to do.

**Giving Advice**

• Youth is passive, possibly resistant
• Cuts off further exploration of problem
• Often premature
• Youth does not learn
• Adult’s solution cannot be imposed on the youth’s situation
• Does not encourage self-esteem
• Advice is often not well received

**Problem Solving**

• Active youth
• Opens lines of communication
• Eliminates timing troubles
• Youth learns how to handle problem
• Solutions belong to the young person
• Fosters self-esteem
• Problem solving creates tools for future

**Tips**

• Know your appropriate role
• Be honest with the youth if he or she has given you information that you will be unable to keep confidential.
• Suggest that your supervisor may have thoughts, if you don’t know what to do.
• Provide information if youth are unaware of resources or options.
• Brainstorm with youth and be creative in finding a solution—there is usually more than one way to handle a situation, and this process is educational for young people.
• Offer to accompany a young person if (s)he is uncomfortable with something (s)he has decided to do.
• Be collaborative—you are a team.
• Follow through with any and all commitments
• Other thoughts:
Confidentiality
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General Considerations Regarding Confidentiality
- Policies must be established for safety & liability concerns
- Also helps build trust with young people
- Adhere to local laws, reviewed by board, legal counsel, insurance carriers
- Train staff & volunteers on legalities and processes of mandated reporting

Guidelines for Confidentiality

Why Establish Confidentiality?
In addition to safety and liability issues, the reasons to establish confidentiality include that a young person typically won’t open up if he or she thinks you are going to tell others information disclosed to you.

Developing Confidentiality Policies
Organizations should carefully think through and establish written guidelines on confidentiality. It is also highly recommended that these policies be reviewed and approved by an organization’s board of directors (or administration), by legal counsel, and by insurance carriers. In addition, initial training should be given to staff and volunteers before they have contact with youth; ongoing training and support should also be provided.

Below are some general guidelines that organizations may find useful when developing their confidentiality policies. However, because reporting laws vary, programs need to make sure that their guidelines adhere to local statutes within their jurisdictions.

Exceptions for Maintaining Confidentiality
- Talking to Program Personnel
- Interagency Communications
- Group Work (Including Peer Support)
- Child Abuse, Neglect & Endangerment

Because of safety and liability issues, and because volunteers and staff need to communicate in order to receive and provide support, there are several exceptions where adults are allowed to (or they must) break confidentiality.

Exception 1: Talking to Program Personnel: Program staff and volunteers should be allowed (and highly encouraged) to talk to their supervisors and other staff about any particular problem, issue or concern they have with a young person. This does not mean, however, that confidentiality does not apply in these situations. (It is best to have youth and parents sign a release stating that they understand that staff may work as a team and therefore share information.)
**Exception 2: Interagency Communications.** Additionally, when agencies collaborate to provide services, in order to effectively serve youth, at times it will be necessary to exchange specific information about these young people. With such collaborations, all organizations involved must gain permission before they share information about clients across agencies. Staff and volunteers must then remain respectful of confidential information when interacting with youth and parents after such information is disclosed.

**Exception 3: Group Work.** In some programs, staff and volunteers have group sessions to discuss with their peers issues about the young people they are working with (in order to get suggestions). Again, once information about a youth has been disclosed in this manner, group members must still avoid divulging this information with anyone outside of the program.

**Exception 4: Child Abuse, Neglect, Endangerment / Child Abuse Reporting.** In many jurisdictions (including California) when a person receives pay for their work with minors, and they suspect that a child is being or has been abused neglected, or endangered, they must make an immediate report to children’s services and/or law enforcement. In some jurisdictions, volunteers (those who are not paid) that interact with minors are not required to make a report to children services and law enforcement. However, all programs should train volunteers about child abuse, neglect and endangerment, and they should also require volunteers to immediately report any suspicion to program staff.

The operative word is suspicion. If adults who work with youth witness or hear anything that might be of concern, they should report it right away.

Even in this extreme situation, the privacy of individuals must be protected from other program participants and others in their lives—only the child welfare system, (and sometimes law enforcement), and program staff should be notified.

**What Constitutes Possible Abuse, Neglect, and Endangerment?**
(Note that the information provided below includes only partial descriptions.)

**Physical Abuse**
This includes any striking of a child where it leaves marks, bruises, welts, etc. In addition, any intentional and cruel exposure to water, heat, or any other unusual or painful punishments.
Physical Neglect and Endangerment
Basic needs include food, shelter, hygiene, safety and health care. Physical neglect may include leaving young children either alone, or leaving them with other young children.

Sexual Abuse
Any sexual conduct or relationship where a minor is being manipulated and exploited is reportable. In addition, note that sexual intercourse, even though consensual, between an adult (18 or older) and a minor (under the age of 18) is a violation within various jurisdictions (check your local statues for a full description of violations, and for laws relating to the specific ages of offenders and victims).

Emotional Abuse
This type of abuse may include a lack of care and attention, humiliation, terror, intimidation and character assassination. Domestic violence can also be considered form of emotional abuse. Violence is terrifying, loud, and it leaves physical damage on bodies and property. Violence can also leave caregivers unable to tend to their children.

How About Abuse in the Past, or in the Future?
Suspected abuse must be reported past, present or future. For example, someone may have abused the minor in the past who is not currently around this individual, but they may be abusing other children elsewhere. In addition, if you hear or suspect that anyone might be harmed in the future, this is also reportable.

How About Danger to Someone Besides Youth I Am Working With?
Any suspicion is also reportable even if it concerns minors other than those you are working with. For example, if a young person you are working with tells you about abuse that is occurring with their friends, this is reportable.

Talk to Your Youth about Confidentiality
During early meetings, you should make this or a similar statement to the young people you are working with (and the program will do the same during youth and parent orientations):

“Anything you tell me will be between you and me, except if I hear that you or anyone else has been hurt, or is in danger (past, present, or future), then I need to tell someone in the program.” (Or, if you are a staff person, “...then I will need to make a report.”)
When adults work with youth, sometimes young people will want to know about the adults’ personal lives. It can be tricky finding an appropriate response, especially when the question comes without warning, so adults should be trained on how to manage these situations. In general, when adults help young people, they should refrain from going deeply into their own personal issues.

The following are some things to consider about a young person’s probing questions:

**Their Question May be a Conversation Starter**
Before you panic, consider that the questions that young people are asking might not be about you; instead, it could be a way to begin talking about something that’s on their mind. For instance, “How old were you when you first had sex?” may be a way for them to begin talking about a friend they are concerned about.

**Don’t “Get It Off Your Own Chest”**
When you respond to a young person’s question, does it feel really good? If it does, STOP, as it’s likely that you are using the relationship for your own therapy, even if you are telling yourself that you are providing the youth with a needed lesson.

**Maintain Your Role as a Stable Person**
Going deeply into your own issues might shake the young person’s confidence in you. They might end up asking themselves, “Why does this person, who has so many problems, think that they can help me? Maybe I should be helping them!”

**“The Bus Stop Test” – A Rule of Thumb**
Have you ever found yourself waiting for a bus, and struck up a conversation with someone else who is also waiting? It can be nice to share an exchange in such a moment... “are you married? Hey, me too...” or “I work in youth services, how about you?” But have you had the experience where someone starts “unloading” their deep dark needs and issues in such a setting? It feels wrong, doesn’t it? So if you are considering divulging something to a young person you are working with, ask yourself how you would feel if someone brought this up at a bus stop.

**Strategies for Responding to Probing Questions**
While there is no set formula for answering a young person’s probing questions, below are strategies for you to consider.

1. “I’m wondering why you are asking?” – Immediately asking a question back helps return the emphasis to the youth. This often inspires the young person to begin relating their own experience, instead of probing further into your life.

2. “I’m a little uncomfortable talking about my personal life.” – If you don’t want to answer the question, consider being truthful; hopefully, the young person will respect your boundaries. (This can also be a good lesson to the youth about his or her own boundaries.)
3. Show your humanity, but without disclosing. Young people want to know you are not “bullet-proof,” but at the same time it is not good thing for them to hear your dark secrets. So, you might say something like, “There are things in my life I’ve done that I wished I hadn’t, and things I didn’t do that I wish I did. And if I tell you what I did or didn’t do, it might make you decide to do the same thing, even if it isn’t right for you. So I’d rather talk about you, since you seem to have something on your mind. How can I help you?” This way, you haven’t made it seem that you must have done it or would otherwise tell the truth, but you have placed the focus back on them.

Another example of showing your humanity with disclosing, for instance, if they ask about your past break-ups, is to say, “Gee, I’ve had plenty of problems with relationships in my life. Who hasn’t!”

4. Hesitate before saying, “Yes, I did, but…” Some people who work with youth feel that they need to be totally open, and so when questions come up they readily discuss their past discretions. Adults need to weigh their intent (which is usually good) with what the young person might actually hear (which is what they want to hear). For example, you might say, “I had sex when I was 14, but I really, really, really wish I had waited!” and the young person might hear, “They had sex when they were 14, and look how successful they are now—it must have not hurt them.” Therefore, it is recommended that you use another strategy (such as the ones listed above), before you get into “Yes, I did, but…”

Additional Resources
- Dealing with Difficult Issues with Youth: Crises and Opportunities. (interactive DVD self-administered training for adults who work with youth) [www.emt.org](http://www.emt.org)
- Plain Talk Program [http://ppv.issuelab.org/home](http://ppv.issuelab.org/home)
- Incorporating an Understanding of Youth Culture and Development into Your Mentor Program (2005). [www.emt.org](http://www.emt.org)
- Responsible Mentoring - Talking About Drugs, Sex and Other Difficult Issues (2000) [www.emt.org](http://www.emt.org)
- Ethics Consultation: From Theory to Practice, by Mark P. Aulisio (Editor), Robert M. Arnold (Editor), Stuart J. Youngner (Editor). 2003; The Johns Hopkins University Press
- Keeping the Relationships Going, Module 4, Education Northwest
- Meeting the Challenge: Mentoring in a Diverse Society.
- Respecting Culture: Foster Care Youth
Key Listings
National and California CLAS Standards / Community Alliance for CLAS Research Clearinghouse
In 2011, the State of California adopted 14 standards for Culturally and Linguistically Appropriate Services (CLAS), for alcohol and other drug (AOD) providers. More recently, the Department of Health and Human Services released a blueprint for implementing culturally competent minority healthcare more generally. A brief overview of both sets of standards are provided in this section, and more information about these is available at the following links:

- CA and National CLAS Standards
- CA AOD CLAS Standards and Recommendations
- The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
- CLAS Research Clearinghouse

A comprehensive array of research and practice information related to CLAS in the AOD and allied fields can also be found at the California Community Alliance for CLAS Research Clearinghouse (funded by the California Department of Alcohol and Drug Programs, administered by the Center for Applied Research Solutions). This site includes information about how to work with and treat specific populations, including ethnic minorities, houseless individuals, transgender individuals, veterans, and youth. It is updated monthly and is a great resource for coordinators seeking to provide culturally appropriate support and services to transitioning foster youth.
Culturally and Linguistically Appropriate Services (CLAS) Standards

The Office of Minority Health, a division of the U.S. Department of Health and Human Services, formally adopted the CLAS Standards in March 2001. These standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. As stated, the Partnership’s goal is to bring these recommendation standards to human and social service organizations as well. The principles and activities of culturally and linguistically appropriate services should thus be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations, as follows:

- CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).
- CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).
- CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

**Standard 1**
Health care organizations should ensure that patients/consumers receive, from all staff members, effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

**Standard 2**
Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

**Standard 3**
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

**Standard 4**
Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

**Standard 5**
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
Standard 6
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9
Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10
Health care organizations should ensure that data on the individual patient’s/consumer’s race, ethnicity, and spoken and written language are collected in health records, integrated into the organization’s management information systems, and periodically updated.

Standard 11
Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12
Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS related activities.

Standard 13
Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14
Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
The Case for the Enhanced National CLAS Standards

“The Case for the Enhanced National CLAS Standards

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”
— Dr. Martin Luther King, Jr.

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization, 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, 2010). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization’s ability to address health care disparities.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (HHS National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

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Considering Culture When Working with Foster Youth
Jerry Sherk, M.A. and Dustianne North, M.S.W., Ph.D.

When working with youth in foster care, complex and multilayered cultural concerns must be considered. Each youth in foster care is unique, in terms of their ethnic background (which can also be different in their bio family vs. their placement), gender and sexual orientation, class experiences, education levels, and age. There is also a shared culture in the foster care community as a whole as well as one within each placement and geographical area. Different backgrounds may also mean differential treatment within foster care and other systems. All of these aspects of culture must be considered when serving foster care youth.

The following slides illustrate some of these ideas, as follows:

We first provide a slide from a webinar entitled *Demographic Changes: Cultural Competence*, by Lucy Wong Hernandez, Samuel Teruel-Velez, Daniel Wong. 2009, suggesting that gaining cultural “competence” progresses through a spectrum of first learning to avoid negative approaches to culture and then learning to offer positive cultural interactions. We note that we disagree, however, with the term “cultural competence,” as it would be presumptive to claim to become competent in someone else’s culture. One can, however, learn to act in an increasingly culturally appropriate manner.

