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Mental Health Treatment of Infants and Toddlers: Creating an Integrated System of Care for Infants and Toddlers in the Child Welfare System

Kathryn Orfiirer, PhD and Jill C. Rian, LCSW

Well-meaning and caring professionals in and out of the child welfare system still hold beliefs that reflect misconceptions about the capacities and capabilities of infants. Society in general is still catching up with the expanding knowledge available from the science of infant mental health. This burgeoning field can make us more aware of the detrimental impact of traumatic early experiences, guide us in lessening traumatic impact, and help us treat infants and toddlers once we do the important work of recognizing their experience of trauma.

The infant mental health field includes clinical applications of attachment theory, research on the impact of trauma on young children, and studies on early brain development, all of which promote an in-depth understanding of the experiences and needs of young children, their families, and caregivers in the child welfare system. Infants in foster care are more likely than any other population of infants to have experienced inadequate and disrupted attachments, trauma, and environmental deprivation. Substance abuse has been identified as a contributor in percentages as high as 80% of children in the child welfare system (Reid et al., 1999). For a large number of these children, in utero physiological insults compound the above-mentioned concerns. In addition, experiences of attachment disruption and less than optimal placements can set a trajectory of continued emotional, relational, and developmental disruption and dysfunction.

Child welfare is the system that touches society’s infants and toddlers who have suffered trauma through experiences such as physical and emotional abuse, chronic exposure to violence, attachment dysfunction, neglect, and serial abandonment. In addition, attachment disruptions continue as they are built into the child welfare system itself. Misconceptions like those quoted above can serve as a psychological defense for professionals and paraprofessionals who face the painful and often quite horrific experiences of the very young children they are entrusted to protect. Therefore, infant mental health information must be brought to this very system in order to inspire developmentally-based practice and policy. Equally important, infant mental health practice with these families must take an ecological approach by understanding the child welfare system that so greatly impacts these families’ lives.

This article will introduce critical issues in the child welfare system, explore pertinent infant mental health concepts, and then describe a unique model of bringing child welfare and infant mental health together in hopes that others can use elements of this approach. The model was created by the SEED (Services to Enhance Early Development) Program, a collaboration of the Center for the Vulnerable Child (a department at Children’s Hospital & Research Center Oakland) and the Department of Children and Family Services (DCFS) of Alameda County.

“She is only 13 months old; she is not going to remember any of this.”
“Babies adapt.”
“He’ll grow out of it.”
“Babies’ bones break easily and besides I don’t think infants experience pain in the same way as adults.”
ASFA made significant changes in child welfare policy and practice for very young children by shortening the period of time for family reunification and mandating the practice of concurrent planning (simultaneous efforts toward reunification and an alternate permanent family arrangement). ASFA thus recognizes the unique developmental needs for relationship attachment during this critical period by providing for early and lasting placement permanency, but has incurred some controversy both on the policy and practical level. Parent advocates question how reasonable it is for parents to make substantial change in these shortened time periods. Parents with substance abuse problems, in particular, have a shortened timeframe to recognize and reverse often long-standing addictions. Simultaneously, child welfare workers struggle with supporting alternative families who are grappling with the expectation that they be able to both foster and adopt the young children placed in their homes. Parents and child welfare workers worry that concurrent planning can present an obstacle to the reunification process and increase resentment between the two families.

In family reunification practice, the focus of child welfare services tends to be on the parents. The child welfare agency is held to a legal standing that reasonable efforts be made to provide support services to parents toward their reunification with their child. A byproduct of this parental focus is that very young children, in particular, are often overlooked and presumed to be doing fine in their placements. This is especially true when there are no overt signs of distress. However, even when such signs exist, they can be hard to understand or erroneously interpreted. Decisions are sometimes made regarding visitation, placement, and even transitions that do not consider the unique developmental and emotional needs of infants and toddlers.

Significant challenges exist for traditional child welfare workers, including caseloads larger than the recommended state standard, limited time to do the basic mandated tasks, insufficient resources, and limited opportunities to consult with their supervisor or other professionals when conducting assessments and making recommendations for the Juvenile Court. They are held to high standards but must make key decisions in isolation that have significant impact on families and children. Moreover, families in the child welfare system are transferred between social workers every time there is change in the legal status of their case, causing built-in disruptions to relationships as children and their families move through the dependency system. This continues to be standard practice, despite research evidence showing that a key element in supporting parents in reunification is the relationship with their workers (Regional Research Institute for Human Services, 1998).

The SEED model is based on the premise that when working with infants, toddlers, and their families in the child welfare system, particularly those affected by substance abuse and HIV, service provision should optimally involve the mutual and collaborative efforts of professionals and paraprofessionals in the fields of child welfare and infant mental health. Both fields have a wealth and depth of understanding to offer families; neither can work best in isolation. This dynamic and evolving ten-year-old program has afforded opportunities to learn about the complex challenges, as well as the unique benefits, of a collaborative relationship-based approach.

**The Child Welfare System and Very Young Children**

Recognizing the inherent vulnerability of children, child welfare agencies have historically been entrusted with the primary mandate of protecting and ensuring the safety of the nation’s children. The field of social work takes this a step further, emphasizing the importance of making an impact on the well-being of children and families beyond safety. These aims are balanced, however, by an intrinsic, strongly held belief that states should not interfere with the sanctity of people’s homes and families. Child welfare policies have shifted back and forth through the years in response to this tension. The most recent shift in child welfare policy is reflected in the Adoption and Safe Families Act of 1997 (ASFA), which recognizes the unique needs of children in foster care by placing safety, permanency, and well-being in the forefront as primary mandates.
The Contribution of Infant Mental Health Concepts to Child Welfare Practice

It can be daunting to try to understand the needs of preverbal infants in order to make life-defining recommendations and/or decisions on their behalf. Infant mental health concepts guide child welfare and dependency court professionals to better interpret infants’ communication about their needs. Infant mental health training offers these professionals a window into the world of the infant and their relationships. This information can then be factored into decision-making and used to lessen the impact when unavoidable yet stressful experiences occur, such as moves from home to home (Frame et al., 2004).

These same concepts underscore how integrally connected the social/attachment world of infants is to their psychological well-being and overall development. The primary relationships formed during this critical period deeply impact all areas of children’s development (cognitive, motor, language), as well as their sense of who they are in the world, how secure, safe, and reliable they perceive the world around them to be, and their belief that they can act on that environment. Very young children experience a large range of emotions, including grief and depression. Information from attachment theory, therefore, has critical implications for practice and policy in child welfare.

Young children in the child welfare system exhibit high rates of developmental delays (Halfon et al., 1995), which must be assessed and treated in their relational and social context. Infant mental health concepts aid in understanding both the etiology of delays for these children, the appropriate treatment response, and policy implications.

A high proportion of infants coming into the child welfare system are either prenatally exposed to substances or experience the dangers, abuse, neglect, or abandonment of the caregiving environment of a parent with an ongoing substance abuse problem. Infants may be removed at birth, but are often placed back in residential recovery facilities with their parent. Attention to the actual needs of the prenatally exposed infant, beyond fears created by media reporting, and to reparation of ruptures in the infant-parent relationship are all aided by the infant mental health clinical work. Additionally, infant mental health collaborations can be brought into residential substance abuse treatment centers that are traditionally designed for the recovering parent’s needs and not as focused on the separate needs of the infant who is also placed in their care. Collaborations between child welfare, infant mental health clinicians, and substance abuse counselors aid everyone in creating a comprehensive treatment plan and clinical understanding of the dyad’s needs.

Child welfare and infant mental health professionals alike hold successful family reunification as the highest goal. The field of infant mental health can help in conceptualizing case plans that fit an individual family’s needs and increase the likelihood of addressing and treating ruptured infant-parent relationships. Additionally, infant-parent psychotherapy provides a means to work with these troubled relationships. The parent’s own relational and trauma history, and the ways that it impacts the parent-child relationship, can be seen and treated. The impact on relationships of poverty, institutionalized racism, and disenfranchisement of minority groups can be identified and explored. This nuanced understanding can lead to case plans that have increased potential for successful, sustained reunification.

The SEED Model

The SEED team model implements ongoing integrated services that take into account both the developmental/mental health needs of the child and child welfare mandates for reunification and permanency. The SEED collaborative team gives clinicians and child welfare workers alike an ongoing experience of hearing and understanding differing roles and differing legal, professional, and ethical mandates. Members grow and learn together as relationships develop over time.

The SEED team is made up of child welfare workers and supervisors, public health nurses, infant mental health clinicians, and case managers. Child welfare workers use a vertical case management approach, in which a consistent relationship between the worker and the family is maintained in the movement through the child welfare system. This approach allows for the child and family to be held in the mind (Pawl, 1995) of the child welfare worker and given the necessary respect and continuity. The team supports the child welfare worker throughout the course of each
Making the child central and asking, “How will this affect the child?” or “What does the child need?” has eased many difficult dilemmas.

The SEED model supports the use of attachment theory and infant mental health principles to guide decision-making in child welfare. When working with infants and toddlers who are placed out of home, multiple primary relationships may exist requiring support or intervention. Flexibility in working with children in their changing and concomitant relationships may be necessary.

Intakes occur with every case and involve a comprehensive look at the child in primary relationships. The SEED model places an emphasis on the use of clinical tools to bring the child to life for those who need to be paying attention: the child welfare worker, the caregivers, the parents, and the bench officers. This is done by considering the narrative created through the enhanced screening process, the birth family information the child welfare workers present based on existing information, relationship-based interviews, and the public health nurse’s birth and medical information. The narratives bring real people into the room during weekly team meetings when cases are discussed and decisions made. Making the child central and asking, “How will this affect the child?” or “What does the child need?” has eased many difficult dilemmas. Cases are reviewed regularly, affording opportunities for team members to receive ongoing support and guidance.

