While the goal of many parenting interventions in families at risk is to help caregivers develop the skills to become more effective parents and keep their children safe, the main focus of the parenting model presented here is on the emotional development of young children, particularly in terms of attachment and affect regulation. The reason for this emphasis lies in the increasing recognition of the importance of healthy attachment as not only a protective factor for resilience, but also as representing positive infant brain development in those areas affecting emotional health and empathy (Schore, 1994; Schore, 1997). Furthermore, the attachment relationship can galvanize caregivers to make positive changes in their lives and enhance their own emotional health and development for the benefit of both caregiver and child.

Attachment and quality of the parenting relationship

The basis for attachment in the early years is the quality and frequency of interactions between the infant and a primary caregiver over the first 18 months of life (Ainsworth, Blehar, Waters & Wall, 1978). Although the specific characteristics of the interaction that predict healthy (secure) attachment are not known, research suggests that sensitive, responsive care giving with positive regard for the infant “enough of the time” are important (Van Ijzendoorn, Juffer, & Duyveseyn, 1995). On the other hand, chaotic, inconsistently responsive care giving may lead to ambivalent or anxious attachment; and care giving characterized by hostility and intrusiveness much of the time is the trajectory for avoidant attachment (Crittenden & Ainsworth, 1989; Egeland & Sroufe, 1981). When the care giving is unpredictable, abusive, or frightening, as may occur when caregivers have unresolved trauma or losses or are actively using drugs, disorganized attachment without any attachment strategy may result and is the biggest predictor of later psychopathology (Main & Goldwyn, 1984; Schuengel, Bakermans-Kranenburg & van Ijzendoorn, 1999).
Risk factors in substance using caregivers

Many factors may affect the quality of the caregiver-child interaction (Gowen & Nebrig, 1997). These include:

- Factors affecting the capacity of the caregiver to respond to the infant: internal working model, physical and mental health, stress, and cognitive ability.
- Factors affecting the capacity of the infant to respond to the caregiver: health, temperament, and maturity of the infant.
- Factors affecting caregiver availability.
- Ecologic factors: support systems, housing, safety, economic stability, etc.

In substance using women, the effects of drugs on parenting behavior and health, as well as the antecedents of substance use, can have a negative impact on the capacity of the caregiver to provide sensitive, responsive care to the infant (Lyons-Ruth, Connell, Grunebaum & Botein, 1990; Luthar, Cushing, MariKangs, & Rounasville, 1998; Beckwith, Howard, Espinosa & Tyler, 1999). Many substance-using women have experienced significant trauma, such as childhood maltreatment, sexual abuse, and family violence, resulting in post-traumatic stress disorder, depression, or other mental health problems (Singer & Snipes, 1992; Murphy, 1995-1998). Past parenting failure and loss of children heighten fear and anxiety that subsequent children will be removed. Drug use and drug seeking behavior, inadequate social supports, incarceration, separation or removal of the child, and sub-optimal visitation, as well as the competing demands of treatment programs may limit the availability of the caregiver. As a result, although some substance-using mothers may not differ in the overall quality of interactions with their infants, the frequency and consistency of such interaction over time are often compromised.

Prenatal exposure to drugs or withdrawal from opiates or methadone may compromise the capacity of the infant to interact positively with the caregiver. As a result, the caregiver may then perceive the child as rejecting or difficult (Black, Schuler & Nair, 1993).

The few studies of attachment in children of drug or alcohol users have shown an increase in insecure, as well as disorganized attachment, irrespective of whether the child was with the biological mother or a foster or kinship alternative (O’Conner, Sigman & Brill, 1987; Rodning, Beckwith & Howard, 1991). The latter is not surprising when one considers that alternative placement does not guarantee warm, responsive, and available care giving and multiple disruptions in care giving often occur. In fact, biological mothers, who were able to achieve abstinence from drugs had the highest rate of attachment security.

PROkids Plus and development of Empathic Care

A major obstacle when working with substance using families is the multiplicity and intensity of needs, which must be addressed. All too often, the desired focus on the parenting relationship is pulled towards a primary focus on the needs of the caregiver, e.g., housing, income security, treatment, legal issues (Davidson, 1991). There is thus a need for approaches, which accept the real life context of the intervention but carry out the mission of the program to enhance the quality of the relationship.

PROkids Plus is a center- and home-based comprehensive intervention program for infants and children with prenatal substance exposure in Hartford, Connecticut. Its goal is to promote resilience and optimal development through strengthening the postnatal care giving environment. The components of the program include: enhanced primary care in which visits are increased in frequency and duration, home visitation and family development, developmental assessment, collaboration with community agencies, and advocacy. The team consists of a combination of professionals and paraprofessionals with the latter doing most of the home visits under supervision of clinical social workers. Thus, there are frequent touch points for parenting intervention by workers with varied levels of skill and experience.

All staff members receive training in motivational enhancement therapy, trauma sensitive care, and attachment. The intervention begins with newborns and follows them through 5 years of age. It is most intense in the first 18 months and then intervention is adjusted according to the needs of the family. Although infants with their biological mothers are the focus, PROkids also works with other attachment relationships such as fathers, domestic partners, and alternative caregivers.

In the absence of a parenting model that fits well with the needs of our program and families, we developed an attachment-based model, EMPATHIC CARE. This approach provides parenting intervention “on
the go”. Every encounter is considered therapeutic, in which the child’s needs and the parenting interaction are held in mind and addressed as crisis and non-crisis intervention is provided. The strong undercurrent of this intervention is empathy, which we define as the ability to feel for another and show compassion while maintaining healthy psychological boundaries. In this way, we hope to reach into the caregivers’ own affective areas, promoting healing and enhancing their emotional development so that they may have the capacity to respond more sensitively and be available to their infants. Two essential techniques are utilized:

- **“Pivoting”** the caregiver’s consciousness to the child so that the needs of the child and relationship are not lost in the myriad other seemingly more pressing needs. Thus, the developmental timeline of the child does not fall victim to the needs of the caregiver, but both are addressed in parallel.

- **Parallel processing** by which the approaches, strategies or behaviors exercised between the team and the caregiver mirror those between the caregiver and child. Relationships between staff members and caregivers are as necessary and important as that between the caregiver and the child. In the words of Jeree Pawl, “Do unto others as you would have others do unto others” (Pawl, 1994/1995).

The strategies of EMPATHIC CARE and its dual focus are outlined in table 1 (see page 4).

**EMPATHIC CARE and Attachment, Parenting, Addiction and Recovery Timelines**

**BIRTH TO THREE MONTHS: WINDOW OF OPPORTUNITY**

The birth of a baby provides a window of opportunity to reach a high-risk mother when motivation to change is high. The dependency needs of the baby are paramount. Facilitating the caregiver’s reading and responding to the cues of the baby is the focus of the dyadic intervention during this phase. Staff encourage holding and carrying as well as early response to crying and calming techniques for both mother and child. Soft infant front carriers are given to each caregiver as this simple intervention was shown to promote secure attachment in at-risk dyads (Ainsfeld, Casper, Nozyce & Cunningham, 1990). At the same time, the program seeks to engage the trust and confidence of the caregiver through acknowledging her own dependency needs and providing much support. We enable now to empower later.

Focus groups reveal that chemically dependent mothers may identify more as mothers than with their addiction during this phase (Pursley-Croteau, 2001). Less attention to recovery needs, as well as fatigue and stress make this a high risk period for relapse. The intervention helps mothers hold their children in mind by understanding the importance of their recovery and care giving to the well-being of their children. This is also the time when child protection involvement is often at its most intense. Investigations, treatment requirements, or alternative placements make it a lot harder for mothers to learn to read and respond to their infants and may precipitate depression and increased anxiety—triggers to post traumatic stress reactions and substance use. Thus, if separated, it is imperative for practitioners to both advocate for frequent visitation and provide intense support to mothers. Separated mothers are included in our expanded primary care visits along with the alternative caregiver so that they may participate in normative parenting activities and dyadic intervention.

**FOUR TO SIX MONTHS: DANCING TOGETHER**

The focus here is the development of reciprocal positive interactions

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<table>
<thead>
<tr>
<th><strong>TABLE 1: EMPATHIC CARE</strong></th>
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<tr>
<td><strong>STAFF TO CAREGIVER</strong></td>
</tr>
<tr>
<td>E  Empathy</td>
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<tr>
<td>Show empathy for:</td>
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<tr>
<td>• Transition to mothering</td>
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<tr>
<td>• Struggle to achieve sobriety</td>
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<td>• Competing demands</td>
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<td>• Childhood story</td>
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<td>• Prior or current losses/parenting failure</td>
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<td>• Mistakes, despair, or frustrations.</td>
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<td></td>
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<tr>
<td>M  Maintenance of contact</td>
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<tr>
<td>Frequent contact between staff &amp; caregiver</td>
</tr>
<tr>
<td>Touch &amp; nonverbal communication</td>
</tr>
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<td>Advocacy for frequent contact if mother and child are separated</td>
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<tr>
<td>T  Tuning in to cues/affect &quot;The dance&quot;</td>
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<tr>
<td>Match affect to the caregiver:</td>
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<tr>
<td>• Share and enhance positive affect</td>
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<td>• Soothe negative affect</td>
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<td>• Avoid over stimulation/ intrusiveness</td>
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<td>I  Internal working models</td>
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<td>Mirror positives to caregiver</td>
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<td>Develop trust – “I am worthy”</td>
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<td>Belief in mother’s capability “You can do this”</td>
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<tr>
<td>Healing – own childhood</td>
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<td>C  Communication</td>
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<td>Listen with ears, eyes and heart – hear the pain</td>
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<td>Reflect caregiver’s expressed feelings</td>
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<td>Non-judgmental, compassionate, respectful</td>
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<tr>
<td>A  Affirmation</td>
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<tr>
<td>Build on strengths</td>
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<tr>
<td>Avoid being the “expert” (caution when role modeling)</td>
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<tr>
<td>Look for opportunities to highlight caregiver/child’s strengths</td>
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<td>Review videotaped play interactions together</td>
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<tr>
<td>Celebrate small achievements</td>
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<tr>
<td>C  Consistency</td>
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<tr>
<td>Reliability of staff</td>
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<tr>
<td>Rituals</td>
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<td>Consistent expectations</td>
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between the caregiver and the infant (Letourneau, 1997). The building blocks of attachment are the countless interactions between caregiver and infant during daily activities. Availability, sensitivity, and positive regard for the infant are important in these interactions, as well as avoidance of over-stimulation or intrusiveness. The emphasis is on providing opportunities for face-to-face interactions, following the baby’s lead in play, amplifying positive and soothing negative affect, and providing routines and quiet time. Staff parallels this through availability and positive regard for the mother, and following her lead in goal setting. The mother’s identity may now begin to shift to that of addict, and treatment/recovery needs may become more primary. The goal is to help mothers maintain the child as their primary relationship through positive experiences and growing parental competence so that substances do not resume this position.