We then present what has been termed in the field the “iceberg” view of culture, in which only a few elements of another culture are visible on the surface while the rest are hidden and can be the source of unexpected and unseen conflict or disconnect.

The last three slides suggest ways to approach culture with foster care youth, including tips for learning about a young person’s culture, as well as ways to be more respectful of foster care experiences by recognizing the positive aspects of their traits and habits, and by re-framing their challenges in a strengths-based perspective.
The Cultural Competence Continuum

The Iceberg Conception of the Nature of Culture

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Slides: Considering Culture
Becoming Culturally Appropriate

- Research the youth’s culture
- Strive to understand the difference between the youth’s culture and your own (and your own biases)
- Initiate conversations about youth’s culture, when appropriate

Being Culturally Appropriate: Use a Strengths-Based Approach!

**FOSTER CARE YOUTH**

**Challenges**
- Attachment disorder
- Lack of trust
- Trauma and loss
- Developmental and behavioral problems
- Sense of entitlement
- Manipulative behavior

**Assets**
- Adaptability
- Caution
- Wisdom/compassion
- Resiliency
- Self-advocacy
- Social aptitude
Get to Know Each Youth’s Culture

The youth’s culture can, in part, determine their challenges and strengths, and influence the kinds of difficult issues that may arise:

- Race and ethnicity
- Socio-economic status
- Foster youth
- Other system-involved youth
- Gang-involved youth
- Other cultures?
Trauma and Recovery

Trauma-informed care: highlights from SAMHSA’s National Center for Trauma Informed Care

What is Trauma-Informed Care?
Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

What are Trauma-Specific Interventions?
Trauma-specific interventions are designed specifically to address the consequences of trauma in the individual and to facilitate healing. Treatment programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding recovery
- The interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

Following are some well-known trauma-specific interventions based upon psychosocial educational empowerment principles that have been used extensively in public system settings. Please note that these interventions are listed for informational and educational purposes only. NCTIC does not endorse any specific intervention.

- Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Risking Connection
- Sanctuary Model
- Seeking Safety
- Trauma, Addictions, Mental Health, and Recovery (TAMAR) Model
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM and M-TREM)

Trauma and Development
All youth who have survived foster care have experienced trauma, and there are major considerations practitioners must make in working with traumatized youth. The slides that follow, excerpted from When Stakes are High: Research-Based Mentoring for Youth With Multiple Risk Factors (updated 2013, by Dustianne North M.S.W., Ph.D, Denise Johnston M.D., and Brenda Ingram, L.C.S.W., produced by the Center for Applied Research Solutions) provide perspective on how youth development works, how trauma affects that development, and how interventions can take a developmental approach that allows trauma to heal and development to get back on track.
Module II: Guiding Principles

A Developmental Approach to Mentoring
Denise Johnston, MD

What Does “Risk” Mean?

Risk Factors:
- Can be environmental, behavioral, or biological
- Risk versus functioning
- Risk factors versus risk behaviors
- Risk versus resiliency

Developmental Insults and Resources
Denise Johnston, MD

Some Common Developmental Insults
- Developmental, physical or mental disabilities
- Impaired (substance-dependent, mentally ill primary caregiver)
- Physical, emotional and sexual abuse
- Sever neglect
- The witnessing of violence (domestic or in the community)
- Bereavements
- Separations from home and family

Some Common Development Resource/Supports
- A consistent, nurturing primary caregiver
- Protection from physical, mental and emotional harm
- An additional consistent, nurturing adult in a child’s life
- A safe, healthy home environment
- Health care
- Formal education

Some Populations of “High Risk” Youth

Britner et al. (2006)
Special Populations:
- Abused and neglected youth
- Youth who have disabilities
- Pregnant and parenting adolescents
- Juvenile offenders
- Academically at-risk students

Others to Consider:
- Children of prisoners
- Youth in extreme poverty
- Homeless youth/runaways
- Domestic violence situations
- Recently traumatized/grieving youth
- Gang involved youth
Why These Distinctions Matter

IF risk and functioning are not the same thing, and
IF risk levels vary within an identified “high risk” populations, and
IF youth facing equal risk exhibit varying risk behaviors, and
IF youth facing equal risk factors also benefit from varying resiliency factors

THEN it is dangerous to lump all “high risk youth” together:
• Could leave out youth that could benefit
• Issues of equal access
• Mainstreaming/ community connectedness

The Developmental Perspective
Denise Johnston, M.D., 2004

Definition of Development:
The acquisition of skills through integration of experience

Some “Packages” of Developmental Skills:
• Walking
• Attachment
• Logical Thinking
• Identity
The Attachment Bond

- Enduring
- Emotional and physical components
- Security and comfort is sought from the
- Attachment figure
- Distress is experienced following involuntarily separation from the attachment figure

Attachment

- The “package” of developmental skills that supports and is produced by the attachment relationship.

The Attachment Cycle

Mother & infant form attachment bond

- Baby engages in attachment-maintenance activity: Smiling, cooing, molding, cuddling, etc.
- Mother returns & soothes baby
- Baby engages in attachment-seeking activity: Crying, whining, pursuit
- Baby experiences fear, pain, or separation

Behaviors Developed in the Attachment Cycle

- Attachment-maintenance (“keeping someone around”)
- Attachment-seeking/agression (“getting someone back when they go”)
- Self-soothing
John Bowlby

Attachment behavior is drive behavior and attachment is like other basic human drives.

What skills do children learn in the primary attachment relationship?

Attachment Skill Sets

Children learn to love & trust

Attachment Skill Sets (Continued)

Children achieve a sense of “felt security” in their environment
Attachment Skill Sets (Continued)

Children achieve the ability to self-regulate:
- Activity
- Affect
- Arousal
- Attention

Attachment Skill Sets (Continued)

Children develop cognitive representations of themselves & others in relationships

Attachment Creates Cognitive Representations of Relationships

Attachment answers the question:
What do I look like in an attachment relationship?

Like this?

Attachment Creates Cognitive Representations

Attachment answers the question:
What do my attachment relationships look like?

Like this?
The process of acquiring the capacity for attachment illustrates the way development works.

**RECALL**

The definition of development:

The process of acquiring skills by integrating experience

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Development is like baking a cake

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Some people have had good things go into their cake...
These things are called “developmental resources.”

Some people have had other things go into their cake...

These things are called “developmental insults”.

Some Developmental Insults That May Have a Life-long Effect

- Severe illness
- Major injuries
- Forced separations from caregivers
- Caregiver or sibling bereavements
- Multiple placements
- Physical, sexual, or emotional abuse
- Witnessing violence in the home or in the community
Many developmental insults that have major, lifelong effects are referred to as...

**An emotional or physical shock capable of producing lasting developmental damage.**

**The Trauma State**
- Shuts down unnecessary functions
- Focuses all systems on sources of threat
- Physical, cognitive & emotional component

**Physical Aspects of the Trauma State**
- Shut down of digestive, reproductive and other functions unnecessary for survival.
- Preparation of the body for “fight or flight”:
  - Increased heart rate & blood pressure
  - Increased respiration
  - Increased blood flow to muscles
Cognitive Aspects of the Trauma State

- Shut down of learning, reasoning and reflective functions
- Focus of cognitive functions on sources of threat:
- Increased speed of mental activity
- Attention/concentration on survival

Emotional Aspects of the Trauma State

- Freezing or numbing of “positive” emotions
  - Love
  - Happiness
  - Joy
- Emotional flooding
  - Anxiety
  - Fear
  - Anger

When Does Trauma Affect Development?

Elements of Recovery from Trauma

- Individual coping skills
- Emotional support
- Basic needs are met, including the need for safety
1. Individual Coping Skills

- Good health
- Normal cognitive function
- Physical strength
- Self-esteem

2. Emotional Supports

- A caring adult helper
- Validation of the traumatic experience
- Provision of a sense of belonging and identity

3. Basic Needs Are Met

- Shelter
- Food
- Clothing
- Safety

All of these elements are critical, but if one is missing, recovery cannot occur.

Which one?
Without safety, traumatic experiences continue and recovery cannot occur.

Long-Term Effects of Trauma Without Recovery

- Emotional effects
  - Persistent emotional numbness
  - Persistent emotional flooding
- Cognitive & moral effects
  - Powerlessness, hopelessness, despair
  - Attention-concentration & learning problems
- Behavioral effects
  - Irritability, impulsivity, hyper-arousal, hyper-vigilance
  - Depression
  - Aggression

Children who exhibit these long-term manifestations of trauma (or other developmental insults) are often said to engage in “high risk behaviors.”

Developmental insults, including trauma, are most effectively addressed by developmental intervention.
Principles of Developmental Intervention

- Principles
- Mechanisms
- Methods

1st Principle: Development is adaptive.
Developmental outcomes reflect life experience.

If you look like what has gone into your cake, you are developmentally normal.

2nd Principle
Developmental outcomes are the sum of the effects of:

developmental resources/supports
("good experiences")
+
developmental insults
("bad experiences")
Children who have experienced many developmental insults are often referred to as “high-risk” children.

3rd Principle:
Developmental pathways and outcomes can always be changed by new experience.

Improving Developmental Outcomes

- “What are some ways that mentors/mentor programs can act to increase the developmental resources of mentees?”
- “What are some ways that mentors/mentor programs can act to decrease developmental insults, or the effects of developmental insults mentees have experienced?”
- “What other kinds of services might be helpful, in conjunction with mentoring, for either increasing developmental resources or decreasing insults and their effects?”

Methods of Developmental Intervention

Like primary development:

- Address developmental tasks
- Are resource-intensive
- Involve multiple modalities
- Are relationship-based
Developmental Intervention Methods
Address Developmental Tasks: Examples

Approaches that build the capacity for attachment:
• Mother-child residential treatment programs
• Mentoring

Techniques that support development of cohesive identity:
• Life calendars
• Narrative therapies

Developmental Intervention Methods Are Resource-Intensive

• Clients do not compete for resources
• Diverse and accessible intervention staff
• Availability of resources anticipates and is sensitive to client needs

Developmental Intervention Methods Involve Multiple Modalities

Use of multiple modalities supports a global approach that:
• Engages a greater proportion of clients
• Engages clients in several developmental domains
• Allows clients to modulate the impact of activities in different domains
• Is more effective

Developmental Intervention Methods Are Relationship-Based

Relationship-based intervention:
• Replicates the circumstances in which developmental skills are normally acquired (i.e. within supportive relationships)
• Replicates the sequence in which developmental skills are normally acquired (emotional/relational development precedes development in all other domains)
• Requires and enhances the use of language and narrative
• Is more powerful than any other type of intervention in changing developmental outcomes
Tips for Talking With and Helping Children and Youth Cope After a Disaster or Traumatic Event

A GUIDE FOR PARENTS, CAREGIVERS, AND TEACHERS

“Adult support and reassurance is the key to helping children through a traumatic time”

Children and youth can face emotional strains after a traumatic event such as a car crash or violence. Disasters also may leave them with long-lasting harmful effects. When children experience a trauma, watch it on TV, or overhear others discussing it, they can feel scared, confused, or anxious. Young people react to trauma differently than adults. Some may react right away; others may show signs that they are having a difficult time much later. As such, adults do not always know when a child needs help coping. This tip sheet will help parents, caregivers, and teachers learn some common reactions, respond in a helpful way, and know when to seek support.

Possible Reactions to a Disaster or Traumatic Event

Many of the reactions noted below are normal when children and youth are handling the stress right after an event. If any of these behaviors lasts for more than 2 to 4 weeks, or if they suddenly appear later on, these children may need more help coping. Information about where to find help is in the Helpful Resources section of this tip sheet.

PRESCHOOL CHILDREN, 0–5 YEARS OLD

Very young children may go back to thumb sucking or wetting the bed at night after a trauma. They may fear strangers, darkness, or monsters. It is fairly common for preschool children to become clingy with a parent, caregiver, or teacher or to want to stay in a place where they feel safe. They may express the trauma repeatedly in their play or tell exaggerated stories about what happened. Some children’s eating and sleeping habits may change. They also may have aches and pains that cannot be explained. Other symptoms to watch for are aggressive or withdrawn behavior, hyperactivity, speech difficulties, and disobedience.

- **Infants and Toddlers, 0–2 years old**, cannot understand that a trauma is happening, but they know when their caregiver is upset. They may start to show the same emotions as their caregivers, or they may act differently, like crying for no reason or withdrawing from people and not playing with their toys.

- **Children, 3–5 years old**, can understand the effects of trauma. They may have trouble adjusting to change and loss. They may depend on the adults around them to help them feel better.
EARLY CHILDHOOD TO ADOLESCENCE, 6–19 YEARS OLD

Children and youth in these age ranges may have some of the same reactions to trauma as younger children. Often younger children want much more attention from parents or caregivers. They may stop doing their school work or chores at home. Some youth may feel helpless and guilty because they cannot take on adult roles as their family or the community responds to a trauma or disaster.