Clinical interventions meld our knowledge of infant mental health and child welfare. Infant mental health clinicians work with clients’ complex psychological issues and reality-based challenges. Their close work with child welfare helps them to stay aware of a family’s case plan and journey through the court process. Clinicians understand that clients are usually seeing them under court mandates. Complex trust and confidentiality issues are addressed in an ongoing way.

Clinical work is accessible, providing the greatest opportunity for families to utilize and benefit from the work. Clinical visits are in homes, substance abuse treatment centers, day care centers, DCFS visitation rooms, and parks. Children may be seen in the contexts of multiple primary relationships, which influence the type of therapeutic work that is selected. For example, repeated and cyclical relationship disruptions can often be prevented by helping new caregivers understand that very young children’s behaviors can be reenactments of past traumatic experiences or unconscious attempts to recreate old and painful, but familiar, relationships. Reminders of past trauma that newer caregivers cannot understand or interpret might trigger children. Even very young children may act in angry and rejecting ways toward caregivers, evoking similar reactions because they are expected and familiar.

Attention to cultural context is formalized using a framework called ADDRESSING Cultural Complexities in Practice (ADDRESSING) created by Pamela Hays, Ph.D. ADDRESSING is an acronym that guides the team in considering Age, Disability, Religious upbringing, Ethnic identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National identity, and Gender (Hays, 2007). This format helps the team consider each family’s unique cultural experiences, including how they might influence the experience of the child welfare system and relationships with professionals. The framework also helps us reflect on how our own backgrounds influence our assumptions and behaviors in relation to the families with whom we work.

Faced with daily decisions that require making very difficult choices and recommendations, we have learned to take the time to be thoughtful in our discussions. We strive to be open-minded, not eliminating options too quickly. A reflective stance is integrated in team meetings, supervision, and on-going consultation. Children, families, caregivers, service providers, administrators, and policy makers...
Agency Impact

At the inception of the SEED Program a decade ago, there was very little knowledge of infant mental health in Alameda County child welfare. The prevailing assumption in the agency was that child welfare was already operating from a knowledge base of what was best for infants and toddlers. This belief was not due to arrogance, but to a lack of understanding of young children and the assumption that ensuring their safety was sufficient. Only as the information became integrated through SEED did child welfare workers come to recognize the importance of the infant mental health field.

A real desire to alter practice and to be more responsive to the needs of infants, toddlers, and their families has spread and significantly changed the culture of the agency as a whole. In the same way, clinicians’ assumptions that they were knowledgeable about child welfare were quickly challenged when confronted with the reality of the complex decision-making child welfare workers face. The SEED team infant mental health clinicians have altered and improved their practice through developing a deeper and more comprehensive understanding of the child welfare system.

Ongoing Challenges

We have found that an integrated infant mental health perspective allows the Court and the child welfare agency to more fully consider the needs of the infants served and is highly supportive to reunification efforts. This perspective has brought with it new, perhaps inevitable, tensions. The SEED Program faces misconceptions that too much attention is paid to young children at the expense of reunification with birth parents or placement with relatives. Birth parents’ attorneys, the Courts, and even some staff believe that by placing the child’s best interest above all else, we are holding the bar too high for parents and relatives and creating barriers to reunification and family continuity.
Misconceptions, uninformed practices, and misdirected anger within our agencies continue to be challenging. These misconceptions and misdirected feelings of anger and resentment seem to be rooted in part in the adversarial system in which child welfare operates: A system that emphasizes the ways in which the needs of parents and of children are in conflict can increase resentment and anger in all parties. Professionals can easily come to absorb those feelings and direct them at each other.

Conclusion

Though a formalized collaboration might not always be possible, certain principles can be generalized to clinicians and child welfare workers alike. This relationship-based reflective model brings to light an awareness of the primacy of relationships on all levels. Through working side by side, both child welfare and mental health clinicians have realized that this difficult work cannot be done in isolation. A multi-disciplinary team approach provides ongoing support and sharing of information for staff and leads to meaningful interventions for young children and their families. Just as child welfare workers provide more optimal services by working with infant mental health professionals, infant mental health clinicians provide better therapy when they understand the child welfare system and the unique experiences of children and families in the system.

Collaborative efforts require sustained attention to be successful. Building these relationships takes time, commitment, and a degree of openness. Young children grow and develop within the security of their primary relationships; therefore, those who are attempting to intervene and work with families and their young children should be cultivating and promoting relationships with each other. Sometimes it may feel impossible to build these relationships, but the experience of this collaborative effort has demonstrated that it is both possible and key to working with this population.

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Many women of childbearing age abuse legal and illegal drugs. Although the majority of them cease substance use when pregnant, approximately 4.6% continue to drink alcohol, 16.5% continue to smoke cigarettes, and 4% continue to use illegal drugs (SAMHSA, 2007a). Consequently, every year, many children in this country are prenatally exposed to substances.

Some of these children show direct negative outcomes that can range from birth defects and growth retardation to problems with cognitive development. Postnatally, unless there are supportive interventions, exposed children often grow up in homes negatively impacted by the issues associated with their parents’ addiction. These can include mental health problems, protective service involvement, and financial and legal difficulties. The postnatal environment can either help or hinder the child’s development and trajectory. Without effective and appropriate services, exposed children may demonstrate problems in development and behavior in infancy that often presage later academic, social, and vocational difficulties (Coles, 2006; Howell et al., 2008; Streissguth et al., 1996).

It is likely that many children presenting for clinical services (particularly those in the foster care and/or adoption system) are prenatally exposed. However, drug or alcohol exposure is often not considered in assessing neurodevelopment or in designing treatment plans. Given the risks, it is puzzling that relatively limited attention and funding has been allotted to developing intervention services for exposed children. Recent research on the effects of treatment, particularly for alcohol-affected children, suggests that it is important to take this issue into consideration.

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Interventions That Help Children Affected by Alcohol and Drug Exposure

Claire D. Coles, PhD, Mary Ellen Lynch, PhD, and Viorica Pencea, MD

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**Intervention Methods**

There are several approaches to helping children affected by prenatal exposure, each with its own merits. For infants, the most common has been to work with the addicted woman or family, both to encourage abstinence and to improve parenting and the home environment. This approach is sometimes used with older children as well. Less common are programs that work directly with affected children to treat cognitive, academic, and behavioral problems.

**Working to Strengthen Families**

In response to the problems associated with maternal addiction (e.g., poverty, homelessness, inability to work), many intervention programs, past and present, focus on working with substance-using mothers, often those who are pregnant or postpartum (Belcher et al., 2005; Kim & Krall, 2006). By providing medical care, substance abuse treatment, social support, and education concerning parenting practices to the
When older prenatally exposed children come to clinical attention (usually because of school failure and significant behavior problems), they are frequently no longer in the care of their birth parents. The Families Moving Forward (FMF) Program, developed at the University of Washington in Seattle, provides an intervention for families based on positive behavioral support techniques. The alcohol-affected, school-age children in this study were identified as having significant disruptive behavior problems. Parents were described as highly stressed with many unmet needs for clinical services and community resources (Olson et al, 2008, in preparation). Through support and consultation using a home visiting model, the FMF program modified parental attitudes and behavior with the goal of providing parents the skills to work with their children. The approach combined techniques based on social learning theory with an understanding of the neurodevelopmental impact of prenatal alcohol exposure on behavior. Over a period of 9 to 11 months, parents received specialized education, emotional support, and assistance with advocacy. Compared to a non-treated group, parents showed improved parental competence and self-esteem as a result of the intervention and felt their needs were being met; children were reported to show fewer challenging behaviors.

Beyond infancy, few programs have been developed for children that treat the direct effects of prenatal exposure. Several possible reasons exist for this lack of attention. First, this is in many ways a “hidden” population. Children come into therapeutic situations based on a decision made by one of the adults in their lives. Even when children exhibit behaviors of concern, substance-abusing caregivers can overlook these signs because of distraction, guilt, or denial. If the child is referred for treatment, parents may not inform clinicians of prenatal exposure or participate as actively as necessary in the therapeutic process. Consequently, children who come to clinical attention due to concerns about alcohol and drug effects are often in foster care or adoptive homes. However, similar problems are seen among children in foster care. While many foster parents are excellent advocates for the children in their care, others are overburdened or lack the level of commitment necessary to participate in interventions. Finally, children’s placements may not be stable enough to allow effective participation.
The educational system, from preschool on, would seem to be an ideal setting for improving cognitive, behavioral, and educational outcomes for prenatally exposed children. Some programs described below for alcohol-affected children have been successfully initiated in these settings. However, programs for older children related specifically to cocaine or heroin, if they exist, are not well-publicized or documented. Moreover, alcohol- and drug-exposed children are often not recognized as such, and the consequences of exposure are often mislabeled as behavioral disorders (e.g., attention deficit hyperactivity disorder, ADHD; oppositional disorder). Academic failures that might be predicted from knowledge of prenatal exposure and early developmental delays frequently go unidentified. Many school systems, and others who pay for intervention services, require that treatments be “evidenced-based” before they are implemented.