SEVEN TO 18 MONTHS: A SAFE PLACE FROM WHICH TO EXPLORE

Attachment behaviors emerge as the child develops a strong preference for the primary caregiver. Separation anxiety and stranger awareness manifest, as well as increased exploration of the environment and striving for autonomy. The intervention during this phase focuses on maintaining a trusting relationship through consistency, understanding attachment security needs, providing comfort after immunizations or other upsetting experiences, and allowing increased autonomy in feeding and play. Videotaping caregiver-child interactions and reviewing the videotapes with the caregiver provide the opportunity to affirm strengths of both child and caregiver and reflect on their behaviors. Staff also attempts to empower mothers to advocate for the needs of their children. This is particularly important as treatment programs sometimes misinterpret a child’s attachment behaviors (e.g., separation anxiety) as pathological, bringing into question maternal competency.

Attachment behaviors can trigger anxiety in mothers who were abused or parentified as children, resulting in rejecting, frightening or ambivalent responses. The staff encourages mothers to explore such feelings in the present and reflect on the effect of their responses on their children. Socially isolated and traumatized mothers may indeed become enmeshed with their children or be extremely protective. Supportive relationships, celebrating small steps towards autonomy while ensuring children’s safety, can help these mothers feel less isolated and anxious.

Additionally, toddlerhood is a high-risk period for relapse. Mothers, faced with the demands of the toddler, may feel ambivalent about separation from the substances in their lives, especially if emptiness, isolation, and continued stress are the result. It is therefore important to facilitate shared fun and wonderment with toddlers, and build a support network. Should relapse occur, the parenting intervention must ensure that the child is safe as a first priority. However, it should also avoid equating relapse with child abuse and should support mothers in regaining and strengthening their sobriety, while holding their children in mind. In the words of a PROkids mother, “Relapse is part of recovery; don’t take my baby from me.” Addiction is a chronic relapsing disease, and removal of a child from the caregiver during this phase (7-18 months) places the child at high risk for emotional and attachment problems. The child may respond with apathy, anger, depression and ultimate resignation with indiscriminate attachment to people. Therefore, staff problem solves with mothers so that appropriate plans can be developed in the event of relapse. In a trusting, non-judgmental therapeutic relationship, mothers are more likely to be open about relapsing and seek assistance to get back on track.

When children are removed, parents need support during and after visitation as well as guidance in remaining focused on the present during the visits (Haight, Kagle, & Black, 2003). Understanding that their children may act indifferent or angry in response to the separation can prevent parents from reacting from a place of hurt and frustration, which may trigger relapse or increased use. Staff can pivot the parent’s focus on how to help their child, such as by providing familiar transitional objects and engaging in comfortizing interaction during visits following their child’s lead. Adopting an EMPATHIC CARE approach will also include advocating for frequent and regular visitation.

Between 12 and 18 months, attachment security style becomes organized and can be assessed. The PROkids Program uses the Strange Situation (Ainsworth, Blehar, Waters & Wall, 1978) both clinically and as an outcome measure. If insecure (ambivalent/avoidant) or disorganized attachment is suspected, it is necessary to review the family trajectory and current status, and to facilitate corrective interventions such as treatment of maternal depression or parent-infant relationship therapy.

Training and Supervision Needs

It is important that all staff members who have encounters with caregivers receive appropriate training and supervision at all levels of expertise. Most providers, professional and paraprofessional, will slip back into more traditional

Continued on page 28 . . .
In 1994, the Institute for Health and Recovery (IHR) in Cambridge, Massachusetts, developed the Nurturing Program for Families in Substance Abuse Treatment and Recovery (Nurturing Program) as part of a Center for Substance Abuse Prevention Demonstration Project called the Coalition on Addiction, Pregnancy and Parenting (CAPP). The CAPP project included an array of parenting and parent-child services at two women’s residential substance abuse treatment programs in Massachusetts (Camp & Finkelstein, 1997). The Nurturing Program is a psycho-educational, group-based program that assists parents in strengthening their own recovery, facilitating recovery within their family, and building nurturing family lifestyles. It was developed in response to the documented connection between substance abuse and child abuse/maltreatment (VanBremen & Chasnoff, 1994), and the growing recognition that substance abuse treatment services for pregnant and parenting women were insufficient to meet their needs, particularly in relation to parenting, parent-child relationships, and other significant relationships (Camp & Finkelstein, 1997; Moore & Finkelstein, 2001).

**Background and Development**

The Nurturing Program is an adaptation of the Nurturing Program for Parents of Children Birth to Five Years Old by Stephen Bavolek, Ph.D. (1989). This original program was chosen for use in the CAPP project because it had demonstrated success at improving parenting skills and reducing risk of child maltreatment, and it had a validated measure of effectiveness, the Adult Adolescent Parenting Inventory (AAPI) (Bavolek, 1989; Camp & Finkelstein, 1997). Bavolek’s program was adapted to focus more specifically on the particular needs of parents in residential substance abuse treatment. Program revisions included adaptations for literacy and cultural competence, the addition of new experiential activities, and a strong focus on addiction and recovery.

**PRINCIPLES/DESCRIPTION OF CURRICULUM**

With a focus on participants’ strengths, the Nurturing Program is guided by a set of values and principles that include: a love of life and learning; respect for self, others and the environment; fun and laughter; recovery happens in families and relationships, as well as in the individual; parenting is a relationship, not solely a set of skills; and nurturing oneself is the first step toward nurturing others. It also is based on the relational principles of authenticity, mutuality and empathy that enhance and strengthen relationships (Finkelstein, 1996).

The Nurturing Program is made up of 17 weekly group sessions, 90 minutes in length. Throughout the sessions, group facilitators use a combination of experiential exercises and didactic approaches to help parents build nurturing skills and enhance self-awareness, thereby increasing their understanding of their children. For example, in the session on Families and Substance Abuse, group facilitators begin by exploring differences, prejudices, and strengths of families with group participants. After this exploration and a discussion of the effects of both substance abuse and recovery on families, group members participate in an activity where they create their own “family portrait.” This is a symbolic picture of their families created with paints, markers, magazine clippings, etc., which allows participants to describe and define their family in whatever way they choose. After portraits are completed, group members form pairs and describe their portrait to their partner. Finally, each person describes to the group their partner’s picture and family.

Throughout the sessions, parents explore their childhood experiences, fears, and strengths, as well as the effects of substance abuse on themselves and their families. They also explore individual processes of development as adults in recovery, with emphasis placed on recovery as a dynamic process, with movement through stages and re-working of issues. Parallels and differences in recovery development and children’s development are highlighted. For example, a person entering recovery must, like an infant, build (or rebuild) a basic sense of trust, and become effective in asking for help.

Additionally, a Family Activities Manual to Nurture Parents and Children has been developed as a companion volume to provide age-based
activities for parents and children to do together. This manual includes a collection of playful and creative activities designed to include all members of the family. It also provides clear information to assist families in selecting, storing, and using materials, in helping children participate, and in establishing enjoyable clean-up routines. The Family Activities Manual can be used in conjunction with the Nurturing Program. In addition, activities from Stephen Bavolek’s Nurturing Program for Parents and Children 5 to 11 years can be used to provide structured activities for children throughout the program.

As parents focus on skills for understanding and responding to their children, they can rebuild a sense of themselves as capable parents. Practicing relational skills within the parent-child relationship allows parents to re-establish the strength of their connections with their children, so that parents and children can heal together.

Outcomes

The CAPP demonstration project generated very positive evaluation results. Significant improvements were made in all four domains measured by the AAPI: inappropriate expectations, lack of empathy, corporal punishment, and role reversal (Camp & Finkelstein, 1997). Significant improvements in self-esteem and mother-child interaction were also demonstrated at both original residential treatment sites (Camp & Finkelstein, 1997). Additionally, participant feedback was very positive. Upon group completion, one parent stated: “Most of what I learned had to do with ways I thought I should parent and that there really is no rulebook or manual to being a good parent. I also spent time learning about my child’s boundaries.” Another said, “I have learned that my child will learn different skills on her own time and not mine, and that I need to be patient and loving and supportive no matter what.” Related to strengthening recovery, a program participant stated, I learned “how to have fun as a clean and sober person; how to recognize certain feelings and situations and how I can deal with them; how to interact with other people; and how to nurture myself, my family and friends, and feel comfortable with it.” Another reflected that she learned “what nurturing is, how to nurture and care for myself as well as others; that I am a truly worthwhile human being who deserves safety, respect and happiness.”

Dissemination

Programs across the United States (39 states) and Canada have utilized the Nurturing Program in a wide range of settings, and achieved positive results in the areas of parenting, relationship and recovery. The program has been replicated in outpatient and residential programs serving both women and men, residential shelter programs serving women and men, community housing programs, prisons and jails, and programs that exclusively serve families whose children are in state custody.

In Massachusetts, the Nurturing Program is now used in the majority of women’s residential and shelter programs funded by the Department of Public Health, Bureau of Substance Abuse Services (approximately 30 programs), as part of a range of parenting support and education services. IHR’s team of Parent-Child Specialists (PCS), experienced staff knowledgeable in both substance abuse and child development, have worked for over ten years with staff in outpatient and residential substance abuse treatment programs throughout Massachusetts to co-facilitate parenting groups, and to provide consultation and technical assistance around parenting, parent-child relationships, and child development. IHR staff use a train the trainer model, in which program staff co-facilitate groups with a PCS, who trains them on the Nurturing Program curriculum and group facilitation. After the 17 group sessions are completed, the PCS leaves the program and the trained staff member is able to continue to facilitate parenting groups as new people enter the program, with continuing technical assistance and consultation available from IHR as needed. In addition, PCSs provide statewide training 2–3 times a year on facilitating Nurturing Program groups, and they provide information about parenting and the effects of substance abuse, mental illness, and trauma on parenting and the parent-child relationship.

Overall, efforts to build parenting capacity in the substance abuse treatment system in Massachusetts have

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been successful. Working directly in treatment programs, providing statewide training, technical assistance, and support have strengthened programs’ abilities to meet the parenting needs of their clients, and have thereby strengthened family relationships. There have also been difficulties with this process. High staff turnover, a common situation in treatment programs, results in the need for ongoing training of new staff. Additionally, pressures on staff time in treatment programs, made worse by current budget cuts, sometimes make staff co-facilitation, and therefore capacity building, difficult.

Adaptations to the Nurturing Program

The Nurturing Program has been adapted in a number of ways to meet a variety of needs within the population of families affected by substance abuse. Adaptations include: (1) Building Family Recovery, which emphasizes school-aged children and issues surrounding reunification; (2) an 11-week version targeted to an outpatient population; (3) Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma; and (4) a version being developed for men and fathers. The latter two adaptations are discussed below.

NURTURING FAMILIES AFFECTED BY SUBSTANCE ABUSE, MENTAL ILLNESS AND TRAUMA

The impact of co-occurring disorders on parenting cannot be understated. While national data on the prevalence of custody loss among this population is not available, data does suggest that parents affected by co-occurring disorders are at particular risk of losing custody of their children (Joseph et. al, 1999; Marcenko et. al, 2000; Mowbray et. al, 1995). In fact, a number of states currently cite mental illness alone as reason to remove a child from parental custody (Hemmens et. al, 2002; Nicholson & Biebel, 2002).