❖ **Children, 6–10 years old,** may fear going to school and stop spending time with friends. They may have trouble paying attention and do poorly in school overall. Some may become aggressive for no clear reason. Or they may act younger than their age by asking to be fed or dressed by their parent or caregiver.

❖ **Youth and Adolescents, 11–19 years old,** go through a lot of physical and emotional changes because of their developmental stage. So, it may be even harder for them to cope with trauma. Older teens may deny their reactions to themselves and their caregivers. They may respond with a routine “I’m ok” or even silence when they are upset. Or, they may complain about physical aches or pains because they cannot identify what is really bothering them emotionally. Some may start arguments at home and/or at school, resisting any structure or authority. They also may engage in risky behaviors such as using alcohol or drugs.

How Parents, Caregivers, and Teachers Can Support Children’s Recovery

The good news is that children and youth are usually quite resilient. Most of the time they get back to feeling ok soon after a trauma. With the right support from the adults around them, they can thrive and recover. The most important ways to help are to make sure children feel connected, cared about, and loved.

❖ Parents, teachers, and other caregivers can help children express their emotions through conversation, writing, drawing, and singing. Most children want to talk about a trauma, so let them. Accept their feelings and tell them it is ok to feel sad, upset, or stressed. Crying is often a way to relieve stress and grief. **Pay attention and be a good listener.**

❖ Ask your teen and youth you are caring for what they know about the event. What are they hearing in school or seeing on TV? Try to watch news coverage on TV or the Internet with them. And, limit access so they have time away from reminders about the trauma. Don’t let talking about the trauma take over the family or classroom discussion for long periods of time. **Allow them to ask questions.**

❖ Adults can help children and youth see the good that can come out of a trauma. Heroic actions, families and friends who help, and support from people in the community are examples. Children may better cope with a trauma or disaster by helping others. They can write caring letters to those who have been hurt or have lost their homes; they can send thank you notes to people who helped. **Encourage these kinds of activities.**

❖ If human violence or error caused an event, be careful not to blame a cultural, racial, or ethnic group, or persons with psychiatric disabilities. This may be a good opportunity to talk with children about discrimination and diversity. **Let children know that they are not to blame when bad things happen.**

❖ It’s ok for children and youth to see adults sad or crying, but try not to show intense emotions. Screaming and hitting or kicking furniture or walls can be scary for children. **Violence can further frighten children or lead to more trauma.**

❖ Adults can show children and youth how to take care of themselves. If you are in good physical and emotional health, you are more likely to be readily available to support the children you care about. **Model self-care, set routines, eat healthy meals, get enough sleep, exercise, and take deep breaths to handle stress.**
Tips for Talking With Children and Youth of Different Age Groups After a Disaster or Traumatic Event

**PRESCHOOL CHILDREN, 0–5 YEARS OLD**

Give these very young children a lot of cuddling and verbal support.

- Take a deep breath before holding or picking them up and focus on them, not the trauma.
- Get down to their eye level and speak in a calm, gentle voice using words they can understand.
- Tell them that you still care for them and will continue to take care of them so they feel safe.

**EARLY CHILDHOOD TO ADOLESCENCE, 6–19 YEARS OLD**

Nurture children and youth in this age group:

- Ask your child or the children in your care what worries them and what might help them cope.
- Offer comfort with gentle words, a hug when appropriate, or just being present with them.
- Spend more time with the children than usual, even for a short while. Returning to school activities and getting back to routines at home is important too.
- Excuse traumatized children from chores for a day or two. After that, make sure they have age-appropriate tasks and can participate in a way that makes them feel useful.
- Support children spending time with friends or having quiet time to write or create art.
- Encourage children to participate in recreational activities so they can move around and play with others.
- Address your own trauma in a healthy way. Avoid hitting, isolating, abandoning, or making fun of children.
- Let children know that you care about them—spend time doing something special; make sure to check on them in a nonintrusive way.

*A NOTE OF CAUTION!* Be careful not to pressure children to talk about a trauma or join in expressive activities. While most children will easily talk about what happened, some may become frightened. Some may even get traumatized again by talking about it, listening to others talk about it, or looking at drawings of the event. Allow children to remove themselves from these activities, and monitor them for signs of distress.
Helping Children Adjust to Placement

It is often difficult for children to adjust to a new home with new people and new rules. This section includes information about how to make a child's adjustment to the foster home a little easier.

If there has not been a pre-placement visit, foster parents will need to show the child around, including where the child will put his or her belongings, sleep, and be a part of family events. The child should also be given an opportunity to have time alone. Foster parents need to explain the household routine and let the child know the family rules; children need to know what the rules are in order to be able to follow them. Keep in mind the child's age and developmental abilities; this will also help foster parents ensure that their expectations for the child are realistic.

Another thing foster parents may do when a child arrives in their home is to talk to the child about his or her likes and dislikes and plan how to make introductions to new people. It may reassure the child to let him or her know that the reasons for his or her placement are private and that no one else needs to know unless the child wants to tell them. Foster parents can help the child come up with truthful and appropriate ways to answer the most common questions asked of children in foster care. For example, the child could tell others, “I am staying with this family for a while.”

Foster parents should not throw away toys or clothes that a child has brought along, even if they are in very poor condition, unless the items are unsafe or contaminated. These items are familiar and may help the child feel more comfortable in the new environment. Also, it is important for the child’s family to see their child with toys and clothes they have sent. Sometimes it is better not to wash the children’s items right away, as they are used to the smells of their family and home. If a foster parent must get rid of a child’s things, he or she should tell the child beforehand and try to help the child understand why his or her things need to be thrown away.

Foster children are allowed, according to licensing regulations, to have their own personal items, including clothing, written and recorded materials, and other items that are appropriate to the child’s age and understanding. While foster parents may not particularly like a child or youth’s choice in clothes or music, it is important that the child or youth have the opportunity to express him or herself in an appropriate manner.

Those items may be restricted under certain circumstances but should not be permanently taken away from the foster child without specific consent of the child’s caseworker. If foster parents have concerns about a child’s choice of music, clothing, or other recreational or personal items, they should discuss the situation with the child’s caseworker.

The first few weeks of placement will be a period of adjustment for everyone. The most important thing foster parents can offer during this time is a stable and consistent family life. Because children who come to foster care have a variety of backgrounds and experiences, every child’s adjustment will be different. Foster parents can help
a child through this time by being patient, flexible, and understanding. It is also important that foster parents pay close attention to the adjustment of other children in the home during the transition of a new child into the home.

Some foster parents have routines that they share with every child who comes to live with them. One foster parent said she takes every child to the grocery store—just the two of them—on the child's first day in the home to buy food that the child likes and to have some time with the child. It may be helpful to talk with other experienced foster parents to find out if there are ways they have learned to help children feel a little more comfortable in their new home.

**The Process of Adjustment and Grieving**

Children entering foster care typically react to separation from their families and express their feelings through behavior, not with words.

Children react to being placed in foster care in a variety of ways. Some create problems or act out while others withdraw from the people around them. Still other children react by being model children. Although these outward behaviors are very different, children feel many of the same things when they are placed in a foster home. They may feel confused about why they have been separated from their families, and upset about what happened to them. Some children feel angry, fearful, and powerless.

Many children eventually respond to patience and consistent parenting and adjust well to their placement. Children work through the process of grieving the separation from their birth family at their own paces. This process may seem to move forward but then stall; it may take days, weeks, or even years.

The following section describes the stages, or phases, of grief that children in foster care often go through, ways children may act in these stages, and some tips for helping children work through their feelings.

**Stages of Grief and Loss**

This section discusses the different ways and stages that children process grief and loss in their lives. All children in foster care experience significant loss and grief when they are separated from their families, and some of the children in foster care have experienced even more loss prior to being placed in foster care. This section has suggestions for helping children work through their struggles of grief and loss.

It is important to note that children in foster care often move from one stage of grief and then back again or even appear to experience two stages at one time. There may be a spiraling effect, and children's situations, duration in care, and emotional development will affect how they handle their grief. The stages are not simply a “checklist” that children go through. They may be experienced for a variety of reasons and for varying periods of time.

**Stage 1: Shock and Denial**

When a child is first placed, he or she may be very eager to please, cooperative, and generally enjoyable to be around. Experienced foster families recognize these behaviors as the “honeymoon” stage. Other children in the shock and denial stage may have difficulty eating or sleeping or may revert to the behaviors of a much younger child.

**Working Through the Shock and Denial Stage**

- Receive the child calmly. Settle down to a regular routine as quickly as possible.
• Explain and discuss the reasons for placement in a way that the child can understand and in a soothing and reassuring tone. Repeat this information as often as needed.
• Give factual information about the placement and the location of the child's parents and siblings.
• Respect the child's feelings about what has occurred. Let the child know that you are available if he or she wants to talk.
• Respect the child's family and the child's loyalty to them.
• Help and support interaction with the child's family to the greatest extent possible.
• Let the child have his or her favorite things and provide a place to keep them.
• Focus on good behavior.
• Avoid threats. Warnings of “I'll tell your worker” or “I will give my 30-day notice” leave painful impressions and make a child feel insecure. The child has already lost one or more homes and may feel threatened by losing another. In the long run, this undermines the child's sense of attachment and security and is extremely hurtful.
• Give the child responsibilities in line with his or her age and ability: not too many and not too few.

**Stage 2: Bargaining**

Children in this stage will do everything they can think of to go back home. Many believe that if they are good, they will go home. For example, a child may ask if he or she can go home if he or she does well in school and gets good grades. Or, he or she may decide to be “bad” so the foster family will want to send him or her home, to another foster home, or to another placement.

**Working Through the Bargaining Stage**

• Explain and discuss the reasons for placement again, but do not argue with a child who does not accept the reasons. Allow the child time and space to process what is occurring.
• Continue to help and support interaction with the child's family.
• Communicate the child's beliefs to his or her parents and other people involved with the case; when possible, develop a collaborative plan for helping the child work through this process.
• Continue to reinforce and practice tips given in the shock and denial stage.

**Stage 3: Anger**

When bargaining does not appear to work, anger often sets in. Most children have difficulty expressing their feelings, so they act them out. Some may come to a foster home in the anger stage. They may refuse to follow house rules, break things, attempt to run away, or try to hurt themselves. The anger stage is typically the most difficult for foster families because it is hard to cope with the behavior, understand what the child is feeling, and find ways to support the child through this process. Foster families may need to discuss how the agency can provide additional support through respite or other resources during this stage.

**Working Through the Anger Stage**

• Tell the child that it's OK and normal to be angry.
• Teach the child acceptable ways to express anger.
• Remind the child of the rules and be consistent with consequences if the rules are broken.
- Find a safe place for the child to be angry.
- Help children understand that they are not to blame for their placement in foster care.
- If the child tells exaggerated stories, don’t argue.
- Think of the challenging behaviors as messages of unmet needs: “I’m lonely,” “I’m bored,” “I have no power,” “I don’t feel safe,” “You don’t value me,” or “I don’t know how to tell you what I need.”
- Work with the child’s therapist, case worker, tribe (if applicable), parents, and other professionals to determine the best intervention strategies to help the child adjust to placement and his or her situation.
- Give the child time and space.
- Find supportive resources for both the child and your family.

**Stage 4: Despair**

Eventually, reality sets in. The child may have a variety of reactions as he or she starts to understand and accept what is happening. Foster parents should pay attention to changing behaviors of the child, including loss of appetite or sleep, not wanting to be around the foster family or any other people, dangerous or risky behaviors, or other new or unusual actions.

**Working Through the Despair Stage**

- Encourage the child to talk about his or her feelings but also respect the child’s choice to not talk or to talk about things at his or her own pace.
- Use dolls and pictures to help younger children act out feelings through play.
- Help older children express hurt and worry in their own ways.
- Get the child interested in creating a life book (discussed later in this chapter).
- Show respect for the child’s feelings and provide reassurance through supportive gestures—for example, hugs or extra time and attention.
- Work with the child’s caseworker, therapist, parents, and other professionals to develop the best plan for support. Regularly update everyone about the child’s behaviors.

**Stage 5: Acceptance or Managing Loss**

At this stage, children may begin to develop new friendships and accept the foster parents’ role in their lives. They may be able to move into new situations more easily and experience less frustration.

**Working Through the Acceptance Stage**

- Provide the child with opportunities to develop new relationships.
- Continue to assist with reunification efforts or, if reunification is not the plan, support the permanence goal for the child.
- Allow the child to continue to remember and talk about his or her family.
- Continue to work on the life book with the child.

(Information in this section is adapted from Illinois and Iowa Foster Parent Handbooks)

**Reminder:** Foster children often move from one stage and then back again or even appear to display two stages at one time.
Helping Children Adjust to Placement

A foster child’s reaction to his or her experience in foster care will vary from child to child. Changes in permanency plans or life events may impact a child’s grieving process.