PROGRAMS FOR ALCOHOL-AFFECTED CHILDREN

Since first recognizing the effects of prenatal alcohol exposure in the United States (Jones & Smith, 1973) and describing the fetal alcohol syndrome (FAS), it has become evident that there are milder and less obvious consequences that can go unrecognized but still affect learning and behavior. As a result, we now refer to the fetal alcohol spectrum disorders (FASD). Despite 30 years of research in this area, it was not until very recently that interventions were developed targeting the problems associated with these conditions. Because the literature is so limited (Premji et al., 2007), it is possible to briefly describe the evidence-based interventions that have been developed or, more usually, adapted for alcohol-affected children. The limited number of interventions available specifically for these children has focused on preschool and school-age children. There is no published information on adolescents.

Parent-Child Interaction Therapy (PCIT): This well-researched and successful treatment method (Bearss & Eyberg, 1998) for improving parenting and child behavior in young children has been adapted for use with alcohol-affected children. Originally designed for use with families at risk for child abuse, PCIT addresses negative parent-child patterns contributing to young children’s disruptive behavior while teaching parents to develop more supportive, nurturing relationships with their children. Underlying this approach is the theory that behavior problems in children arise as a result of both neurodevelopmental deficits associated with prenatal alcohol exposure and parent/child interactions. Previous studies have established that PCIT can decrease the coercive cycle of behavior often observed in abusive families and lower the risk for child abuse. Children treated using PCIT typically show significant reduction in problem behavior while parents report less stress and show more positive parenting attitudes and behaviors. Two sites have reported their outcomes using this method: the University of Oklahoma Health Sciences Center, Oklahoma City, and the Chadwick Children and Families Center at Rady Children’s Hospital, San Diego, CA (Chaffin et al., 2007). Oklahoma’s PCIT program, which modified the usual one-on-one intervention to allow a group format, was evaluated in families with children three to seven years old. The investigators noted that retention in treatment was a problem and that the “change trajectories” seen with this population are unlike those seen in other clinical groups. However, clinical levels of behavior problems were significantly reduced following treatment. (Mulvihill et al., 2003).

Language and Literacy Training (LLT) (Adnams et al., 2007). This South African study addressed effects on cognition, academic achievement, and behavior for children with FASD. Forty third-grade children were randomly assigned to LLT or a nontreated group and compared to normal controls. At pretest, children with FASD were poorer on both language and math skills. The classroom intervention was administered in a group format, twice a week, by a speech and language therapist. Fifteen minutes were spent on phonological awareness and 15 on language therapy. The intervention group demonstrated improved outcomes on language and literacy measures relative to the untreated FASD group, but both performed more poorly than nonexposed controls. Improvement was specific to LLT with no effects seen on overall scholastic achievement. The authors suggest that methods developed to work with learning disabled children
can be applied effectively to FASD. Attempts to involve parents were not as effective as anticipated, probably due to limited family resources.

**Math Interactive Learning Experience (MILE)** (Kable et al., 2007; Coles et al., in review). While prenatal alcohol exposure affects cognitive and academic functioning in many areas, cognitive skills that contribute to the development of mathematics are particularly vulnerable. These problems may be attributed to the effects of alcohol exposure on the brain and the lack of adequate environmental support. The MILE program uses parent training, individualized educational intervention, and modifying arousal regulation to improve behavior and math functioning in children ages 3 to 10. In a study carried out at the Marcus Institute in Atlanta, Georgia, 61 children were randomly assigned to either a math-tutoring program or a standard psycho-educational group. Parents in both groups were provided information about the neurodevelopmental impact of FASD on learning and behavior, methods for interacting with educational and social systems, and behavioral management techniques. The Math group received six sessions of individual tutoring while parents were provided with “home work” to support math development. An active learning approach adapted from the methodology developed by the High-Scope Perry Preschool Project (Luster & McAdoo, 1996) was used. At follow-up, children in both groups showed fewer behavior problems, and those in the math group had significantly more gains in math achievement. At a six-month follow-up, improvements in both areas were maintained, and teachers reported significant declines in behavior problems at school.

**Project Bruin Buddies: A social skills training program** (O’Connor et al., 2007). Alcohol-affected children, from early school age through young adulthood, have difficulties making friends and developing and using appropriate social skills (Streissguth, 1997). Researchers at the University of California at Los Angeles adapted a social skills program based on social learning theory (Frankel, 2005) for use with alcohol-exposed children, ages 6 to 12. They modified the well-researched protocol to accommodate the neurodevelopmental deficits associated with FASD by changing how the treatment was delivered rather than altering content. Significant skills, including social network formation, goal-directed information exchange, group entry (“slipping in”), play dates, and conflict avoidance, were taught in a group format. Additionally, parents were taught how to “coach” children to support skill development. Half of the 96 children were randomly assigned to parent-assisted Children’s Friendship Training (CFT) and half to a Delayed Treatment Control (DTC). The 12-session intervention was evaluated immediately after completion and three months later. Children showed significantly improved knowledge of appropriate social behavior, and parents reported improved social skills and decreased problem behavior at home. Teachers, however, did not report significant improvements at school. Observed gains were maintained over the three-month follow-up period. Parents reported increased understanding of FASD and satisfaction with treatment.

**“Games that Work”: Using computer games to teach alcohol-affected children about safety** (Coles et al., 2007; Strickland et al., 2008). Cognitive limitations and behavior problems place children with FASD at high risk for unintentional injuries that are a leading cause of death and disability for youngsters. Teaching safety skills can prevent such injuries, but this may be difficult for parents and teachers because of the need to tailor the instruction to the specific needs of the child and to persist until the skill is mastered. In this project, 32 children, ages 4-10 and diagnosed with FAS or FASD, learned fire and street safety, which pose significant issues for young children, through computer games that use “virtual worlds” to teach recommended safety skills. The game format addresses children’s skill learning deficits by allowing repeated, consistent practice, clear on-screen guidance.
The aforementioned studies used methods that were developed for other groups of children, including those with learning disabilities, psychiatric disorders, and behavior problems. When interventions were adapted to accommodate the neurodevelopmental characteristics associated with prenatal exposure, as well as the impact of postnatal environment, children were able to benefit significantly. In the past, it has been suggested that alcohol- and drug-exposed children are particularly resistant to treatment, perhaps because “brain damage” resulting from their exposure renders them unable to learn or change or react like other children. This suggestion is often made either to deny children services or to excuse a lack of effort to improve outcomes. Happily, the studies mentioned in this article directly refute this idea and may help dispel such negative thinking in the future.

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Conclusion

This brief review of treatment methods demonstrates that, in the right circumstances, prenatally exposed children respond well and demonstrate significant improvements in development, cognition, and behavior. The findings point out the importance of early identification of affected children with significant delays, the need for more resources, and the insight that certain factors greatly increase the likelihood that interventions will be successful. Particularly with young children, caregiver involvement in, and commitment to, the treatment process are important to successful outcomes.

These studies also suggest an answer to the frequently asked question concerning alcohol- and drug-exposed children, “Is it not possible that their needs can be met through the “usual and customary” methods used to treat other neurodevelopmentally-based disorders instead of specifically designing interventions for them?” The answer to this question is probably “yes and no.” Clearly, prenatally exposed children respond in most ways like other children. However, prenatal exposure can lead to particular patterns of neurodevelopment and is many times associated with certain kinds of life experiences, such as parental psychopathology, poverty, foster care placement, and school failure, that affect child development and behavior. Understanding these patterns allows greater efficiency in designing more effective interventions. Indeed, it has been demonstrated that effective intervention strategies must target disability-specific strengths and weaknesses and adapt techniques to accommodate to these characteristics (Sobo & Kurtin, 2007).
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SHIELDS for Families, Inc. has been providing services to the entire family unit, with specific programs for children ages 0-18, since opening its first substance abuse program, Genesis, in 1990. Since 2002, over 1200 children have been served in conjunction with their mothers.

This unique model allows the entire family unit to enroll in the program and receive services on site. Currently, SHIELDS offers five family-centered programs located in the communities of Compton and Watts in South Los Angeles. Each program provides substance abuse treatment, child development and youth services, case management, and vocational services at the facility. Families are also able to access housing either on- or off-site, depending on the program, through one of the 126 units of low-income housing provided by SHIELDS. For the past 18 years, completion rates at all programs have averaged between 65%-82%, with the length of stay averaging 18 months.

SHIELDS implemented family-centered treatment because we believe that addiction is truly a family disease. All members of the family must have access to services in order to break the cycle of addiction and allow the family to heal and achieve well-being. This article highlights the services we have offered children in our child development and youth programs. A description of program services, along with evaluation results of the past five years, is provided for both components.

**CHILD DEVELOPMENT CENTERS:**
**Children 0-5**

**PROGRAM DESCRIPTION**

The target population of the Child Development Centers is children 0-5 who have been exposed to substances prenatally or environmentally and who are at high risk for physical, social, emotional, and developmental delays. The primary goal of the SHIELDS Child Development Program is to promote the healthy development, social and emotional well-being, and school readiness of these children through the provision of therapeutic and developmentally appropriate services. In addition, the program seeks to enhance the parenting and child development skills of the substance-abusing mothers enrolled in our treatment programs.

Staffing at each site includes full-time Child Development Workers and a Child Development Specialist. Consultants are utilized to provide specialized services. Children, ages 3-5, with special behavioral needs are referred to the SHIELDS Therapeutic Nursery, which is on-site at the Genesis program location and staffed by two full-time Therapists, a Mental Health Rehabilitation Specialist, a Child Development Specialist, and a Child Development Worker. The Nursery serves a maximum of 16 children utilizing a day treatment model to provide intensive mental health services.