In 2001, IHR received a SAMHSA grant to establish the Women Embracing Life and Living (WELL) Project. The WELL Project was one of nine sites nationally aimed at developing, promoting and providing integrated services for women and their children affected by substance abuse, mental illness, and trauma. As part of this project, IHR adapted the Nurturing Program to develop Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma (Nurturing Families).

The Nurturing Families program is designed to increase women’s awareness of the impact of substance abuse, mental illness and trauma on themselves and their children, and, similar to the original Nurturing Program, to help parents develop skills to promote healing in their relationships. The process of adapting the Nurturing Program included extensive research designed to integrate additional information about co-occurring disorders and trauma. For example, research indicates that individuals with extensive trauma histories and histories of substance abuse may have difficulty participating in groups where they are asked to reflect on traumatic childhood memories or events (Najavits, 2002). Therefore, the adapted curriculum focuses on enhancing coping skills and exploring coping strategies before delving deeply into discussions related to trauma.

Additionally, some topics were either modified or eliminated to lessen group members’ experiences of recalling traumatic memories, and to lessen anxiety and decrease possibilities of relapse and self-blame. For example, in the Feelings session, the original Nurturing Program utilizes an activity related to a feeling each participant is uncomfortable with. Group members think about sensations associated with the feeling, the purpose the feeling serves, and ways to respond to the feeling. The Nurturing Families curriculum follows this same procedure, then adds discussion and brainstorming about ways to cope with the particular feeling that causes discomfort. Another example is in the Safety and Protecting Children session. In the Nurturing Program, group members learn about baby proofing their home, teaching their children important personal information such as their name, address, and telephone number, teaching fire safety, how to select a child care provider, and what to do if a child gets hurt. Nurturing Families expands on the topic to include the creation of a “protection plan” for children, where parents identify safe places to go or to hide in case of danger or when feeling threatened. Names and telephone numbers of trusted relatives, friends, or neighbors are listed, with discussion remaining focused on safety. While this activity may provoke anxiety for some group members, group leaders continually focus the discussion on what would make the situation safe, as well as on ways for parents to have a similar discussion about safety with their children at home.

Different from the original Nurturing Program, the Nurturing Families program consists of three modules. Module 1, One-on-One Mentoring and Intensive Skill Building, was developed on the premise that individual learning styles and abilities
must be considered when providing parenting support, skill building activities, and interventions. This module consists of two sessions between a staff member and parent, and allows the staff member to conduct a general assessment of the parent-child relationship, establish goals, and begin to develop a relationship with the parent. Module II, Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma, is the structured parenting education program consisting of 12–16 90-minute group sessions. The number of groups varies based on individual group needs. For example, a number of group meetings may be conducted in 1 or 2 sessions, depending on the amount of emphasis that facilitators deem appropriate for a particular topic. The sessions consist of experiential exercises followed by participatory discussion. The exercises were designed to: 1) support women in identifying ways in which substance abuse, mental illness and trauma have impacted their lives, 2) practice skills to enhance coping for themselves and their children, 3) identify ways in which their children have been impacted, and 4) practice skills to enhance the resiliency of children. Module III, Parent-Child Skill Building Activities, consists of four sessions in which a staff member works with small groups of parents and their children together on fun activities.

Participants in Nurturing Families groups have had very positive comments about their experience in the group. One group member stated, “Today’s group was very helpful to me so that I can understand my children’s feelings better. One way I can be more nurturing of my children’s feelings is to ask how they’re feeling and then be more understanding and present emotionally.” Another group member noted, “This group was helpful in telling me about my children’s feelings and losses and how I can help them begin healing from those losses.”

NURTURING FOR MEN AND FATHERS

Parenting work with men and fathers in substance abuse treatment is just beginning in Massachusetts and around the country. It is well documented (Doherty et. al, 1998; Engle & Leonard, 1995; United Nations Children’s Fund, 1997) that men’s active partnership in the parenting role enhances the successful outcome and well being of their children (McMahon & Rounsaville, 2002). Research has also identified the likely positive connection between active fathering and positive personal development and increased self-esteem in men (Parke, 1995).

Less well documented is the role of substance abusing men as fathers. Men affected by substance abuse are negatively stereotyped and there is very little documented about their parenting status (McMahon & Rounsaville, 2002). While substance abusing men are often considered unconcerned and indifferent in their role as parents, there is research to support the fact that estranged, marginalized groups of fathers are often very concerned about their children and interested in being more involved in their lives (McMahon & Rounsaville, 2002). In fact, the negative stereotypes and attitudes of society may end up further alienating fathers from their children (McMahon & Rounsaville, 2002). Instead, men in recovery frequently need nurturance and reassurance in their role as fathers. Parenting programs for men offer an opportunity to understand what healthy relationships are and what it means to nurture and be nurtured.

IHR’s initial work with fathers at a residential substance abuse treatment program supported the notion that fathers, even those who have little or no contact with their children, often have a strong desire to improve relationships with their children and become more active in their lives. This treatment program, funded by the Massachusetts Children’s Trust Fund, used the Nurturing Fathers Program developed by Mark Perlman (1998).

However, concerns about encouraging a father’s involvement with families where domestic violence and/or child abuse had occurred resulted in more careful and deliberate planning. For example, staff received training from an expert in work with male batterers, who also had expertise in integrating issues of substance abuse and battering. This training helped provide the context for working with men who may have battered, and assisted in creating a screening tool to help identify abusers and batterers, which was used prior to group start up. Contact with

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is currently utilized in the majority of substance abuse treatment programs and shelters for women and families across the state and is beginning to be implemented in some men’s programs. Parent-Child Specialists, using a train the trainers’ and co-facilitation model, have supported treatment program staff in their efforts to meet the parenting needs of the families they serve. They have also helped to build the statewide capacity of the substance abuse treatment system to expand previously individual-based treatment models into more family-focused systems of care. The Nurturing Program has been adapted to meet the specific needs of certain substance using populations. The model appears to be effective at strengthening recovery and improving parenting and parent-child relationships, however, further research is imperative as the model continues to expand and be replicated throughout the country.

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REFERENCES


RAISING KIN: The Psychosocial well-being of Substance-affected Children in Relative Care

This two-day conference will consider the mental health and developmental needs of children residing in kinship care due to parental substance abuse. This forum will address: What are the emotional, psychological and developmental needs of the children? How can we build upon the resiliency of the children and the benefits of the kinship placement? What services, clinical approaches, and family and community-based interventions successfully address these needs? Experts will provide an overview of the needs and strengths of these children, and will facilitate a panel discussion of youth, caregivers, and parents. Practical, skill-building workshops will present useful strategies and interventions for working with the children.

September 2004

Location:
Chicago, IL

Sponsor:
National Abandoned Infants Assistance Resource Center

Collaborating Organizations:
The Center for Child and Youth Policy
National Resource Center for Foster Care & Permanency Planning
National Resource Center for Youth Services
Casey Center for Effective Child Welfare Practice
National Center on Grandparents and Other Relatives Raising Children
Children of Alcoholics Foundation

Contact: May Espeña, Training Coordinator email: may@ucr.cnm.berkeley.edu phone: 510-643-7018 website: http://aia.berkeley.edu
While a portion of the general population faces parenting challenges primarily from lack of modeling, lack of understanding of developmental phases, and/or lack of tools, drug-recovering mothers face additional challenges due to past or present trauma, emotional issues, legal and financial problems, and/or physical health concerns. Other considerations, such as learning disabilities and permanent brain damage from sustained drug use, typically influence how these women learn, their ability to retain information, and how they apply new information.

This article describes how the Strengthening Multi-Ethnic Families and Communities: A Violence Prevention Parent Training Curriculum has been used by Central Washington Comprehensive Mental Health (CWCMH) as part of their Strong Families Program to enhance the parenting skills of women residing at a home for recovering single mothers who are living together with their children in transitional housing. The Strong Families program has received support from the Comprehensive Health Education Foundation and the Washington Council for Prevention of Child Abuse and Neglect. Strong Families is also the proud recipient of the 2002 Washington State Exemplary Substance Abuse Prevention Award.

The Curriculum

The Strengthening Multi-Ethnic Families and Communities: A Violence Prevention Parent Training Program was developed by Dr. Marilyn Steele, a child clinical psychologist. It is a strength-based, culturally-sensitive, facilitative model that is based on the idea that "true learning comes from within". This discussion-oriented approach is presented in 13 three-hour sessions and is geared toward parents with children 3-18 years of age. The Strengthening Multi-Ethnic Families and Communities Program has trained over 3000 facilitators in 38 states and in the United Kingdom.

The information and activities are presented in five component areas interwoven throughout the curriculum. The areas include: cultural/spiritual acknowledgement, enhancing relationships—violence prevention, rites of passage, positive discipline, and community involvement.

CULTURAL/SPIRITUAL

This component is designed to assist parents and children in understanding the family/cultural components that influence their beliefs, values and behavior, and to reconnect parents and children to the positive aspects of their past. Parents are encouraged to develop family rituals, customs and traditions to pass on their beliefs and values to their children. When children (and parents) feel they are part of something larger than themselves (e.g., family, community, cultural, spiritual group), they develop a sense of purpose and more accountability for their actions and behavior.

ENHANCING RELATIONSHIPS—VIOLENCE PREVENTION

This component consists of three topic areas: (1) enhancing the parent-child relationship, (2) child development information, and (3) anger management/problem-solving skills. Parents learn that using special time to build a stronger relationship with their children will enhance their ability to model and teach their children a variety of skills, and to more effectively pass on their values and beliefs. By understanding what is appropriate for children at different ages and stages of development, parents learn how to successfully guide their children in learning the tools and skills they will need to transition from childhood to adulthood. Parents become more effective teachers and positive role models for their children by learning anger management and problem-solving skills.

RITES OF PASSAGE

This component encourages parents to look back on how they were raised and to reflect on the values and behaviors they want to pass on and promote with their children. Historically, rite of passage
cere monies marked a child’s transition into adulthood. Because many youth are defining adulthood in negative ways (e.g., drinking, having sex, making babies, going to jail, joining a gang, committing an act of violence), it is important that parents take responsibility for teaching their children positive social skills and values. Information and activities are presented in 10 Rite of Passage areas: personal, spiritual, physical, mental, cultural, historical, emotional, economic, social and political.

POSITIVE DISCIPLINE

This component provides information on a variety of parenting practices to increase respectful behavior and to decrease disrespectful behavior. Information is presented within a Process of Discipline. Parents learn the importance of utilizing the first four steps of the process consistently (Modeling, Clear Instructions, Positive Attention, and Praise) in order to minimize the use of the remaining methods (Ignore/Praise, First/Then, Confrontation, Logical Consequences, Family Rule Discussions, Time Out, Incentives-Contracts, and Spanking). Parents discuss the ability of each of these techniques to enhance child self-esteem, self-discipline and social competence. They learn that spanking often creates problems rather than corrects them and that if they use the other methods presented, they will have little or no need to spank.