**Other Ways to Help with the Adjustment Process**

**Understand Normal Behavioral Development**

Even experienced parents may forget the normal developmental stages and patterns of child behavior. Children in foster care may have behavioral or developmental challenges unlike other children their age. It can be helpful to recognize that many challenging behaviors are “normal” and that not all difficult behaviors are related to placement. Also, keep in mind that many foster children may function at a level more typical of a younger or older child. For example, a 7-year-old may have the social skills of a 3-year-old. Foster parents will have to work with the child on a 3-year-old level until the child’s social skills increase.

**Understand the Child’s History**

Foster parents should refer to the Information for Foster Parents form provided by the caseworker and ask questions about the information provided. Understanding the child’s experiences with his or her parents and other foster families may provide insight into the child’s behaviors.

**Provide a Supportive Home Environment**

A safe, nurturing, and predictable home can help a child work through feelings of fear, anxiety, loss, grief, and other emotions. Being predictable and consistent can also help a child who may have difficulty transitioning from one thing or one place to the next, and it can help foster parents develop an understanding of the cause and effect of his or her behaviors.

**Try to Understand Problem Behavior**

Foster parents should try not to take a child’s misbehavior personally. There are many reasons children behave the way they do. It may be that, in the past, acting out was the only way to get the attention of a parent or caregiver. It may be that the child thinks certain behaviors will get a response from their caregiver. When a caregiver does not take a child’s behaviors personally and remains calm, it is easier to think more objectively about how to respond.

**Identify What Triggers the Problem Behavior**

When a child displays problematic behavior, foster parents should think about what happened before the behavior took place or the “trigger” for the child’s behavior. Sometimes the child’s behavior is an immediate response to the trigger. Other times the trigger may have occurred the day or week before the behavior. It can be hard to discover what events trigger a child’s behavior, but foster parents should look for patterns. Working closely with the child’s case manager, therapist, school staff, parents, and other professionals may help foster parents and the child’s team to understand what triggers a child’s behaviors and how to address those behaviors.

**Bring Triggers to the Child’s Attention**

Not every trigger is observable. Once a child has calmed down, it is good to ask the child what he or she did that make you feel?” may allow the child to connect feelings to behavior and give foster parents information about what triggered a behavior.

Foster parents need to address the situation with the child when the child is calm so that both the foster parent and the child can work together to find a solution. For example, a foster parent might say: “I’ve noticed that when
I say that it’s your bedtime, you usually seem to have a hard time getting your pajamas on. Is there anything we can do together to help you when it is time for bed?”

By bringing these observations to children’s attention, foster parents will help children understand the cause and effect of their behavior and give them ideas about how to react differently.

**Try Not to Label a Child’s Behavior**

It is easy to slip into a habit of using labels. For example, a foster parent may observe a child acting “depressed” and communicate that to the therapist or case worker. “Depressed” has different meanings to different people. Giving descriptions based on the behaviors observed is much more helpful to everyone. For example: “John stays in his room for most of the day and doesn’t eat very much. He doesn’t laugh or smile at all and doesn’t want to play with other kids” is more helpful than saying “John is depressed.”

**Document Behaviors to Help You Understand and Respond**

Writing down observations and being specific can help identify what triggers the problem. Foster parents should write down what led up to the child’s behavior, what behaviors or actions the child engaged in, and how the situation was addressed.

A record of the behaviors also helps measure the child’s progress. It allows the child’s caseworker, therapist, parents, and the child to see how positive change has occurred over time, no matter how small the change may be.

The chart on the next page is an example of how to document a child’s behaviors to try to determine what triggered the event and how to address those triggers and the child’s response.
## A Sample Chart for Documenting a Child’s Behaviors

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>What Happened Before</th>
<th>What Happened After</th>
<th>Duration and Intensity of Incident</th>
<th>Who was present</th>
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(Information in this section adapted from Illinois Foster Family Handbook)
When Problem Behaviors May Be Signs of Emotional Disturbance

Sometimes it is difficult to separate behaviors and concerns associated with foster care placement from those associated with a more serious emotional disturbance or mental health concern. Signs of emotional disturbance typically are behaviors and reactions that last too long, are exaggerated, or are consistently inappropriate for the situation or the child’s stage of development.

Possible Signs of Emotional Disturbance

- It is logical that a child would get mad when someone calls him or her a name, but plotting to seriously hurt the person simply due to an insult is cause for concern.
- Two-year-olds typically throw themselves on the floor during temper tantrums; teenagers typically do not.
- It is normal to panic and flee from a fire, but not from a working elevator.
- Crying in reaction to separation and loss can be expected. Crying that goes on every day in school for 6 months is concerning.
- It is not unusual for a child to talk to himself or herself on occasion, but it is concerning when a child reports hearing voices or takes action based on what the voices are saying.

(Adapted from the State of Illinois Foster Family Handbook)

Note: Foster parents should always ask questions or seek help if a child’s behavior is unusual or something they have never seen before.

Grief, Loss and Substance Abuse

References and Resources, with abstracts. By Koren Paalman, Dustianne North, and Siobhan Stofka (Updated August 27, 2010)

Books and Book Chapters

  Description: Trends in substance abuse prevention have not adequately addressed the needs of girls and female adolescents. The precursors to substance use and abuse in adolescence are analyzed specifically from a gender-specific perspective. Female drug use as both a maladaptive and adaptive pattern of coping behavior is examined within a socio-cultural context. This new understanding points to the need for alternative models of prevention with particular attention to risk, resiliency and protective factors. The expanded role of the family therapist as “Family Life Cycle Specialist” within a prevention model will be highlighted.

  Description: This book features articles by leading educators and clinicians in the field of grief and bereavement. The chapters entitled “Voices” are the writings of children and adolescents. The book includes a comprehensive resource list of national organizations and a useful bibliography of age appropriate literature for children and adolescents.
  Description: Although the circumstances surrounding a death are difficult to handle at any age, adolescence brings with it challenges and struggles that until now have been largely overlooked. But in this unique and compassionate guide, renowned grief counselor Helen Fitzgerald turns her attention to the special needs of adolescents struggling with loss and gives them the tools they need to work through their pain and grief.

  Description: When a Friend Dies: A Book for Teens About Grieving & Healing... If you are grieving the death of a friend, do something for yourself. Take the time to read this book. It isn't very long —there aren't a lot of words—but you may find the help you need to cope with your sadness and begin to heal. Author Marilyn Gootman has seen her own children suffer from the death of a friend, and she knows what teenagers go through when another teen dies. Let her genuine understanding, gentle advice, and compassionate wisdom guide you through the next few days, weeks, or months. If you're a parent or teacher of a teen who has experienced a painful loss, this book is for you, too.

  Description: This is a self-help guide for teenagers who are struggling with bereavement and the emotional difficulties it presents. This book provides an overview of grief as a painful but normal process, and it offers insights from bereavement experts as well as practical suggestions for coping with loss, including accounts from teens. This book closes a gap in the available literature on grief and bereavement that has tended to focus on adults and younger children. It provides a warm, accessible resource that will reassure teen readers about the normality of grief, encourage their understanding of what happens during the grief process, and provides resources to help teens cope with their experiences of loss. The author accomplishes these goals by explaining the psychology of grief, by providing psychologists' comments and advice on dealing with bereavement, and by offering teens' insights into their own experiences.

  Description: The second edition of Helping Teens Work Through Grief provides a more complete and updated manual for facilitators of teen grief groups. It includes additional background information about developmental aspects of teens, the process of grief, aspects of trauma and its effects on teens.

  Description: This article describes perceived differences in social support between adolescent boys and girls who have experienced the death of a friend or relative in the last year. The article also evaluates the relative contribution of five sources of social support on adolescent girls’ and boys’ reports of their self-esteem, depressive symptoms, and disruptive school behavior. Boys and girls do report different levels of social support from different sources. However, the results suggest that the sources of support needed to maintain mental health and school functioning in the face of a loss is the same for boys and girls.
Curricula, Handouts, and Tools

Curriculum

- **Grief Education for Preteens, VK Howard**
  
  Death is a difficult topic to discuss for most everyone regardless of age. It is especially difficult to discuss with young children or adolescents. Most of us have a difficult time dealing with the death of someone very close to us. Children may have an especially hard time dealing with the loss of a parent, sibling, or grandparent. In these perilous times in which we live, a child may even have to deal with the sudden and sometimes tragic death of a playmate or classmate. When children or adolescents lose someone who has been a part of their lives and activities, the normal and predictable response to loss is grief. The concern is not whether the youth will grieve, but whether his or her grief will be healthy and functional or pathological and dysfunctional (Parkes, 1990). This curriculum unit was written to help children ages 9 to 12 understand and cope with the loss of a loved one.

Toolkit

- **Hospice’s “Grief at School”**
  
  Excerpt: “Welcome to Grief at School.” In this corner of our website, you will find materials to help address children’s grief, including articles, tools, resources such as guidelines for running a grief support group for teens, fact sheets and more. We invite you to click on a menu item at left to begin browsing through our materials.

Guidebook

- **Helping Your Teen Cope with Traumatic Stress and Substance Abuse**
  
  Description: Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

Handbook

- **Caring for Children in Foster Care, Chapter 3**
  
  Excerpt from page 16: This section discusses the different ways and stages that children process grief and loss in their lives. All children in foster care experience significant loss and grief when they are separated from their families, and some of the children in foster care have experienced even more loss prior to being placed in foster care. This section has suggestions for helping children work through their struggles of grief and loss.

Guidebook

- **Teens and Grief: A Guide for Parents**
  
  Excerpt: Adolescence is one of the most difficult and chaotic stages in life, and is widely recognized as a particularly difficult time for dealing with the death of a parent or other loved one. According to renowned developmental psychiatrist Erik Erikson, the task of adolescence is to begin to find one’s unique identity, and if this task is not accomplished, it can result in what Erikson calls “role confusion” or the “identity crisis.”
Other important developmental tasks in the teen years are finding a sense of belonging and peer acceptance, withdrawing emotionally from parents, and achieving emotional independence.

**PowerPoint Presentations**

Conference Powerpoint/Lecture

Cites statistics from: Ribben-mccarthy, J. 2007- NCB highlight #232

Team Training Presentation

**Program Evaluation**


Executive Summary: This report presents findings from the evaluation of the Los Angeles Unified School District’s IMPACT program during the 2005-06 school year. IMPACT is the District’s prevention and early intervention program for middle and high school students who exhibit behaviors related to possible substance use, violence, or other crises and are consequently not performing well in school. The program is designed to provide students with the skills and support necessary to make positive life choices. The goals of the IMPACT program are to improve student achievement and attendance, provide students with coping skills, and develop resiliency. This is accomplished via school-wide awareness activities and education, as well as curriculum-based instruction for students who need additional support. This report provides findings regarding the characteristics, uniformity, school climate, quality of instruction, curriculum fidelity, and effectiveness of the program.

**Scholarly Articles**

- **Adolescent Grief: “It Never Really Hit Me…Until It Actually Happened.”**

  In the United States, more than 2 million children and adolescents (3.4%) younger than 18 years have experienced the death of a parent. When death can be anticipated, as with a terminal illness, and even when the death is sudden, as in the September 11, 2001, attacks on the World Trade Center and Pentagon, physicians and other health care professionals have an opportunity to ameliorate the impact of the loss. Developmental factors shape adolescents’ reactions and responses to the death of a parent. Recent research in childhood and adolescent bereavement shows how health professionals can support the adolescent’s coping strategies and prepare the family to facilitate an adolescent’s mastery of adaptive tasks posed by the terminal phase of the parent’s illness, the death, and its aftermath. Robert, a bereaved 14-year-old, illustrates some of these adaptive challenges.

- **Tipping the Scales: A Substantive Theory on the Value of group Music Therapy for Supporting Grieving**

  Abstract: The value of group music therapy for bereaved young people has been described in a number of studies using both qualitative and quantitative approaches. This article details a qualitative investigation of
a school-based program in Australia and presents the results of a grounded theory analysis of focus-group interviews conducted with adolescents. A brief empirical theory is presented in combination with a set of relational statements, which conceptualize the phenomenon. This theory states that bereaved teenagers feel better if they have opportunities for fun and creative expression of their grief alongside their peers. This statement is compared to findings in the literature and addresses clinically relevant issues of: how music therapy engages young people; what active music making means in this context; what constitutes the action of letting your feelings out; how the group influences the outcomes of its members; and how important a specific bereavement group is compared to a group with a broader loss and grief focus.

**Article from the Field**

- **Kelly, J.** (July 23, 2009). *Parental Death Has Major Impact on Depression Risk in Youth*. Published in Medscape Medical News.
  
  Excerpt: A parent’s death more than quadruples the risk for depression for children, adolescents, and young adults, new research shows. Further, depression affects 10% of bereaved youth compared with 2% of nonbereaved youth, and those who continue to be depressed at nine months are likely to continue to suffer from depression during the second year after the loss.

  Investigators at the University of Pittsburgh’s Western Psychiatric Institute and Clinic say these data point to an important “window of opportunity” in the period soon after a parent’s death when appropriate intervention might be most effective at preventing long-term depression in young people who have suffered the loss of a parent.

