University of Massachusetts Medical School
eScholarship@UMMS

Psychiatry Publications and Presentations | Psychiatry

4-15-2002

The Invisible Children's Project: A Family-Centered Intervention for Parents with Mental Illness

Beth R. Hinden
University of Massachusetts Medical School, bhinden@rcn.com

Kathleen Biebel
University of Massachusetts Medical School, Kathleen.Biebel@umassmed.edu

Joanne Nicholson
University of Massachusetts Medical School, Joanne.Nicholson@Umassmed.edu

Liz Mehnert
Mental Health Association in Orange County. Inc.

Follow this and additional works at: http://escholarship.umassmed.edu/psych_pp

Part of the Psychiatry Commons

Hinden, Beth R.; Biebel, Kathleen; Nicholson, Joanne; and Mehnert, Liz, "The Invisible Children's Project: A Family-Centered Intervention for Parents with Mental Illness" (2002). *Psychiatry Publications and Presentations.* Paper 143.
http://escholarship.umassmed.edu/psych_pp/143

This material is brought to you by eScholarship@UMMS. It has been accepted for inclusion in Psychiatry Publications and Presentations by an authorized administrator of eScholarship@UMMS. For more information, please contact Lisa.Palmer@umassmed.edu.

The Invisible Children's Project: A Family-Centered Intervention for Parents with Mental Illness

Beth Hinden, Ph.D.
Kathleen Biebel, M.S.
Joanne Nicholson, Ph.D.
Liz Mehnert, CSW

Mental Health Association in Orange County, Inc.
20 Walker Street
Goshen, NY 10924

and

Center for Mental Health Services Research
Department of Psychiatry
University of Massachusetts Medical School

Prepared for the Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Office of Policy, Planning and Administration
5600 Fishers Lane, Room 17C-02
Rockville, MD 20857

SUBMITTED: April 15, 2002

ACKNOWLEDGEMENTS

The Mental Health Association in Orange County, Inc. (MHA) is a not-for-profit organization providing an array of services to the mentally ill, developmentally disabled, sexual assault victims and their family members. The agency focus is on education, advocacy and training for the community through direct service programs, support groups, information and referral services, 24-crisis services, outreach efforts and a cross systems approach to services.

The Invisible Children's Project, (ICP) a program of MHA was developed to address the needs of, and gap in services for parents with mental illness and their children. In addition to providing direct services to parents and children, ICP aspires to create systems change on a local, state and national level. ICP receives funding from the New York State Office of Mental Health, Orange County Department of Mental Health, Orange County United Way, Mental Health Association in New York State, National Mental Health Association, Orange County Department of Health, Jewish Family Services in Orange County, Eli Lilly, Solomon Smith and Barney and private donations. ICP also benefits from the ongoing support of Chris Ashman, Commissioner of the Orange County Department of Mental Health and James Bopp, Executive Director of Middletown Psychiatric Center, both of whom have collaborated on the project since its origins.

Many individuals have contributed to the success of this study. Judith Katz-Leavy, Senior Policy Analyst at the Center for Mental Health Services of the Substance Abuse Mental Health Services Administration (SAMHSA), was pivotal in the initial conceptualization of the study and has continued to provide support and consultation. Lucinda Sloan Mallen, former Executive Director of MHA and founder of ICP, also participated in the initial conceptualization and has offered on-going support and consultation. Pat Shea, Project Officer at SAMHSA, provided needed guidance throughout the process. Numerous MHA agency and ICP staff significantly contributed to this study. These include Michael Bassett, ICP Program Coordinator, Monique Boniello, ICP Case Manager, Maryanne Quirk, File Extractor, Linda Norman, MHA Division Director, Nadia Allen, MHA Executive Director, and Cindy Urbin, ICP Case Manager. This team's commitment and dedication to providing innovative and high quality service is unsurpassed in the field of mental health. Their passion for making a difference in the lives of parents with mental illness and their children is extraordinary, and greatly appreciated and respected.

MHA's partners in this study, The Program for Parenting Well at the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts Medical School (UMMS) is a multi-disciplinary group of parents and professionals committed to understanding the experiences of parents with mental illness and their families, and developing resources to meet their needs. The Program for Parenting Well receives on-going funding and support from their colleagues and partners at the Massachusetts Department of Mental Health and the UMMS Department of Psychiatry. This study could not have been completed without the dedication, commitment and expertise of the Parenting Well staff. A special thanks goes to Heather DiGiovanni, Stanley Scholar Intern at CMHSR, for her participation in data collection and management.

The Orange County Department of Social Services (DSS) is responsible for providing social services for children and families. Services include but are not limited to child protective and preventive services, foster care, residential treatment, group homes, childcare, youth advocacy services, home monitoring, respite and parent aide services. DSS administration provided critical information on service costs for individual families participating in this study, and agreed to time consuming interviews with DSS case workers that had worked with family participants. Specifically, we are grateful to Margaret Kirshner, Commissioner, Elizabeth Mustion, Supervisor, Connie Antona, Director of Services, Nicole Disiglio and Mike Milano, Youth Advocates, Bill Jolly, Director of Youth Advocacy Program, Margot Mitchell, Supervisor, and Beth Gold, Debbie Pazola, Jeff Schmidtt, Case Workers, for their generous assistance with this study.

Finally, our greatest thanks go to the parents and children living with mental illness that agreed to participate in this study. Parents invited us into their homes and into their hearts. In lengthy conversations

about experiences prior to and since involvement with ICP, parents shared profoundly moving stories about their struggles and successes as parents with mental illness. We are particularly grateful to Sharon Butler, who agreed to join the evaluation team as Parent Consultant. Sharon acted as a voice for all parents. Her input into the development and implementation of this study has been invaluable.

TABLE OF CONTENTS

EXECUTIVE SUMMARY AND RECOMMENDATIONS i
INTRODUCTION 1
METHODS 2
RESULTS 12
SUMMARY AND CONCLUSIONS 48
REFERENCES 51
FIGURES 2-6 52

FIGURES

Figure 1. Family change
Figure 2. Behavioral and Emotional Rating Scale
Figure 3. CBCL Competence Scales
Figure 4. CBCL Broad-Band Syndromes
Figure 5. CBCL Total Problems
Figure 6. Family-Centered Behavioral Scale
Figure 7. Mark and his family
Figure 8. Alison and her family
Figure 9. Kathy and her family
Figure 10. Dionne and her family
Figure 11 Amy and her family
Figure 12. Melissa and her family
Figure 13. Janet and her family
Figure 14. Sandy and her family

TABLES

Table 1. Shared and non-shared key ingredients across informants
Table 2. Comparison of ICP and DSS case management services

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Millions of adults in the United States are affected by mental illness. The majority of these adults are, or will become parents (Nicholson, Biebel, Hinden, Henry & Stier, 2001). Despite the prevalence of parenthood among adults with mental illness, and the potential for negative effects on some children, there are very few programs or services available to meet the needs of parents and their children. In addition, available services have not been rigorously evaluated. Little is known about what is helpful for families, or effective with respect to enhancing family and family member functioning as well as quality of life.

The Invisible Children's Project

The Invisible Children's Project (ICP) in Orange County, New York, a nationally recognized program for parents with mental illness, is one of very few programs available to families in which a parent has a mental illness. ICP provides *home-based, family-centered* case management services. The program is founded upon the assumption that mental illness does not preclude good parenting, and that all parents want to be the best parents they can be. The *family* rather than the individual is the unit of service. ICP emphasizes access to and coordination of multiple services to support the safety and functioning of *all family members* for as long as is necessary.

The majority of referrals to ICP initiate from child welfare authorities at the Department of Social Services (DSS). ICP is often a mandated element in DSS service plans for parents who have lost or are at risk for losing custody of their children. The ability of ICP to address these child safety issues and achieve family preservation with respect to families involved with DSS has never been formally assessed.

The current report describes an evaluation of ICP as it affects families with a history of child welfare involvement. A family study[1] methodology was used to describe ICP services, define key program ingredients, examine family outcomes, and assess costs over time. One hundred percent of the families involved with ICP at the time of the study with a history of DSS involvement (N=8; 50% of ICP families overall) were included in the study. Parents, ICP case managers, and DSS caseworkers were interviewed; ICP files were examined; and service costs were assessed for ICP and DSS services[2] to tell the ICP story.

Key Findings

Services and Key Program Ingredients. Families, ICP case managers, and DSS caseworkers described ICP services as family-centered, strengths-based, and comprehensive. These qualities and practices were reported to be unique when compared with other services received by parents and families, and critical to successful intervention with families in which a parent has a mental illness. Parents, case managers, and caseworkers defined multiple key ingredients based on these qualities. Several key ingredients were common across informants (e.g., families, case managers, caseworkers), while others were more specific to an informant group. Shared and unshared key-ingredients identified across informants are portrayed in *Table 1*.

Family Outcomes. Families, case managers, and caseworkers agreed that ICP services improved multiple family outcomes, including those prioritized by DSS, i.e., parenting skills and child safety.

---

[1] This study involved case-study methodology, a recognized methodology that allows for qualitative examination of the relationship of processes to outcomes. We use the term "family study" rather than the more traditional term to underscore ICP's approach to clients as people and families rather than cases.

[2] Costs were assessed over time for "comparable" services across agencies. These included case management, childcare/respite, and parenting education and support service costs. Housing and foster care costs, critical services provided by ICP and DSS respectively, were not included because there were no comparable services across agencies.

Table 1. Shared and non-shared key ingredients across informants

Informant	Key ingredients of ICP case management *
Parent	• **Availability of case manager** • **Strengths-based, non-judgmental approach** • **Trusting relationship** • **Emotional Support** • **Liaison with DSS** • Flexible funds to provide concrete support (e.g. utility bills, furniture, holiday presents)
ICP Case Manager	• **Availability of case manager** • **Strengths-based approach** • **Trusting relationship** • **Emotional support** • **Liaison with DSS** • Crisis management • Comprehensive services coordination • Referral and access to services • Role modeling
DSS Caseworker	• **Availability of case manager** • **Strengths-based approach** • **Trusting relationship** • **Emotional support** • **Liaison with DSS** • Sharing of critical information about family strengths and risks • Mental health expertise and knowledge

* Bold text reflects ingredients identified by all three informants.

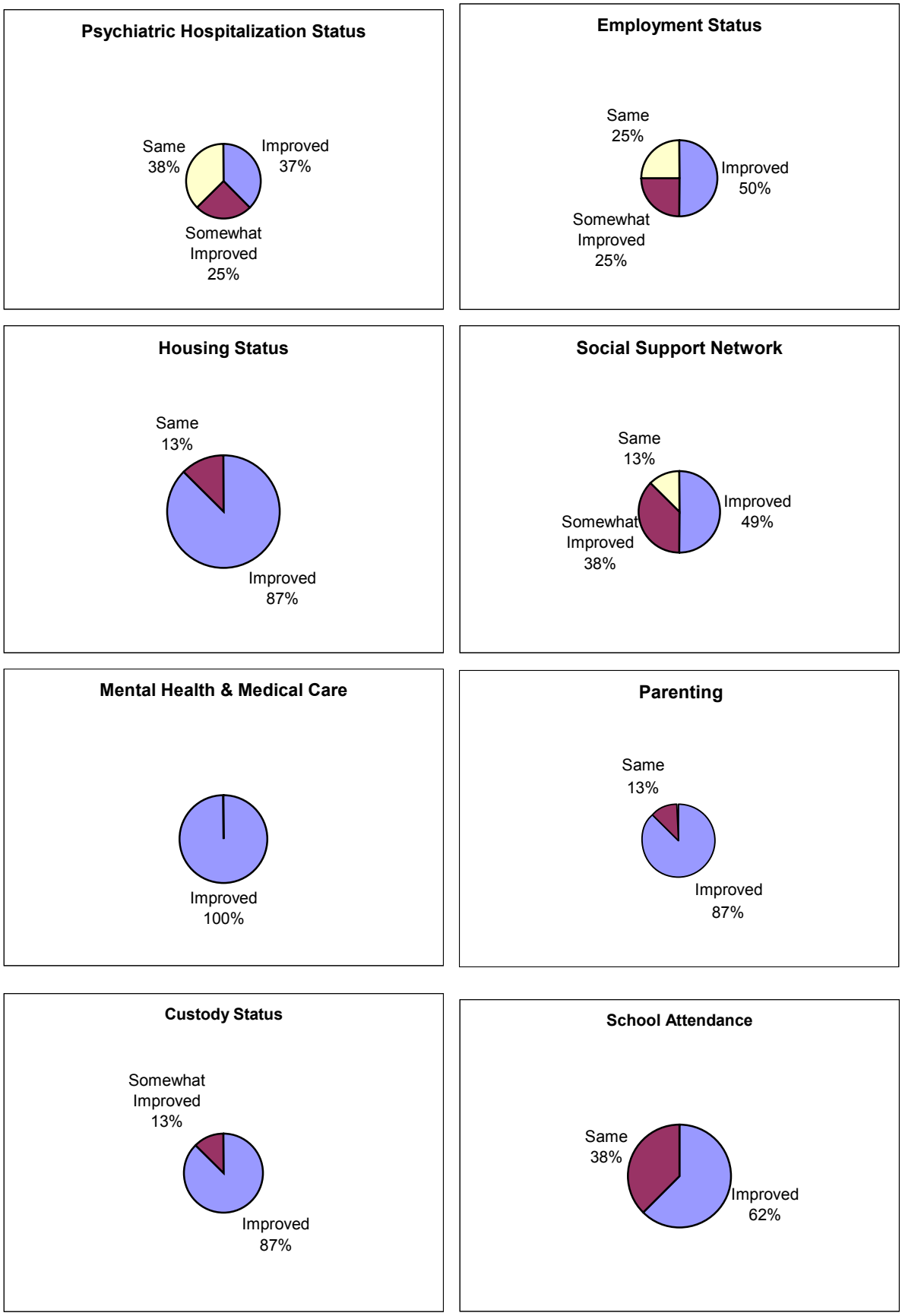
Family change over the period of involvement with ICP on eight outcomes targeted by ICP and DSS is portrayed in *Figure 1*. As can be seen, the majority of families improved or somewhat improved on targeted outcomes, or remained the same over time. None of the families evidenced deterioration on any outcome during their period of involvement with ICP.