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Each SHIELDS Center provides developmental assessments and evaluations for all enrolled children, utilizing the Denver II Developmental Screening and the Ages and Stages Questionnaire. Developmentally appropriate Individual Education Plans are created and implemented for each child. Children are in the Centers for a minimum of six hours per day, five days a week, during the course of their parents’ enrollment in treatment. Based on their age and developmental stage, children are divided into three groups—infants, pre-toddlers, and toddlers. Structured lessons are provided daily and focus on specific skill sets appropriate to each age group, with an emphasis placed on the development of gross and fine motor skills and social skills.

Mothers enroll in child development and parenting skills education groups, receiving information and skills to prepare them to better care for and interact with their children. Mommy and Me parent/child interaction classes and parenting education classes are each provided one time per week. Supervised Early Intervention is also incorporated into the mothers’ schedules in order to allow them to practice parenting skills in the Center. All families receive in-home visits a minimum of two times per month to ensure that the knowledge gained in the program is transferred to the home environment. Additionally, all participants engage in an in-home literacy program that encourages the ongoing development of the children’s language skills and enhanced mother-child bonding.

EVALUATION RESULTS

Between 2002 and 2007, 461 children (ages 0-5) were enrolled in the Child Development Program. Of these, 96% were ethnic minorities (61% African American; 35% Latino). At admission, nearly one-third (31%) of all enrolled children suffered prenatal exposure to drugs or alcohol, almost one-fifth (19%) had low birth weight, and approximately half (49%) had open Department of Children and Family Services (DCFS) cases.

A total of 436 children remained in services a minimum of 30 days and received at least one developmental screening. On average, over the six-year period evaluated, 85% of the children had scores that fell within the normal range of development upon entry into the program, and 15% of the children were identified with potential delays and referred on for additional assessment and specialized services. The rate of developmental delays identified in the initial assessment continued to decrease over the intervention period, with 24% identified in the first year of data collection decreasing to 5% identified in the last year. This decrease is attributed to the aggressive outreach and early enrollment of families in the program through our collaboration with DCFS. These efforts have enabled children to remain in the custody of their parents, mitigating the developmental risks associated with separation and loss of attachment and bonding.

From 2002 to 2007, a total of 314 families were enrolled in the Child Development Program. More than 800 in-home parenting visits and 1,000 center-based individual sessions were conducted with parents by the Child Development Workers and Specialists in order to enhance parental ability to implement appropriate developmental activities and interventions. In addition, pre- and post-test results documented that mothers consistently demonstrated an increase in knowledge in the area of child development and parenting skills. At pre-test, mothers had an average score of 75%. After completion of a minimum of 16 weeks of parenting and 16 weeks of child development classes, the average post-test score was 90%, an average increase in parental knowledge of 15%. Moreover, more than 200 mothers completed the requirements for the child development and/or parenting certificates.

Finally, SHIELDS’ Family-Centered Programs have been highly successful at achieving low rates of very low birth weight among infants born to enrolled mothers, averaging 4.5% over the last six years, as well as high rates of early entry into prenatal care, averaging approximately 67% over the last six years. Immunization rates among all enrolled children have averaged approximately 80%, and all mothers and children (100%) have been linked to a regular medical doctor and/or clinic. Most significantly, of the 264 infants born to mothers enrolled in the program between 2002-2007, less than 6% had positive toxicology screens at birth.

HEROS AND SHEROS PROGRAM: Children 6-18

PROGRAM DESCRIPTION

The Heros and Sheros Program provides after-school and full-day programming (during summer and school vacations) to a static capacity of 300 youth, ages 6-18, whose parents are enrolled in treatment. The goal of Heros and Sheros is to decrease risk factors and to increase protective factors by addressing five risk domains—individual, family, school, peers, and community—through culturally-based programming. Services are designed to increase self-esteem, improve family functioning, increase decision-making and problem-solving skills, improve academic performance, and increase community awareness of challenges affecting youth.
After-school program services include individual and group counseling, mental health services, cultural enrichment, alcohol and substance abuse education, recreational activities, computer training, leadership development, and educational support. Staffing includes a minimum of three full-time Therapists at each site and Mental Health Case Managers.

The Heros and Sheros Program was designed to address the cultural needs of our program youth. Consequently, all of our program activities and materials were developed from a cultural context to meet specific cultural needs. Because our programming is “culture-based and culture-driven,” there is a “natural” integration of our support services and prevention strategies with arts and humanities. This might be best exemplified in our activities focused on self-esteem/self-identity development. As opposed to focusing on generic self-esteem development, our program utilizes an ethnic-specific curriculum that focuses on historical and current role models who have life experiences consistent with those of our program participants. Our Winners Curriculum—with a heavy emphasis on reading, writing, and discussions—utilizes literature to provide youth with strong cultural values. Our Pen Pal Writing Program with children from West Africa emphasizes writing and the sharing of ideas and values for self-discovery and illumination. These ideas and values are integrated into African and Salsa dance and drumming classes and youth performances in Juneteenth, Kwanzaa, and Cinco de Mayo celebrations.

In 2002, the SHIELDS’ Heros and Sheros Program was specifically recognized by the California Institute for Mental Health’s CalWorks (California Work Opportunity and Responsibility to Kids) Program as a model after-school program. The program also has the rare distinction of receiving funding from the Center for Substance Abuse Prevention for three different research-driven, high-risk youth substance abuse after-school prevention programs.

**EVALUATION RESULTS**

To ensure that testing data is available on every program participant, youth are tested quarterly. The program’s main testing instruments are the SSI (School Sentiment Index), SAI (Self Appraisal Inventory), the CAVS (Children Africentric/Latino-centric Value Scale), and the CRIS (Children Racial Identity Scale). During the 2003 program year, the measures used to gauge program impact on participating youth were expanded to include the Rosenberg Self-Esteem Scale and a Computer Literacy Checklist and Social Skills Assessment Form developed by SHIELDS. In 2004, two additional assessments were added to our testing regimen—a Community Mobilization (Leadership) Scale and an ATOD Awareness Scale. Finally, in the 2005-2006 program year, a Community Event Survey form was added to our arsenal of evaluation assessments.

Based on the results of our quarterly program assessments, the program has had a positive impact on participating youth: 60% of participants improved attitudes towards school and education; 75% improved their grades in math and English; 77% improved their self-esteem and self-confidence; 77% improved their cultural awareness/identity and community mobilization activities; and 80% improved their awareness of substance abuse-related issues in their community and recommitted to live drug-free lives.

**Summary**

Since implementation of our first program in 1990, SHIELDS has continued to maintain a strong emphasis on the provision of services for our children. Our evaluation results indicate the significance of providing interventions designed specifically for the children of parents impacted by substance abuse and reinforces the need to make the delivery of these services an integral part of all substance abuse programs.

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This article describes a new model of early dyadic and group intervention that targets these patterns with biological mothers in the process of reunifying with their children. It supports mindful parenting and secure attachments through facilitation that includes infant massage, parenting education, real-time infant-parent mental health interventions, and parental self-awareness. The program was founded on the proposition that relational stability and secure attachment are inevitably connected to regulatory stability in parent and child.

**History**

Fostering Mindful Attachment (FMA) is a program of A Home Within (AHW), a national nonprofit organization offering mental health services to the foster care community. Executive Director Dr. Toni Heineman initiated the program in 2005 as a pilot project affiliated with teen foster homes. The program has since evolved into a court-approved curriculum for biological parents of infants in, or at-risk of, placement. Co-directors Amy Cooper, MFT and Mark Ludwig, LCSW developed the 20-hour curriculum with infant massage as a central platform for teaching attunement and supporting the early attachment processes. The FMA project, in collaboration with the University of San Francisco, is now in the first stages of program evaluation. The first data are expected to be available in mid-2009.

**Population**

Throughout the first year, project staff worked with two ongoing groups of biological mothers and babies; one took place at the AHW agency office; the other continues to meet at a community-based substance recovery center. All the infants in the program were exposed to drugs in utero, and all the
mothers are in residential drug treatment programs. As children, most of them were developmentally stressed by poverty, loss, and exposure to violence, and as adults they experienced the chaotic environments associated with substance abuse (Lester et al., 2002). Like most biological parents of infants in foster care, FMA parents had a significant history of trauma. Many had been raised in foster care and had multiple caregivers, disrupting their own capacity to form secure attachments.

The Model in Practice

Like all infants, Marie is most available for contact when her body is handled in a way that supports her development and does not unduly compromise her ability to remain organized. Pacing interactions at a speed that is not over-stimulating enhances infant attachment security (Beebe & Lachman, 2005). A mother learning infant massage is guided in real time to become curious and attentive to her infant’s bodily response to the pacing of her touch. If any baby in the group becomes overly excited, the mother is encouraged to experiment in the moment to see what happens when she slows down the rhythm or depth of the touch. Often the infant encourages this slowing down. Imagine the impact of Marie finally meeting her mother’s gaze as her mother leans over and strokes her cheek. An engaging infant response has the potential of reinforcing a mother’s more attuned and sensitive interaction. This dynamic expansion between infant and mother may become a positive pattern supported by the feedback loop of touch and response (Tronick, 2007). The group format allows facilitators to model and mirror the pacing and reflective process by their interactions and communication with each other and the mothers.

Facilitator interventions in the FMA approach to infant-parent massage are aimed at cognitive, emotional, sensory, relational, motoric, and arousal patterns. Through practice, caregivers learn to track infants’ responses to qualities of touch and interactions, as well as to recognize and attend to their own internal states of arousal (Ogden et al., 2006). Mothers learn self-awareness and relaxation exercises to calm their own aroused nervous systems, which in turn support their availability to respond to their infants during the infant massage process. As mothers successfully attend to their infants’ distress, they extend the state of calm and positive affect to the mother-child relationship.