  
  Excerpt: Resources and information on grief and loss issues and their relation to various aspects of child welfare, including child abuse and neglect, out-of-home care, and adoption.

  
  Excerpt: When children—like those in or adopted from foster care—experience multiple losses, the psychological damage may extend well into adulthood. Ambiguous loss can erode trust and adults who cannot trust typically struggle with relationships—sometimes avoiding closeness to forestall loss, sometimes clinging to a bad relationship due to deep-seated abandonment issues. The sooner children can address issues raised by ambiguous loss, the more likely it is they will learn better ways to deal with the fallout.

**Websites**

- **Coping with Loss and Grief Through Online Support Groups**
  
  The death of a loved one is a natural and inevitable life experience. Those who must cope with the loss experience various grief reactions. Typically, people discuss their grief reaction with someone they know or do not discuss it at all. Current technology now enables people to cope with grief through participation in online support.

- **Maine Youth Suicide Prevention Program: How to Support Grieving Youth**
  
  Excerpt: Grieving is a natural reaction to a death or other significant loss. Grief over the loss of a loved one is a process that is incorporated into the lives of survivors, forever changing their lives. The grief reaction to suicide typically includes expression of shock, disbelief, denial, anger, guilt and shame. The suicide of a friend
or classmate can cause a special form of grief for children and teens. Children and teens will need your help—provide them with information, understanding and comfort. Follow normal household routines as much as is possible. This can provide a sense of comfort and safety to a grieving child. Children express their reactions to a crisis in different ways. Children and teens may show anger, get upset easily, want to talk, or withdraw to make sense of it themselves. Younger children may be more open about their feelings than older children and teens.

• **Pets, Loss and Teen Grief: The Bill of Rights of Grieving Teens**

  Excerpt:
  
  A grieving teen has the right....
  ...to know the truth about the death, the deceased, and the circumstances.
  ...to have questions answered honestly.
  ...to be heard with dignity and respect.
  ...to be silent and not tell you her/his grief emotions and thoughts.
  ...to not agree with your perceptions and conclusions.
  ...to see the person who died and the place of the death.
  ...to grieve any way she/he wants without hurting self or others.
  ...to feel all the feelings and to think all the thoughts of his/her own unique grief.
  ...to not have to follow the “Stages of Grief” as outlined in a high school health book.
  ...to grieve in one's own unique, individual way without censorship.
  ...to be angry at death, at the person who died, at God, at self, and at others.
  ...to have his/her own theological and philosophical beliefs about life and death.
  ...to be involved in the decisions about the rituals related to the death.
  ...to not be taken advantage of in this vulnerable mourning condition and circumstances.
  ...to have guilt about how he/she could have intervened to stop the death.

  Scholastic (2012). **Children & Grief: Guidance & Support Resources.**
Part III: Being a Strong Link in the Chain: Furthering Your Local Continuum of Care

Introduction

Collaboration and alliance with complementary services/resources are necessary if we are focusing on training and not treatment when delivering this curriculum. It will be necessary to respond appropriately to health and mental health needs among our TAFY population.

Increasing emphasis is placed today, throughout public and private service systems, upon the importance of a quality continuum of care when serving high needs populations. An effective continuum of care both (a) addresses the comprehensive and multiple needs of those served, (b) is easily accessed, geographically, economically, at any age, and no matter what one’s cultural background, and (c) provides assistance at every point along the spectrum from public health and prevention to intervention. CalMHSA explicitly supports efforts to build such continuums.

How can a program, such as the YESS Programs at various California community college campuses, act as an important link in the chain of local services? How can we leverage local resources to best serve our youth, and how can we help strengthen the local continuum for the benefit of all?

Several of the important resources provided in Part II emphasize how important it is, if one is to work effectively with TAFY, to be able to work well within and across the silos and systems that serve these youth. As such, some of those sources offer important tips and tools for collaboration. Here in Part III, we add more concepts and information oriented toward a positive continuum of care: how programs may fill a key niche among other services, develop strong relationships with other providers and provide coordinated care, make effective referrals, build high-functioning partnerships, and work with others to strengthen local service systems.

Sources included are organized as follows:

A. CalMHSA statement. CalMHSA has outlined a vision and strategy for developing a quality continuum of care. Program sites should strive to meet this vision whenever possible.

B. Building a Quality Referral Network and Making Excellent Referrals, by Dustianne North. A handout with tips and strategies for creating and utilizing a quality local referral network

C. Going Further: Developing and Sustaining High-Functioning Service Partnerships. This section contains several components; all aimed at helping you build effective partnerships:

D. A chart depicting the Stages of Collaboration, from lower levels to full-grown service partnerships.

E. A Partnership Building and Assessment Exercise, which you can use at any time, to evaluate your current partnerships. The worksheets can be copied while still blank, so that you can repeat the process periodically throughout the course of the partnerships. This makes it possible to track stages, strengths and weaknesses, and improvements.
F. The overview page of Navigating Information Sharing, a toolkit produced for the Safe Schools/Healthy Students Initiative by the National Center for Mental Health Promotion and Youth Violence Prevention, (January, 2013; http://sshs.promoteprevent.org/nis), to help you understand when and how to share information about youth across organizations and systems.

CalMHSA Statement

The California Mental Health Services Authority (Cal MHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded through the voter-approved Mental Health Services Act (Prop 63). Prop 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California’s diverse communities.
Below are some tips and strategies for identifying the needs of the youth you serve, finding available resources in your area, designing action plans for various needs, building a referral network and maintaining it, and for making effective referrals when issues arise.

**Generating and Connecting to Referral Networks**

- Actively seek out and research agencies in your area that serve the same population you do.
- Join community coalitions and other organizations which are designed to promote collaboration among agencies.
- Invite potential and existing partners to fundraising and other events or programs. Continually create new alliances of agencies serving the same or related populations.
- Always look for potential new referral sources and agencies with whom to collaborate.

**Assessing Needs**

- Work collaboratively with youth and also community partners to identify problems youth are facing and areas of need.
- Identify programs and organizations that address needs, as well as holes in local service systems.
- Pursue relationships with promising partners and allies, continuing the local debate and furthering collective understandings about the needs and interests of foster care youth.
- Always involve youth advisory groups and youth planners in designing and implementing solutions.

**Developing Action Plans**

Select an area of RISK your program faces (may be related to the activities in which you engage, or the populations of youth served, for example).

- **Policy Points:** List points to be included in a policy to address the risk area.
- **Consults:** List other parties that will need to be consulted in finalizing your policy (e.g., legal counsel, board of directors, program participants, oversight agencies, clinical experts)
- **Agency Networks:** List some types of agencies that the program should contact to form referral relationships or partnerships in order to address the risk area identified.

**Note:** Full page worksheet using this approach to action planning is included on the following page.

**Selecting Partners**

- Visit the agencies you are considering working with. Collect their literature and get to know their staff.
- Look for ways to coordinate services (avoid duplication, make smooth referrals, share information as appropriate, make multiple services seamless)
Establishing Roles

- Establish an open line of communication with other agencies; share with them about the needs of your participants as well as the philosophy of your agency, and ask about theirs.
- When entering into a partnership and/or referral relationship, create written agreements (Memorandums of Understandings or similar documents) to ensure that each agency understands what is expected of them.
- Invite representatives from agencies to offer training to your staff or participants regarding the services they provide, and conversely offer to train their personnel about your program.

Once Collaboration is Established

- Ask agencies to keep you informed about the services they offer, including changes over time.
- Visit agencies periodically so you can see the environment for yourself.
- Support partner agency fundraising and PR efforts, and ask for reciprocal support from them.
- Continue to look for new ways to collaborate and/or complement each other!

Making Effective Referrals

- Sharpen your listening skills and be thorough: there is nothing worse than a rushed solution that fails to help someone in need. Take your time with youth who are having problems, and make sure to get all of the pertinent information before deciding what to recommend or where to refer.
- Ask young people whether they would rather follow up on the referral themselves, or whether they would like further assistance. Be available to assist but allow them to do as much as they can on their own.
- Be thoughtful about when to involve foster or biological families, and when to provide referrals confidentially.
- Always follow up: contact both the youth / family and the referral agency to make sure contact was made. Ask: How did it go? How can I help?
- Know the legalities and ethics of sharing information among providers and across systems, and act thoughtfully.
- Be prepared to re-refer if an attempt is unsuccessful. It may take a few tries before another provider fully takes responsibility for someone’s case. Serve as a temporary case manager while other services solidify, but then be ready to abdicate that role as soon as safely possible.
- Keep an open line of communication with referral sources and partnering agencies.
Developing an Action Plan

Select an area of RISK your program faces (may be related to the activities in which you engage, or the populations of youth served, for examples)

RISK AREA: ________________________________

1. Policy Points: List points to be included in a policy to address the risk area.

2. Consults: List other parties that will need to be consulted in finalizing your policy (e.g., legal counsel, board of directors, program participants, oversight agencies, clinical experts)

3. Agency networks: List some types of agencies that the program should contact to form referral relationships or partnerships in order to address the risk area identified.
Going Further: Developing and Sustaining High-Functioning Service Partnerships

Stages of Collaboration

1. **Competition**
   - **Initiating**
     - Staff of partner programs, see new/collaborative projects as another pressure to their day
   - **Nurturing**
     - Partners observe or assist each other in respective service provision

2. **Networking/Cooperation**
   - Staff trained in new collaborative program, partners jointly implement program, and continuous dialogue and support between staff of different partners

3. **Coalition**
   - Alliance built between partners, staff begins to see collaborative program as integral part of services

4. **Cooperation/Coordination**
   - Collaborative services considered part of official mission or strategy plan, staff informed, aware, and supportive of services, partners work together to secure continuing funds for collaborative services
Partnership Building and Assessment Exercise

Dustianne North
Jerry Sherk

Who are Your Partners?

Using the worksheet on the next page, please draw a diagram of your partnership

- Begin with your agency near the center of the drawing
- Now draw in the school you serve and any other central and formal partners
- With whom else do you collaborate in some formal or informal capacity? Draw these out toward the periphery of the diagram
- What external stakeholders have relations with your program?
- What about youth and their families or caregivers?

Note: Remember to make copies of the worksheets BEFORE you fill them in, so you can do this exercise again sometime in the future.
Partnership Map

External community stakeholders

Collaborators and supporters

Central and formal partners

Your agency
Status of Your Partnerships:

Using the worksheets on the next 2 pages, now evaluate:

- The stage of evolution,

- Partnership strengths,

- And areas for growth

For EACH of your current partnerships

**Note:** Remember to make copies of the worksheets BEFORE you fill them in, so you can do this exercise again sometime in the future.
Partnership Evaluation

Your Program

Partner 1:
Stage of Partnership:

Strengths:

Needs Improving:

Partner 2:
Stage of Partnership:

Strengths:

Needs Improving:

Partner 3:
Stage of Partnership:

Strengths:

Needs Improving:

Partner 3:
Stage of Partnership:

Strengths:

Needs Improving:
Strengthening Your Partnerships

Based on the mapping exercise, brainstorm things you might do to strengthen your partnerships.

1. 

2. 

3. 

4. 

5. 

6. 

7.
From the possibilities on the previous page, write “3 Big Things” you will do to strengthen your partnerships.

For each, include WHAT you will do, the FIRST step you will take, and the DATE you will take that first step!

<table>
<thead>
<tr>
<th>BIG THING</th>
<th>FIRST STEP</th>
<th>DATE TO BEGIN</th>
</tr>
</thead>
<tbody>
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<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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</table>
Navigating Information Sharing

“This toolkit was created to help local school and community partners address the complexities of information sharing about young people in multiple systems. Many students today find themselves involved with mental health, law enforcement, juvenile justice, child welfare, and other providers trying to assist them and their families. NIS was created to help these young people and their families by supporting school and community providers to more effectively develop and navigate information sharing systems, policies, and procedures.”

Access Toolkit and Desktop Companion PDF at: http://sshs.promoteprevent.org/nis
Partnerships for Youth Prevention
References and Resources (January 24, 2013)
By Dustianne North, Siobhan Stofka and Andrea Barrera

Curricula, Handouts, Handbooks

Curriculum

Excerpt: As interest in community-based participatory research (CBPR) grows, there is a growing need and demand for educational resources that help build the knowledge and skills needed to develop and sustain effective CBPR partnerships. This evidence-based curriculum is intended as a tool for community-institutional partnerships that are using or planning to use a CBPR approach to improving health. It can be used by partnerships that are just forming as well as mature partnerships.

Handout
Learn and Serve America’s National Service-Learning Clearinghouse.
{This website contains a volume of sources related to service learning partnerships.}

Handout

Excerpt: This inventory will help you identify your school’s present practices for each of the six types of involvement that create a comprehensive program of school, family, and community partnerships. At this time, your school may conduct all, some, or none of the activities listed. Not every activity is appropriate for every school or grade level. You may write in other activities that you conduct for each type of involvement.