Most families evidenced less need for hospitalization while involved with ICP. Four parents had no psychiatric hospitalizations. Two parents were hospitalized briefly, compared to multiple, lengthy psychiatric hospitalizations prior to ICP involvement. Two had not had any hospitalizations prior to ICP involvement and were able to remain hospitalization free.

Many parents showed improved employment outcomes. Three parents achieved full-time employment during their involvement with ICP, two were employed at the time of the interview, five participated in vocational training and supported employment programs, two received GED's, two completed certificate programs (programs in phlebotomy, nurses' aid), and one was a full-time student at community college.

With respect to housing, most families received and maintained housing subsidies, moved to more adequate and appropriate housing in safer neighborhoods, and showed increased housing stability.

Figure 1. Family change



Families also increased their social support networks. At the time of ICP admission, six of eight families had very limited support from family, friends, and the community. Four parents became engaged or remarried during the period of ICP involvement. Seven families reported new community contacts and supports through work, church, or community events.

Access to and appropriate utilization of medical and mental health care improved for all eight families while involved with ICP. Family members received needed mental health, substance abuse, and/or parenting skills interventions.

With respect to child custody, parents regained custody of children living in DSS placements, and maintained custody for children at risk for removal. Before ICP involvement, eight families were actively involved with the child welfare system: Four families had child protective investigations, two families had open child protective cases, and two families had children in foster care. In addition, three families had or had had children in residential treatment or in psychiatric hospitals. At the time of this study, all children had returned home and were in the custody of their parents. Finally, school attendance improved for 67 % of the children, and child behavior problems decreased for families who had identified them as a problem.

Cost of Services. Case management and childcare/respite services comprised the majority of comparable DSS and ICP costs for families. Service costs increased during their involvement with ICP for most families (88%; n = 7). This increase generally reflected the increased cost of intensive case management services provided by ICP. According to DSS caseworkers, these services were unparalleled by DSS, and absolutely necessary to support DSS goals of family reunification and preservation. Only one family in the study showed decreased costs overall. Five families (63%) showed decreased DSS costs overtime and decreased DSS costs proportionate to total costs. Costs assessed for the current study did not include DSS costs for foster care and residential treatment, because ICP provides no comparable services. However, two children were returned home during the period under study at considerable savings to DSS. In addition, it seems likely that out of home placements were avoided for the remaining families who were at very high risk for losing custody of their children at the time of referral to ICP.

Conclusions

Parents with mental illness and their children who received family-centered case management services through ICP, showed improvement across multiple outcomes. This improvement was consistently reported by parents, ICP case managers, and DSS workers. It is noteworthy that DSS workers stated unequivocally that children were returned home, or maintained in the home as a direct result of ICP involvement. While service costs increased for some families, benefits were great. Parent and agency goals were achieved, and more expensive, disruptive, and potentially damaging out of home placements, e.g., hospitalization and residential care or foster care, were avoided.

Policy Implications and Recommendations

Findings of the current evaluation have important policy implications.

- Family-centered case management services meet the needs of both adults with mental illness who are parents and their children, who may have, or may be at risk of developing psychosocial problems themselves.
- Family case management services require the integration of adult- and child-focused service sectors and systems, e.g., mental health, child welfare, public health, housing, educational/vocational services, early intervention, etc.
- Organizational, administrative, and financial mechanisms must support and facilitate the coordination and integration of adult and child services, and the collaboration of direct service providers.
- Providers from all service sectors need to be educated about the prevalence of parenthood among adults with mental illness, their goals, strengths and challenges in caring for children, and the benefits of appropriate and adequate supports and services for all family members.

- Providers must be encouraged to consider the strengths and resources, needs and goals of clients as family members, in the context of family life, rather than as individuals living in isolation.
- The number of families assigned to a provider must allow the provider to be accessible and supportive to family members, sometimes as often as daily. Provider availability and dependability are essential for parents with mental illness to establish meaningful and useful relationships.
- Flexible funds must be available to allow for the purchase of appropriate formal and informal (e.g. summer camp) services for all family members regardless of agency or service system affiliation; and to support families during times of financial crisis.
- Programs and services need to be documented and manualized to allow for rigorous evaluation with respect to specific and meaningful outcomes, and to facilitate the development of evidence-based practices for families in which a parent has a mental illness. Replication of successful programs is needed to evaluate practices in different communities and with diverse samples of parents and families. Technical and financial assistance for programs will be necessary to support such development and evaluation.

INTRODUCTION

Millions of adults in the United States are affected by mental illness. The majority of these adults are, or will become parents (Nicholson, Biebel, Hinden, Henry & Stier, 2001). Despite the number of parents with mental illness, mental health systems are generally designed to provide services for individuals. These systems are not prepared to support individuals in their role as parents, and not well prepared for working with families. Adults and children are funneled into separate, categorically funded service systems that cannot provide a cohesive *family plan*. As a result, there are gaps in available services, and there are very few places that parents with mental illness can obtain the services they need for themselves and their children.

The Invisible Children's Project

The Invisible Children's Project (ICP) in Orange County, New York is one of very few programs available to parents with a serious mental illness. ICP is nationally recognized as an innovator in services for families. ICP provides *family case management* for families in which a parent has mental illness. Case management services are intentionally home-based, and emphasize access to and coordination of multiple, comprehensive services for all family members.

ICP is part of a private, not-for-profit agency, Mental Health Association (MHA) in Goshen, New York. ICP was founded in 1994 on the principles that parents want to be the best parents they can be, and the act of parenting is a significant, and potentially healing role for adults with mental illness. ICP embraces a family-strengths/family-centered case management model, where ICP staff and families work together to assess strengths and determine needs. With these principles in the forefront, ICP strives to empower parents to create a safe and nurturing environment for their children, while supporting efforts to keep the family unit together. More specifically, ICP is built on the assumptions that parents have strengths, parents may require services from multiple systems, children are usually better off with their parents, families need and deserve support, mental illness is not the cause of good or bad parenting, enhanced parenting leads to enhanced child development, and dependable, consistent relationships are therapeutic.

ICP services include 24-hour family case management; referrals to community resources; advocacy with schools, child welfare agencies, and courts; family crisis planning; respite childcare; access to financial assistance; parenting education; pregnancy and post-partum education, children's art therapy, 24-hour Helpline; and supported housing. Most ICP services are provided in families' homes, and clinical services are provided via consultants and community-based providers. ICP staff stress the importance of creating meaningful relationships with families, built on trust and mutual respect.

ICP's primary funding comes from the New York State Office of Mental Health, with additional support from HUD, the United Way, local fund-raising, and state reinvestment money. However, since ICP serves families rather than individual clients, flexible funding is required for costs not covered by traditional adult mental health funding streams. MHA covers the difference between ICP's funding and the true costs of serving ICP families.

ICP and the Department of Social Services

Since its beginning in 1994, ICP has served over 150 families. The majority of these families were referred by the Department of Social Services (DSS) as a result of child safety concerns. The ability of ICP to address these child safety issues and achieve family preservation with respect to families involved with DSS has never been formally assessed. Using a "family-study" methodology, the current study provides such an assessment. The primary goals of the current study were to describe and document ICP practices, and examine the relationship of these practices to meaningful outcomes including family functioning, DSS involvement, and service costs. ICP practices and their relationship to outcomes will be explored from the perspective of multiple informants or stakeholders: Parents, DSS workers, and ICP case managers.

METHODS

Study Participants

Families were chosen for inclusion based on three criteria:

1) Currently receiving ICP services
2) Receiving ICP services for at least one year at the time of the study (November 1, 2000)
3) History of DSS involvement either prior to or during time of ICP involvement

A total of eight families met these criteria. The parent who was originally referred to ICP was recruited for participation in the study. At least one parent from all eight families agreed to participate. Thus, the current study represents the entire population as defined by inclusion criteria. Six of the parents interviewed were mothers and one was a father. In one family, two parents (mother and stepfather) were interviewed together because, although the mother was the original ICP client, the stepfather had been referred to ICP during the course of the family's involvement with ICP.

Parent Participants. Parents ranged in age from 26 to 40 years. Six parents were Caucasian and three were African American. Five parents had primary diagnoses of Major Depression, one with psychotic features, one parent had a diagnosis of Bipolar Disorder, one had a diagnosis of Schizoaffective Disorder, and one had a diagnosis of Adjustment Disorder with features of anxiety and depression. Two parents had secondary diagnoses of Borderline Personality Disorder, and one parent had Mental Retardation. Seven parents had histories of substance abuse, and six had histories of suicide attempts.

There were 16 children and two grandchildren currently living with parents interviewed for this study. Several families had additional children who were grown or were being raised by other family members or foster parents. Children (including grandchildren) living at home (N=18) ranged in age from 2 to 14 years. Ten of the children living with their parents had mental health diagnoses of their own, and five had histories of psychiatric hospitalization or residential treatment for emotional and behavioral problems. Among the 18 children currently living with their parents, 14 had a history of DSS involvement at the time of referral to ICP. The remaining four children were born or came into ICP after referral to DSS.

Child Participants. Although parents are the family member referred for ICP services, ICP provides family case management that includes assessment of children's needs, and referral to and coordination of necessary services to address these needs. In order to better describe the families participating in the study, and the complex needs often addressed by ICP, two standardized instruments on child adjustment were administered. These instruments were collected only on those children who had a history of DSS involvement at the time of referral to ICP (N = 14). Instruments were administered by ICP case managers.

Child Adjustment Measures

The Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998) is a standardized measure of child strengths. The BERS includes 52 questions that ask parents to identify strengths across five dimensions: 1) Interpersonal Strengths represents the child's ability to control emotions in a social setting; 2) Family Involvement reflects the child's participation in the family and his or her relationships to other family members; 3) School Competence is a measure of the child's functioning in school; 4) Intrapersonal Strengths represents the child's sense of confidence in his or her abilities and accomplishments; and 5) Affective Strengths is the child's ability to express emotions appropriately and to accept affection from others. The BERS also creates a score for a "Strengths Quotient" which provides an overall assessment of child strengths.

Figure 2 portrays the number of children out of the total of 14 assessed that showed average or better than average strengths across the five dimensions and the Strengths Quotient. Half of the children were reported to show average or better strengths for emotional expression and ability to give and receive affection (Affective Strengths). Almost half of the children showed strengths for Family Involvement, Intrapersonal Strengths, and School Competence. Interpersonal Strengths were less prevalent among this

group of children, with only three of the 14 showing average or better than average strengths on this dimension. Five children had average or better than average Strengths Quotients.

The Child Behavior Checklist (CBCL; Achenbach, 1991) is a checklist of emotional and behavioral problems completed by parents about their children. Scoring of the instrument creates scores for four competency subscales, eight "narrow-band" problem syndromes, and two "broad-band" problem syndromes. A Total Problems Score is also created. Competency subscales reflect Activities/Involvement, Social Competence, School Competence, and Total Competence. The narrow-band syndromes reflect Social Withdrawal, Somatic Complaints, Anxiety/Depression, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior. The broad-band syndromes reflect total scores for Internalizing Problems (e.g., Social Withdrawal, Somatic Complaints, Anxiety/Depression), and Externalizing Problems (Delinquent Behavior, Aggressive Behavior). Scores on each of these scales can be compared to other children of the same age and gender to determine if a child is showing clinical, borderline clinical, or non-clinical levels of competency or problems.[3]

Parents' reports on the CBCL revealed that children involved with ICP showed both competency and symptoms. As illustrated in *Figure 3*, eleven children (79%) showed clinically low levels of Total Competence. However, fewer children showed clinically low levels of Activity/Involvement, Social Competence, and School Competence. *Figure 4* illustrates the range of narrow-band behavioral and emotional problems of children receiving family-centered case management from ICP. Clinical levels of Somatic Complaints were least frequently reported, while Thought Problems, Attention Problems, and difficulties with Delinquency and Aggressive behavior were more common. Clinical levels of Social Withdrawal, Anxiety/Depression and Social Problems were evidenced by either half or nearly half of the children. When broad-band syndromes (Internalizing and Externalizing Problems) and Total Problems were examined *(see Figure 5),* most of the children in the study were reported to have borderline clinical or clinical levels, indicating a substantial degree of child mental health issues among the families referred to ICP.

The Invisible Children's Project: Family-Centered Case Management

ICP provides comprehensive case management services to parents with mental illness and their children. Parents qualifying for public sector mental health services are referred to ICP by a variety of other providers, including case managers working for the New York State Office of Mental Health, mental health clinicians, and DSS case workers. Parents are enrolled into the program as space becomes available. Enrollment priority is given to families representing the highest risk for loss of child custody. Case managers[4] develop service plans related to explicit goals for all family members. Case managers facilitate access to services defined in the plan, and provide ongoing coordination of services received by all family members, and support communication between all service providers involved. ICP case managers maintain regular contact with families, and are available by pager for crisis management 24 hours per day, seven days a week. In a time of crisis, parents can call the Emergency Helpline at MHA, the parent agency for ICP, and ask the Helpline worker to contact their case manager. The program currently has two full-time case managers, one of whom is also Program Coordinator. The Coordinator works with six families, and the case manager works with twelve families. ICP case managers have a Bachelors degree and a minimum of two years experience in direct human services.

ICP case management is comprehensive and fundamentally flexible in an effort to be responsive to specific and changing family needs. ICP relies on a "whatever it takes" approach, and as a result case

---

[3] For the competency scales, clinical range reflects scores less than or equal to the 5th percentile, borderline clinical reflects scores less than or equal to the 10th percentile, and non-clinical reflects scores greater than the 10th percentile. On the narrow-and broad-band scales, scores greater than or equal to the 98th percentile fall into the clinical range, scores greater than or equal to the 95th percentile fall into the borderline clinical range, and scores below the 95th percentile fall into the non-clinical range.

[4] ICP staff will be referred to as ICP case managers or case managers. DSS staff will be referred to as DSS workers or DSS caseworkers.

managers wear many hats. Case managers provide education and referral, but are also available to transport parents and accompany them to important appointments if needed to assure parent attendance. Provision of emotional support is also a central function of ICP case managers. The development of a trusting and supportive relationship between ICP case managers and all family members is a critical component of ICP case management. Availability and reliability are considered necessary in order to promote trust among families who have often felt unsupported and sometimes betrayed by professionals in the past. Contact with families is therefore highly intensive when needed. ICP case managers are available for daily contact by phone or in person, and in times of crisis may speak with parents multiple times in a single day. During times of stability, phone contact may be weekly and in-home visits bi-weekly.