When babies are cared for in predictable and calming ways, then both mothers and infants are less distressed and have more opportunity for shared experiences of excitement and security (Stern, 1985). Furthermore, a pattern of nurturing touch reduces the developmental “costs” (Sander, 2000) that infants incur when they must continuously adjust to insensitive handling. In fact, certain types of gentle touch have been proven to calm the infant nervous system (Field, 2003). Attuned rhythmic touch and sensitive caregiving have also been linked to neurodevelopmental success in children’s recovery from trauma (Perry, 2007).

The face-to-face positioning during infant massage offers opportunities for communication, connection, and shared experiences of mutual delight between caregivers and infants. This is significant, as maternal delight, viewed by the infant, has been linked to attachment security (True, 2006). Positioning optimizes chances for contingent communication loops (Greenspan & Benderly, 1998) that form the basis for language development. Positioning also optimizes the many positive developmental effects of well-regulated interactions (Barnard et al., 1998). By continually attuning to infant responses, caregivers learn about the importance of communicating through rhythms, pacing, and tone. In the process of receiving increasingly responsive touch, infants experience a powerful sense of self-organization that comes from being “recognized” (Sander, 2000) in the encounter.
Early interactions structure the child’s “internal working models” (Bowlby, 1983) via repeated behavioral exchanges and mutual regulatory processes. In the group, we frequently explore new strategies for mothers to calm themselves and to comfort their infants. Mothers slowly become more available for the task of regulating their babies’ immature nervous systems, and more able to tolerate and attend to their babies as they move continuously between excited and calm states.

Our model is always cognizant of infant developmental-motoric reflex patterns. When supported by a caregiver, these patterns provide a secure base for infant and caregiver alike to explore their relationship, balancing space, gravity, and the relational fields. For instance, an infant’s startle reflex is frequently initiated by the parent’s unattuned handling. When we notice that a mother has startled her baby by insufficient neck support, we encourage the mother to experiment by tossing her head back without support and then, alternatively, support her own falling head with a cupped hand. When she can change the way she lifts the baby, a relational pattern that is responsive to the infant’s bodily needs is set in place and reexperienced. Each time the baby is picked up, the experience of responsive parenting generalizes to a pattern of comfort and security.

Summary

Dyads like Marie and Bella who have suffered many losses cannot tolerate more disruption to their fragile sense of trust. A model that offers compassion to both mother and baby and engages their unique capacities for self and co-regulation helps both partners move into contact with themselves and with each other. This changes everything. They now move from loss to love.

The focus on the body-to-body interactions of caregiving provides a unique perspective on the biopsychological basis of secure attachment. The infant’s body is born dependent on attuned care. This dependency extends from the basic needs for feeding and bodily care to more regulatory needs for feeling secure within themselves, in the daily rhythms needed for self-regulation, and in their relationships. Through body-to-body contact and touch communication, the infant and caregiver begin to develop ways of mutually regulating affect, arousal, and attunement.

Touch is especially meaningful in the context of attachment security because most caregiving interactions involve touch and/or touch deprivation. The teaching of infant massage within an infant-parent mental health context provides a uniquely rich experience for each mother and facilitator. Both can delight in the study of the baby’s responses to appropriate touch and care, as well as be curious about pacing and positioning for positive interactions and secure attachment outcomes.

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Abandonment, however and whenever it happens, has the same result: emotional devastation. Once a child is abandoned, the effort to restore wholeness can take a lifetime. My personal experience with this subject has spanned more than 15 years. I have watched my two grandchildren struggle with their very identity, their value as human beings, and most importantly, their self-worth.

My son is the father of my grandchildren. Although he has played a large part in their lives, he has been incarcerated 14 out of the last 20 years due to drug addiction. The children’s mother was just 16 years old when she gave birth to her first child, a daughter who just turned 19. Her brother is now 16 and will be a junior in high school this fall.

In 1993, when my granddaughter was two and my grandson 10 months old, I became their legal guardian. My son was incarcerated at the time. Their mother simply left one day and did not return for long periods although court-ordered visitation was in place. She started seeing them more regularly when my grandson was about five.

In 1997, the children’s mother confided in me that she had HIV/AIDS. Because I had always promised myself to be honest with the children about their situation, I sought help in dealing with this sobering news. On a day when no one wanted to face this reality, the children, their mother, and I sat with two counselors and spoke in terms that the youngsters could understand about their mother’s illness. That day is etched in my memory, as I am sure it is the children’s.

The years that followed were full of stressful situations, especially dealing with the children’s mother who had no parenting skills and was not dependable. Her contact with the children was unpredictable and often upsetting. Many planned visits were not kept. My granddaughter would sit in the doorway crying for her “Mommy.” On days when her mother did come, my granddaughter would beg her, “Please don’t go, Mommy. Please don’t leave me.” Bedtime was the worst. Night after night, my granddaughter cried herself to sleep, whimpering through her tears, “I want my Mommy.”

Because my grandson was a baby when his mother left, it seemed that he hadn’t bonded with her or experienced the same trauma. But, as a child, he would hide in my bed at night and was very insecure, frightened, and easily discouraged. The odd thing is, as he grew older, he grew closer to his mother.

Over the years, my granddaughter was in counseling: at first play therapy, then more intense counseling. I found a wonderful counselor, which was the healthiest thing I could have done for her and myself. I made sure my granddaughter was able to do the things she wanted to do; I encouraged her to take part in sports, gymnastics, swimming, cheerleading, dance, and other activities she enjoyed. My grandson, on the other hand, did not like counseling or group activities. We tried Boy Scouts, swimming, and even gymnastics. None of these appealed to him. He seemed more than shy; he struggled with social situations and is still a bit awkward socially.

Establishing routines and having a schedule was vital. We had a chart posted on the wall where the children would “earn” stickers for doing small chores. Stickers equaled rewards, so they worked hard to attain them. While they were young, this worked very well.

Because of my financial situation, I applied for and received scholarships for the children to attend a Catholic elementary school. I think that the structure and stability of the school was helpful. We all went to church every Sunday; my granddaughter was even an “alter server.” It was important to me to give them a strong base so they’d have something to fall back on.

The children seemed to flourish until they reached their teens. My granddaughter is very bright and creative but is also crisis-oriented with very low self-worth. She is now a parent, raising her child in my home. My grandson seems more social at his public high school, but I’m not sure why. I worry about teen drug use. I’m not completely sure what portion of their problems are ordinary teen problems and what portion are directly related to their abandonment and subsequent childhood upbringing.

The children’s father has always written them letters while incarcerated, but these children got abandoned again every time their father returned to prison. I took them to visit him in prison until they no longer wanted to go. And they got abandoned again every time their mother left. My granddaughter still calls her mother. I don’t think my grandson has much contact with her.

Throughout the years my grandchildren had everything that other children had, everything but their parents. I sometimes think it would have been better had they not had contact with their parents growing up. I feel mixed about open adoption. I only know that I did the very best I could.
The stress of a parent’s or caregiver’s HIV diagnosis permeates the entire family system (Rotheram-Borus et al., 1998), especially for those living below the poverty line (Silver et al., 2003). Elevated rates of dysphoria, (i.e., depression, anxiety, and behavioral problems) among children of adults living with HIV/AIDS have been documented (Bauman et al., 2002; Brackis-Cott et al., 2007; Rotheram-Borus & Stein, 1999). Disclosure worries, health concerns, and social stigma all contribute to a conflict-ridden environment.

Psychosocial family intervention models for HIV/AIDS education, prevention, and management have received much recent attention (Donenberg, Paikoff, & Pequegnat, 2006) due to a growing recognition of the impact of family dynamics on health. Family-centered interventions should be particularly effective at promoting communication and cooperative problem-solving in HIV-affected families—all the more so for interventions involving multiple families. This is the theme of The Family Center’s Family Pride, an intervention that we believe contributes to child well-being.

Each cycle of Family Pride involves five to seven families (adults and children ages 7 – 17 years) who meet weekly for 10 two-hour sessions at The Family Center in New York City. The group is facilitated by social workers with advanced training in family therapy. Family Pride participants engage in structured tasks, including role-plays, cooperative games, art projects, team building, and reflective discussions, all designed to enhance emotional awareness and productive conflict resolution skills. Sessions focus on, for example, appreciating oneself and other family members, identifying feelings, and managing anger. Toward the end of the cycle, families attend a camping trip where they practice skills developed in prior meetings.

In recent research, we demonstrated that family members develop a more accurate understanding of one another over the course of Family Pride (Reich & Ahn, 2008). We also saw that many participants who initially reported using competitive conflict tactics (e.g., “argues over who is ‘right’”; “tries to win arguments”) no longer did so by the end of Family Pride. This bodes well for effective conflict resolution.

Family members with discordant perceptions of one another might find it difficult to focus their conversations on solving problems and might instead be sidetracked by cross talk, accusations, and recriminations. Family members who develop stable, consensually validated views of each other are that much closer to being able to rationally approach, frame, and discuss problems at hand. Accuracy (i.e., mutual agreement) in the perception of family members has been related to positive family functioning and to child mental health (Hastings & Grusec, 1997; Knafo & Schwartz, 2003; Pelton et al., 2001).

Why is Family Pride Beneficial for Children?

We offer three accounts for why Family Pride benefits children in HIV-affected families.