Webinar

Excerpt: This webinar will examine practical examples of how to build successful strategic partnerships that foster community engagement, including how to select the organizations, people, and services to be included; how to structure communications to ensure ongoing collaboration; and how to build connections with families and schools.
Handout


Toolkits


Arts Education Partnership, Learning Partnerships: Improving Learning in Schools with Arts Partners in the Community (PDF).

This internet-based toolkit covers topic such as:
Rationale for establishing partnerships.
Characteristics of good partnerships.
Resources (publications).
Case studies of state and local partnerships, including some involving afterschool programs.


This is a two-part toolkit for establishing and sustaining collaborative partnerships. The Community-Based Organization toolkit includes research on benefits of community based organization-run afterschool programs, promising practices and sample forms and checklists. The Local Education Agency/State Education Agency Toolkit covers similar areas, with a special focus on how LEAs and SEAs can recruit community-based organizations to be afterschool providers.


Establishing relationships with a wide range of community organizations in neighborhoods where referral rates to the child welfare system are high and collaborating to create an environment that supports families involved in the child welfare system.

Institute for Educational Leadership, Building Effective Community Partnerships. (PDF).

W.K. Kellogg Foundation, Community Partnership Toolkit.

This is a Tool Kit for building and maintaining partnerships to strengthen communities. It starts with people getting involved and using better information. Each of the tools drives home a critical message learned about partnerships. Success takes time and commitment—picking the right tools, sharpening them with experience and eventually learning how to master the tools.

**Organization Websites**
(Some have publications embedded)

**Center for Collaborative Solutions**

CCS is passionately committed to helping afterschool programs achieve their goals by creating powerful visions, developing capable leaders and high performing teams, constructing authentic partnerships and implementing approaches and solutions that build the capacity of programs to help children and young people succeed in all areas of their lives.

**Interagency Working Group on Youth Programs (IWGYP), Building and Sustaining Partnerships**

No one person or organization can provide for all the needs of a community’s young people. Supporting them fully requires collaboration among schools, youth-serving organizations, faith-based institutions, businesses, and government agencies.

Strong partnerships with relevant organizations and agencies in your community are critical because working together will help you deliver consistent messages and reach youth through a variety of channels. It also presents valuable opportunities to share resources, develop joint goals and objectives, and learn from each other.

**SEDL, Family and Community**. Many resources available, including the following:
- Building Home, School, Community Partnerships: The Planning Phase
- Partnership Research
- A Resource Guide for Planning and Operating Afterschool Programs: Programming & Management
- Program for Refining Educational Partnerships
- Annotation from the Connection Collection

**Ohio Youth-Led Prevention Network: Drug-Free Action Alliance**

The Ohio Youth-Led Prevention Network (OYLPN) consists of youth-led substance abuse prevention providers and youth across the state who are committed to the cornerstones of youth-led prevention, peer prevention, positive youth development and community service. The OYLPN fosters partnerships and collaborations among these youth-led prevention programs throughout Ohio.

**The Global Youth Network**

This page contains tools to help you plan, implement, monitor and evaluate prevention activities that are effective and that involve youth at each stage of the project.

**United Nations Educational, Scientific and Cultural Organization**

Partnerships for Youth Prevention
FRESH: Focusing Resources on Effective School Health

FRESH is an inter-agency initiative for Focusing Resources on Effective School Health. It proposes a framework for designing and implementing effective school health programs—a ‘boiling down’ to basics of the partner agencies combined with experience in the area of school health.

Drug and Alcohol Abuse Prevention Partnership Resources

Redwood City 2020 (RWC 2020) brings together key public and private organizations in our community in ongoing efforts to ensure the health and success of all children, youth and families served by the Redwood City School District. Together, RWC 2020 partners identify barriers and then implement collaborative approaches that will open the doors to success.

Articles from the Field

Vogel, Carl (2006). **Building a Strong Community Partnership**

Learn and Serve America’s National Service-Learning Clearinghouse, (2003). **School/Community Partnerships**

Selected Resources

Research Reports

Billett, Stephen; Clemans, Allie; Seddon, Terri. {2005). **Forming, developing and sustaining social partnerships**

Principles required to sustain social partnerships

- Maintaining shared purposes and goals involves the partners actively reflecting upon, reviewing and revising goals, identifying achievements, and renewing commitment.
- Maintaining relations with partners involves endorsing and consolidating existing relationships, recognizing partners’ contributions, and facilitating new and strategic relationships.
- Maintaining capacity for partnership work involves securing and maintaining partners who engage effectively with both community and external sponsors, and managing the infrastructure required to support staff and partners.
- Maintaining governance and leadership involves developing and supporting close relations and communication between partners, and effective leadership.
- Maintaining trust and trustworthiness involves focusing on partners’ needs and expectations, and ensuring that differing needs are recognized and addressed.

Bray, Mark; Comparative Education Research Centre, The University of Hong Kong, (2000). **Community partnerships in education: Dimensions, variations and implications**

Scholarly Articles

Partnerships for Youth Prevention:

Abstract: Although scientific knowledge of youth development has grown dramatically over the last 2 decades, theoretical frameworks for translating research into more supportive environments for youth have lagged. This article proposes a risk/protective theoretical perspective grounded in ecological and developmental contextualist theories. Principles extrapolated from the theory are illustrated with the success of Wisconsin Youth Futures, a campus/community partnership that has built 18 community coalitions to promote positive youth development and prevent problem behaviors.


Abstract This article documents the processes behind a community-based prevention initiative. It describes how city leaders used a crisis created by increasing demand for services and decreasing resources to shift to an investment in prevention. Support for better parenting was identified as the strategic investment most likely to ensure school success and later workforce participation, and a new partnership and organizational structure was developed to implement the initiative. Key components of the organization are described and critical elements of the program model and evaluation results are presented. Specific attention is paid to the community’s plan for taking the initiative to scale through system conversion—a comprehensive reorganization of city services. To provide useful information for others interested in developing sustainable community-based prevention initiatives, lessons learned that transcend this specific model are described.

Fagan, A., Hawkins, David J. **Engaging communities to prevent underage drinking**. Alcohol Research and Health. 34:2.

Abstract: Community-based efforts offer broad potential for achieving population-level reductions in alcohol misuse among youth and young adults. A common feature of successful community strategies is reliance on local coalitions to select and fully implement preventive interventions that have been shown to be effective in changing factors that influence risk of youth engaging in alcohol use, including both proximal influences and structural and/or environmental factors related to alcohol use. Inclusion of a universal, school-based prevention curriculum in the larger community-based effort is associated with the reduction of alcohol use by youth younger than 18 years of age and can help reach large numbers of youth with effective alcohol misuse prevention.


Abstract: The successful development and implementation of prevention curricula requires seeking strategies that combine the strengths of researchers and community members. Because young people are considered to be the experts in their own lives, it is important to determine effective ways to engage them in substance abuse assessment and prevention initiatives. The community-based participatory action research methodology of photovoice is one
Partnerships for Youth Prevention

Way to engage youth in assessment of this public health issue. “Our Community in Focus” was a project that used the photovoice methodology to engage high school youth in a community-based assessment of adolescent substance use and abuse. Through the photovoice method, youth were able to reflect their community’s strengths and concerns with regards to adolescent substance abuse, as they took photographs to answer the question “What contributes to adolescents’ decisions to use or not to use alcohol and other drugs?” The youth and the community were highly receptive to the project and its methodology, and photographs taken by photovoice participants presented a compelling argument for action.

School-Community-Family Partnerships:


Abstract This study explores the preparation of future teachers and administrators to conduct school, family, and community partnerships. Based on a sample of 161 schools, colleges, and departments of education (SCDE) in the United States, the survey examined not only the courses and content presently offered to prospective educators, but also leaders’ perspectives and projections for the future. The results extend previous studies by identifying structural, organizational, and attitudinal factors associated with differences in SCDEs’ coverage of partnership topics, preparedness of graduates to conduct family and community involvement activities, and prospects for change. Specifically, SCDE leaders’ beliefs that partnership skills were important, required by accreditation organizations, and preferred by school districts hiring new teachers and administrators were significantly associated with more content covered on partnerships, better preparation of graduates, and future plans to require courses on partnerships for undergraduate and graduate students. SCDE leaders pointed to factors that may limit program change, including faculty attitudes, university procedures, and state restrictions on additions to graduation requirements. The data suggest that SCDE leaders must be active change agents and team builders to guide their institutions to prepare future educators to conduct effective family and community involvement programs and practices.


Epstein, Joyce L. School/family/community Partnerships: Caring for the Children We Share. Phi Delta Kappan, Vol. 76, 1995. Available at:

Excerpt: “...There are many reasons for developing school, family, and community partnerships. They can improve school programs and school climate, provide family services and support, increase parents’ skills and leadership, connect families with others in the school and in the community, and help teachers with their work. However, the main reason to create such partnerships is to help all youngsters succeed in school and in later life. When parents, teachers, students, and others view one another as partners in education, a caring community forms around students and begins its work....”

Abstract The Kentucky Education Reform Act of 1990 established a system of statewide coordination of child-serving agencies through a school-linked collaborative arrangement. Kentucky family resource centers (FRCs) are designed to assist families and improve.


Abstract: The increased interest in parent involvement as a strategy for school reform stems from two bodies of parent involvement research. One set of studies examined family learning environments; the other investigated the impact on student learning of school-initiated parent involvement programs. This article reviews these two bodies of research, which have influenced current discussions about home-school partnerships, shows the relationship between practices of successful home-learning environments and effective schools research, and uses this relationship to propose a typology of home-school-community partnership roles and activities. When the research on effective family practices is combined with effective schools research and placed within a typology of partnership roles, schools have a framework for examining current parent involvement practices and exploring strategies that will enhance student learning both at home and at school.


Abstract: Title I’s requirements for parent and community involvement in both schoolwide programs and targeted assistance schools, along with requirements for funding such involvement, challenge Title I schools to think seriously about and to plan for involvement that will help make a difference in children’s learning. In this article, we (a) review the requirements and how they may be interpreted (especially the requirement for school-parent contracts); (b) briefly summarize recent research on the effects of school-family partnerships on students, teachers, and parents; and (c) discuss two major research-based comprehensive programs for building school-family-community partnerships that provide a foundation upon which Title I schools could develop, in conjunction with parents, their own comprehensive and effective programs.


Abstract: In the face of today’s challenging social and family issues, many new efforts are underway to help children and families. One solution that many communities have adopted is the establishment of a collaborative partnership that involves all the relevant partners—home, school, and community—in the planning and monitoring of services for children. Unfortunately, achieving a strong partnership with meaningful participation can often be difficult and time-consuming. This article focuses on a set of training materials that has been developed to assist community partnerships in their efforts. These materials highlight eight elements of continuity and successful partnerships: (1) families as partners, (2) shared leadership, (3) comprehensive/responsive services, (4) culture and home language, (5) communication, (6) knowledge and skill development, (7) appropriate care and education, and (8) evaluation of partnership success. Results from a field study that included more than 200 reviewers and 8 pilot sites are summarized. Results indicate that a majority of reviewers found the training materials easy to understand, relevant
to their work, and up-to-date. In addition, data gathered from the pilot sites indicate that the partnerships found the materials practical and useful for addressing a variety of issues, including time constraints, communication gaps, differences in professional training, and funding limitations.


**Partnership Sustainability**

**For health:**

Abstract: Sustainability is a key requirement for partnership success and a major challenge for such organizations. Despite the critical importance of sustainability to the success of community health partnerships and the many threats to sustainability, there is little evidence that would provide partnerships with clear guidance on long-term viability. This article attempts to (1) develop a conceptual model of sustainability in community health partnerships and (2) identify potential determinants of sustainability using comparative qualitative data from four partnerships from the Community Care Network (CCN) Demonstration Program. Based on a grounded theory examination of qualitative data from the CCN evaluation, the authors hypothesize that there are five primary attributes/activities of partnerships leading to consequential value and eventually to sustainability of collaborative capacity. They include outcomes-based advocacy, vision-focus balance, systems orientation, infrastructure development, and community linkages. The context in which the partnership operates provides the conditions for determining the appropriateness and relative impact of each of the factors related to creating consequential value in the partnership.

**For child welfare:**
Bremond, Deborrah; Milder, Teddy; Burger, Janis, (2006). **Sustaining Community Partnerships on Behalf of Young Children and Families.** Published by Zero to Three, v27 n2 p5-10 Nov 2006.