These values on relationship and the capacity to provide comprehensive and intensive services distinguish ICP from less comprehensive case management programs in general and from DSS services in particular. *Table 2* illustrates some of the differences with respect to comprehensiveness in case management between DSS and ICP, and makes evident that one unit of service has very different implications across the two agencies.

ICP case management is *family-centered*. Family-centeredness reflects practices that are strengths-based, collaborative, and respectful of family "voice and choice" about both needs and goals (Allen et al., 1995). ICP assumes that parents want to be the best parents they can be, and that mental illness is not a determinant of parenting ability. The parenting role is valued, and the goals and needs of the entire family are considered in the creation of a service plan. These values and principles provide the foundation from which case managers work with families, and are believed to be related to positive outcomes for ICP participants.

Family-Centered Measure

The Family Centered Behavior Scale (FCBS; Allen, Petr, & Brown, 1995) was used to assess the presence of family-centered qualities in ICP services from the perspective of parents participating in the current study. The FCBS includes 26 items that assess whether ICP case managers behaved in a family-centered, strength's based manner when providing support and services to families. The FCBS asks respondents to rate the frequency of family centered behaviors in interaction with their ICP case manager on a 5-point scale (1=never; 5 = always). For the current study, an overall Family Centeredness score was calculated for each family by averaging across all 26 items. The FCBS was administered to parents by researchers as part of a longer interview (Parent Interview; see below). ICP case managers were not present for the administration, and parents were assured that individual responses would not be shared with ICP staff, nor affect their services in anyway.

As can be seen in *Figure 6*, all eight families reported that ICP case managers exhibited family-centered behavior "most of the time" (score = 4) or "always" (score=5). Average overall scores ranged from 4.15 to 5.00 on a scale of 1 to 5. The mean score across families was 4.75, with a standard deviation of .26, indicating that the parents in the families involved in this study felt respected and treated in a strengths-based, culturally competent manner "almost always."

Procedures

Interviews. Interviews were constructed for the current study to gather information from parents, ICP case managers, and DSS case workers. Interviews included questions related to ICP practices and family outcomes, and were informed by a collaborative process between research staff, program staff and administrators, and an ICP family representative. Over the course of several meetings and structured conversations, program staff and the participating family member defined critical risk factors, and related areas of functioning that are targeted by ICP. These areas of functioning were defined as common "critical outcomes" and were specifically assessed through interviews and file extraction.

Table 2. Comparison of ICP and DSS case management services

	ICP	DSS
Focus of Service	Case management services provided for the entire family. Focus is on all meeting family needs through referral, linkage, support and advocacy.	Services provided for identified parent and child(ren). Focus is on child safety through referral to mandated services and home monitoring.
Family Contact	Minimum contact is two times a month in home. Actual minimum contact is once weekly in-home.	Minimum contact is once monthly face to face. Actual contact is one time monthly.
Availability	Case manager available 24-hours per day, seven days a week via Crisis Helpline at parent agency.	Caseworker available Monday to Friday, 9 A.M to 5 P.M. Emergency line available for child safety concerns, but does not access family case worker.
Caseload	On average, full-time ICP case managers carry a caseload of 12 families.	On average, full-time DSS caseworkers carry a caseload of 20 families.
Service Coordination	ICP case manager coordinates multiple services for all family members. ICP maintains regular contact with other providers and facilitates provider and interagency communication and conflict resolution, and convenes interagency meetings as needed.	Caseworkers provide referral to services, but do not coordinate services.
Advocacy/Support	Case managers advocate for appropriate services, forge relationships with other providers when needed, and accompany parents to school, court, and DSS meetings to provide support and to advocate for appropriate services and supports.	Caseworkers do not generally provide direct advocacy services.
• ***Legal Advocacy***	Case managers make referrals to and maintain contact with professional legal advocates.	
• ***Educational Advocacy***	Case managers make referrals and facilitate relationships with professional educational advocates for children receiving special education or in need of evaluation for school placement. Case managers attend IEP meetings, incorporate child services and needs into overall family service plan, and provide transportation if needed.	

	ICP	DSS
Housing	Subsidized HUD housing available for six families. Referral to Section 8 and other supported housing programs in the community. Case manager assists parent with completion of application and other requirements.	Caseworkers provide referral to Section 8 and other supported housing programs in the community.
Flexible Funds	Case managers have access to flexible funds to address critical or clinically relevant needs. These can include payment of rent and utility bills to avoid eviction or discontinuation of services, purchase of home furnishing, and additional funding for school clothing and activities, birthday and holiday gifts, and recreational activities.	DSS does not provide flexible funding to cover concrete needs.
Home Furnishings	In addition to funding for purchase of home furnishings, case managers make referrals and advocate for families in need of home furnishings through existing financial programs such as people for people fund, flexible fund, Jewish family services and catholic charities. Case managers assist with transporting furniture and households to the family home.	DSS does not assist families with home furnishings.
Entitlements Counseling	Case managers educate parents about entitlements, assist with meeting all requirements, ensure completion of application, and provide transportation to all related appointments.	Caseworkers may refer to appropriate agency but do not provide direct entitlement counseling services.
Transportation	Case managers provide personal transportation to any and all appointments, meetings, and court appearances. Vouchers/bus passes also made available.	Caseworkers do not generally provide transportation. DSS provides vouchers for taxi or bus services for medical and mental health appointments when these are Medicaid eligible.

	ICP	DSS
Psychiatric Evaluation	Case managers assist with referral and linkage to psychiatrist. Case managers transport and accompany family members to hospital for emergency psychiatric evaluation. Case managers utilize mobile mental health services (in-home) for individuals in need of psychiatric evaluation.	DSS provides transportation vouchers if Medicaid eligible.
Family & Parenting Assessment	Clinical consultants provided by ICP for in home clinical assessment during difficulty times. This is not ongoing in-home therapy, but assessment and brief therapy.	Caseworkers provide referral for assessment.
Parenting Skills/Behavior Modification	Case managers and ICP In-home Consultants provide modeling, develop behavior management plans, and assist with parent-child relationship.	Caseworkers do not provide direct services. DSS parent aide services available for in-home services 3 days per week to assist with parent-child relations. Referrals are made to parenting classes. Transportation is available.
Psychotherapy	Individual and family therapy are not provided by case managers. Referral to providers, assistance with appointment scheduling and provider communication, and transportation to appointments are provided.	Caseworkers provide referral for therapy.
Medication Management	Case managers assist with scheduling appointments, accompany clients to appointments if desired, maintain contact and facilitate parent communication with psychiatrist if desired by parent and/or required by DSS. Case managers provide information and education about medications and mental illness.	DSS provides transportation vouchers to appointments if Medicaid eligible
Healthcare Management	Case managers provide transportation to appointments, and with medication management.	DSS provides transportation vouchers for appointments if Medicaid eligible
Reproductive Counseling and Prenatal Care	Case managers provide referrals to appropriate medical providers and provide transportation to and support during appointments as needed.	Caseworkers do not provide direct services.

	ICP	DSS
Budgeting and Financial Management	MHA, ICP's parent agency acts as representative payee if needed. Case managers also assist parents with developing a budgeting and financial planning, and provide referral to budgeting and financial planning programs.	Caseworkers do not provide direct services.
Respite	ICP Respite program provides in-home or out-of-home Respite by a trained childcare provider as needed for (but not limited to) therapy appointments, medical/psychiatric appointments, hospitalizations, work, school, support during meal times, give parent and/or child a break. There is no maximum amount per family. Each request is individually reviewed for approval based on service availability.	DSS provides a two-week maximum out of home placement with a foster family. To receive Respite, there must be an open protective/preventive case and show risk to child safety or absence of parent due to some circumstance such as need for hospitalization. Specialized daycare services are available for families. Transportation is available.
Mentoring	Case managers and Respite workers act as positive adult role models for parents and children. Referral to existing services also provided.	DSS Youth Advocacy Program (YAP) provides mentorship services on a daily to weekly basis, generally in the community.
Tutoring	Homework assistance provided by Respite workers.	DSS does not provide direct services.
Art Therapy for Children	ICP provides a monthly art therapy for children involved with ICP. Case Managers provide transportation and coordination of groups.	DSS does not provide direct services. Transportation is available if therapy is Medicaid eligible.
Family Recreation	ICP organizes summer picnics, holiday parties, skating parties, trips to the zoo, and other recreational opportunities for involved families. Transportation and funding are provided for families.	DSS does not provide recreational services for families.
Links to Other Services	ICP is a program of Orange County MHA, a comprehensive human service agency providing an array of mental health services to the public sector. Case managers work with multiple providers within MHA to access services quickly and maintain good communication across providers.	DSS maintains contracts with many local providers and provides direct services for youth through the Youth Advocacy Program.

	ICP	DSS
MHA Programs		
• ***Crisis Helpline***	MHA 24-hour phone service that provides information, referral, crisis intervention and support during a crisis. MHA helpline staff will contact ICP case managers after hours or on the weekends in emergency situations.	DSS provides a hotline to report child safety concerns but does not provide other emergency services for parents.
• ***Vocational Assessment***	MHA has vocational and educational support programs. ICP case managers assist with referral process, linkage and ongoing support for maintaining service including transportation.	Caseworkers provide referral to MHA or other programs.
• ***Supported Education services***	MHA provides supported education programs to clients enrolled in programs. Provides, tutoring, GED placement and readiness as well as support in college. (VESID funded). Transportation available if needed.	Caseworkers provide referral to MHA or other programs.
• ***Clubhouse Services***	Hudson House is a program of MHA providing psychiatric support, socialization and educational/vocational support. ICP case manager coordinate services provided through Hudson House for involved families, and provide transportation.	Caseworkers refer parents to Hudson House.
• ***Mentorship***	Compeer is a MHA program pairing a volunteer friend with adults with mental illness for socialization and community integration.	Caseworkers refer parents to Compeer.
• ***Support Groups***	MHA sponsors numerous support groups for children, parents and families. Case Managers assist with referral, linkage and transportation if needed	Caseworkers refer parents to support groups in the community.
Non-MHA Programs		
• ***Parenting Classes***	Case managers assist with referral and linkage to parenting classes available in the community as well as transportation.	Caseworkers refer to mandated parenting classes. Transportation available. Parent aides provide in-home parent modeling.
• ***Substance abuse treatment***	Referral and linkage to needed services. In-home consultants can provide assessment and recommendations	Caseworkers refer to mandated treatment programs. Transportation available if Medicaid eligible.

Critical outcomes defined for this study included number of hospitalizations[5], housing status, employment status, social support network, mental health and medical care, parenting, child custody status, and child school attendance and behavioral functioning. Interviews were conducted by research staff. Every attempt was made to perform interviews in person for all participants. All families were interviewed in person. Phone interviews were necessary for one former ICP case manager, and one DSS caseworker.

Parent Interviews

Parents were asked to describe their lives prior to ICP involvement and since ICP involvement. In particular, we asked parents to tell us about their strengths, needs, and issues; and to assess changes in their lives and the lives of their children. We also asked them to tell us about their experience with ICP, whether it was helpful, and what "made the difference." ICP case managers transported research staff to family homes, and introduced researchers to each parent interviewed. Informed consent was obtained. The research benefits of providing interview information in the absence of ICP case managers was explained, and each parent was offered the choice of having his/her case manager remain for or leave the interview. Only one participant chose to have her case manager remain for support.

ICP Case Manager Interviews

Consent was obtained from all case managers for participation in the study. ICP Case managers were asked to identify key strengths and issues for the families with whom they worked, and to discuss family progress since involvement with ICP. Case managers were also asked to identify the ways their work with families had been helpful/effective, and to speculate on the "key ingredients" that made their work with families successful.

DSS Interviews

Consent for participation was obtained from DSS workers who were assigned to the families in the study. DSS workers were asked to discuss their experience of collaboration with ICP on the families in the study. They were also asked to define critical issues identified by DSS for each family, and ICP's ability to facilitate change with respect to these issues. Similar to parents and ICP case managers, DSS workers were asked about what seemed to be the "key ingredients" to ICP's success with families.

File Extraction. Information on family outcomes provided by interviews was supplemented by data from ICP family files. File extraction was performed by a research assistant. Each family file included a screening instrument, an intake assessment, initial service plan, 6-month follow-up assessments, and progress notes that were reviewed for information.

Service Costs. Cost data was gathered for services provided by DSS in the year prior to ICP involvement, and for services provided by both DSS and ICP for all years of family involvement with ICP through November 2000. Only costs reflecting "comparable" services across the two agencies will be presented graphically. Comparable services include Case Management services, Childcare/Respite services and Parent Aide/In-home Parent Consultant services. Critical services provided by each agency but not comparable across agencies, such as housing (ICP) and foster care/residential treatment (DSS) will not be reflected graphically, but will be discussed. Families formally agreed to the release of cost data from DSS. These data were gathered with the cooperation of DSS and reflect total cost *adjusted for inflation.*

Presentation of Results

Results of this evaluation study will be presented in two ways. Interview information for each of the eight families will be presented in an integrated "Family Study" narrative. Progress on critical outcomes will be portrayed in individualized "Progress Reports" for each family that reflect functioning across selected outcomes (see above) from the time of enrollment into ICP to the time of data collection

---

[5] Although hospitalization is a critical outcome in that it is related to risk of child custody loss, hospitalization is not always a negative outcome. Appropriate hospitalization in combination with a Crisis Plan that specifies temporary custody arrangements can reflect an improvement in access to services, and is often in the best interests of child and family. There are indications that parents will avoid needed hospitalizations due to lack of child care arrangements and fear of custody loss.

for this study (November 2000). The narrative and progress reports will be supplemented by graphs to illustrate service costs. Together these qualitative and quantitative approaches tell the "ICP story." [6]

Methodology Limitations

In order to provide as rich and full a report as possible, the current study includes reports from multiple informants. However, one important informant is missing – the children. All child information for this study was gathered from parents, case managers, or caseworkers. Child reports would certainly have enriched the family studies that follow, however time constraints and ethical considerations precluded gathering of these reports.

In addition, it must be noted that families interviewed for this study were currently receiving services from ICP. In order to avoid positive bias in parents' reports, efforts were made to ensure confidentiality of parent reports by performing interviews in the absence of ICP case managers. Parents were also assured that the services they received from ICP, and the relationship they enjoyed with their ICP case manager would not be affected in anyway by their participation or their report. Despite these efforts, the possibility for positive bias must be acknowledged with respect to both the Parent Interview and the Family-Centered Behavior Scale data. Similarly, child data that were collected from parents by ICP case managers, may have been influenced by the desire for parents to "make their children look good" or "look bad."