Cooperation on joint tasks. Sherif’s (1966) field experiments with school-age boys and Aronson’s closely related
“jigsaw” classroom (Aronson & Bridgeman, 1979) demonstrated that working together toward meaningful and mutually beneficial goals can ameliorate negative attitudes and create harmony. Because successful interchanges elicit prosocial sentiments (Lawler & Yoon, 1996), the highly interactive, cooperative tasks in Family Pride promote warmth and fondness among family members.

Observation of other families. Bandura (1986) argued that learning complex social skills is facilitated by observing and modeling others’ behaviors. This learning is particularly effective when the role models are those facing similar circumstances. Family Pride participants are well attuned to the problem-solving strategies of other families and adapt what they see to problems in their own families. This process, which need not be fully conscious, picks up where pedantic instruction leaves off. It also provides an opportunity for adults to reinforce lessons learned to children long after the intervention ends (Pequegnat & Szapocznik, 2000) and to generalize these lessons beyond the confines of the intervention itself (Grizenko et al., 2000; Pfiffner & McBurnett, 1997).

Reflection. Interactive tasks in Family Pride are followed by reflective group discussions that allow family members to develop grounded conceptions of themselves engaged in cooperative action (Bem, 1972). Participants also learn how they appear to others, which, they discover, may not correspond with the way they want to portray themselves. Coming to see ourselves as others see us is an important social skill that strengthens group cohesiveness and stabilizes the self-concept (Leary et al., 1998; Reich & Rosenberg, 2004; Swann, 1990); it is also a key developmental milestone for young persons (Hart, 1988). As conceptions of “cooperative self” are validated over time, children’s defensive, conflict-escalating behaviors should decrease as communication remains focused on problems, not people.

The Communication Impasse Posed by a Simple Sandwich

How difficult can it be to tell someone how to make a peanut butter and jelly sandwich? More so than it appears, much to participants’ surprise. Even the most mundane events can challenge notions of what is, or should be, understood as “common sense.” This is the theme of an activity in which each family is asked to write instructions on how to make a peanut butter and jelly sandwich. The social workers then proceed to follow each instruction, to the letter, in front of the entire group. This is exactly the point of the exercise: The objective is to heighten families’ awareness of barriers to effective interpersonal communication.

For example, one instruction is to spread the peanut butter and jelly, then cut the sandwich in half. The social workers do so by spreading with their hands and ripping the bread. Indeed, no rules are broken. Some participants become vocally upset because they believe the group leaders know what they mean but deliberately “misunderstand” their instructions. Others chime in, echoing their complaints. This leads (with some facilitation) to a reflective group discussion about the frustration of being misunderstood—seemingly deliberately disobeyed—by one’s own children. Eventually, a consensus emerges that adults should not assume that children fully understand what adults ask them to do, or become angry when it becomes obvious they do not. Better solutions are collaboratively generated: explaining the task in a different way, inquiring into the child’s understanding of what is expected. Many participants later voice their appreciation for seeing they are not alone in their experiences. They become visibly more willing to express affection to their children in ways not apparent before Family Pride.

Psychosocial Benefits for Children: The Benevolent Emotion Script

Throughout Family Pride, family members and staff talk extensively about emotions. These discussions generate emotion scripts: sequences of events identifying “actors’” feelings and linking them to causes and consequences. Research literature associating family discussion of emotion and children’s subsequent peer relations, social competence, interpersonal sensitivity, and empathy (Eisenberg et al., 2002; Garner et al., 1997; Harris, 2000) suggests that emotions best promote children’s positive interpersonal development when they are contextualized in coherent, rational, and benevolent narratives.
This is what we believe happens in Family Pride. The cooperative activities and the observations they invite concretely demonstrate that multiple, seemingly contradictory feelings can co-exist. The subsequent reflective discussions crystallize these observations into emotion scripts that promote harmony—Family Pride participants collectively learn that negative feelings can be resolved into positive ones. These insights can be parlayed into future real-life situations. For example, a child might form sophisticated attributions toward a friend who appears angry (e.g., maybe she’s avoiding me while secretly wishing I would help her) and would see options other than retaliation or dissolving the friendship.

Decisions based on complex emotional reasoning are critical to sustaining friendships through inevitable conflicts. Strong peer relations are indispensable to children from HIV-affected families as they enter their teen years, protecting them from isolation, depression, and anomie, and providing the basis for a meaningful identity—a sense of place in the adult world.

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Participants learn that negative feelings can be resolved into positive ones.

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Improving Child Well-Being in Latina-Headed Families Faced with Substance Abuse and HIV/AIDS: Moving Theory into Practice with Outcomes

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Project Milagro at Bienvenidos, Inc. provides comprehensive, culturally sensitive, theory-based services to families residing in a large Latino community in Southern California. Family-centered, client-driven services are embedded in a humanistic approach guided by Maslow’s hierarchy of needs (Maslow, 1999). Contextual factors that are culturally specific to Latinos and that extend beyond linguistic correctness are well-integrated into the project’s conceptual framework.

Family violence, family and home environmental instability, and medical risks involving prenatal drug exposure and poor prenatal health care are challenges faced by parents and children impacted by HIV/AIDS and/or substance abuse (Schuster et al., 2000; Kim & Krall, 2006). Project Milagro serves Latino families who are living with a myriad of these challenges and more: generational poverty, language barriers, marginal education, unemployment, and physical and mental illness. To improve child well-being, a comprehensive family approach that aims at stabilizing families while increasing overall support has been effectively applied. The project’s underlying principle is that in order to improve child outcomes, primary interventions must meet the needs of the family as a unit. The project has learned over the years that family and parental stabilization are key indicators for improving child functioning.

Families receive comprehensive home-based services once weekly over 12 months. Services follow Maslow’s hierarchy of needs, first fulfilling basic physiological and safety needs in the early stages of service delivery, then moving on to the enhancement of social networks and eventually strengthened self-esteem. Because the high incidence of child abuse and neglect is likely due to parental drug and/or alcohol dependence, the program provides interventions that target substance abuse and parenting skills: recovery-focused counseling, parent education, and case management services linking parents to substance abuse treatment. While the family is addressed as a whole, services are also offered specifically to children, including linkages to medical care, the Regional Centers, and child-focused therapy, and assistance with enrollment in school, day care, and school readiness programs.
**Culturally Specific Services**

The heterogeneity among Latino families, particularly Latinas and their children, continues to be defined as pertinent in developing culturally sensitive interventions for this ethnic group (Alvarez et al., 2004). Project Milagro delivers services, literature, program documents, and educational materials in Spanish. Bicultural staff is knowledgeable about the culture and cognizant of acculturation factors.

Identifying family acculturation levels ensures culturally sensitive services beyond Spanish translations. A linear assessment of acculturation (Marin, 1987) distinguished two groups: 50% of Latinas who were identified as less acculturated and represent HIV/AIDS families; and 50% of Latinas who were identified as more acculturated and as bicultural (Mexican and American cultures) and represent the substance abuse families. Acculturation differences were significant ($p<.001$) and served as a culture-specific guide for service delivery strategies, case plans, and family services.

**Evaluation Plan: Methods for Assessing Child Well-Being**

Like the Project Milagro service model, the evaluation plan was linguistically and culturally appropriate for Latino families. Child outcomes for 125 children, ages three months to eight years old, were examined using a pre- and post-test six-month assessment. Measures included a 20-item child risk factor and developmental screening tool developed by the Bienvenidos agency, the Developmental Profile II (DP2) (Alpern et al., 2000), and the Ages and Stages Questionnaires (ASQ) (Squires et al., 1999). Parents were engaged during the assessment process and provided prenatal histories for the children.

**CHILD RISK FACTORS AND DEVELOPMENTAL SCREENINGS**

Risk factors identified at program entry for children delineated the problems faced by project families. At program entry, “lack of stable family composition” within the past six months was the most prevalent risk factor for 71% of HIV children and 73% of substance abuse children. Prevalent risk factor rates during the past 12 months were also high for both groups: exposure to domestic violence and victimization by abuse or neglect (42%), exposure to substance abuse (40%), and residing in unstable housing (36%). Among substance abuse children, 51% were prenatally drug-exposed and 24% lacked prenatal or well baby care, compared to 18% and 13%, respectively, for HIV children. For the total sample, premature births were reported for 19% of children, and 13% of children had low birth weight (under six pounds).

Child risk factor outcomes suggest pronounced differences between substance abuse and HIV children. Substance abuse children experienced more risk factors for longer periods than their HIV counterparts but had significantly less risk factors at termination. Baseline and post-test comparisons showed positive significant changes ($p$-levels $<.05$): Drug and/or alcohol exposure in the home significantly decreased for substance abuse children during program engagement. Overall, child abuse and neglect and out-of-home placements decreased significantly for all children, particularly for substance abuse children. Exposure to domestic violence, stable family relationships, and stable housing also improved for these children. The reduction in risk factors for HIV children was minimal, suggesting that these children continue to experience multiple risks. At termination, “lack of stable family composition” (52%), “unstable housing” (36%), and “exposure to domestic violence” (19%) were reported for them.

Importantly, acculturation levels determined the cultural context for understanding and working with children. Overall, children in HIV families lived in monolingual Spanish-speaking homes with foreign-born parents. The project’s substance abuse families were more acculturated, with children and parents more likely to be second or third generation Mexican Americans born in the United States. To ensure cultural sensitivity, applied interventions respected acculturation and cultural beliefs and practices, and integrated Latino values (Harper & Lantz, 2007). For example, Familismo is the high value and regard for the family with the view that the family is the primary unit of support; Personalismo is formal friendliness, the value of interpersonal relationships.
Developmental screenings assessed medical, mental health, and behavioral problems based on child history, diagnosed conditions, staff observations, and parent input. At baseline, approximately 18% of children were detected with behavioral problems, and 5% with developmental language delays/learning disabilities. Medical screenings identified 13% of children with health conditions. Post-test changes were detected only for children with behavioral problems, indicating an improvement of 17% (p<.001). In addition, developmental language delays had a small improvement of 8% among substance abuse children. However, these results are limited and interpreted with caution due to small samples. Overall, developmental screening outcomes at termination did not identify additional or new conditions; rather, child screenings provided early detection for supplemental testing and appropriate program interventions.