Abstract: Another Road to Safety (ARS) is a prevention and early intervention program of family support services for children who are at high risk for abuse and neglect in Alameda County, California, funded by Proposition 10 of the Children and Families Act of 1998. ARS is a collaboration between First 5 Alameda County’s program Every Child Counts, the Alameda County Social Services Agency, and two community-based organizations. This article describes how these entities worked collaboratively to facilitate systems change in six areas: (1) strengthening prevention as part of a continuum of care; (2) improving service quality through reflective supervision; (3) improving provider capacity to deliver quality services; (4) increasing coordination and communication between agencies; (5) developing infrastructure to support high-quality coordinated services; and (6) leveraging resources for sustainability. The collaborating agencies discovered that sustaining a community-based model of prevention required a thorough understanding of the risk levels of families, the ability to fully engage families in the program, and the ability to triage families to the appropriate levels of care.
University-community partnerships and research utilization in partnership:


Abstract: Community partnerships or networks of collaborating public and nonprofit organizations are an important way of addressing a wide range of problems and needs that communities face. In the academic literature, network analysis has been used to analyze and understand the structure of the relationships that make up multiorganizational partnerships. But this tool is not well-known outside the small group of researchers who study networks, and it is seldom used as a method of assisting communities. This article briefly discusses network analysis and how community leaders can use the results generated by this tool to strengthen relationships among public and nonprofit organizations, thereby building the community’s capacity to address critical needs in areas such as health, human services, social problems, and economic development.


Abstract: This paper presents a model to guide capacity-building in state public education systems for delivery of evidence-based family and youth interventions-interventions that are designed to bolster youth competencies, learning, and positive development overall. Central to this effort is a linking capacity agents framework that builds upon longstanding state public education infrastructures, and a partnership model called PROSPER or PROmoting School-community-university Partnerships to Enhance Resilience. The paper presents an overview of the evolving partnership model and summarizes positive results of its implementation over a 12-year period in an ongoing project.


Abstract The complexity of many urban health problems often makes them ill-suited to traditional research approaches and interventions. The resultant frustration, together with community calls for genuine partnership in the research process, has highlighted the importance of an alternative paradigm. Community-based participatory research (CBPR) is presented as a promising collaborative approach that combines systematic inquiry, participation, and action to address urban health problems. Following a brief review of its basic tenets and historical roots, key ways in which CBPR adds value to urban health research are introduced and illustrated. Case study examples from diverse international settings are used to illustrate some of the difficult ethical challenges that may arise in the course of CBPR partnership approaches. The concepts of partnership synergy and cultural humility, together with protocols such as Green et al.’s guidelines for appraising CBPR projects, are highlighted as useful tools for urban health researchers seeking to apply this collaborative approach and to deal effectively with the difficult ethical challenges it can present.
Community Coalition-Building:


Abstract: This article presents the results of a qualitative analysis of 80 articles, chapters, and practitioners’ guides focused on collaboration and coalition functioning. The purpose of this review was to develop an integrative framework that captures the core competencies and processes needed within collaborative bodies to facilitate their success. The resulting framework for building collaborative capacity is presented. Four critical levels of collaborative capacity—member capacity, relational capacity, organizational capacity, and programmatic capacity—are described and strategies for building each type are provided. The implications of this model for practitioners and scholars are discussed.


Abstract: Community coalitions, as they are currently applied, are unique organizations whose ability to promote community change is different from other types of community organizations. This article explores those differences and elaborates how community coalitions can use those differences to transform conflict into greater capacity, equity, and justice. Concerns are also raised in this article about how community coalitions can intentionally and unintentionally protect the status quo and contain the empowerment of grassroots leadership and those of marginalized groups. There is a need for more theory, research, and discourse on how community coalitions can transform conflict into social change and how they can increase the power of grassroots and other citizen-lead organizations.


Abstract: Community coalitions have become popular vehicles for promoting health. Which factors make coalitions effective, however, is unclear. The study’s aim was to identify coalition-building factors related to indicators of coalition effectiveness through a review of the empirical literature.

Published articles from 1980 to 2004 that empirically examined the relationships among coalition-building factors and indicators of coalition effectiveness were reviewed. Two indicators of coalition effectiveness were examined: coalition functioning and community-wide changes. A two-phase strategy was employed to identify articles by reviewing citations from previous literature reviews and then searching electronic reference databases. A total of 1168 non-mutually exclusive citations were identified, their abstracts reviewed, and 145 unique full articles were retrieved. The review yielded 26 studies that met the selection criteria. Collectively, these studies assessed 26 indicators of coalition effectiveness, with 19 indicators (73%) measuring coalition functioning, and only two indicators (7%) measuring changes in rates of community-wide health behaviors. The 26 studies identified 55 coalition-building factors that were associated with indicators of coalition effectiveness. Six coalition-building
Factors were found to be associated with indicators of effectiveness in five or more studies: formalization of rules/procedures, leadership style, member participation, membership diversity, agency collaboration, and group cohesion. However, caution is warranted when drawing conclusions about these associations due to the wide variations in indicators of coalition effectiveness and coalition-building factors examined across relatively few studies, discrepancies in how these variables were measured, and the studies' reliance on cross-sectional designs.

**Emancipatory Partnerships:**


Abstract: We propose a value-based conceptualization of partnership, defining partnership as relationships between community psychologists, oppressed groups, and other stakeholders, which strive to achieve key community psychology values (caring, compassion, community, health, self-determination, participation, power-sharing, human diversity, and social justice). These values guide partnership work related to the development of services or supports, coalitions and social action, and community research and program evaluation. We prescribe guidelines for building such partnerships and conclude by considering some of the challenges in implementing value-based partnerships.

**Community Development Partnerships and Campaigns**


Abstract The Sisters Together, Move More Eat Better pilot communication program focuses on young Black women in three inner-city communities to encourage improved nutrition and increased physical activity. The design for Sisters Together is based on an expansion of a public health campaign that combines social marketing with community building efforts. The pilot program design comprises five phases: design, promotion, demonstration, transfer, and sustained activity. The proposed five-stage model holds potential for increasing the life span of a campaign and contributing to community building. Partnerships and coalition development promise to maintain the campaign beyond the limited budget period. This descriptive article illustrates the elements of a hybrid model for the design of a communication program with examples from Sisters Together, Move More Eat Better, a pilot program currently in the last year of implementation.
Books and Book Chapters


Abstract This user-friendly handbook guides school, district, and state leaders to organize and implement positive and permanent programs of school, family, and community partnerships. The Third Edition includes research summaries and useful tools for developing and evaluating programs of family and community involvement.

A CD comes with the Third Edition. It provides a PowerPoint presentation to conduct the NNPS One-Day Team Training Workshop, copies of workshop handouts, activities, planning and evaluation forms, and selected Spanish translations of workshop materials.

The handbook focuses on schools because that is where the children are. It is designed to guide the work of Action Teams for Partnerships (ATPs) consisting of teachers, parents, administrators, and others. The information, forms, and activities in the handbook also enable district and state leaders support, facilitate, and reward the work of their schools.


Abstract Community Partnerships is an interesting collection of twelve case study chapters and overview chapter edited by Elsa Auerbach. The articles tell about successful collaborations between schools and universities, community groups, and government departments in five countries. This book is part of TESOL’s Case Studies in TESOL Practice Series. This series describes twenty teaching contexts, the contexts’ issues and demands, and practical suggestions for addressing these situations.


Description Based on the presentations and discussions from a national symposium on family-school links held at the Pennsylvania State University, this volume brings together psychologists, sociologists, educators, and policymakers studying the bidirectional effects between schools and families. This topic- the links between families and schools, and how these affect children's educational achievement- encompasses a host of questions, each of key social and educational significance.

• How far does parental involvement in schools affect children's experiences and achievement at school?
• What explains the great differences between schools, families, and communities in the extent of such involvement?
• Are these differences a matter of school practices, or do they reflect much broader social and cultural divisions?
• What is the nature of the impact schools have on children and their families?
How can family-school-partnerships be fostered in a way that helps children?
Description: Completely revised and expanded from four to five volumes, this new edition of the Handbook of Parenting appears at a time that is momentous in the history of parenting. Parenting and the family are today in a greater state of flux, question, and redefinition than perhaps ever before. We are witnessing the emergence of striking permutations on the theme of parenting: blended families, lesbian and gay parents, and teen versus fifties first-time moms and dads. One cannot but be awed on the biological front by technology that now not only renders postmenopausal women capable of childbearing, but also presents us with the possibility of designing babies. Similarly on the sociological front, single parenthood is a modern day fact of life, adult child dependency is on the rise, and parents are ever less certain of their own roles, even in the face of rising environmental and institutional demands that they take increasing responsibility for their offspring.

The Handbook of Parenting concerns itself with:

- different types of parents—mothers and fathers, single, adolescent, and adoptive parents;
- basic characteristics of parent-behaviors, knowledge, beliefs, and expectations about parenting;
- forces that shape parenting—evolution, genetics, biology, employment, social class, culture, environment, and history;
- problems faced by parents—handicap, marital difficulties, drug addiction; and
- practical concerns of parenting—how to promote children’s health, foster social adjustment and cognitive competence, and interact with school, legal, and public officials.

Description: This book examines historical approaches and current research and practice related to the education of adolescents placed at risk of school failure as a result of social and economic conditions. One major goal is to expand the intellectual exchange among researchers, policymakers, practitioners, and concerned citizens on factors influencing the achievement of poor and minority youth, specifically students in middle and high schools. Another is to encourage increased dialogue about policies and practices that can make a difference in educational opportunities and outcomes for these students. Although the chapters in this volume are not exhaustive, they represent an array of theoretical and methodological approaches that provide readers with new and diverse ways to think about issues of educational equality and opportunity in the United States. A premise that runs through each chapter is that school success is possible for poor and minority adolescents if adequate support from the school, family, and community is available.

*The conceptual approach (Section I) places the research and practice on students placed at risk in a historical context and sets the stage for an important reframing of current definitions, research, policies, and practices aimed at this population.
Multiple research methodologies (Sections II and III) allow for comparisons across racial and ethnic groups as well as within groups, and contribute to different and complementary insights. Section III, “Focus on African-American Students,” specifically addresses gender and social class differences among African-American adolescents.

Current reform strategies presently being implemented in schools throughout the United States are presented and discussed (Part IV). These strategies or programs highlight how schools, families, and communities can apply research findings like the ones this book presents, thus bridging the often wide gap between social science research and educational practice.


Description: Improving the connection among schools, families, and communities has emerged as a recent focus of the education reform movement posing many challenges for educators, social service professionals, community activists, and parents. This book provides information on the diverse goals of the coordinated services movement and the problems of reconciling competing goals within the movement. The political environment surrounding coordinated services reforms is discussed, including efforts to scale-back the scope of “the welfare state.” Different models of coordination are presented, such as Kentucky’s Family Resource Centers, the Nation of Tomorrow project in Chicago, a community-school coalition in Philadelphia, community youth organizations, and programs for the homeless as well as organizational and management issues surrounding coordination drawn from programs throughout the United States and Canada.
Part IV: Additional Resources

This section is intended to provide coordinators and instructors with links to additional resources for transitioning foster youth ranging from services and support for health, medical and dental needs, to childcare and housing support. Resources included are:

**California Department of Education- foster youth resources listings**
These listings are aimed to assist foster youth and those who serve them to access education- and transition-related services, such as grants, community resources, additional rights, and other resources relevant to transitioning foster youth progressing toward independent living.


“Kidsdata.org is your gateway to comprehensive data about the health and wellbeing of children across California. The site offers data for every city, county, and school district in the state, making it easy to monitor trends and pinpoint disparities.” We have selected the resources from this site that may be most helpful to transitioning foster youth, and we have organized them by category of need, for your convenience.

California Department of Education
1430 N Street
Sacramento, CA 95814
Resources
Resources related to foster youth services programs including Web links, reports, etc.

**Assembly Bill 167**

**Frequently Asked Questions** (PDF)
Common questions about the implementation of the AB 167 graduation requirements for students in foster care who transfer in grades eleven or twelve.

**Assembly Bill 490 Frequently Asked Questions** (PDF)
Developed by the California Foster Youth Education Task Force to clarify foster youth’s educational rights pursuant to AB 490.

**Assembly Bill 490 Training and Implementation**
National Child Welfare Resource Center on legal and judicial issues ensuring educational rights and stability for foster youth.

**California Blue Ribbon Commission on Children in Foster Care**
The charge of the California Blue Ribbon Commission on Children in Foster Care is to provide recommendations to the California Judicial Council on the ways in which the courts and their partners can improve safety, permanency, well-being, and fairness outcomes for children and families.
California Chafee Grant
Provides free money to current or former foster youth to use for career and technical training or college courses.

California Child Welfare Council
The California Child Welfare Council was established by the Child Welfare Leadership and Accountability Act of 2006 (Welfare and Institutions Code Sections 16540–16545) and serves as an advisory body responsible for improving the collaboration and processes of the multiple agencies and the courts that serve the children in the child welfare system.

California College Pathways
Web site designed by the John Burton Foundation to help California’s foster youth access higher education and their educational goals.

California Community Colleges Chancellor’s Office Foster and Kinship Care Education Program

California Department of Social Services, Foster Youth Ombudsman Office
Provides information about the Foster Care Ombudsman Office and various programs and services available to youth in foster care.

California Foster Youth Education Task Force
The California Foster Youth Education Task Force is dedicated to improving educational outcomes for foster youth in California by bringing together subject matter experts representing more than 35 organizations and agencies to engage in cross-systems collaboration. Membership is open to anyone interested in promoting improved educational opportunities and successes for California’s foster youth.