[6] Parent interviewees reviewed all narratives and revisions were made according to their direction.

RESULTS

Meet Mark[7] and His Family

Mark is a single parent of Katie, a 10-year old girl who loves to ride her bike and roller blade. Mark enjoys fixing cars and radios, and together, they enjoy fishing, taking long walks, and watching TV. Mark and Katie live with Mark's fiancée, Maria and her 5-year old daughter Kim, and have built close relationships with Maria's family and in the community.

Family Challenges/Pre-ICP

Mark has Major Depressive Disorder and mild Mental Retardation. He was diagnosed with these disabilities before Katie was born. Mark's own family had many problems including domestic violence and a history of alcoholism and drug use. However, Mark has remained sober since 1992. Mark left school after the seventh grade because of teasing from other children about his mental retardation.

Mark and Katie have limited family support. Mark's mother died in 1997 and Mark has only occasional contact with his brothers and sisters. Mark has been separated from Katie's mother since before Katie's first birthday. Katie's mother has a history of mental retardation, mental illness, and physical health problems, and has never been a consistent caregiver for Katie.

Prior to ICP involvement, Mark and Katie were homeless at times. During one of these periods, they lived in a motel for 8 weeks. Mark also had difficulty maintaining employment, and often worked in fast food restaurants where he could not make an adequate living to support himself and Katie. Tasks of daily living such as personal hygiene, meal preparation, and budgeting were challenging, and he often felt irritable and depressed.

Mark and Katie were originally referred to DSS in 1992 due to concerns of both abuse and neglect. According to their DSS caseworker, Mark had a lot of anxiety about parenting – "He had no idea how to be a parent in concrete ways." Mark had trouble with certain parenting tasks and had a limited understanding of child development and age appropriate needs. Katie's hygiene was poor, and Mark was uncomfortable giving Katie baths. Mark also had difficulty making responsible decisions about Katie's well being. For example, on more than one occasion, Mark had left Katie with strangers not realizing this may have put his daughter at risk. DSS filed numerous Child Protective Services (CPS) reports on Mark, and had many concerns regarding Katie's safety and well-being.

ICP Becomes Involved

Mark and Katie were referred to ICP by DSS in 1993. It was clear that Mark and Katie needed supports and services beyond what DSS could provide. Working with his ICP case manager, Mark was able to set realistic goals for himself and Katie, including improving parenting skills, learning about hygiene and behavior management techniques, understanding different stages of child development, finding better housing, and securing employment. ICP also worked with Mark to create a budget and better manage his finances. Mark and his ICP case manager met regularly to review the family's goals and progress.

ICP provided intensive preventive services to keep Mark and Katie together. ICP helped Mark move from a transitional housing program to permanent and independent housing. ICP provided Respite services that enabled Mark to attend a weekly social club and increase his social network and supports. Mark was also matched with a Compeer, a community volunteer who provides support and friendship.

Mark's ICP case manager modeled appropriate parenting behaviors and helped Mark with even the most basic of skills, including how to hold and bathe an infant, choosing seasonally appropriate clothing, and preparing well-rounded meals for himself and Katie. ICP helped Mark enroll in a parenting class. In addition, the case manager helped Mark improve his own hygiene and grooming.

ICP's intervention with Mark and Katie, has been tailored to fit the family's changing needs over the years of family involvement. When needed, Mark has attended family counseling with Katie. As

[7] Names have been changed in all family stories

Katie has gotten older, ICP has worked with Mark to establish appropriate discipline. When Katie's learning disability became apparent, ICP worked with the special education teachers at Katie's school to create a service plan that matched the needs of Katie and the family. ICP has also worked with the school to address Katie's inconsistent attendance and poor grades.

The Family Today

Over the seven years that Mark and Katie have worked with ICP, they have made tremendous progress. They now live in a clean apartment, in a safe neighborhood and have created relationships in the community. Employment continues to be challenging due to childcare and medical problems. However, Mark is working with a job coach and hopes to find meaningful employment.

Two years ago, Mark met Maria, a woman living in his apartment building. Mark and Maria now live together with Katie and Maria's daughter Kim, and are planning to get married. Since Katie has never had to share her father's attention, Mark's relationship with Maria has been challenging for the family. Mark has shown insight into Katie's anxiety about his relationship, is sensitive to her concerns, and recognizes the need to spend special time with Katie as well as time together as a family. Through his relationship with Maria, Mark has developed some natural social supports and is somewhat less dependent upon his ICP case manager. ICP, DSS and Mark all agree that Mark's problem-solving skills have greatly improved and he has become a better parent. As Mark said, "I've gone to a parent group. They gave me ideas about how to raise my kid better."

Today, Katie attends speech therapy at her school's Developmental Learning Center. In addition, due to a referral for Early Intervention, she receives occupational therapy outside of school. Katie's school attendance is consistent, and she is part of a regular classroom where she receives 'A's' rather than 'F's' on her schoolwork. Her acting out at school, which was once, a problem, has decreased. According to her father and the ICP case manager, she is doing better socially, and gets along better with Maria's daughter and other children in the neighborhood.

In 1998 after six years of monitoring, DSS determined that protective services were no longer needed, and were able to "close the case," making Mark very proud. With ICP's help, Mark is confident that he will not lose custody of Katie The Family Progress Report identifies progress across several critical dimensions including psychiatric hospitalization status, employment status, housing status and school attendance.

What Made the Difference?

For Mark and Katie, ICP created a critical link to needed services. Beyond referral, ICP coordinated the array of services needed by Mark and Katie, and acted as a liaison to these services in an on-going way. ICP was flexible and responsive to the family's changing needs. ICP also helped Mark redirect his anger towards DSS, and his fear of losing custody into the motivation to better himself as a parent. His case manager understood that Mark needed individual counseling and a great deal of modeling to improve his parenting skills. As a result of these efforts, Mark has become more confident as a parent and is better able to access services he needs to be a better parent.

Equally as important as the services provided, ICP created a trusting bond with Mark, and instilled the sense that someone was always available and willing to help. ICP saw Mark as a whole person, and his mental illness as one part of his family's experience, rather than a defining characteristic. His ICP case manager formed a personally meaningful relationship with Mark. For example, when the family received a new ICP case manager in early 2000, Mark and the case manager spent their first weekend together cleaning out Mark's attic. This created an opportunity to get to know each other in a non-clinical, non-traditional setting. Mark related what he appreciated about his ICP case manager: "He calls just to ask how my weekend was – that makes me happy."

In addition, ICP provided support that exceeded traditional case management when the family needed it. When Mark's mother was dying, ICP coordinated with Hospice, helped Mark manage her care, and ultimately planned her funeral. The loss of Mark's mother was devastating to both Mark and Katie – losing her support sent Mark into a depression and he was unable to attend to his family's daily needs.

When this happened, ICP was there to pick up the pieces. Someone from ICP was with Mark and Katie everyday, for as long as was necessary. ICP worked with Mark through his grieving process and made sure Katie received bereavement counseling. As often noted by ICP case managers, "we do whatever it takes to support a family."

Both DSS and Mark agree that ICP involvement has kept Mark's family together. As stated by Mark's DSS caseworker, "The risk of placement in foster care was gone so DSS could close the case: ICP addressed Mark and Katie's daily issues." As articulated by Mark during our interview, "Without ICP, I would have lost Katie by now. I don't have to run anymore." Intensive and responsive service coordination, and ICP's unique relationship with Mark -- the value placed on trust, mutual respect, friendship and genuine concern – are what made the difference.

Cost of Services

In all likelihood, Mark and Katie are a family that will always need some assistance. As can be seen in *Figure 7* reflecting total adjusted cost, as ICP became more involved with the family, DSS was able to pull back, provide less service, and therefore incur fewer costs. DSS costs began to steadily decrease in 1994; the year ICP began working with Mark and Katie.

ICP costs reflect both services originally covered by DSS (e.g. case management) and a greatly expanded range of services need by Mark's family. Thus, while the overall costs for Mark and Katie have increased since ICP involvement, the entire family was being served, and was being served more completely. ICP costs also reflect the flexibility of their program. For example, the increase in costs noted in 1998 reflects the dramatic increase in case management and respite services needed when Mark's mother died. Similarly, the decrease in costs since 1998 reflect the decreased dependence on ICP services as Mark and Katie have developed more natural supports.

An Individualized Service Mix (Not all services were in place at the same time)

This list identifies services used by Mark and Katie since working with ICP. Some services are provided directly by ICP while others were secured by ICP through referrals.

Case management*
Housing*
Representative payee* [8]
Budgeting and financial management*
Entitlements counseling*
Transportation to appointments*
Crisis Helpline*
Crisis Funds*
Respite*
Art therapy*
Family Recreation*
Parenting classes
Mental health clinic
Medication management
Medical management
Vocational training
Rehabilitation counseling
Clinical evaluation (for both Mark and Katie)
Individual therapy (for both Mark and Katie)
Family therapy

---

* Identifies direct ICP service.
[8] ICP/MHA of Orange County, New York does not charge for representative payee services.

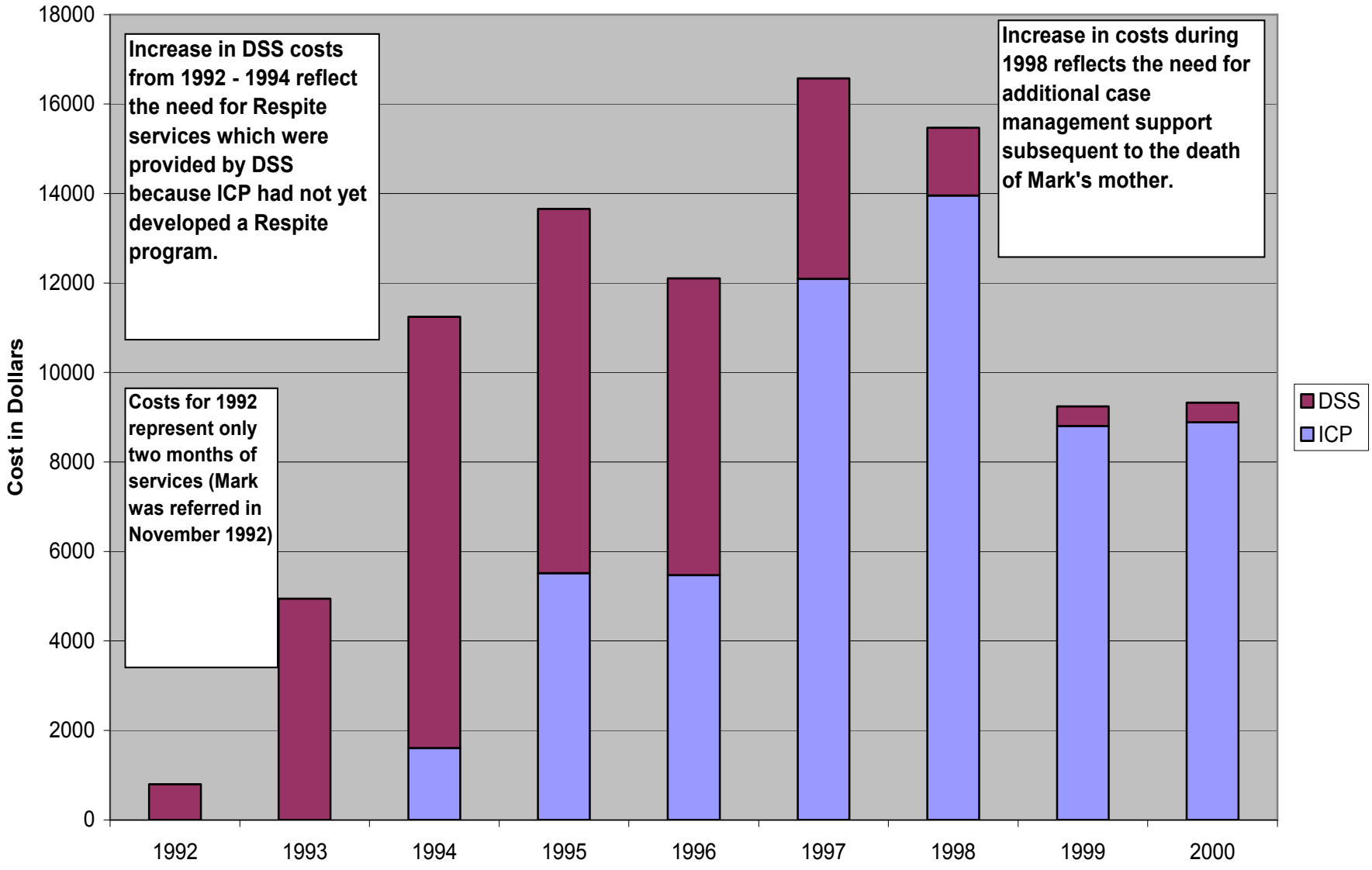
Compeer
Literacy classes
Social Club
Hudson House (psychiatric support program)
Early intervention
Big Sister

MARK AND HIS FAMILY
PROGRESS REPORT

Area of Progress	At Time of Admission to ICP	November 2000	Trends
Hospitalization Status	No prior hospitalizations.	No new hospitalizations.	Same
Employment Status	Sporadic employment; unskilled labor.	Job coaching program. Work in landscaping, maintenance, retail, stock and inventory.	Somewhat Improved
Housing Status	Homeless	Section 8 housing.	Improved
Social Support Network	Contact with mother. Socially isolated from peers. Professional supports only.	Increased relationship with mother. Developed community relationships. Currently engaged.	Improved
Mental Health & Medical Care	Inadequate access and utilization of mental health services.	Access to and regular utilization of adult and child mental health services, parenting services, and early intervention services.	Improved
Parenting	Basic parenting deficits	Basic parenting skills learned. Increased understanding of developmental needs	Improved
Custody Status	Child in custody of father. DSS protective services due to child safety concerns	Custody maintained. DSS services terminated/case closed.	Improved
School Attendance & Child Behavioral Functioning	N/A, child too young to attend school	Good attendance and behavior	Same *

* Can not be evaluated because child did not attend school at the time of admission.