COMMUNITY INVOLVEMENT

This component utilizes two speaker sessions to heighten parent awareness of violence against self (drugs, depression/suicide), violence in the family (domestic violence, child abuse) and violence in the community (gangs, criminal behavior). Parents are encouraged to create a list of community resources that will support them in their role as parents, and to participate in neighborhood groups or to form their own community action council.

Strengths/Benefits of the Curriculum

One of the strengths of the curriculum is that it encourages parents to acknowledge their unique differences at the first class. From this foundation, respect and support thrive and grow as parents focus on their common denominator—raising children in difficult times. The remaining time in the program builds upon that common denominator, and the parents begin to support and bond with one another. In each participant, they find another resource, another person who can relate to their concerns. This is especially important to parents in recovery because often they feel isolated with their problems and do not seek out support.

Addressing the specific topics in the curriculum prepares parents to “respond rather than react” to their children’s behavior. It helps parents in recovery identify their role as models to their children and see how their behaviors will be perceived by their children. It also enhances parents’ self-esteem, self-discipline and social competence which is vital for parents in recovery who generally suffer from low self-esteem and question their ability to address parenting challenges. In an evaluation of the program, parents commented on their increased competency in addressing their children’s behavior, and they noted that they no longer feel discouraged with their discipline efforts. Additionally, the curriculum helps women to identify stress factors within their families, develop anger management skills, set goals for themselves, and break cycles that have been learned from their own parents.

The curriculum’s flexibility has been an asset, allowing facilitators to incorporate needed repetition, role-plays and additional activities. For instance, given the various learning styles and the multitude of issues these women are dealing with, it has been necessary to emphasize the concept of modeling even more than the curriculum prescribes. Discussions and role-plays are used frequently, and the positive discipline methods are repeatedly reviewed to assist participants in demonstrating understanding and implementing changes.

The curriculum’s flexibility also allows for tailoring to unique populations with specific issues. While presenting this curriculum to women in a recovery center for the past three years, the Strong Families facilitators were able to mold the curriculum to address the overall needs of the participants. Since many of the women had difficulty listening and staying focused for long periods of time, some of the information segments were shortened or modified to enhance learning. Also, facilitators found it beneficial to stray from a lecture/discussion format to more of a large motor/interactive one. Some examples include:

- Creating a game to stress the difference between co-dependent and interdependent relationships.
- Role playing scenarios that the participants have scripted themselves.
- Learning problem solving skills by having a “suggestion circle” and allowing each one to contribute a solution to a problem.
- Cooking activities to stress the importance of clear instructions while communicating with others.
- Physical exercises to comprehend the consequences for one’s choices.

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Challenges

Some of the hurdles the facilitators have addressed include the timing of breaks, snacks, and monopolization of the discussions. Clock watching became a past time that would disrupt the group as one participant would watch the clock in anticipation of breaks. To avoid this, facilitators began to inform everyone when the scheduled break would happen and remind them regularly throughout the session. Having the clock on the wall removed or placed on the back wall also helped to eliminate this distraction.

Another challenge occurred during break time when the women would stray off their regimented diets of no-caffeine and no junk food. Although nutritious snacks were provided within the class, the snack machine had many visitors. The facilitators took this teachable moment to address issues related to food choices, health and trading one addiction for another.

Finally, because most adults who have gone through treatment are very comfortable telling their story about how they got to where they are, who helped or hindered that process, and what their goals are for the future, it was often challenging to moderate the discussion. The average class size for Strong Families is 20, and allowing one person to control the conversation can be detrimental to the learning process. To address this, the facilitators organized rules for the group. They also began to set aside a short period of time before class for the women to rate their week from 1 – 10. This allowed a time for venting, sharing a problem, or commenting on the previous class. Providing this opportunity in the beginning, along with a reminder of group rules, reduced any one person from controlling the discussion.

Evaluation

Between 2000 and 2003, 71 women participated in the program. Overall, 74% of the participants graduated (completed all 13 sessions), with an additional 17% participating in 5-8 sessions. Using a pre, post and retrospective questionnaire, parents answered 35 questions about their parenting skills. This outcome-based evaluation targeted six protective factors (listed below).

Factors have been associated with resulting decreases in a variety of problem behaviors including drug and alcohol use, violence, early sexual activity, gang involvement, and child abuse and neglect (Marigna & Steele, 1999).

In our experience, parents tend to over-inflate their scores at the beginning of the class—believing that they are doing pretty well as parents. It is not until parents are exposed to different ideas and parenting techniques that they can more objectively compare their prior parenting behavior with the new behaviors they have learned through the Strong Families Program. Therefore, when parents were asked at the end of the program to think back to the beginning of the class and rate their skills at that time, they rated their parenting skills lower than they did when they started the program. However, evaluation of Pre (then), Before (retrospective), and Now (post) test scores show that parents perceived themselves as significantly improving in all six targeted areas:

- Factor 1 – Positive, Pro-Social Bonding With Children
- Factor 2 – Ability to Set Clear and Consistent Boundaries
- Factor 3 – Development of Life Skills for Parents and Children
- Factor 4 – Caring and Support Within the Family
- Factor 5 – Ability to Set and Communicate High Expectations
- Factor 6 – Opportunities for Meaningful Participation within Families

Given that the curriculum is based on a problem-solving model that helps parents to think through the potential consequences of the choices they are making, the observed change in true pre-test scores and the retrospective pre-test scores (“Before”) represents a change in awareness on the part of the parent.
When parents complete the Strong Families Program, they are able to more realistically assess their parenting skills and are parenting with a raised level of consciousness regarding the potential consequences of the types of parenting techniques they select to influence their children's behavior.

Also of significance is the fact that program participants gave the program an overall satisfaction rating of 4.8 out of a possible 5.0. Parents commented that their participation in the program (a) positively impacted their relationships with their children, “Individual time with each child has improved our family’s relationships”, (b) increased the use of positive communication and discipline strategies, “I am a lot more observant of my children and I listen to them more than I used to.”; (c) enhanced parent anger management and problem solving skills, “[My] frustration level has decreased. I am able to handle situations with my children in a calm manner”; (d) provided welcomed support, “Understanding that I’m not the only parent dealing with this.”; and (e) enhanced parent self-esteem and competence, “This program helped me to become a better parent to my kids”.

I genuinely believe, as I share in the graduation ceremonies, that ‘Success should not be measured by the position we attain in life, but by the obstacles we overcome to reach our position.’ These women have more than the average share of obstacles. I am continually encouraged by their examples of determination and willingness to try new things.”

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Inquires about the curriculum can be directed to the Program Developer, Dr. Marilyn Steele, (323) 936-0343; e-mail: dr_mls@earthlink.net.

REFERENCES

CALL FOR ARTICLES

The National AIA Resource Center is soliciting articles for the fall 2004 issue of The Source. This bi-annual newsletter is distributed to over 2,500 administrators, policy makers, and direct line staff throughout the country. Current issues of The Source also are available on-line at http://aia.berkeley.edu/publications/source.html.

The fall 2004 issue will focus on helping children transition to new caregivers. Specifically, we are looking for articles that describe effective strategies, services, and programs for supporting and assisting children affected by substance abuse and/or HIV in their transition to new or different caregivers. This may include transition to a foster or adoptive parent, transition to a standby guardian or new caregiver following a parent’s death or hospitalization, and/or reunification with a birth parent. Articles should address strategies for preparing children for the transition, assisting them in the actual move, and/or supporting them after the transition. Additionally, while the focus of this issue of the newsletter is on the children, articles may address transitional support provided to caregivers and siblings as well.

To be considered for publication, please send/fax/email a brief (150-200 words) abstract of your proposed article to the AIA Resource Center at the address below. Abstracts are due Friday, February 13, 2004.

SEND ABSTRACTS AND DIRECT QUESTIONS TO:
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National AIA Resource Center
1950 Addison Street, Suite 104, #7402
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A child born in many Los Angeles communities, or any urban area characterized by high rates of poverty and unemployment, domestic and community violence, poly-substance abuse, and family instability, is at considerable risk. The risks begin during pregnancy and continue throughout childhood, often resulting in delayed or disrupted development, emotional dysregulation, disorganized attachment, abuse and neglect, mental illness, and eventually school failure. California’s Little Hoover Commission’s (2001) report on children’s mental health summarized research indicating that disparities in health and social outcomes of children have their origins in disparities that begin early in life and may be compounded over time, affecting long-term emotional and intellectual functioning. Add to this the increasing state and federal budget crises that threaten programs providing essential education, social, and medical services, and the question arises: How will the many basic needs of these children and their parents be met?

The Needs of Families Served by AIA

Polls suggest that “82% of Americans believe it is harder to be a child today than in past years . . . (and) most parents face times when they really need help raising their children” (Halfon, McLearn & Schuster, 2002, p.1). Twenty-five comprehensive service programs throughout the United States, currently funded by the Federal Abandoned Infants Assistance (AIA) Act, are designed to meet these needs and assist with the many additional challenges of children and families affected by substance abuse and/or HIV.

One of these programs is Project Stable Home (PSH) at Children’s Institute International in Los Angeles. Project Stable Home began in 1994, and currently serves pregnant women as well as families with children from birth to age five. The 127 participants in the program during 2002 were primarily biological mothers who were single heads of households, with a mean age at intake of 28 years (range 17 to 44). When they entered PSH, fewer than half of them had graduated from high school, and only 9% had any earnings from employment. These parents often report poor mental health and limited prenatal care. For example, 50% scored in the clinically significant range on the Center for Epidemiological Studies—Depression (CES-D) measure, and 36% reported having attempted suicide as a child. In addition, only 60% received prenatal care during the first trimester of any pregnancy.

Family characteristics such as these affect the resources that are available to the developing child. Kilburn and Wolfe (2002) speak to limitations in purchased, time, psychological, and human capital resources. They report, for example, that 57% of the caregivers in single-parent households are unemployed, thereby making purchased resources extremely limited. Further, the greater the number of children in each family, the fewer the resources available for each child. They note that 41% of the families earning under $20,000 a year “had trouble paying for (basic) supplies such as diapers and food” (p.29). Almost 75% of PSH families live on less than half that amount!

Project Stable Home Model: Enhancing Parenting Skills Through Relationships

The PSH model that has evolved in recent years has been influenced by four considerations: (1) addressing the identified needs of the target population while respecting the culture, strengths and individual goals of each family; (2) basing program development on current research and best practice guidelines in all fields addressing child development and family
systems issues; (3) blending strength-based clinical and case management services with a rigorous evaluation component; and (4) recognizing that an integration of home visitation with center-based services not only is cost-effective, but also provides a secure base for consistent relationships for every member of the family, both with service providers and with members of other families.