California Foster Youth Education Summit Materials 2007
Background and Issue Papers from the summit posted on the Child and Family Policy Institute of California.

California Legislature Bill Information
The full text of bills, resolutions, and constitutional amendments, and their status, history, votes, analyses, and veto messages are available.

California Supplement to the Judicial Checklist (PDF)
Supplement to Asking the Right Questions: A Judicial Checklist to ensure that the Educational Needs of Children and Youth in Foster Care Are Being Addressed and the Judicial Education Checklist.

California Youth Connection
Current and former foster youth working to improve foster care, educate the public, and policy makers.

Child Welfare Services/Case Management System (CWS/CMS)
A statewide tool that supports an effective Child Welfare System of services.

Children’s Law Center of Los Angeles
California Foster Care Education Law information.
**Community College Foundation**
Independent living program, campus peer mentoring program, Early Start to emancipation program.

**Disability Rights Education and Defense Fund Clearinghouse on Foster Youth and Transition**
This Clearinghouse offers a variety of selected resources to help foster parents, kin care providers, child welfare workers, educators, Court Appointed Special Advocates (CASAs), and other professionals to provide effective services and support for children with disabilities in foster care.

**Education Liaison Model** (PDF)
Developed by the Mental Health Services Agency, the Education Liaison Model is a comprehensive interagency program to support social workers in obtaining appropriate educational services for children in the foster care system.

**Foster Care Education Fact Sheets (English)** (PDF)
Developed by the California Foster Youth Education Task Force, these fact sheets summarize the laws pertaining to foster youth in California.

**FosterEd Connect**
Free education resource is staffed by a panel of education experts who can answer programmatic issues with education laws that impact children and youth in foster care.

**Foster Youth Education Rights Wallet Card (English)** (PDF)
Developed by the California Foster Youth Education Task Force, this wallet-size card summarizes the California Education Code sections pertaining to foster youth.

**Free Application for Federal Student Aid (FAFSA)**
U.S. Department of Education free application for federal student aid.

**Helping Your Child Succeed in School** (PDF)
An Education Handbook for Parents and Caregivers of Children and Youth in the Foster Care System created by Mental Health Advocacy Services.

**Local Group Homes and Foster Family Agencies**
Database of Licensed Facilities.

**McKinney-Vento**
The McKinney-Vento Act includes foster youth awaiting placement in a foster or group home in the definition of homeless.

**University of California, Berkeley Center for Social Services Research**
Timely and useful data about children in the California Child Welfare System.
National Center for Youth Law
A private, non-profit law office serving the legal needs of children and their families.
Questions: Educational Options, Student Support, & American Indian Education Office | 916-323-2183
Last Reviewed: Tuesday, December 18, 2012
Health and Wellness Resources
Excerpted from Kidsdata.org*
Links to all of these organizations can be found at HERE.

Services and Support for Health, Medical, Dental, and Disabilities

Access to Services for Children with Special Health Care Needs (State-Level Data)

Child Health and Disability Prevention Program (California Department of Health Care Services)
Description: The Child Health and Disability Prevention Program delivers periodic health assessments and services to low-income children. CHPD assists families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Refer HERE for a list of local county offices.

Family Voices of California
Description: The mission of Family Voices of California is to improve the lives of children with special health care needs by serving as a statewide clearinghouse for information, education, developing family and professional partnerships, and promoting quality health care.
Phone: (415) 282-7494

Through the Looking Glass
Description: Seeks to improve the quality of life for disabled individuals by conducting research and offering training and services for families in which a child, parent or grandparent has a disability or medical issue.
Phone: (800) 644-2666

Dental Care

California Healthy Families Program
Description: Apply for the Healthy Families Program and find a local dentist that accepts Healthy Families. Four different dental plans are available: Delta Dental, Access Dental, Health Net Dental and Premier Access Dental.
Phone: (800) 880-5305

Denti-Cal
Description: Denti-cal offers various dental care information and services for Medi-Cal recipients.
Phone: (800) 322-6384
Health Care

100% Campaign
Description: Offers information about California’s child health insurance programs, best practices for outreach, current legislative proposals affecting children’s health care coverage, and ways to increase the number of insured California children.
Phone: (510) 763-2444
Email: info@100percentcampaign.org

Hospitalizations

Children’s Health Access & Medical Program
Description: Offers training materials to advocates and outreach workers related to free and low-cost health insurance programs for children and pregnant women.
Phone: (213) 538-0774

Children’s Health Initiative
Description: California residents can apply for free or low-cost public health insurance available to children from low- and moderate-income families. Multilingual staff (English, Spanish, and Tongan, with referrals for Tagalog and Chinese assistance) can answer questions and assist in the application process.
Phone: (888) 244-5222

Medi-Cal
Description: A public health insurance program which provides needed health care services for low-income individuals. Visit the website to find out if you qualify and to download an application.
Phone: (888) 747-1222

Food Access and Nutrition Information

California Food Policy Advocates
Description: Find local Summer Food Service (Summer Lunch) sites offering meals and snacks to children when school is out. Learn how to make the School Breakfast Program available and attractive to students. CFPA offers extensive, multi-lingual outreach materials and can answer questions about child nutrition programs.
Phone: (510) 433-1122

Child and Adult Care Food Program (Child Care Component)
Description: The Child and Adult Care Food Program seeks to instill good eating habits in children and improve the diets of children under the age of 13 by providing well-balanced meals. CACFP offers state and federal meal reimbursement and one time startup funds for child care facilities. Claim instructions and forms can be found on the website.
Phone: (800) 952-5609
Nutrition - Breakfast

California Association of Food Banks
Description: Offers information on the location of food banks in all of California’s 58 counties. Educational materials are available to food banks and other organizations serving low-income Californians at low or no cost.
Phone: (510) 272-4435

Healthy Habits for Healthy Kids: A Nutrition and Activity Guide for Parents
Description: This website provides practical strategies to engage families in healthy eating and physical activity. The online guide is available in English and Spanish.

Take Charge of Your Health: A Teenagers Guide to Better Health, National Institutes of Health’s Weight-Control Information Network
Description: Teens can read about lifestyle and diet changes to promote healthy weight.

Hotline for Teens

Contact Cares
Description: Youth can speak with trained telephone counselors who will listen and offer support and referrals 24 hours a day, any day of the year on a special teen line.
Phone: (888) 247-7717

Domestic and Dating Violence

California Department of Public Health Violence Prevention Resource Directory
Description: This publication lists county-specific resources for domestic violence, sexual violence, child and elder abuse.

National Domestic Violence Hotline
Description: Victims or anyone calling on their behalf are provided with information regarding crisis intervention, safety planning, and referrals to agencies in all 50 states.
Phone: (800) 799-7233

Parent Perceptions of Emotional Health

Teen Relationships Website
Description: Teens can learn how to recognize if they are in an abusive relationship and what to do about it. This website offers forums to submit questions and receive suggestions from trained teen counselors.
Phone: (800) 300-1080

Substance Abuse- Alcohol, Tobacco, and Other Drugs
California Department of Alcohol and Drug Programs
Description: California residents have access to a comprehensive collection of booklets, research papers, pamphlets and other helpful materials providing information on alcohol, tobacco, and other drug abuse prevention and treatment.
Phone: (800) 879-2772

Low Income Needs (Housing, finance, healthcare, food, etc.)

CalWORKs
Description: CalWORKs provides temporary financial assistance and employment-focused services to low-income families. CalWORKs participants may receive domestic violence services, treatment for mental health and substance abuse problems, and assistance from the Family Preservation Program. Families may also be eligible for short-term financial assistance for housing, food, utilities, clothing or medical care needs.
Email: piar@dss.ca.gov

Catholic Charities of California
Description: Refugees or current and recent CalWORKs recipients can participate in free employment and training programs. All low-income individuals can participate in financial education programs addressing saving, investing, and budgeting. Housing, food distribution services, emergency services, health care, child care, and immigration services are available to those in need. The program sponsors an Individual Development Account (IDA) program, though eligibility varies depending on funding. Other services include behavioral health/counseling for insured families and CalWORKs participants, which may require a fee. Services provided in multiple languages.
Phone: (916) 313-4005

Housing Affordability

California Affordable Housing Institute
Description: Provides housing resources and information to serve people with development disabilities. Statistical reports and funding resources are also available along with a map of regional centers throughout California.
Phone: (877) 300-5100

Housing for Youth Transitioning from Foster Care from U.S. Department of Health and Human Services’ Administration for Children and Families

California Department of Housing and Community Development
Description: Search for low and very low income rental housing developments in California by county.
Phone: (916) 445-4782

EAH Housing
Description: Browse EAH’s 81 affordable housing properties in California and Hawaii made available to families, seniors, students, and the disabled.
Phone: (415) 258-1800
**LINC Housing**
Description: Develops and constructs new affordable housing for seniors, families and special needs populations. Visit the website to view all 51 properties throughout California.
Phone: (562) 684-1100

**Making Home Affordable**
Description: Offers homeowners detailed information about the Home Affordable Refinance Program and the Home Affordable Modification Program, along with self-assessment tools and calculators to help determine whether you might be eligible. Borrowers can also connect with free counseling resources to help with questions, locate homeowner events in your communities, find a checklist of key documents and materials to have ready before calling your servicer as well as FAQs from borrowers in similar circumstances.
Phone: Urgent helpline: (888) 995-HOPE

**National Coalition for the Homeless**
Description: Provides information on how to prevent or prepare for homelessness. The directory lists local and national organizations to contact for help if you are concerned about becoming or are currently homeless.
Phone: (202) 462-4822

**Childcare, Infant Health, and Other Parenting Resources**

**Black Infant Health Program**
Description: African-American mothers who are pregnant or have babies under age 2 can receive monthly home visits from public health nurses and community workers; get help accessing public health services; and participate in health, nutrition, and social support workshops. Services are free, regardless of income, for women who have lived in the U.S. for at least 5 years.
Phone: (866) 241-0395

**California SIDS Program**
Description: Provides a crisis line, and offers resources about prevention of Sudden Infant Death Syndrome (SIDS). Resources also are available for those grieving for a child who died from SIDS.
Phone: (800) 369-SIDS (7437) (also operates as crisis line 24 hours, every day of the year).

**FirstCandle Crisis Hotline**
Description: Bilingual crisis counselors are available 24 hours a day, 7 days a week to parents who are coping with the death of a baby. Information is also available on infant health and safety.
Phone: (800) 221-7437

**California Child Care Resource and Referral Network**
Description: Child Care Resource and Referral agencies are located in all California counties and support parents, providers and local communities in finding, planning for, and providing affordable and quality child care.
Phone: (415) 882-0234
Email: Info@rrnetwork.org
Comprehensive Perinatal Services Program
Description: Provides a wide range of services to pregnant women, from conception through 60 days postpartum. In addition to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education.
Phone: (866) 241-0395

WIC Program
Description: Low-income pregnant and postpartum women can apply to receive vouchers for nutritional assessments, counseling, and nutritious food supplies. The program also provides information about breastfeeding, nutrition, smoking cessation, child health and safety, and other related topics, as well as referrals to health care providers and community agencies. Services are free, in English and Spanish (Vietnamese may be available), and available regardless of immigration status.
Phone: (888) WIC-WORKS (942-9675)

Prenatal Care

Access for Infants and Mothers (AIM)
Description: Pregnant women can apply for comprehensive, low-cost health insurance to cover prenatal care, delivery, and 60 days of postnatal care (newborns also are covered until age 2). Benefits are provided regardless of immigration status, but applicants must have resided in California for the past six months. Only uninsured women are eligible, but exceptions may apply.
Phone: (800) 433-2611

First 5 California
Description: Families with children 0-5 can receive a wide range of services encompassing literacy, health and dental care, child development, behavior, and kindergarten transition. The program is a partnership among schools, families, and communities to support healthy development of children ages 0-5 and foster school readiness.
Phone: (916) 263-1050

Teen Births

America’s Pregnancy Helpline
Description: This free and confidential helpline offers assistance from reproductive and pregnancy educators in answering questions and providing referrals. The helpline is available Monday through Thursday 7:00 am–10:00 pm CST, Friday 7:00 am–8:00 pm CST, and Saturday and Sunday 11:00 am–7:00 pm CST.
Phone: (888) 672-2296

CTIS Pregnancy Risk Information Line
Description: Speak with a Teratogen Information Specialist about your questions regarding exposure to medications, vitamins, supplements, drugs, chemicals, diseases or infections while pregnant or nursing.
Phone: (800) 532-3749
Planned Parenthood Affiliates of California
Description: Teens of any age can visit free teen clinics that offer answers to questions about sexuality, sexually transmitted diseases, and reproductive health, as well as pregnancy tests, information on options to prevent pregnancies, and comprehensive reproductive health care. Services are free, and provided in English and Spanish, regardless of immigration status.
Phone: (916) 446-5247

TeenNow California
Description: TeenNow serves as a support network to agencies, professionals and communities who are driven to promote the well-being of parenting teenagers and their children, and to prevent adolescent childbearing through workshops, education and advocacy.
Phone: (619) 741-9650