FIGURE 7
Mark and his Family: Total Adjusted Costs



Meet Alison and Her Family

Alison and Fred are the parents of Sarah. Sarah is 8 years old, and has lived with foster families for most of her life. She has a seizure disorder and a serious emotional disturbance. She receives case management services from Mental Health Association (MHA) funded by the Office of Mental Retardation and Developmental Disabilities (OMRDD). When Alison, Fred, and Sarah are together, they enjoy going to the park, playing softball, and fishing. Alison and Fred have been involved with many professional providers, but have a very limited social support network. They have one cousin to whom they are close and see regularly.

Family Challenges/Pre-ICP

Alison and Fred both have a history of psychiatric problems. Alison is diagnosed with Schizoaffective disorder and Borderline Personality Disorder. She has made several suicide attempts and had several hospitalizations in her life. Fred is diagnosed with Personality Disorder, Not Otherwise Specified (NOS), and Mental Retardation. Fred and Allison have had periods of violent arguments during their marriage.

Alison and Fred have been involved with mental health and social service professionals for at least ten years. SSI has been their primary income. Due to limited financial resources, Alison and Fred have had to live in substandard housing for much of their life together. In addition to poor living conditions, it has been difficult for Alison and Fred to manage all the responsibilities of independent living such as cooking, cleaning and budgeting.

Over her years of involvement with service providers, Alison developed a reputation for being very demanding, and difficult to work with. In particular, professional providers noted that Alison was unable to understand or observe "boundaries." They reported that she considered "everything an urgent crisis," made repeated calls with "inappropriate requests," and became distraught and disrespectful when she did not get the help she felt she needed. These difficulties interfered with the development of alliances, and often compromised Alison's mental health treatment. In particular, Alison's disappointment with multiple psychiatrists often resulted in poor medication management, which further compromised her ability to parent well. It is important to note, however, that Alison had established a long-standing relationship with a single therapist, whom she saw for many years.

Prior to becoming involved with ICP, Alison was involved with DSS due to repeated concerns of abuse and neglect. Sarah was in foster care, and DSS was initiating a termination of parental rights. DSS had concerns about Alison's' poor mental health status and its effects on her ability to parent. In particular, DSS was concerned about poor nutrition, poor hygiene, and inability to manage Sarah's behavior and/or her mental health issues. They also recalled that Alison showed little understanding of or accountability for the impact of her mental health issues on parenting or Sarah's well-being. She blamed Sarah's problems on Sarah's mental health issues, and her parenting difficulties on medical problems that made her too sick to parent well.

ICP Becomes Involved

Alison was referred to ICP by her mental health case manager in April 1999. Reunification with Sarah was established as the central goal for Alison, and a service plan was constructed to achieve that goal. As a cornerstone of this plan, it was decided that ICP would mediate the relationship between Alison and DSS, and help Alison learn more effective strategies for working with DSS to achieve her goals. Crisis calls were to be directed to the ICP case manager rather than to DSS, and communication between Alison's case manager at ICP and her DSS workers was prioritized. DSS requirements for family reunification were integrated into Alison's ICP service plan. Specifically, ICP focused on arranging and supporting consistent mental health treatment and medication management for Alison. To accomplish this, the ICP case manager scheduled and attended all medical and mental health appointments with Alison, who lived an hour away from the ICP office. The case manager's role was often to facilitate communication between Alison and her providers, and to ensure that follow through with treatment recommendations occurred. In addition, home visits by the ICP case manager and home-based services

such as a parent consultant and Residential Habilitation (RESHAB), put into place by ICP, provided parent education and monitoring of progress. In addition to general child development education, and behavior management strategies, school attendance was a primary focus of intervention.

The ICP case manager also worked with Alison on distinguishing "true" crises that warranted a call to a worker, from distress that Alison might manage in some other way. The ICP case manager developed a plan for problem-solving that involved Alison's attempting to solve problems on her own with strategies they had identified, and calling her ICP case manager only if those strategies were not successful.

The Family Today

According to both ICP case managers and DSS workers, many of the family's goals have been achieved. ICP was able to develop a good working relationship with DSS that enabled DSS to continue to provide services to Alison and her family, and to be willing to develop a reunification plan. Alison's mental health care is well coordinated today. She attends appointments regularly and has a good relationship with her primary psychopharmocologist. Treatment has been consolidated and her symptoms appear to be reduced. Alison has not needed to be hospitalized during the entire period that she has worked with ICP. ICP has also helped arrange for adequate family housing and continues to work with Alison at home on issues related to child nutrition, hygiene, and school attendance. According to the ICP case manager, Sarah's school attendance, once a significant problem, is excellent.

With the help of ICP and the assurance that ICP would provide home monitoring and supervision, Sarah was returned home with Alison and Fred two months before our visit with Alison in April 2001. Alison admits parenting is hard for her and that she has trouble with managing Sarah's behavior, and knowing the "right thing to do" a lot of the time. Both DSS and ICP workers note that Alison loves Sarah, and is trying very hard. In addition, they noted that her most significant progress has been in being able to identify when she needs help with parenting, and to ask for help from an appropriate source – often her ICP case manager, or Sarah's case manager from MHA.

What Made the Difference?

DSS workers that have worked with Alison for over ten years stated unequivocally that "Sarah would not be home if [the ICP case manager] were not involved." From DSS's perspective, ICP can provide the accessibility and availability of a case manager needed by Alison and her family that DSS cannot provide. They were able to trust ICP to provide the supervision and monitoring that they needed to establish safety for Sarah. In addition, DSS agreed that without ICP as an intermediary, they would not have been able to work with Alison. They give ICP credit for being able to advocate for the parent and to respect DSS at the same time. Stated by one DSS worker, "they (ICP case managers) understand our role in the family and respect our role, and support our role in families.

This may be the only thing that Alison and DSS agree upon. Alison identified her relationship with her ICP case manager as the central ingredient to success. She felt that her case manager "was always there" and "listened" to her. Alison was able to trust her case manager in a way she had not been able to trust other workers. This trust allowed Alison to listen, and learn the things she needed to learn, and make necessary changes. ICP is "there for me when I'm at my wits end - when my brain is not right. The case manager helps me get my brain straight." In addition, ICP involvement with both DSS and other professional providers made Alison feel that her concerns were "heard" and she was given a voice. As a result, conflict was often avoided or quickly resolved, a better provider-consumer relationship was established, consistent care was provided, and outcomes improved.

All providers agreed that in addition to the supportive relationship built between Alison and her case manager, access to a wide array of services (see individualized service mix) that were tightly coordinated and supervised by the ICP case manager were critical to Sarah's being returned home. As can be seen below, Alison and her family received a highly individualized "mix" of services to meet multiple family needs. It is this flexibility and responsiveness that distinguishes ICP "case management."

Cost of Services

As can be seen in the graph reflecting costs (see *Figure 8*) for Alison and her family, DSS costs have remained the same while ICP costs have risen since ICP involvement began in 1999. DSS continued to provide case management services for Alison and her family, while ICP also provided case management and aggressively accessed and coordinated services addressed at achieving reunification. In particular, increased costs between 1999 and 2000 reflect the increase in case management services needed to provide the level of medication management required by DSS. The ICP case manager traveled the two hours roundtrip to Alison's home regularly to attend all appointments, and provide in-home supervision and monitoring. Thus, while costs in total have increased for Alison and family, stabilization was achieved for a family with a long history of instability and high services cost; and reunification, something DSS thought impossible, took place just two months prior to our visit with Alison and her family. In addition, because only comparable DSS and ICP costs are shown in the attached chart, DSS costs do not reflect substantial foster care costs prior to reunification.

DSS is required to continue services for monitoring purposes for one year after reunification. According to DSS workers, ICP involvement enhances DSS ability to monitor child safety, and increases the likelihood for a successful reunification and subsequent termination of DSS services. Thus, if we had been able to follow Alison and Sarah for another year or two, we might have seen DSS costs drop to zero, while ICP costs remained the same or decreased slightly. It is likely that Alison will always need and want case management services, and that these costs will be somewhat high in order to maintain stability and insure child safety. However, these costs need to be weighed against the fiscal and emotional costs of long-term out-of-home placement for Sarah.

Individualized Service Mix (Not all services were in place at the same time)

This list identifies services used by Alison, Fred, and Sarah since working with ICP. Some services are provided directly by ICP while others were secured by ICP through referrals

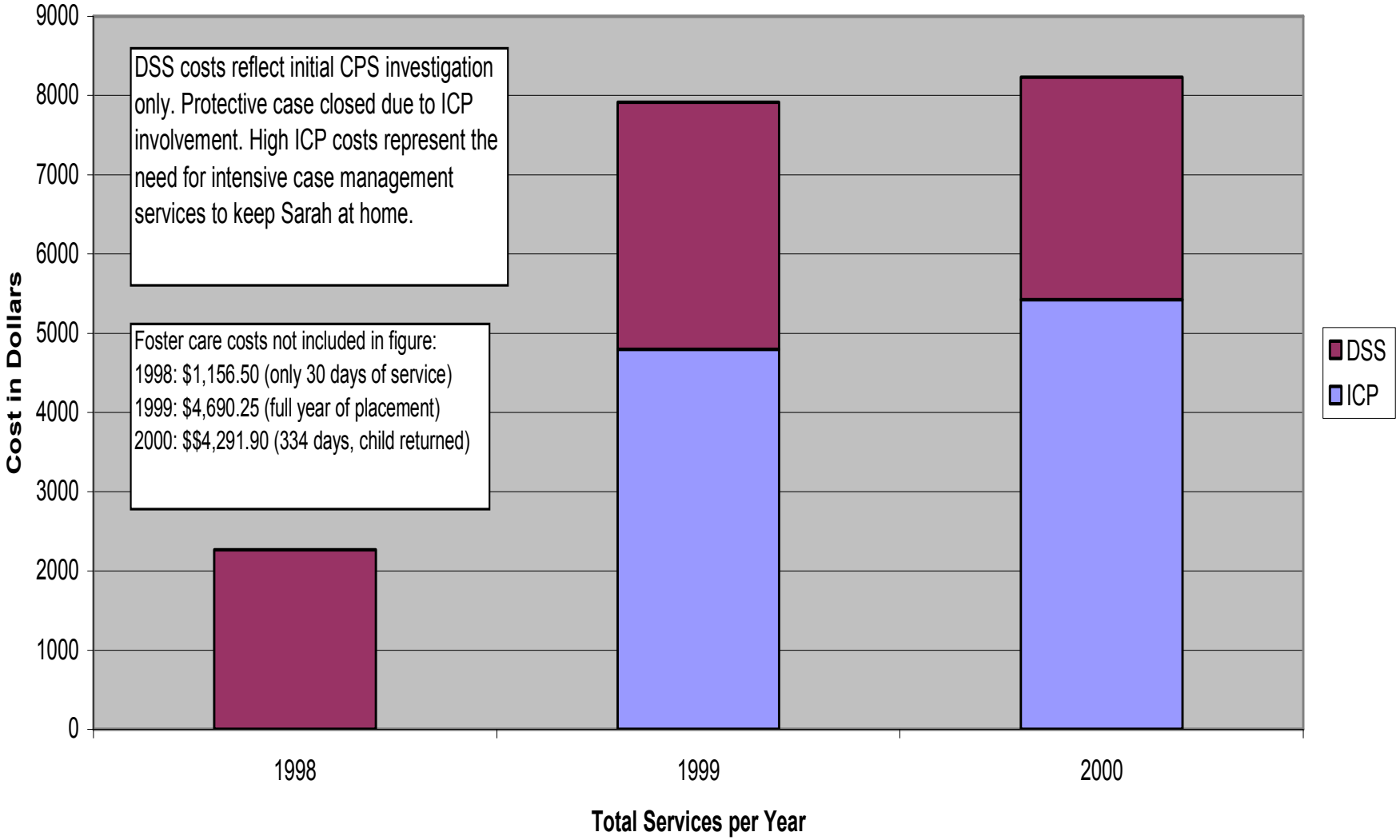
Case management*
Liaison with other services agency (school, DSS, clinical services, medical, OMRDD case manager)*
In-home parent consultant*
Budgeting and finances*
Entitlement counseling*
Crisis Helpline*
Crisis funds (utility payments)*
Funding for special activities (e.g., holiday and birthday gifts, summer camp)*
Recreation*
Transportation*
Medical Management*
Medication Management*
Housing
Legal Advocacy
Individual Therapy
Family Therapy
Residential Habilitation
Behavior Modification

* Identifies direct ICP service

ALISON AND HER FAMILY
PROGRESS REPORT

Areas of Progress	At Time Of Admission To ICP	November 2000	Trends
Psychiatric Hospitalization Status	Three or more prior admissions (records unclear)	No new hospitalizations	Improved
Employment Status	Sporadic employment, "off the books"	Sporadic employment, "off the books"	Same
Housing Status	At risk of losing Section 8 housing due to pending eviction.	Secured Section 8 housing; stable housing since ICP involvement	Improved
Social Support Network	Limited contact with friends and family. At times relations were negative and inappropriate.	Friends and family continue to be involved. Inappropriate relations have discontinued.	Somewhat Improved
Mental Health & Medical Care	Inadequate access and utilization of mental health services.	Access to and regular utilization of adult and child mental health services, parenting services, and early intervention services.	Improved
Parenting	Poor parenting skills and understanding of child development	Small improvement of skills; home-based parenting supports in place	Somewhat Improved
Custody Status	Child in foster care	Child returned home with DSS preventive services	Improved
School Attendance & Child Behavioral Functioning	Child in foster care attending school. Severe emotional problems.	Regular attendance, closely monitored by ICP case manager. Severe emotional problems.	Same

Figure 8
Alison and Her Family: Total Adjusted Costs



Meet Kathy and Her Family

Kathy is a thirty-three year old divorced, single parent of Matt (14-years old), Jim (12-years old), and Charlotte (7-years old). Kathy and her children enjoy watching movies, going fishing and having a weekly games night. Kathy is in a loving relationship with her fiancé, Tim, who has a great relationship with the kids. She maintains a close relationship with her extended family, especially her mother and sisters.

Family Challenges/Pre-ICP

Kathy is diagnosed with Major Depression, anxiety and Borderline Personality Disorder. She has a history of psychiatric hospitalizations, substance abuse, and suicide attempts. Kathy was in a violent marriage for seven years with an emotionally and physically abusive husband, and her most recent hospitalization occurred after her divorce four years ago.

Kathy's three children have multiple challenges. Matt, the eldest has various physical and emotional problems including mild Cerebral Palsy, reflux difficulties, Attention Deficit Disorder, and anxiety. Jim, the middle child, suffers from Major Depression and is clinically obese. While Charlotte, the youngest, has no psychiatric diagnosis, she often exhibits violent behavior, including biting, kicking, throwing objects and screaming.