PSH is a relationship-based, multi-disciplinary model grounded in attachment, cognitive and developmental theories. Beginning with a full child, parent, environmental and family assessment, the program offers each family an individualized treatment plan and concrete resources. Interventions for children address, individually and collectively, the systemically-related domains of sensory, motor, affective, social, language and cognitive functioning that are key to healthy development (Greenspan, 1997). For the caregivers, interventions are offered individually, with their child, and in peer groups, with the goals of identifying and enhancing family strengths and reducing the dilatory effects of maternal depression, substance abuse, and exposure to violence on children’s development and family relationships.

Case management services support the parents’ efforts to move through challenging social, educational, legal and medical systems to put in place the necessary structures that will help facilitate a healthy and stable future for the family. A Lending Library of developmental toys, books and videos is also available for children and parents to use, and emergency resources such as diapers, child-proofing supplies, and taxi vouchers for medical appointments are provided to families as needed. Finally, because no one program can effectively provide every service a family may need, PSH has developed long-term, collaborative relationships with residential drug treatment centers and agencies providing access to quality child care and low-cost housing.

PSH services are provided by psychologists; a social worker; a peer counselor; a family nurse practitioner; in-home service workers (IHSWs) with masters degrees in child development, psychology or nursing; and occupational, physical and speech/language therapists. At the present time, selected services may continue from birth until the target child reaches the age of five, or the family completes its self-identified and/or PSH team-identified goals.

This view of family development is not linear, so adults as well as children can be viewed as having accomplished only portions of each developmental task. Nonetheless, PSH’s comprehensive approach has proven to be an effective means of addressing many needs of children, meeting the social-emotional needs of caregivers, enhancing the parent-child dyad, and empowering the entire family system (Baker, Macauley & Boller, 2002). And, at the core of success is always the cycle of relationships: between program supervisor and therapist; therapist and parent; parent and child; other social service providers and the family; and among social service providers.

Parenting-Focused Components of PSH

Three components of the PSH program focus directly on supporting parenting skills and parent-child relationships: home visitation for parent education and support; center-based group experiences for parents and children; and videotaped parent-child play interactions.

HOME VISITATION

Early intervention can be effectively delivered through home visitation programs (Olds, 2002). Indeed, the American Academy of Pediatrics has recommended that pediatricians “recognize that home-visitation programs are . . . part of a continuum of care, and support referral of high-risk parents to . . . programs as early as possible” (American Academy of Pediatrics Council on Child and Adolescent Health, 1998). Yet the availability of integrated home visitation services in the United States has historically trailed other industrialized nations.

The core of the PSH program is weekly home visits by an In-Home Service Worker, who aims to develop a supportive relationship with the care provider and assist in meeting individualized goals. These generally fall under the broad categories of enhancing the quality of attachment and personal relationships: between program supervisor and therapist; therapist and parent; parent and child; other social service providers and the family; and among social service providers.

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well-being, increasing parenting skills, supporting family stability, improving the child’s developmental outcomes, and preventing child abuse. The initial phase (4 to 6 weeks) is focused on relationship building, addressing immediate needs, and assessment. During the first or second home visit, the IHSW verbally administers the 47-item Parent Needs Questionnaire to assess the parent’s perceived service needs in the areas of information, support, and community resources. These responses have been helpful in shaping the overall program, as well as individualizing the program to meet each parent’s particular needs. Following are the top eight needs expressed by parents:

- I need more information about how to properly discipline my child (Information)
- I need help handling stress (Support)
- I need more information about how infants grow and develop (Information)
- I need more information about how to teach my infant (Information)
- I need help finding a place to live suitable for myself and my child (Resources)
- I would like to meet more with a counselor to talk about problems (Support)
- I need help finding infant care (Resources)
- I need help handling my anger and frustration (Support)

Following the initial phase, an individualized and comprehensive intervention plan is developed, drawing on initial experiences and the broad-based assessment results. The subsequent focus of home-visits varies according to the intervention plan, but will always include ongoing parenting education and support for the long-term relationship between in-home service worker and parent and, by parallel process, between parent and child.

**CENTER BASED GROUPS**

PSH offers a total of four center-based, weekly groups. There are two psychosocial-educational groups for caregivers: (1) Anger Management/Domestic Violence Prevention for Women and (2) Parenting. There are also two groups where parents participate with their children: (1) Baby and Me and (2) Pediatric Occupational-Physical-Speech and Language Stimulation and Therapy.

In recent years, PSH has learned that the vast majority of caregivers in the program were exposed to significant levels of violence during childhood. A striking 84% of these parents reported being a victim of, or witness to, at least one severe act of violence (e.g., mugged, raped, attacked with a knife, shot at with a gun, witnessed murder) as a child. For many, the violence was repeated over several years. As adults, more than 50% of those women who had witnessed or been a victim of violence in childhood became perpetrators of violence.

To help address the needs of these women and reduce the risks to their children, PSH developed a 24-week anger-management intervention and domestic violence prevention group (Boller, 2001). The group’s aims include: 1) increasing awareness of what constitutes violence and child abuse; 2) generating awareness of how violence and fear of victimization may become part of an individual’s relationships, internal world, behavioral repertoire and parenting style; 3) providing alternative, non-violent strategies and behaviors for problem-solving and emotional regulation; and 4) educating caregivers about the impact of exposure to violence on infants, toddlers and young children.

A recent qualitative study with participants who had completed the group demonstrated the potential for change in beliefs, behaviors, and relationships (Baker, Macauley & Boller, 2003). Participant comments included: “I had to attend classes in prison, but I didn’t get it . . . here they don’t just talk at you, you get to share your experiences and feelings;” “I learned in this class that you need to give people a chance . . . before I didn’t talk to no one;” “I learned to not just react and hit someone . . . that’s not going to solve my problems;” “We learned how to listen in this group, and how to try to understand other people’s feelings.”

PSH’s 24-week parenting groups are both psychoeducational and psychotherapeutic in design, and they focus specifically on the issues relevant to parents of children from birth to age five. The goal of the model is to enhance positive parent-child relationships through: increased knowledge of how children grow and thrive; support for an expanded repertoire of evidence-based parenting techniques; and the development of empathy for their children’s individual needs by better understanding the effects of their own traumatic childhoods have had on their adult lives.

PSH’s Baby & Me class is an interactive parent-infant/toddler group that is designed to provide opportunities for each dyad to enhance their relationship in a fun and supportive atmosphere. Set in a stimulating environment that offers a variety of age-appropriate play and exploration opportunities, mothers and fathers are empowered to nurture their baby’s development through music, movement, social interaction, and dialog with other parents and the group facilitators.
Like Baby & Me, PSH's occupational/physical/bilingual speech and language therapeutic groups encourage parent-child interaction and affective engagement as the means to promoting child development for children with a delay that does not meet the severity of local Regional Center criteria for services. Each group provides playful opportunities to enhance fine and gross motor development, expressive and receptive language skills, sensory integration, and social skills—all the tools necessary for school readiness—while supporting the parent in learning to apply the techniques learned in everyday situations at home. With a ratio of two children for each therapist, the individual needs of each parent, child and dyad can be addressed each week.

When asked, in a blind survey, if participation in the parenting or parent-child groups had changed their relationship with their children, responses included: “I do more things with her . . . I don’t let her play alone all the time like I always did;” “Sometimes I expected more from my child than I should . . . now I know her behaviors are normal for her age so I’m more patient with her;” “I learned that spanking and yelling is not the way to treat kids . . . they get all messed up that way;” “We learned to take care of our kids so we don’t have to never neglect them again . . . we don’t have to never leave our kids with somebody and tell them that we’re going to the store and just don’t come back;” “I learned to love my child” (Baker, Macauley & Boller, 2003).

**VIDEOTAPE D PLAY**

Observing parent-child play interactions helps the program team assess how caregivers utilize their relationships with their children to support development. When the tapes are viewed with the parents, they are also powerful learning tools to help caregivers recognize strengths upon which new skills can be built. Thus, videotaped interactions are utilized in three ways: as an aid in identifying treatment goals; as an intervention and education component; and as a measure of change.

Following Greenspan’s framework for the Developmental Structuralist Theory and the Developmental, Individual-Difference, Relationship Based (DIR) model, the Functional Emotional Assessment Scale (FEAS) was designed as a way to systematically observe and assess the emotional functioning of young children and their caregivers. According to Greenspan (1997), “emotional capacities serve as the ‘orchestra leader’ that enables all the developmental components to work together in a functional manner.”

The FEAS is a videotaped free play session involving the parent and child (seven months to four years old). The caregiver is asked to play with the child as he/she “normally would.” This free play is split into two 7.5 minute segments. In the sensory segment, toys that are provided are oriented to sensory input, such as a tactile “koosh” balls, and a visually stimulating “glitter wand.” During the symbolic segment, children and parents use objects that have potential for symbolic play, such as a baby doll with a bottle of milk and a diaper; multi-cultural figures representing a mother, father and child; and pretend food.

Each caregiver-child dyad is videotaped at least every six months. The tapes are coded to assess both the caregiver and the child in each of Greenspan’s developmental domains: emotional regulation, “attachment,” intentional two-way communication, behavioral organization, and representational elaboration, which is the ability to expand on themes in symbolic play (Greenspan, 1997). The coding system was developed by Greenspan, DeGangi and Wieder (2001), and subsequently modified by Boller, Baker and Macauley (2003), to better assess the high-risk population PSH serves and to enhance inter-rater reliability.

The FEAS is a useful component of a comprehensive assessment, providing information on both the child’s and the parent’s development, as well as the parent-child relationship. To date, this measure indicates that most PSH children have not reached the higher level, age-appropriate, social-emotional developmental milestones at intake (Boller, Baker, Macauley, 2003). Further, many of the caregivers initially score in the clinically significant range for “attachment,” and most score in this range for two-way communication, behavioral organization, and representational elaboration.

Using Evaluation to Inform

Project Stable Home has an extensive evaluation protocol, aimed both at informing program planning and assessing program outcomes. In addition to the Parent Needs Questionnaire, Violence Exposure, and FEAS videotaped interactions, PSH administers a full battery of standardized child and parent measures, including measures of child cognitive and language functioning, parent mental health, family health and safety, and consumer satisfaction. These are brought together for individualized treatment planning and assessment of change through two primary measures: the Goal Attainment Scale and Progress Evaluation Form. A Goal Attainment Scale (Baker, Boller, Macauley, 2002) is constructed following intake for each client and

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includes 4 to 6 outcome goals for the first six-month period. For each goal, five possible levels of progression, or regression, and the source of information are identified. For example, for one mother living in a drug treatment center, goals included: (1) enhancing the quality of attachment to her child, (2) reducing her own depression, and (3) maintaining sobriety. Progress at six months could be assessed, in turn, by (1) the attachment code on the FEAS, (2) our standardized self-report depression scale, and (3) reports from the IHSW and residential center staff.