**CHILD RISK FOR DEVELOPMENTAL DELAYS**

Supplementary testing was conducted for approximately 20% of the program’s children identified as “high risk” for developmental delays. The ASQ was used to test children, ages three months to five years old, and the DP2 tested children between 5.1 years to 8.0 years. These standardized measures provide developmental functioning scores for communication/language, motor skills (fine and gross), socialization, self-help skills, and problem-solving/cognitive development. Baseline data indicated that 27% of children had one or more delays. The most common delay for 17% of children was communication/verbal skills (in their native language), followed by delays in fine motor skills (19%). Overall, these skills are critical to school readiness and transitioning into kindergarten. The project staff focused on assisting families in developing activities that enhanced developmental tasks. Most importantly, referrals to Regional Centers were completed for 100% of children identified with at least one delay. Post-test assessments were non-significant.

**Summary**

Improving child well-being can be achieved via various interventions. Project Milagro’s interventions are family-focused, strongly culturally influenced, and based on Maslow’s hierarchy of needs. Evaluation outcomes show that family-focused interventions, while not child-specific, have effectively resulted in improved overall child well-being. Especially, program interventions that target parental substance abuse and parenting skills have contributed to the positive outcomes reported for children.

Child risk factors, due to the lack of family and housing stability, reflect the social conditions and environmental stressors experienced by these families. Project services have focused on stabilizing families and providing family counseling. Additionally, advocacy and entitlement assistance have been effective in increasing family and housing stability, as well as reducing environmental stressors.

Latinas living with HIV/AIDS and their families continue to reside in shelters and subsidized housing and experience homelessness and isolation. The cultural stigma of HIV/AIDS, language barriers, and limited financial, emotional, and family support contribute to the continuing challenges faced by these mothers and their children.

**REFERENCES**


Videos

**Early Childhood and Brain Development: How Experience Shapes Child, Community and Culture**

Intended for trainers trying to reach the general public, this one-hour program addresses the critical role of early developmental experiences in shaping the child, and ultimately community and culture. Includes an overview of core concepts related to the impact of trauma and neglect on children, and information on the practice, program, and policy implications of maltreatment. Cost: $89.95 plus 10% shipping and handling (DVD).


**Essentials of Play Therapy with Abused Children**

This 40-minute video from practitioner and author Eliana Gil illuminates the unique benefits of play therapy for children who have been physically or sexually abused. Dr. Gil brings viewers into the therapeutic playroom, describes how play activities fit into the reparative process, and provides helpful pointers for practice. The video demonstrates the use of art supplies, the sand tray, puppets, the dollhouse, and masks. Also discussed are ways to allay children’s fears about therapy and establish a good working rapport. Cost: $99.00 (Video or DVD).


**Neurodevelopmental Impact of Prenatal Substance Exposures on the Very Young Child**

This video discusses the primary difficulties young infants and toddlers may experience (i.e., problems in self-regulation, sensory processing problems, delays in development, and attachment and behavior problems) as a result of prenatal substance exposure. Also covered are the various biochemical, neurological, and structural ways in which such exposure can disrupt brain development. Cost: Free streaming at http://www.ntiupstream.com/mchbproject/playVideo.aspx?VideoID=1.


**Risk and Reality: Teaching Preschool Children Affected by Substance Abuse**

This video describes classroom strategies that support at-risk children and outlines methods that can be used to improve their learning. It focuses on creating a nurturing environment, encouraging cooperative play, facilitating transitions, minimizing distractions, helping children manage their behavior, conducting on-going classroom assessments, and building strong links with families. Includes accompanying guide. Local reproduction of videotape is authorized. Cost: Free.


Books, Guides, and Reports

**Art, Angst, and Trauma: Right Brain Interventions with Developmental Issues**

This text demonstrates how art therapy can make a major contribution to the treatment of children who are seriously ill, in foster care, or physically or emotionally traumatized, and of adolescents who are deviant or addicted. It includes clinical documentation of the successful resolution of trauma through art therapy with a variety of clients at various stages of development. Cost: $63.95 (hard copy); $48.95 (soft copy).


This volume provides a comprehensive clinical-developmental framework for understanding and treating behavior problems in early childhood. The author offers an account of the developmental tasks and transitions that young children face in cognitive, social, and family domains and examines what happens when development goes awry. Particular attention is given to the critical question of how certain children manage to overcome difficult transitions while others face the risk of serious, ongoing problems. The book reviews prevention and treatment approaches and offers recommendations for improving the quality and availability of child care and early intervention programs. Cost: $25.00.


Child Neglect: Identification and Assessment

This book explores the causes and effects of child neglect and the personal, professional, and organizational factors that influence identification and assessment. Drawing on new and existing research evidence, it provides a thorough overview of the subject and includes practical suggestions to improve practice, emphasizing throughout the importance of effective multidisciplinary efforts. Cost: $32.95.


Child Welfare Trauma Training Toolkit

This Toolkit is designed to teach basic knowledge, skills, and values about working with children who are in the child welfare system and who have experienced traumatic stress. Through case analysis and corresponding interventions tailored for children and their biological and resource families, the Toolkit offers instruction on using the knowledge presented to support children’s safety, permanency, and well-being. Cost: Free download from website.


Childhood Emotional Abuse: Mediating and Moderating Processes Affecting Long-Term Impact

This book provides the latest data on processes underlying the long-term effects of psychological and emotional abuse. It also presents cutting-edge research that focuses on the who, why, and how of emotional abuse and its negative impact across the life span. Combining theory and research, this resource explores important mediators and moderators of the long-term impact of child emotional abuse. Cost: $49.95 (soft copy); $95.00 (hard copy).


Childhood Victimization: Violence, Crime, and Abuse in the Lives of Young People

This book presents a comprehensive new vision to encompass the prevention, treatment, and study of juvenile victims, unifying conventional subdivisions like child molestation, child abuse, bullying, and exposure to community violence. Developmental victimology, the author’s term for this integrated perspective, looks at child victimization across childhood’s span and yields insights about how to categorize juvenile victimization, how to think about risk and impact, and how victimization patterns change over the course of development. The book also introduces a new model of society’s response to child victimization and a fresh way of thinking about barriers that victims and their families encounter when seeking help. Cost: $35.00.


Creative Interventions with Traumatized Children

Using illustrative case material and artwork samples, this book demonstrates a range of creative approaches for facilitating children’s emotional reparation and recovery from different types of trauma, including parental loss, child abuse, accidents, family violence, bullying, and mass trauma. Experienced practitioners of play, art, music, movement and drama therapies, bibliotherapy, and integrative therapies describe step-by-step strategies for working with individual children, families, and groups. Broader approaches to promoting resilience and preventing post-traumatic problems in at-risk children are also presented. Cost $38.00.

Handbook of Resilience in Children

This handbook presents the current scientific theory, clinical guidelines, and real-world interventions to address such issues as the role of resilience in overcoming trauma, adversity, and abuse; the relationship between resilience and other protective factors; resilience differences between boys and girls; and using resilience in interventions with children and families. Examples of school and community resilience-building programs are included. Cost: $49.95.


Play Therapy with Children in Crisis (3rd Edition): Individual, Group, and Family Treatment

This book presents effective, creative approaches to helping children who have experienced such stressful situations as parental death or divorce, abuse and neglect, violence in the school or community, and natural disasters. Chapters reflect the latest knowledge on crisis intervention, trauma, and short-term play therapy. Timely new topics include the crisis of parental military deployment, the impact of Hurricane Katrina on families, immigration-related trauma, terrorism, and disrupted adoption. Cost: $48.00.


HIV, Substance Abuse, and Communication Disorders in Children

This book focuses on a class of serious consequences for the developing child due to maternal use of alcohol, marijuana, cocaine, and crack cocaine during pregnancy. Consequences include poor language development and speech delays, limited vocabulary, the inability to articulate needs, the inability to follow commands, limited expressive language skills, and the inability to understand the real meaning of words and generalize them. The volume also addresses communication disorders affecting the nearly 5,000 children in the United States living with AIDS. Cost: $34.95.


Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment

This book describes an empirically supported treatment of child-parent psychotherapy that engages parents as the most powerful agents of their young children’s healthy development. It provides a comprehensive theoretical framework together with practical strategies for combining play, developmental guidance, trauma-focused interventions, and concrete assistance with problems of living. Filled with “how-to-do-it” examples, the book is grounded in extensive clinical experience and cutting-edge research on early development, attachment, neurobiology, and trauma. Cost: $40.00.


Racial-Ethnic Inequality in Child Well-Being from 1985-2004: Gaps Narrowing, but Persist. FCD Policy Brief: Child Well-Being Index (CWI); no. 9

This report is the first to analyze how child and youth well-being has changed among Black, Hispanic, and White children from 1985-2004. Findings on overall improvements in the quality of life for all children are discussed and compared among groups. Cost: Free download from website.