Kathy became involved with ICP after the children's school filed a Child Protective Services (CPS) report. Matt's attendance was poor, and when he was in school, he often acted out and had to be sent home. Kathy's family was struggling at the time. She was recently divorced, deeply depressed and overwhelmed with anxiety. She was filing for bankruptcy, her house was being foreclosed upon, and she was at risk for homelessness. There was not enough money for food, and the family had to apply for emergency food stamps. Kathy reported having multiple anxiety attacks each day, and was isolating herself from friends and family. In three months, she lost 60 pounds. Her children were unable to sleep, were wetting the bed and becoming physically ill. As Kathy related, "I fell apart completely."

ICP Becomes Involved

When DSS assessed Kathy's family situation, they knew to call ICP. While DSS was concerned about the children's safety, they felt ICP was better able to address the multiple needs of Kathy's family while providing concrete assistance to help Kathy regain control of her life. DSS workers recalled that without ICP intervention, they would have had to remove the children from the home. Instead, they were able to close the case quickly.

Kathy, ICP, and DSS all identified housing as the main priority. Kathy and her case manager worked to find housing that both fit HUD criteria and allowed her children to remain in the same school district. ICP was able to move Kathy's name to the top of the subsidized housing list, and within nine months secured a three-bedroom condominium in a safe and attractive neighborhood. Kathy and her children met with their ICP case manager regularly to identify and prioritize family goals and needed services. ICP encouraged Kathy to improve her financial security, manage her mental health, improve her parenting skills, and continue her education. Goals for the children included accessing better medical treatment, improving their self-esteem, and creating more opportunities to socialize.

To increase Kathy's financial stability, ICP helped Kathy apply for SSI, and work on budgeting her limited resources. While Kathy continued to see her therapist and psychiatrist for medication management, she also began using the 24-hour Crisis Helpline available to families working with ICP; and took advantage of Respite childcare services in order to have a break from her children and some time for herself. As Kathy reported, "Respite helps you to be a better parent. Having a break helps you be a better parent." ICP also provided support around legal issues, acting as a liaison to the family court, and helping Kathy modify the children's visitation with their father due to concerns of substance abuse.

ICP also helped Kathy's children get the support they needed. ICP referred Matt to the Office of Mental Retardation and Developmental Disabilities (OMRDD) for specialized case management and residential habilitation services. Matt was matched with a mentor from a nearby college, and was referred to an educational advocate to help with continuity of special services in the classroom, including

specialized learning needs such as adaptive equipment. Matt received a complete psychiatric evaluation at a local pediatric clinic, and worked with Kathy and her case manager to decrease his feelings of anxiety and increase his coping skills. ICP found Jim a Big Brother to assist with his socialization problems and low self-esteem, and provided a referral to a therapist outside of school to help with his depression. Additionally, an ICP respite worker helped Jim with his homework and provided tutoring when needed. ICP connected Charlotte with a mentor and a respite worker to help with tutoring and homework, and provide some stability in an attempt to decrease her outbursts and tantrums.

Kathy's family has had some rough times over their years of involvement with ICP. Kathy's ex-husband lost his job and was incarcerated due to drug use. As a result, the family lost child support payments, their main source of income, and medical benefits. ICP linked the family to Medicaid and DSS for immediate cash assistance. Many of the family's doctors and therapists did not take Medicaid, and there was a lapse in medical and psychiatric services as a result. Family functioning was negatively affected. During this difficult time, ICP helped Kathy connect with new providers for her family and helped secure additional health care including dental and eye care, and in-home clinical consulting. ICP paid numerous utility bills during Kathy's financial crisis, to prevent her utilities from being turned off.

The Family Today

Today, Kathy is happily engaged to Tim, a man she has been dating for over a year. Tim is very supportive of Kathy and has a great relationship with the children. Kathy's circle of support has increased by reconnecting with friends and family, and attending a local support group. Kathy has completed two semesters at a local community college, and has secured benefits including SSI and TANF. Kathy feels more consistent in her parenting, and better able to discipline her children and set limits.

While the children continue to need specialized services, all have made progress. Matt is back in school after being tutored at home for several months. He is receiving continued care for his physical health problems, and has begun medication for his anxiety. He is more outgoing, has made friends in the neighborhood, and is attending school dances. Jim is excelling academically, and was recently named student of the month. While he tends to isolate when depressed, he is making strides to participate in school activities -- for example tutoring children in school and participating in a peer mediation program. Charlotte is doing well in school and has many friends. Charlotte's teachers are concerned that she may have ADHD, and Kathy is advocating to the Board of Education for an evaluation. Kathy is pleased that Charlotte's tantrums and outbursts at home have decreased in intensity and frequency. Overall, Kathy feels confident in her ability to advocate for her children.

As a family, Kathy and her children have really braved the storm. The contrast between life today and life three years ago is striking. Three years ago, Kathy and her family were filing for bankruptcy and losing their home. Today, they are meeting their bills, living in a three-bedroom condominium, and have just returned from a vacation to Florida. Kathy and her family are doing so well, they are ready to transition out of ICP and are preparing to buy a new home. Kathy and her children have achieved and exceeded goals, which seemed unattainable just a few years ago.

What Made the Difference?

Kathy describes how ICP is different from other service providers: "They (ICP) don't just tell you where to go, they take you by the hand when you're not able. When you're that overwhelmed, you don't know how to prioritize – they help you with that." Kathy's ICP case manager believes this sense of security and trust allowed Kathy's family to improve: "Before ICP, Kathy was afraid to get services because of the fear and stigma associated with mental illness and parenting, but now she can coordinate these services and get what she needs."

In addition, ICP prioritized the social and emotional needs of Kathy's family, and their desire to function like any "normal" family. For example, when Kathy first joined ICP, it was almost Christmas. Kathy was very sad that she could not provide "a real Christmas" for her children. ICP stepped in and found a family to "adopt" Kathy and her children for the holidays. Through the work of ICP and the generosity of the donor, Kathy and her children were able to have a traditional Christmas dinner, a tree

and presents for everyone. As Kathy tells the story, "I sat under my tree and cried. Through all these horrible times, I've met some of the most wonderful people, people who go above and beyond the call of duty."

For Kathy, the relationship with her ICP case manager was just as important as the services coordinated. While Kathy was initially skeptical of ICP and how they would be involved in her life, she came to embrace their help, and to realize that no one can parent effectively without support. "When you spend time with ICP, you develop a relationship and it's not a phony relationship." Kathy also realized that support for her helped her children as well. "ICP helped my kids feel more secure, knowing I had someone to turn to."

Cost of Services

As shown in the cost graph (see *Figure 9*), costs to DSS for Kathy and her family were very low. DSS costs incurred in 1999 reflect an initial DSS investigation only. As a result of the referral to ICP, DSS never "opened a case" on Kathy and her family. ICP became the primary support agency. ICP costs for Kathy and her children were initially very high since the family had many needs and so few supports. A great deal of Respite services were required to keep Kathy's family together and the children out of foster care. As Kathy and her family's life became more stable, Kathy was able to create more natural supports and require fewer ICP services. These changes resulted in the decreased costs seen in 2000. Kathy plans to leave ICP in the fall of 2001.

An Individualized Service Mix (Not all services were in place at the same time)

This list identifies services used by Kathy, Matt, Jim and Charlotte since working with ICP. Some services are provided directly by ICP while others were secured by ICP through referrals.

Case management*
Housing*
Liaison with other service agencies (e.g., OMRDD)*
Legal advocacy*
Budgeting and financial management*
Entitlements counseling*
Art therapy*
Respite*
Transportation*
Crisis Helpline*
In-home clinical consultation*
Crisis Funds*
Funding for special activities (e.g., summer recreational programs)*
Family Recreation*
Vocational needs assessment
Supported educational services
Rehabilitation counseling
Hudson House (psychiatric support program)
Support groups
Tutoring
Mental health clinic
Medication management
Medical management
Psychiatric evaluation
Medication evaluation Individual therapy (for Kathy, Matt and Jim)

* Identifies direct ICP service.

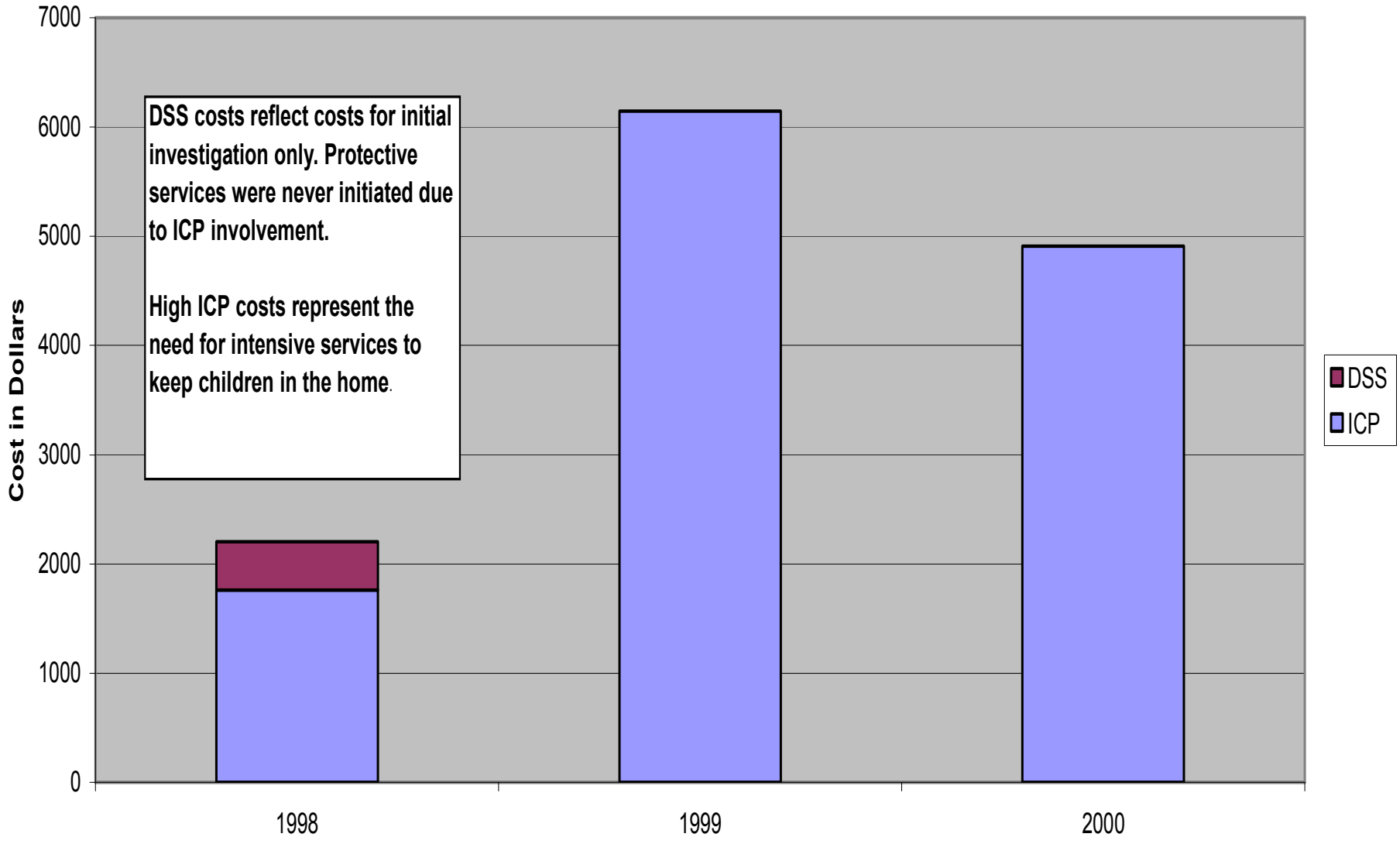
Family therapy
Mentoring
Nutritionist
Early intervention
Educational advocate
Behavior modification
Big Brother/Big Sister

KATHY AND HER FAMILY
PROGRESS REPORT

Areas of Progress	At Time Of Admission To ICP	November 2000	Trends
Psychiatric Hospitalization Status	Two prior hospitalizations.	No new hospitalizations.	Improved
Employment/ Education Status	Sporadic, "off the books" employment.	Supported employment and vocational educational programs. Student at community college, working towards a degree in Human Services.	Improved
Housing Status	Home foreclosure; risk of homelessness.	Subsidized housing in same school district.	Improved
Social Support Network	Close relations with mother and sister. Few friends.	Close contact with mother and sister maintained. Increased friendships in the community and children's school. Currently engaged.	Somewhat Improved
Mental Health & Medical Care	Inadequate access and utilization of mental health services.	Access to and regular utilization of adult and child mental health services, parenting services, and early intervention services.	Improved
Parenting	Difficulty identifying and responding to children's needs.	More active relationship with children, more involved with school and daily activities.	Improved
Custody Status	DSS protective investigation.	No DSS services. Parent has maintained custody of all three children.	Improved
School Attendance & Child Behavioral Functioning	Severe attendance and conduct problems for one child.	Attendance and conduct problems greatly improved due to involvement of educational advocate and classroom aid.	Improved

FIGURE 9

Kathy and Her Family: Total Adjusted Costs



Meet Dionne and Her Family

Dionne lives with her fiancée, William, and her four daughters -- Tiandra who is 11 years old, Chantel who is 9 years old, Melinda who is 3 years old, and Naisha who is 2 years old. Dionne is also six months pregnant. The family enjoys fishing together, listening to R&B music, watching TV, and going to the park. The girls like to "run around and play outside." Dionne is close to her mother, sister, and aunt. They visit and talk on the phone regularly, share meals, and talk about life together. Dionne and William also rely on them for childcare, and the children have good relationships with their relatives.

Family Challenges/Pre ICP

Dionne is diagnosed with Major Depression. Dionne became pregnant with Tiandra when she was 15 years old. She left school in the ninth grade as a result. Dionne was very young, and did not know very much about raising children, or living independently. Chantel was born two years later. During the time when Tiandra and Chantel were young, Dionne had very little support, and became involved with a man who hurt her daughters. Her involvement with this man caused DSS to question her judgment and her ability to protect and care for her daughters. In 1997, DSS removed both girls from Dionne's custody and placed them in foster care. According to Dionne, DSS "treated me like a dog," and told her she would never get her children back. According to her ICP case manager, DSS did not provide support for her as a parent and often set requirements for reunification that were impossible for Dionne to meet. For example, Dionne did not have a car, but was required to attend separate therapy sessions with each of her daughters that could not be reached by public transportation, and were sometimes scheduled at the same time. Missed appointments or visits were presumed to reflect a lack of sincerity on Dionne's part to have her children returned to her. In the meantime, her oldest daughter developed serious emotional and behavioral problems and needed residential treatment, and then day treatment.