The Progress Evaluation Form (PEF) is a rating form completed by the in-home service worker and then reviewed at six-month intervals in a group meeting of the entire program staff. The PEF itemizes the services received over the previous six months, and then evaluates (on 3 to 7 point scales), process and outcome in domains including: attendance and follow-through, openness to services, estimate of benefits received from PSH, changes in parent and child well-being regardless of source, and quality and stability of child’s living situation. The PEF has the advantage and disadvantage of subjectivity. Our experience, however, is that the possibility of positive bias in assessing progress is more than compensated for by the open discussion and multiple perspectives of staff who have worked with the client (Boller, Baker, & Macauley, 2001).

What We’ve Learned

Already overburdened with the stress and risks associated with poverty, violence, illness, and lack of social support, parents assisted by programs such as those funded by AIA no longer struggle alone in maneuvering the labyrinths of public agencies in an effort to obtain the resources they need to provide the home they want their children to have. After only six months in the PSH program, parents and children showed significant benefits. There was a statistically significant decline in Parent Need Questionnaire scores; fully 85% of participants reported a decline in their need for information, support, or community resources. There was also a significant decline in parenting stress and depression scores. On the Program Evaluation Form, after six months in the program, staff ascribed moderate to very high benefits to four in five clients. When client benefits were assessed in relation to individualized goals using the Goal Attainment Scale, the outcomes were even more positive.

Virtually 100% of the clients experienced positive change in the area of child well-being, and 92% had a positive change in parenting skills.

Further, PSH is obtaining an anonymous client satisfaction survey after six months in the program, and the results of the first 27 have been most gratifying. Fully 100% of respondents agreed or strongly agreed: that they feel “closer, more attached to my child” (37% agree; 63% strongly agree); that they “would recommend PSH to other parents” (26% agree; 74% strongly agree); and that “my child has benefited from PSH” (22% agree; 78% strongly agree).

Perhaps not surprisingly, the extent of parent and child gains from the PSH experience is highly related to the extent of their participation in PSH services. Because a range of services is available to all parents and children, the extent of their participation is determined by their openness to staff recommendations and their ability to follow through. Thus, therapists’ success in building positive and trusting relationships with PSH parents goes a long way towards increasing the parents’ capacity to take on the challenges involved in becoming better parents.

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REFERENCES
Immersion programs are commonly considered a more effective way to teach a foreign language than didactic classroom approaches. Although students might learn how to conjugate verbs correctly in a classroom, they are more likely to learn how to use a language in a culturally appropriate way and how to successfully communicate with people in day-to-day activities if they are immersed in the language. Why not apply these principles to parenting education? In fact, that is how many of us learn how to parent—by observing our parents and through the guidance and modeling of friends and family.

Shared family care (SFC) is an innovative model that provides this opportunity for parents who are involved or at risk of involvement in the child welfare system. By placing parents together with their children in the homes of community mentors, SFC immerses families in a healthy family environment where parents receive guidance, modeling, support and education and have an opportunity to practice their new skills and receive supportive feedback in a safe environment. Just as inexperience at a foreign language is best overcome by immersing the person totally in an environment permeated with that language, so too can an inexperienced parent be immersed within a functioning family. There is a confidence, a cadence, and a repetition to successful parenting—a fluency, if you will, that one picks up naturally when involved in it. This article discusses the need for experiential parenting models that address the myriad other challenges substance using parents face. It also presents SFC as an effective parenting immersion approach that addresses a family’s basic needs (e.g., employment, housing, child care) so that they are able to focus on parenting and caring for their children.

Rationale

Parents involved in the child welfare system are commonly urged or mandated to participate in short-term parent education programs as part of their service plan. Despite the widespread use of this service intervention, few studies have measured its effectiveness in changing parental behavior, and the findings have been inconclusive or inconsistent (Huebner, 2002; Layzer & Goodson, 2001; Fennell & Fishel, 1998). Although some studies have found that group-based or didactic parenting education programs positively impact parents’ self-reported parental stress, knowledge about child development and parenting, attitudes about parenting, and perceptions of their children (Gorzka, 1999; Fennel & Fishel, 1998; Telleen, Herzeg & Kilbane, 1989), there does not appear to be any correlation between attitude and actual changes in parents’ behavior toward their children (Ring, 2001; Zepeda & Morales, 2001). For instance, parents participating in a ten-week didactic parent education program did not exhibit more positive parenting behaviors toward their infants than parents in a control group (Leonard, 1985). Forehand & McMahon (1981) identified two primary reasons for the ineffectiveness of didactic parenting: (1) lack of opportunity to practice skills that are taught, and (2) lack of corrective feedback. As a result, parents may not feel confident in their ability to apply new skills, or they may apply them incorrectly (Ring, 2001). Thus, O’Dell (1974) recommends that effective parenting education include three components: modeling, practice, and corrective feedback.

Although numerous studies have found that experiential methods of parent training are more effective than didactic methods alone in helping parents apply skills (Ring, 2001), child welfare agencies continue to offer...
didactic parenting classes to parents in the system. Even if classes include modeling and role playing, parents do not have an opportunity to practice applying new skills in real life situations if their children are separated from them in out-of-home care. Belsky (1984) identified three sources of parental functioning: (1) within the individual parent, (2) the individual child, and (3) the social context in which the parent-child relationship occurs (Gorzka, 1999). If a parent does not have an opportunity to interact with a child on a regular basis in a natural setting, two of these key variables are missing. Even if a parent’s knowledge increases, attitude changes, and potential for abuse decreases, his or her ability to parent a specific child on a day-to-day basis may remain unchanged.

Parenting may be particularly challenging for those with substance abuse histories whose children may have grown to view them as not always able to function and in some cases not able to meet even the basic needs of the family due to their drug use. Often children in these circumstances assume a parental role and may view their parents as unable to set limits and/or untrustworthy. Children who are parentified, hypervigilant, or overly anxious present significant challenges that need to be overcome before ordinary parenting can begin. Thus, parents in these situations need more than basic parenting classes. Building trust and assuring a child that they are safe are sometimes the necessary first order of business.

At the same time, parents with substance abuse problems often struggle with challenges of poverty, homelessness, mental illness, and other related issues, and they may have children with physical or behavioral problems due to prenatal exposure to drugs and/or chaotic lifestyles. All of these factors make parenting even more challenging and influence parenting conduct (Gorzka, 1999). In fact, parents cannot fully engage in or benefit from parent education until their basic needs (e.g., housing and food) are addressed (Forehand & Kotchick, 2002; Hardy & Street, 1989 as cited in Mondro, 2002). Even then, short-term parenting interventions may not be strong enough for parents struggling with substance abuse, who may need strategies of “greater complexity, longer duration, and greater expense” (Barnard et al., 1993 as cited in Huebner, 2001).

Finally, Forehand & Kotchick (2002) suggest that parenting intervention should be delivered within the community in which a family resides, offered at convenient times and locations, and delivered by individuals and agencies trusted by parents. They also highlight the importance of the relationship between the parent and the trainer, and note that “employing with parents some of the same techniques they are expected to use with their children (e.g.,... positive reinforcement) not only models these skills for parents, but also may serve to increase compliance with treatment demands.” (Forehand & Kotchick, 2002, p. 382).

Shared Family Care: A Parenting Immersion Program

Shared family care provides an in vivo, hands-on parenting education experience while helping to stabilize families. In this alternative to traditional child welfare services, whole families are placed in the homes of community members who mentor the families and work with a team of professionals to help the families obtain the skills and resources they need to achieve permanency for their children and move toward self-sufficiency. By providing services to the whole family, SFC enhances a family’s ability to cope with the stresses of daily living while ensuring the safety of the children. Additionally, because SFC places one family within another family, children with various stressors are able to feel a sense of stability and family, often for the first time in their lives. Children who have been “parenting” their parents are allowed to be children, and mentors can assist the parents in assuming or regaining the parenting role, learning how to set limits, and gaining or regaining the trust of their children.

MENTORS

A five-year evaluation of a SFC program in Contra Costa County, CA, found that mentors are primarily African American women (although about half are married, and several are single men), with an average age of 46 years (Clovis, Price & Wichterman, 2002). Most of them have some parenting experience, and about half currently have children or grandchildren living with them. Prior to accepting a placement, mentors must participate in 16 hours of foster parent Pride training that has been tailored to meet the specific needs of SFC, as well as 8 hours of initial mentor training. Additionally, mentors must participate in monthly educational support groups where they receive ongoing training, and they have access to staff on a 24/7 basis.

PARENTING EDUCATION AND SUPPORT

Through intensive case management and monthly educational support groups with a professional facilitator or
trainers, parents in SFC programs learn new skills and gain knowledge about parenting and other related issues (e.g., anger and household management). Living together with their children in a mentor’s home, they have an opportunity to apply this knowledge and practice new skills with the guidance and support of their mentors, who help parents customize what they’ve learned to fit the unique characteristics, behaviors, and experiences of each individual child. As one graduate of the SFC program in Contra Costa County, CA noted, “It’s not that regular parenting classes are bad or useless, they just aren’t real. They don’t teach you how to deal with your kids. The hands-on approach of SFC is so much more helpful.”

Unlike regular foster care, parents in SFC have primary responsibility for the care of their children. However, mentors can model effective parenting techniques for the parents, and intervene by redirecting them or suggesting alternative approaches when appropriate. For instance, a mentor might demonstrate how to bathe a young child or observe that the parent is feeding his or her child too much, too little, or inappropriate foods. A mentor may point out when a parent is being inconsistent or inappropriate with their discipline and help them to think through their goals and develop an appropriate strategy. Unlike traditional parenting classes where parents might discuss an event that happened, in SFC, mentors can intervene during a crisis to prevent it from escalating and turn it into a learning opportunity. They can also help a parent to recognize when they’re overwhelmed and help them to reduce their stress by altering their expectations, behaviors, approaches, and/or routines.

Additionally, because many parents in SFC are estranged from their own families and communities, mentors often become like parents to them, offering guidance, support and, in some cases, “parenting” that the parents never received. One graduate from the SFC program in Contra Costa County, CA noted how much she appreciated having a mentor to ask, “How did you do it?”, and just having someone to talk to and support her when she was feeling fed up. Mentors also engage in recreational, social and religious activities with the families in their care (Clovis, Price & Wichterman, 2002), which teaches families how to enjoy spending time together as a family. This is particularly important for families affected by substance abuse who often need to learn how to socialize without drugs or alcohol.

Finally, from a logistical perspective, with SFC, there is never a worry about parents not showing up for parenting class. Because most of the learning occurs in the home, the most common barriers of attending class—transportation and child care—are removed, and every moment becomes a potential learning opportunity.