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Mental Health Interventions and Services for Vulnerable Children & Young People

This book provides a model offering guidance on effective and appropriate therapeutic interventions and services for vulnerable children and youth who have experienced trauma, abuse, domestic violence or neglect. By addressing practice, theory, and policy, the volume enables professionals working with vulnerable children to choose the right intervention for each individual child. Contributors examine best practice across the United States and Europe and compile the findings in a way that can be incorporated into everyday practice. Cost: $34.95.


The Neurobehavioral and Social Emotional Development of Infants and Children

This book gathers together major writings that present field-defining work on mother/infant relationships, emotional connection, and the healthy development of infants and children. Cost: $68.50.

Real Life Heroes: Practitioner’s Manual
Real Life Heroes: A Life Storybook for Children

The practitioner’s manual presents an innovative, creative arts approach to working with traumatized children to help them overcome the pain of trauma and develop a healthy sense of self. The approach encourages children to collaborate with caring adults in developing autobiographies through a wide range of activities, including drawings, music, movies, and narrative. The accompanying children’s book is an updated classic that helps traumatized children move from painful or fractured memories to a more positive perspective by drawing strength from the supportive people in their lives. Results foster positive values and a sense of pride in children as they form a stronger bond with caring and committed adults. Cost of manual: $24.95. Cost of storybook: $39.95.


Surviving and Transcending a Traumatic Childhood: The Dark Thread

Weaving together 90 stories of survival to offer hope to those struggling to heal from childhood trauma, this book documents the endless challenges facing children and adults who have been subjected to physical, emotional, and psychological abuse. It also examines the proactive coping strategies that have made their recoveries a success. Cost: $39.93 (soft copy); $55.95 (hard copy).


Internet Resources

Chadwick Center for Children and Families
http://www.chadwickcenter.org

Child Trends Data Bank
http://www.childtrendsdatabank.org

Fact Sheet: Vulnerable Young Children

National Alliance for Drug Endangered Children
http://www.nationaldec.org

National Center for Children in Poverty
http://www.nccp.org

National Scientific Council Center on the Developing Child
http://www.developingchild.net

National Technical Assistance Center for Children’s Mental Health
http://gucchd.georgetown.edu/programs/ta_center/

NTI Upstream
http://ntiupstream.com

U.S. Department of Health and Human Services, Administration for Children and Families, Early Childhood Learning and Knowledge Center
http://eclkc.ohs.acf.hhs.gov/hslc

ZERO TO THREE
http://www.zerotothree.org
Healthy Brain Development: Key Impacts and Interventions

This free conference will present current research and prevention science and provide evidence-based strategies and tools to promote healthy brain development for children, ages zero through adolescence, and their families who are challenged by risk factors such as substance use, trauma, environment, violence, and poverty.

Dates: October 22-24, 2008
Sponsor: Lane County, Oregon Health and Human Services
Location: Valley River Inn, Eugene, OR
Contact: http://lanecounty.org/prevention/braindevelopment

Promoting First Relationships

Participants will learn a consultation and intervention strategy applicable to high risk, special needs, child care, or other early childhood fields. This positive, strengths-based strategy can be used one-on-one with parents, childcare providers, and early childhood teachers.

Dates: October 27-29, 2008
Sponsor: NCASE-AVENUE Programs
Location: Seattle, WA
Contact: http://www.interprofessional.ubc.ca/BDL_subpages/othermeetings/Promoting%20First%20Relationships%202008.pdf

2008 Alliance for Children and Families National Conference

This conference provides the opportunity to expand peer connections within the national network of nonprofit human services leaders. This meeting addresses best practices, promising program and organizational innovations, and fine tuning of leadership and advocacy skills.

Dates: October 28-30, 2008
Sponsor: Alliance for Children and Families
Location: Baltimore, MD
Contact: http://www.alliance1.org/Conferences/National2008/index.htm

32nd National Conference: AMERSA

This meeting of the American Association for Medical Education and Research in Substance Abuse (AMERSA) brings together researchers and health professional educators to learn about scientific advances and teaching approaches in substance abuse.

Dates: November 6-8, 2008
Sponsor: AMERSA
Location: Washington, DC
Contact: http://www.amersa.org/conf.asp


This second annual conference will build knowledge and skills, disseminate ongoing practices, and provide an exchange of ideas related to implementing and sustaining differential response in child welfare as a way of transforming how families cooperate with child welfare systems.

Dates: November 12-14, 2008
Sponsor: American Humane Association
Location: Columbus, OH
Contact: http://www.americanhumane.org

24th International Society for Traumatic Stress Studies (ISTSS) Annual Meeting: Terror and Its Aftermath

This meeting will explore the ways people respond to terror in diverse settings, as well as some of the interfaces between basic science, clinical practice, and social policy. Participants will have an opportunity to explore the many ways in which children, adults of all ages, families, communities, responders, and societies address different forms of terror, including sexual and physical abuse within families.

Sponsor: ISTSS
Location: Chicago, IL
Contact: http://www.istss.org/meetings/index.cfm
7th National Harm Reduction Conference
This conference seeks to provide a safe forum for the exchange of information, ideas, and strategies for incorporating harm reduction into direct services, public policies, and individual lives. The conference theme is “Harm Reduction: Towards a National Policy.”
Dates: November 13-16, 2008
Sponsors: Harm Reduction Coalition: various sponsors.
Please refer to website.
Location: Miami, FL
Contact: www.harmreduction.org

Federation of Families for Children’s Mental Health
20th Annual Conference
The conference, Hope on the Horizon for Children, Youth and Families, will focus on eradicating stigma and promoting positive mental health for children and their families.
Dates: November 20-23, 2008
Sponsors: Johns Hopkins University,
Annie E. Casey Foundation, BC Innovations
Location: Hyatt Regency Atlanta, Atlanta, GA
Contact: http://www.ffcmh.org/conference.htm

IAPAC 08: Stronger Together
This conference will feature 152 oral abstract presentations and plenary sessions in three tracks: HIV Clinical Management; HIV Prevention and Psychosocial Support; and Human Rights, Economics, Public Policy. Poster presentations include advocacy, HIV/AIDS prevention, human rights, psychosocial and socioeconomic factors, and public policy.
Dates: November 30, 2008 - December 2, 2008
Sponsor: International Association of Physicians in AIDS Care (IAPAC)
Location: New Orleans, LA
Contact: www.iapaco8.org

23rd Annual San Diego International Conference on Child and Family Maltreatment
The conference aims to develop and enhance professional skills and knowledge in the prevention, recognition, assessment, and treatment of all forms of maltreatment, including those related to family violence and substance abuse. Directed to a multidisciplinary audience, the conference will also enhance investigative and legal skills.
Dates: January 26-30, 2009
Sponsors: The Chadwick Center for Children and Families,
Rady Children’s Hospital-San Diego
Location: San Diego, CA
Contact: http://www.chadwickcenter.org

Advocacy in Action Conference
The National Association for Alcoholism and Drug Abuse Counselors/National Association for Addiction Treatment Providers Advocacy Action conference will focus on legislative issues affecting the addiction-focused professionals and treatment providers.
Dates: March 8-10, 2009
Sponsors: National Association for Alcoholism and Drug Abuse Counselors, Association for Addiction Professionals, and the National Association for Addiction Treatment Providers
Location: Arlington, VA

17th National Conference on Child Abuse and Neglect
The theme for this conference is “Focusing on the Future: Strengthening Families and Communities.” This event seeks to emphasize the need for every child to enjoy a healthy family life in a nurturing community.
Dates: March 30-April 4, 2009
Sponsors: U.S. Department of Health and Human Services,
Children’s Bureau, and the Office on Child Abuse and Neglect
Location: Atlanta, GA
Contact: http://cbexpress.acf.hhs.gov/articles.cfm?article_id=1626&ref=htmlEml
Numerous monographs, fact sheets, issue briefs, and other publications—most of which are available for free download in PDF format.

Archived issues of The Source from 1993—present available for download.

Information about Resource Center trainings and conferences, including our ongoing 2008 teleconference training series.

Archived proceedings from past Resource Center trainings and conferences, including recordings and handouts.

Profiles of federally funded Abandoned Infant Assistance (AIA) projects.

The site also features extensive information and resources about families affected by HIV and/or substance abuse, including special topics such as:

- Kinship Care
- Standby Guardianship and Future Care and Custody Planning
- Shared Family Care
- Substance Exposed Newborns
- Child Welfare

To receive periodic emails from the Resource Center announcing new publications, conferences, and trainings, and other important information, email aia@berkeley.edu and ask to be added to our email list.
The Source is published by the National AIA Resource Center through a grant from the U.S. DHHS/ACF Children’s Bureau (#90-CB-0158). The contents of this publication do not necessarily reflect the views or policies of the Center or its funders; nor does mention of trade names, commercial products, or organizations imply endorsement. Readers are encouraged to copy and share articles and information from The Source, but please credit the National AIA Resource Center. The Source is printed on recycled paper.

The National Abandoned Infants Assistance Resource Center’s mission is to enhance the quality of social and health services delivered to children who are abandoned or at-risk of abandonment due to the presence of drugs and/or HIV in the family by providing training, information, support, and resources to service providers who assist these children and their families. The Resource Center is located at the University of California at Berkeley, and is a service of the Children’s Bureau.

For more information about the Resource Center, visit http://aia.berkeley.edu
The spring 2009 issue of *The Source* will be devoted to fathers in families affected by substance abuse and/or HIV, and their role in the lives of their children. Send a brief (150-200 words) abstract of your proposed article to the *Source* Editor, lblachman@berkeley.edu, by Monday, October 31, 2008. For details, go to http://aia.berkeley.edu.

**Abstracts are due Monday, October 31, 2008.**