Dionne became demoralized and despondent and developed substance abuse problems. She also became pregnant with a third child, and had no place to live. She recalled that she did not want to live anymore and took an overdose in an attempt to commit suicide. She was hospitalized for 5 days and referred to a local day treatment program after discharge. The day treatment program referred Dionne to ICP when Dionne made it clear that regaining custody of her children was her primary goal.

ICP Becomes Involved

Dionne began working with an ICP case manager in March of 1998, approximately one year after her daughters had been placed in foster care. She had recently delivered her third daughter, Melinda, and according to Dionne, "I had nothing. I had a bed out of garbage." Both Dionne and her ICP case manager recalled that Dionne was resistant to help in the beginning. She did not want to talk with her case manager, and was not willing to listen to anyone. With time, however, she began to open up, and to work collaboratively with her case manager. Most specifically, she began to keep her case manager informed, so that they could problem-solve together and avert crises.

Dionne identified many goals with her case manager. DSS mandated objectives for reunification were central to Dionne's service plan with ICP. Dionne and her case manager agreed upon strategies to address these requirements, including mental health and substance abuse treatment, family therapy with her fiancée and with her daughters in custody. Dionne and her case manager also agreed that ICP would transport and accompany Dionne to all meetings with DSS, and would advocate for Dionne, and model appropriate and effective ways to negotiate the child welfare system. With the help of ICP, more reasonable DSS goals were established, and supports to achieve these goals were put in place. Dionne agreed to work on improving her own skills to advocate for herself. Initially, the case manager spoke for Dionne, but with time, Dionne developed confidence and, according to her case manager, a "voice." DSS proved more responsive to Dionne with ICP intervention, and Dionne became less of a victim of the system. ICP also helped Dionne get a telephone, which greatly facilitated communication with DSS – an obstacle in the past.

Dionne also identified goals for herself outside of DSS mandates. She wanted to get her GED and receive training to become a nurse's aid. She wanted to pay off old debts and establish financial stability.

She wanted better housing for her family, and realized that she needed help with all of the tasks of independent living, such as budgeting, and organizing a home. Dionne also agreed that she needed to learn more about children and parenting skills. ICP connected Dionne with multiple services and supports to achieve her goals. Entitlements, housing, and other concrete essentials such as a crib for her new baby, were secured for Dionne. ICP referred Dionne to educational and vocational training at a local psychosocial rehabilitation center (Hudson House). A parent aide and in-home consultant were contracted to provide support with independent living and parenting skills.

With ICP support, Dionne made steady progress toward all of her goals. Her own mental health improved and she was discharged from her day treatment program. She has remained drug free since involvement with ICP, and attends 12-step meetings regularly. She no longer takes medication for depression. Dionne achieved her GED, and began working as a part-time, then full-time nurse's aid. With concrete assistance from ICP in addition to her own income, Dionne was able to furnish her home, and re-establish herself financially. Specifically, she was able to pay off old debts to utility companies. She attended parenting classes, and enhanced her knowledge of child development and behavior management. She was able to maintain custody of her younger children, one of whom was born during the period under study.

The Family Today

Today, Dionne's two oldest daughters live at home with their two younger half-sisters and stepfather to-be. Tiandra and Chantel were returned home in August 2000. DSS is currently preparing to "close the case" as soon as the required period of one year (after reunification) of preventive services expires. Dionne is looking forward to the time when DSS is no longer a part of her life.

Dionne and her case manager report that things are going very well for Dionne and her family. Dionne describes herself as "more situated… more organized." The case manager believes that as soon as DSS closes the case, Dionne will be able to graduate from ICP services as well. According to Dionne, the most important change since ICP involvement is that she has learned to "open up" and to talk and listen to people. Dionne says her family is "becoming whole, as one." They support each other by talking, and she tries to "under stand where the girls are coming from and how they are feeling." She says clearly that she "wants to be the best parent I can be," and acknowledges that it is very hard to be a parent. She sees herself as strict, and responsible as a parent. She knows it is her job to take care of her girls, support them, pick them up when they are down, and teach them right from wrong. Her case manager agrees that Dionne is a good parent, and has a good understanding of her mental health issues and the effect they can have on her children.

Dionne says that all of her children are healthy, loving, and smart. They keep her busy. Dionne notes that the older girls are doing well in school and are becoming more responsible as they grow. Tiandra continues have emotional and behavioral issues and attends a day treatment school program. Chantel is in regular classes and is doing well in general. Both girls attend counseling, and the family receives family counseling at home. Dionne no longer attends individual counseling. She and her counselor agreed that she had developed ways of coping with depression and stress on her own, and no longer needed therapy. Dionne was successful as a nurse's aid for a period of time, and was able to pay down debts and achieve better financial stability. She has stopped working as a result of a work related injury, and has successfully arranged for Workman's Compensation with the help of her ICP case manager. Dionne has maintained very positive relationships with her mother and aunt who continue to provide emotional and childcare support.

What Made the Difference?

Dionne, her ICP case manager, and DSS agree that ICP involvement made reunification of this family possible. Dionne was overwhelmed by DSS requirements, and unable to negotiate the child welfare system on her own. Both she and DSS had become hopeless about the prospect of Dionne getting her children back. ICP involvement changed the relationship between Dionne and DSS. Dionne gained a voice with DSS, and they began to respond to this voice.

Dionne noted that her ICP case manager "supported my goals," and "gave advice but did not tell me what to do." "Anything I needed, she was there for me." This unconditional support, positive regard, and availability were identified by Dionne as the things that were most helpful about ICP. Her own attitude change, and ability to open up and work collaboratively with her ICP case manager were also key ingredients to success.

DSS workers for Dionne and her family agree that ICP availability to support and "tackle all aspects of the family" is what distinguishes ICP from DSS and other providers, and what leads to their remarkable success with family reunification. DSS workers noted that ICP is able to address issues outside the scope of DSS, but critical to reunification. In particular, ICP's ability to bring understanding and support around mental health issues makes a big difference to family outcomes. In addition, ICP enhances DSS's ability to supervise and monitor family progress and child safety, and reduces the need for removal of children into foster care placement.

Cost of Services

As shown in the cost graph (*Figure 10*), DSS costs have increased over the period of ICP involvement. This reflects the expensive Youth Advocacy Program, in which Tiandra and Chantel are involved. What cannot be reflected, however, are the savings in residential costs as a result of reunification. Since ICP does not have an expense comparable to foster care or residential treatment, the actual change in costs to DSS for Dionne's family as a result of reunification are not illustrated. In addition, the costs of long-term foster care or residential treatment, as would have likely been required for Dionne's children had reunification not been achieved, are also not reflected. The "slice" of time that we are able to portray graphically does not tell the story. DSS is planning to terminate services for this family in August 2001, and all agree that the success of family reunification results from ICP's involvement. Thus, although difficult to see, ICP involvement has ultimately resulted in great cost savings to DSS, who prior to ICP involvement had expected to be responsible for life long placement of Dionne's two older daughters, and the probable removal of her two younger daughters.

Individualized Service Mix (Not all services were in place at the same time)

This list identifies services used by Dionne and her family since working with ICP. Some services are provided directly by ICP while others were secured by ICP through referrals

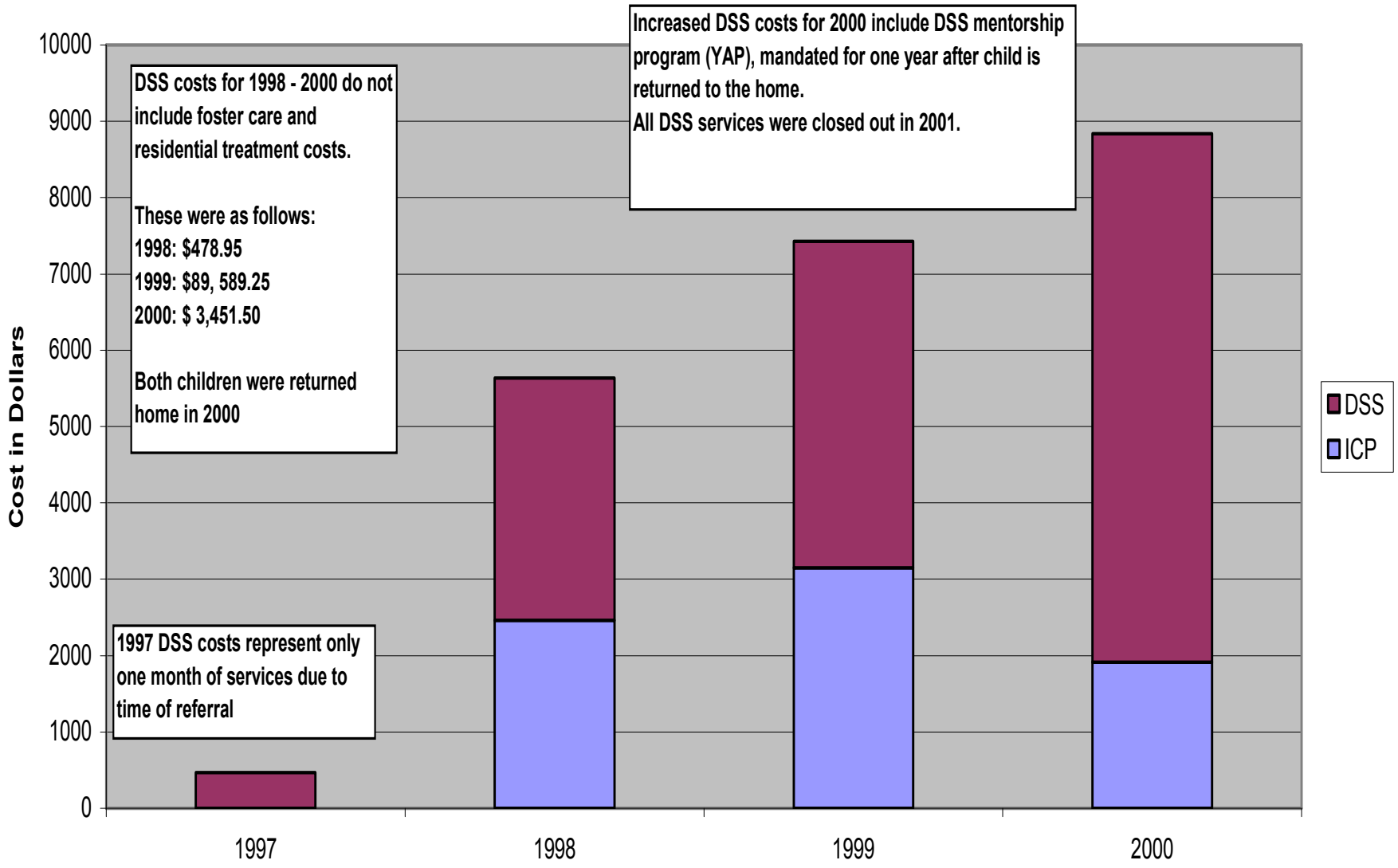
Case management*
Liaison with other services agency (primarily DSS)*
Budgeting and finances*
Entitlement counseling*
In-home parent consultant*
Respite*
Transportation*
Crisis Helpline*
Crisis funds (utility payments)*
Funding for special activities (e.g., holiday and birthday gifts, summer camp)*
Art therapy*
Family Recreation*
Parenting classes
Educational and Vocational services
Residential Habilitation
Day Treatment for parent and child
Substance Abuse Treatment/12-step programs
Individual Therapy for parent and child
Family Therapy
Youth Advocacy Program (DSS Program)
Behavior Modification

DIONNE AND HER FAMILY
PROGRESS REPORT

Areas of Progress	At Time Of Admission To ICP	November 2000	Trends
Psychiatric Hospitalization Status	One brief hospitalization	No new hospitalizations	Somewhat Improved
Employment/ Education Status	Unemployed	Supported employment and educational programs. GED and Nurse's Aid certificate, and full-time employment achieved. Currently unemployed due to work-related injury. Workman's compensation secured	Improved
Housing Status	Sub-standard basement apartment with inadequate living space for family	Subsidized apartment in safe neighborhood with adequate living space for entire family	Improved
Social Support Network	Inappropriate friends and limited family support.	Close contact with mother and sister. Currently engaged.	Improved
Mental Health & Medical Care	Inadequate access and utilization of mental health services.	Access to and regular utilization of adult and child mental health services, parenting services, and early intervention services.	Improved
Parenting	Concerns related to judgement and child safety	Parenting classes attended; enhanced understanding of child development and behavior management	Improved
Custody Status	Two children in foster care and residential treatment. Pregnant with third child.	Children returned home. Maintained custody of third and fourth child.	Improved
School Attendance & Child Behavioral Functioning	Children in foster care and residential treatment attending school regularly	Regular attendance. School attendance and performance are very important to Dionne	Improved

FIGURE 10

Dionne and Her Family: Total Adjusted Costs



Meet Amy and Her Family

Amy and Jimmy are the parents of 9-year old Vanessa and 6-year old Alexis. The family enjoys barbequing, playing volleyball and baseball, and shopping. Amy enjoys having her own garden; it makes her feel like she is in the country. Amy and her family have a close relationship with Rob, a longtime friend who visits regularly. Jimmy has chronic back and arthritis problems that have kept him from working. Amy has also not worked outside the home since 1991. The main sources of income for the family are SSDI and SSI.

Family Challenges/Pre-ICP

There were and continue to be many challenges for this family. Amy has a diagnosis of Major Depression with psychotic features, with a history of self-mutilation, suicide attempts, and psychiatric hospitalizations. Amy also has a criminal record. She served six years in prison (1992 - 1998) on charges of robbery and possession of an illegal substance. Both Amy and Jimmy have histories of alcohol and cocaine abuse. While Jimmy has been sober for seven years, Amy struggles with repeated relapses.