Shared Family Care: More Than Just a Parenting Program

As previously noted, it is difficult for parents to focus on the needs of their children or improving their parenting skills when they are struggling with addiction, poverty and the myriad related challenges. In addition to focusing on improved parenting, shared family care assists families in stabilizing their lives by addressing the challenges they face. At the beginning of a placement, a family support team is established for each family. This team consists of the case manager, the mentor, the child welfare worker, and anyone else who is integrally involved with the family (e.g., substance abuse counselor) and/or who the family invites. The team works with the family to help them identify goals and strategies for achieving those goals. Because almost all of the families in the program are homeless or at risk of homelessness, and they are largely uneducated and unemployed, the goals almost always include housing and employment. In fact, in the SFC program in Contra Costa County, CA, a full-time housing specialist works with families beginning 30 days after they enter the program. By addressing these basic needs, the parents’ self-confidence and esteem begins to improve and they are better able to focus on the needs of their children. One graduate commented, “SFC provided the shelter I needed so that I could concentrate on my kids”, and several graduates noted how SFC helped them build more confidence (Guarino & Price, 2001).

Conclusion

Families involved in the child welfare system, particularly those affected by substance abuse, need more than short-term, didactic parenting classes to positively affect the relationship they have with their children and their parenting abilities. Shared family care provides an experiential learning opportunity that immerses parents and their children in a healthy family living situation, while simultaneously helping them to address their basic needs. In addition to modeling and teaching them important parenting skills, SFC nurtures and supports parents so that they can reciprocate with their children.

Although SFC is not for every family, feedback from participants is extremely positive. In order to benefit

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from the program, however, parents in SFC have to be open to a mentoring experience, ready to make changes in their lives, and willing to take constructive criticism (Guarino & Price, 2001). Preliminary studies of this model show promise in stabilizing families and keeping them out of the child welfare system. More detailed and rigorous studies are needed to evaluate and document the impact that shared family care and other experiential parenting programs have on improving parent-child relationships and parents’ abilities to care for their children.

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REFERENCES


For more information about shared family care, contact Amy Price at amypage@uclink.berkeley.edu, or 510-643-8383 or visit the AIA website at http://aia.berkeley.edu/information_resources/shared_family_care.html

The new AIA website provides on-line access to all of the Center’s recent publications including newsletters, fact sheets, monographs, directories, and other material. The website also allows you to:

- Listen to audio recordings of plenary presentations from our annual conferences
- Peruse a list of upcoming national child and family focused conferences
- Access a database of excellent trainers on a variety of topics
- Register for AIA conferences
- Subscribe to the Source newsletter
- Locate information and resources on a range of topics, including abandoned infants, HIV, substance abuse, shared family care and standby guardianship

We hope this new site will prove helpful to you!
BOOKS

Shared Leadership Series: Book 1, Putting Parent Engagement into Action: A Practical Guide

Book 1 of this series includes recommendations concerning parent engagement for local programs and neighborhood networks, as well as statewide and national systems and organizations. Cost: $15.00


How to Handle a Hard-to-Handle Kid: A Parents’ Guide to Understanding and Changing Problem Behaviors

This book provides tips, skills, and information for parents in order to identify, address and correct problem behaviors. It explores why some kids are hard-to-handle; and it offers parents specific strategies for handling everyday problems, becoming an authoritative parent, responding effectively to unwanted behaviors, and taking better care of themselves. Cost: $15.95


The First Three Years & Beyond

This book draws on the latest research from the social sciences and studies on the brain to answer questions concerning how much children’s early experiences affect their cognitive and social development, how important a parent’s role is in that development, and whether it is possible to ameliorate or reverse the consequences of early developmental deficits. The authors affirm that sound social policy providing for safe and appropriate early care, education, health care, and parent support is critical not only for the optimal development of children but also for strengthening families, communities and nations as a whole. Cost: $24.95


Fatherhood Training Curriculum

This curriculum is designed to improve policies and practice in the child welfare system by providing tools to engage and involve fathers in their children’s lives, strengthen and preserve families by restoring fathers to family life, and reduce the need for foster care and adoptive homes by using the father and his extended family as a placement resource. Cost: $50.00 (includes a CD-ROM)


Attachment Processes in Couple and Family Therapy

This volume shows how attachment theory can inform, enhance, and guide interventions for a wide range of relationship problems and clinical issues. Chapters from researchers and family therapists integrate literature to provide perspectives on the role of attachment in both distressed and satisfying relationships. The book presents research-based therapy models for embattled couples, families struggling with parent-child conflict and adolescent problems, and adoptive and foster families. Cost: $42.00


Evidence-Based Psychotherapies for Children and Adolescents

This book provides a practical overview of evidence-based treatments for social and behavioral problems in children and youth. Clinical researchers offer accessible, hands-on presentations of their respective approaches: what the primary therapeutic goals and methods are, how interventions are delivered on a session-by-session basis, how to tell if the treatment is suitable for a particular child, and what manuals and materials are available to clinicians and researchers. Cost: $50.00


Emotional and Behavioral Problems of Young Children: Effective Interventions in the Preschool and Kindergarten Years

This book provides hands-on tools and resources for addressing common emotional and behavioral problems in preschool and kindergarten-age children. The focus is on evidence-based interventions that are practical and effective, and that help prevent the development of more serious difficulties later on. It offers step-by-step suggestions for managing everything from toileting, eating, and sleep problems to externalizing disorders, internalizing disorders, and the effects of physical or sexual abuse. A variety of assessment methods are demonstrated and guidelines provided for planning and implementing a range of home- and school-based interventions. Cost: $25.00


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Early Intervention Practices Around the World

This book provides an overview of, and rational for, early intervention practices at work in China, Sweden, Ethiopia, Portugal, India, Israel, Australia, Germany, and more. Chapters are built around early intervention practices in four areas: service delivery models, family support, professional development, and organizational support. Each chapter includes a vignette that provides a cultural context; background information on the country’s social, political, and economic structure; the challenges and successes in implementation; and recommendations on how other countries can apply the lessons learned. Cost: $42.00


Author Carol Klass describes practical strategies based on her research and continuing field work in the second edition of this guidebook. Klass shows how to build trust, communicate respect and maintain boundaries with families, make home visits successful, and understand the states of typical child development. New to this edition: chapters on working with psychologically vulnerable and culturally diverse families; information on neurophysiology; emotional regulation, the father’s involvement, peer mentoring, SIDS, prematurity, and preventable childhood diseases; and an updated appendix with a wide variety of resources. Cost: $39.95


The Power of Questions: Building Quality Relationships with Infants and Families

The latest in a series of publications for busy program leaders, this publication focuses on direct service work with parents and children. Strategies for boundary setting and managing one’s reactions to families address the complex decisions staff face everyday. Cost: $10.00


Caring For Your Grieving Child: Engaging Activities For Dealing with Loss and Transition

This book offers advice to parents who want to actively help their children cope with the grief process, and it teaches parents how to recognize the intense attachments, behavior changes, and signs that grieving children show: stress, anxiety, and depression. The author introduces play-based techniques proven to help kids heal emotional wounds. Cost: $14.95


Skilled Dialogue: Strategies for Responding to Cultural Diversity in Early Childhood

This book provides instructions for Using Skilled Dialogue, a field-tested model for respectful, reciprocal, and responsive interaction that honors cultural beliefs and values. It provides a model for honoring the diverse identities of children and families by revising one’s understanding of cultural diversity, learning the essentials of Skilled Dialogue and applying them to early childhood assessment and intervention. Cost: $29.95


Child Welfare and School Readiness—Making the Link for Vulnerable Children

This resource brief is designed to strengthen the connections between child welfare and other early childhood services in state and national efforts to promote and enhance optimal child development. Designed for child welfare staff and individuals in the early care and education community, it serves as a primer on school readiness policy and draws upon growing evidence from brain research, child development, and child welfare to show the need to address developmental issues of children in the child welfare system. Cost: $10.00 ($5.00 for 2 or more copies)


Counseling Lesbian, Gay, Bisexual and Transgender Substance Abusers

This book gives practical suggestions for helping clients including what questions to ask them and what issues may arise in treatment. It provides a vocabulary for discussing issues with patients struggling with their sexual orientation or gender identity. It also looks at multiple oppressions such as racism, sexism, classism, and the interplay among these experiences, and it clarifies the complex interactions among gender identity, sexual orientation, and substance abuse. This edition is an almost complete rewrite of the original, updated with current information about bisexual and transgender substance abusers, LGBT substance abuse, up-to-date resources, and a glossary with extensive, updated definitions. Cost: $24.95


VIDEOS

Age-Appropriate Play: The First Four Years

This three-volume set teaches age-appropriate play techniques. In these videos, The First 12 Months, 12 to 24 Months, and Two and Three Year Olds, parents and caregivers will learn what social, language and motor milestones babies reach during the first year of life and how to play in a way that supports these achievements. The first video is divided into two sections: Birth to 6 Months and 6 to 12 Months and contains information on techniques in: talking and singing, holding and
gazing, floor play, simple games, household toys and outdoor activities. The second video provides age-appropriate guidance in talking and reading, outdoor activities, imaginative play, sand and water play, movement songs and simple arts and crafts. The third video includes teachings on the importance of play through creative play, singing and music, playing with other children, arts and crafts, outdoor activities and movement games. Cost: $249.85


S.O.L.V.E. Parenting Problems: The Toddler Years

This video provides a step-by-step tool that will help any parent handle toddler misbehavior with confidence and consistency. Developed by renowned parenting consultant Ann Corwin, PhD., M.Ed., the S.O.L.V.E. method is a flexible problem-solving process that parents can apply to any number of behavioral issues. With S.O.L.V.E., parents can learn: how to respond to problems calmly, positively and effectively; which behaviors are “normal” for their child’s developmental stage; skills for curtailing temper tantrums, hitting and other misbehaviors; techniques for disciplining in public; alternatives for spanking and yelling; anger management and abuse prevention; and toilet training tips. An additional guided problem solving exercise section is included. Cost: $225.00


This video, hosted by Maya Angelou, focuses on the important grandparent, parent and child relationship. Featuring real-life grandparents and based on the latest child development research, this video highlights the profound effects grandparents can have on the lives of their grandchildren. The video also provides ideas for staying connected even when far away, illustrates various grandparenting roles, and offers practical suggestions and inspiration that will benefit the entire family. Also available in Spanish. Cost: $16.95


The 5 Essentials of Successful Parenting

This five-video set focuses on the critical time from birth through age 5. It teaches easy-to-follow techniques that nurture parent-child relationships and empower parents to become positive models for their children through compassion, consistency and understanding. The first video, Love & Stability, focuses on showing unconditional love, reading and responding to a child’s cues consistently, creating routines based on a family's important needs and dealing with anger and frustration in positive ways. The second video, Time Together, covers building a strong parent-child relationship, supporting a child’s self-esteem, encouraging language skills through reading and talking and creating more time for a child. The third video, Inspire and Challenge, focuses on understanding a child’s abilities, choosing activities that build confidence, allowing a child to explore his/her interests and rewarding a child for successes and attempts. The fourth video, Positive Discipline, lends understanding on how to guide a child toward acceptable behavior, how to set-up and enforce appropriate limits and how to observe causes of conflict. The fifth and final video, Safety & Health, covers potential environmental hazards, age appropriate safety, doctor visits and a healthy lifestyle, as well as how to choose high-quality and safe daycare. Available in closed captioning. Cost: $324.75 for the set of five, or $79.95 each.

2003. 15 minutes (video 1), 12:30 minutes (video 2), 12:30 minutes (video 3), 15 minutes (video 4), 14 minutes (video 5). Available from Injoy Videos, 1435 Yarmouth Ave., Suite 102, Boulder, CO 80304. Ph: (800) 326-2082. www.injoyvideos.com

Why Can’t We Be A Family Again?

Shot over a three year period, this documentary chronicles two brothers struggling to keep their family intact despite their mother’s crack addiction. With the help of their grandmother and a family support organization called Center for Family Life, the film depicts the boys’ resilience and strength despite the odds against them. This film won the award for Best Documentary Short in the Atlanta Film and Video Festival, 2002. Cost: $295


Raising Resilient Children: A Curriculum to Foster Strength, Hope, and Optimism in Children

This nine-session curriculum and 70-minute companion video provide parents with strategies they can use to ensure their children are emotionally prepared to face any challenges or setbacks life may throw at them. The chapters in the manual and their corresponding video segments cover seven key guidelines to raising resilient children. In-class and at-home activities help parents recognize the crucial role they play in their children’s emotional health while real-life examples illustrate how to nurture the inner-strength children need to confront daily challenges and demands. Cost: $69.95 (Video with manual); $24.95 (Manual only)


Learning & Growing Together With Families Video Package

This training package describes specific ways to build collaborative relationships with families and colleagues. The package’s book and video draw upon the core concepts and skills that provide the foundation for the Learning & Growing Together approach: self-awareness, sensitive observation, careful reading of cues, and flexible response. Cost: $69.00 (Video Package). Cost: $14.95 (book only).

modes with the parenting relationship becoming a lesser priority. It is crucial to provide ongoing training in attachment, trauma, and addiction as it affects women and children. Since the EMPATHIC CARE approach relies on empathy, care needs to be exerted when hiring staff, as empathy cannot be taught. Although we have no magic tool to measure empathy, we use case scenarios to elicit empathic responses in the interview process, and we carefully scrutinize references with specific questions related to a potential candidate’s sensitivity to families and other team members. We also have found that paraprofessionals and frontline staff should only interact with families independently after they have received training and are able to integrate the strategies into their work as assessed through direct observation and in client review team meetings. EMPATHIC CARE provides a blueprint for supervision, which needs to constantly promote the holding in mind of the parent-child relationship. Team meetings should include role-modeling techniques such as pivoting, parallel processes, and showing respect for families. EMPATHIC CARE should be reflected in staff-to-staff relationships and team interaction.

Conclusion

PROkids Plus has developed an applied parenting intervention model, EMPATHIC CARE, based on attachment and relationship theory. It utilizes strategies known as pivoting to hold in mind and address the needs of the child and the parenting relationship while addressing the complex needs of high-risk families struggling with substance use. Through parallel processing, it nurtures and affirms the caregiver and helps promote healing from trauma and loss. Through increasing her capacity to respond sensitively and be present for her child, the model seeks to positively affect the neurodevelopment of the child providing a foundation for resilience and emotional robustness as well as interrupting intergenerational cycles of trauma and substance use.

Margaret McLaren, MD, Director, PROkids Plus, Assistant Professor of Pediatrics, Connecticut Children’s Medical Center, University of Connecticut, Hartford, CT

REFERENCES


Zero to Three’s 18th National Training Institute (NTI)

This conference seeks to educate, challenge and inspire infant/family professionals in their work with young children and their families. Sessions led by NTI’s internationally known leaders and experts will deepen participants’ knowledge of infant and toddler development and present new treatment approaches, program models, and policy options.

DATE: December 4-7, 2003
LOCATION: New Orleans, LA
SPONSORING AGENCY: Zero to Three
CONTACT: Ph: (202) 624-1760. Fax: (202) 624-1766. Website: www.zerotothree.org

Using Diverse Methods to Build Knowledge

The 8th annual conference of the Society for Social Work and Research includes institutes by NIH, NIDA, and CDC, as well as a full-day symposium on Drug abuse: HIV/AIDS and other medical and social consequences.

DATE: January 15-18, 2004
LOCATION: New Orleans, LA
SPONSORING AGENCY: The Society for Social Work and Research
CONTACT: Ralph Louis, SSWR. Ph: (512) 565-2051. Fax: (413) 643-8402. Email: ralph@sswr.org. Website: www.sswr.org

2nd Annual Children in Trauma Conference

This conference is designed to provide professional education and network opportunities for those who serve children who have experienced a traumatic event or environment.

DATE: January 16-27, 2004
LOCATION: Chico, CA
SPONSORING AGENCY: California State University, Chico’s Center for Regional and Continuing Education
CONTACT: Ph: (530) 898-6105. Website: http://rce.csuchico.edu/inservice/childrenintrauma.asp

7th Annual Women in Leadership Retreat

The theme of this retreat is When Women Lead: New Challenges, New Hopes. Through a combination of practical workshops and opportunities for self-reflection, the primary purpose is to connect women leaders to each other so that they can develop a network of colleagues who can offer encouragement and advice or serve as a sounding board.

DATE: January 26-28, 2004
LOCATION: Singer Island, FL
SPONSORING AGENCY: Child Welfare League of America
CONTACT: 2004 Women in Leadership Retreat/CWLS. Ph: (202) 942-0305. Fax: (202) 639-4900. Email: register@cwla.org. Website: www.cwla.org

18th Annual San Diego Conference on Child and Family Maltreatment

The objective of the conference is to highlight multi-disciplinary best practice efforts, and to develop and enhance professional skills and knowledge in the prevention, recognition, assessment, treatment, investigation and prosecution of all forms of maltreatment including those related to family violence and substance abuse. A Foundations of Practice track will guide professionals who are relatively new to the field, and a Leadership Track will feature experts on topics that transcend disciplinary lines. Additionally, an entire track of workshops will be delivered in Spanish.

DATE: January 26-30, 2004
LOCATION: San Diego, CA
SPONSORING AGENCY: Chadwick Center for Children and Families
CONTACT: Ph: (858) 966-8572 or (858) 576-1700 x4972. Fax: (858) 966-8018 or (858) 966-7434. E-mail: chadwickcenter@chsd.org. Website: www.charityadvantage.com/chadwickcenter/2004conference.asp

CWLA 2004 National Conference: Children 2004: Vision Action Results

Professionals, community advocates, administrators, and others concerned with the well-being of children will gather to share information and develop the policy, program, and practice action strategies needed to help make children a national priority.

DATE: February 23-25, 2004
LOCATION: Washington, D.C.
SPONSORING AGENCY: Child Welfare League of America (CWLA)
CONTACT: Ph: (202) 942-0305 or (202) 942-0308. Fax: (202) 639-4900. Email: global@cwla.org. Website: www.cwla.org

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Housing Innovations Conference

This conference will bring together experts in the supportive housing field to discuss innovative practices in supportive housing program design and operations, financing and housing development, organizational development and management, and policy advocacy strategies.

DATE: March 17-19, 2004
LOCATION: San Diego, CA
SPONSORING AGENCY: Housing Innovations Partnership
CONTACT: Center for Urban Community Services. Ph: (212) 801-3300. Fax: (212) 801-3325. Email: cucsinfo@cucs.org. Website: www.cucs.org

7th National Child Welfare Data Conference: Making it Work: Systems, Data, Policy and Practice

This conference is designed to enhance cooperation among program, system and administrative staff working together to meet the challenge of good practice reflecting sound policy using quality data. An emphasis will be on making future decisions utilizing existing data. Roundtable discussions and interactive, participative workshops will focus on a wide range of topics.

DATE: April 21-23, 2004
LOCATION: Washington, D.C.
SPONSORING AGENCY: National Resource Center on Information Technology in Child Welfare
CONTACT: Thomas Hay. Ph: (877) 672-4829. Fax: (202) 737-3687. Email: ncritcw@cwla.org. Website: www.ncritcw.org

Family Support America’s 10th Biennial National Conference: Extending the Reach and Building a National Framework

This conference will feature workshops, seminars and forums for attendees of all experience levels on various topics: making the case for family support, shared leadership, extending the reach of family support, and skills building and training.

DATE: May 12-15, 2004
LOCATION: Chicago, IL
SPONSORING AGENCY: Family Support America
CONTACT: Ph: (312) 338-0900. Fax: (312) 338-1522. Website: www.familysupportamerica.org.

HIV/AIDS 2004:
The Social Work Response

The theme of the 16th annual national conference on social work and HIV/AIDS is Empowering ourselves and our clients: Strategies for helping to shape the future of HIV/AIDS care. Through keynote presentations, poster sessions, papers, and advanced content presentations, the conference will address a variety of topics including the 2004 presidential election and the 2005 re-authorization of the Ryan White CARE Act. A pre-conference “advocacy day” will also be offered.

DATE: May 27-30, 2004
LOCATION: Washington, DC
SPONSORING AGENCY: Boston College Graduate School of Social Work
CONTACT: Dr. Vincent Lynch. Ph: (617) 552-4038. Email: lynchv@bc.edu

Putting the Pieces Together: 1st National Conference on Substance Abuse, Child Welfare and the Dependency Court

This conference will provide a unique opportunity to bring together representatives of the substance abuse, child welfare and dependency court systems from around the country to share innovative programmatic and policy efforts, learn about best practices in providing services to families, and support further collaboration across agencies. The sessions will focus on 4 areas: serving children of substance abusers in the child welfare system, practice and clinical issues, increasing collaboration and funding of system issues, and workforce and staff development.

DATE: July 14-15, 2004
LOCATION: Baltimore, MD
SPONSORING AGENCY: National Center on Substance Abuse and Child Welfare
CONTACT: NCSACW. Ph: 714/505-3525. Email: lynchv@bc.edu

American Professional Society on the Abuse of Children (APSAC) 12th Annual Colloquium

This colloquium is a major source of information and research necessary for interdisciplinary professionals in the field of child abuse and neglect. The most up-to-date and relevant research and practice information will be discussed through paper presentations, poster sessions, research symposia, and open forums.

DATE: August 4-7, 2004
LOCATION: Los Angeles, CA
SPONSORING AGENCY: APSAC
CONTACT: Tricia Williams. Ph: (405) 271-8202. Fax: (405) 271-2931. Email: tricia-williams@ouhsc.edu. Website: www.apsac.org

The National Abandoned Infants Assistance Resource Center’s 2004 Teleconference Series

The 2004 teleconference series includes 4 seminars on topics related to working with families affected by substance abuse and HIV. Each 90-minute structured seminar features an expert trainer and opportunities for discussion. The seminars can be accessed from any telephone through a toll-free number.

The 2004 teleconference series schedule and registration information are available at the AIA website: http://aia.berkeley.edu. Brochures will be mailed in early 2004. For further information, contact May Espeña, Training Coordinator, at may@uclink.berkeley.edu or (510) 643-7018.

TRAINING WITHOUT TRAVEL

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** One copy free while supplies last.

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