Amy and Jimmy's oldest daughter Vanessa has a long history of emotional and behavioral problems. She has been given multiple diagnoses over the years, including Major Depression with psychotic features, Oppositional Defiant Disorder, Bipolar Disorder and a sleep disorder. Vanessa has a history of sexual and physical abuse from a family friend no longer in contact with the family. She also engages in self-destructive behavior such as banging her head against the wall. Vanessa fights with other children in school and has been suspended four times. Finally, Vanessa has a history of fire setting, and is responsible for starting a fire that destroyed her grandmother's home. As a result of these issues, Vanessa has been in and out of psychiatric hospitals and residential treatment programs. Amy and Vanessa have a volatile relationship. Amy has become agitated by Vanessa's uncontrollable behavior and violent confrontations have sometimes resulted. There are few tensions with Vanessa's younger sister, Alexis, who Amy and Jimmy describe as a healthy and happy girl. However, Amy and Jimmy have noticed that Alexis sometimes copies Vanessa's behavior to get attention.

In the period before ICP involvement, life was very difficult. The family shared a substandard, one bedroom apartment on the third floor of a rundown building in a dangerous, urban neighborhood. The single bedroom that Amy and Jimmy used had no door, and the girls slept in a closet that was too small to fit a bed. Amy was depressed and isolated herself. She stopped going to therapy, and barricaded herself from her family physically and emotionally. Jimmy was unable to take over as primary parent, and communication breakdowns between Amy and Jimmy were frequent. As Jimmy related, "it was chaos every day. Every morning we woke up, there were problems." The chaotic home life was also difficult for Alexis, who would often sit in her room and cry. DSS had been involved with the family for a long time on multiple occasions.

ICP Becomes Involved

Amy and Jimmy were referred to ICP by hospital staff during Vanessa's first psychiatric hospitalization in April 1999. Vanessa had not lived at home for several years (since 1992). Amy and Jimmy were concerned that they would not be able to handle her violent and sometimes dangerous behavior, and would lose custody again should she be sent home. Amy and Jimmy wanted to stay together as a family and were committed to working with providers who could support them.

Initially, the family had no services or supports in place, and was in constant crisis. Communication between Vanessa and Amy was very difficult, and the family needed a lot of assistance to integrate Vanessa back into the home. The primary goal was to establish stability and safety for all family members, which required intensive collaboration between ICP and DSS around who would provide which services after Vanessa's hospital discharge. While ICP could provide a range of supportive services to Vanessa and her family, DSS was crucial in providing one-on-one daily mentoring for Vanessa. This collaboration was critical given the enormous number of services needed for the family to stay together.

Other immediate goals identified by Amy's family and ICP were to upgrade their housing, develop consistent parenting skills, and improve management of crisis situations. Amy and Jimmy also wanted to create more recreational time with their children, and access Respite care for Vanessa and Alexis.

To accomplish these goals, the ICP case manager met with the family a minimum of twice weekly for the first six months of their involvement with ICP. Amy and Jimmy applied for Section 8 and HUD housing, and ultimately received housing from ICP. A clinical consultant was brought into the home to work on parenting skills, behavior modification, and communication skills for the family. ICP coordinated family therapy, individual counseling and medication management for Vanessa and Amy. ICP also provided crisis intervention, recreation, and referrals for therapists, psychiatrists, and support groups. A particularly critical intervention involved ICP's working with the local school system to find an appropriate placement for Vanessa that could meet both her educational and emotional/behavioral needs.

The Family Today

Life has improved dramatically for Amy and her family. Today, the family lives in a two-bedroom apartment with a backyard, and the children have friends in the neighborhood. The family loves their new home. Amy and Jimmy have a spacious bedroom with its own bathroom, and Vanessa and Alexis share a room they decorated themselves. Having safe housing in an attractive neighborhood has increased the family's self esteem and confidence.

Amy and Jimmy's communication and ability to share parenting duties have greatly improved. Amy isolates less, and is able to ask for help when she needs it. As a result, Jimmy is more aware of Amy's needs, and is better able to help with parenting. Amy and Jimmy have also attended couples' counseling, which has been helpful. As Amy says, "Jimmy supports me. He's always there. I know he's there to take care of the kids. He doesn't throw things in my face – I can talk with him." Amy works individually with her ICP case manager and her therapist to manage her depression, and attends a women's group for support.

Vanessa still "acts out," but is better able to verbalize her feelings. Vanessa has not been suspended from school since February 2001. She is enrolled in special education classes, her grades have improved, and she is making friends. Her transition home has been rocky. She and her mother communicate better, but still have difficulties, and are sometimes verbally and physically abusive to one another. However, Vanessa's need for hospitalization and crisis intervention from ICP has decreased dramatically.

It is unclear whether living at home is the best option for either Vanessa or the family. ICP is working with the family and Vanessa's therapist to determine what is most appropriate for this family. Amy and Vanessa rely on ICP when times are tough – Amy often calls the after-hours Crisis Helpline for support, and Vanessa participates in recreational activities with her Respite worker and ICP case manager.

What Made the Difference?

Amy and Jimmy felt "instant relief" when they were accepted into ICP. Amy describes what makes ICP special: "They are there twenty-four hours a day for you - there is always someone to talk with. They're there for you when you need them the most. They're there even when you don't need them. They're like family." ICP does what ever it takes to support a family, often going above and beyond the call of duty both in times of crisis and times of celebration. For example, when Amy has felt unstable and depressed, her ICP case manager has spent entire days with Amy to provide support and consistency. Similarly, even though their original ICP case manager no longer works with Amy and her family, she is still very close with the family and attends Vanessa and Alexis's birthday celebrations.

Most importantly for Amy was the unquestioning trust she had in ICP: "Everything they told us, they kept their promise." Amy's ICP case manager understands the value of trust for the family: "They are more able and willing to get needed services (e.g. hospitalization) because they trust that ICP will maintain the family, and prevent custody loss." The family's DSS caseworker recognizes that ICP offers

many services that DSS can not provide, including supports and resources for the entire family: "ICP is so much more supportive [than DSS]. Without ICP, Amy would be hospitalized or doing drugs much more frequently. ICP is a guide, coordinating services for both families and providers." ICP represents the first time someone worked with the entire family identifying problem areas and developing supports and resources that addressed everyone's needs, not just those of the "identified client." In addition, ICP's ability to collaborate with DSS around family needs was critical to the family's success.

Amy and Jimmy's family has made significant progress. There is still much work to be done, however. The support of ICP, in collaboration with DSS, has allowed Amy, Jimmy, Vanessa and Alexis to learn the skills necessary to become a family.

Cost of Services

As reflected in *Figure 11*, both DSS and ICP costs for this family have been high. When ICP first began working with Amy and her family, there were no services in place. Intensive services were required immediately to keep this family together. The high DSS costs represent the one-on-one mentoring program for Vanessa, a service ICP cannot provide. ICP's case management costs by contrast, reflect services for the entire family. Both ICP and DSS acknowledge that without ICP involvement, Vanessa would have required costly residential placement for the long-term. Estimated cost for Residential Treatment is $83,950/year[9]. Vanessa has a long history of psychiatric problems, and will likely always require a high level of services and supports. ICP provides an alternative to residential services, and enables Vanessa to stay at home with her family.

An Individualized Service Mix (Not all services were in place at the same time)

This list identifies services used by Amy, Jimmy, Vanessa and Alexis since working with ICP. Some services are provided directly by ICP while others were secured by ICP through referrals.

Case management*
Housing*
Liaison with other service agencies (i.e., school, clinical, DSS, SSI, psychiatric hospital)*
Budgeting and financial management*
Entitlements counseling*
Legal advocacy*
In-home clinical consultation*
Respite*
Crisis Helpline*
Transportation*
Home furnishings*
Funding for special activities (i.e., holidays)*
Family Recreation*
Art therapy*
Vocational needs assessment
Hudson House (psychiatric support program)
Support groups
Mental health clinic
Medication management
Medical management
Psychiatric evaluation

---

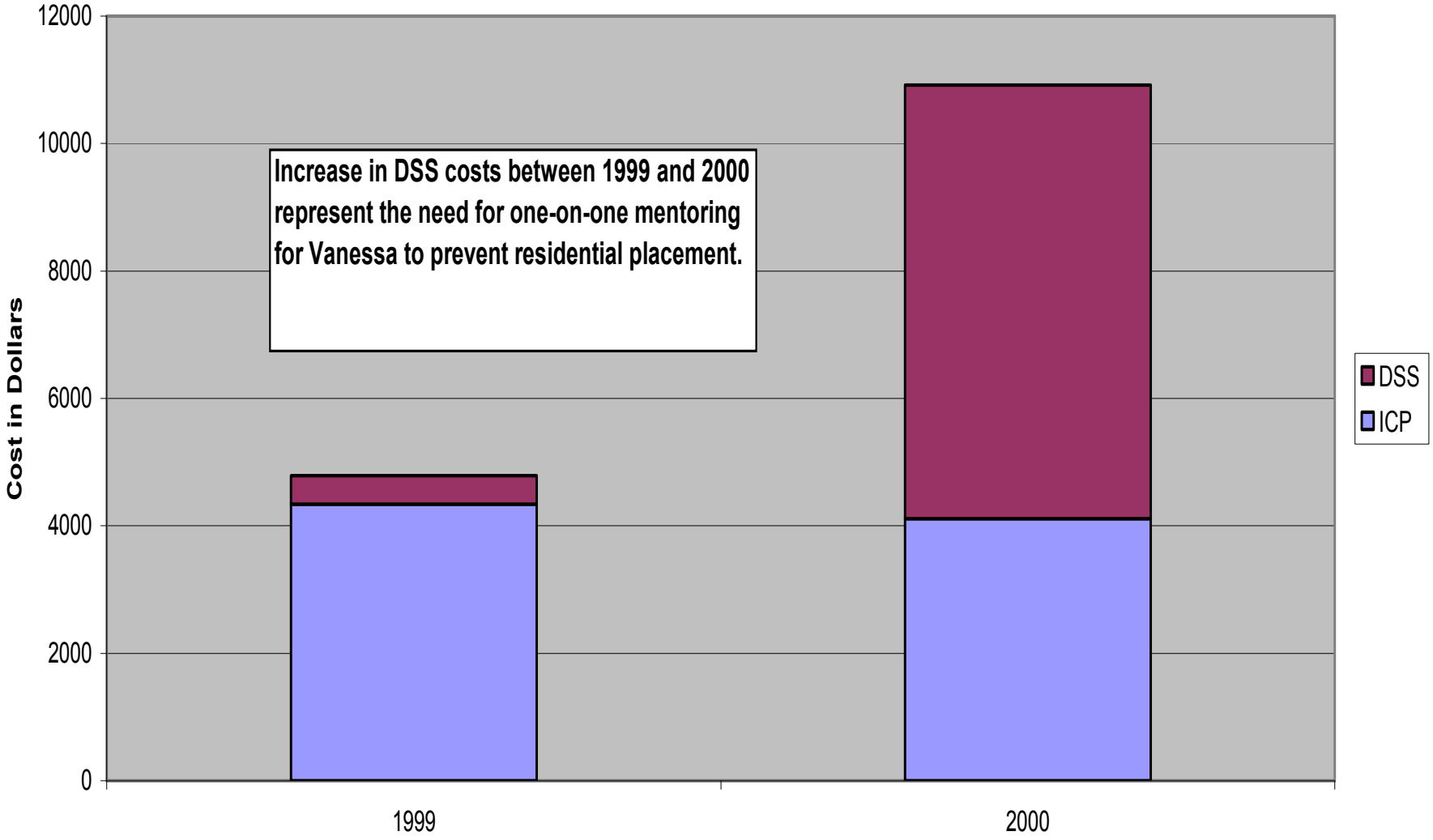
[9] DSS residential placement in Orange County, NY costs $168/day plus $62/day tuition.
* Identifies direct ICP service.

Medication evaluation Individual therapy (for Amy and Vanessa)
Family therapy
Substance abuse treatment
Supported educational services
Rehabilitation counseling
Behavior modification
Tutoring
Youth Advocacy Program (DSS mentoring and crisis service)

AMY AND HER FAMILY
PROGRESS REPORT

Areas of Progress	At Time Of Admission To ICP	November 2000	Trends
Psychiatric Hospitalization Status	Two prior hospitalizations.	One brief hospitalization.	Improved
Employment/ Education Status	Unemployed	Supported employment and educational programs. GED achieved. Currently unemployed	Somewhat Improved
Housing Status	Substandard apartment, inadequate living space in a dangerous neighborhood	Subsidized apartment in safe neighborhood with adequate space for all family members.	Improved
Social Support Network	Close relations with family, friends and community.	Close relations with family, friends and community. New friendships in neighborhood, attends support group.	Improved
Mental Health & Medical Care	Inadequate access and utilization of mental health services.	Access to and regular utilization of adult and child mental health services, parenting services, and early intervention services.	Improved
Parenting	Inappropriate interactions with older child; problems with sharing parenting responsibilities.	Better anger management with older child; father more active in parenting role.	Improved
Custody Status	One child in custody of parents, one in hospital (psychiatric), DSS protective investigation.	Both children at home in custody of parents.	Improved
School Attendance & Child Behavioral Functioning	Poor school attendance for older child due to behavioral issues and multiple hospitalizations.	Improved attendance due to educational advocacy, and appropriate school placement and services.	Improved

FIGURE 11
Amy and Her Family: Total Adjusted Costs



Meet Melissa and Her Family

Melissa and Sherman are the parents of three children – Maria (10.5 years old), Kate (9.5 years old), and Sean (7.5 years old). The family enjoys BBQ's, fishing, playing Frisbee, crafts making, and poem writing. Melissa and Sherman both maintain close relationships with their parents who help take care of the children and provide financial support when needed.

Family Challenges/Pre-ICP

Melissa is diagnosed with Adjustment Disorder with mixed anxiety and depression, and with a substance abuse disorder. Melissa's moods are sometimes difficult for her to handle. She becomes depressed and irritable, and has a hard time "dealing with" her children when she feels this way. She recalled the period before ICP involvement: "I felt like I was gonna lose it with the kids. I wanted to block them out and have them not do what they were doing." Melissa also has a bad back and other medical problems. According to Melissa, her substance abuse problems stem from her efforts to deal with the pain resulting from these conditions.

In the period before Melissa became involved with ICP, things had gotten very difficult for her and her family. Both Sherman and Melissa were unemployed, and had accumulated large debts, which made her feel entirely overwhelmed and hopeless. There was not enough money for essentials, or for activities for the children. The family had stopped paying rent and was being evicted from their home. Sherman and Melissa were not getting along. Their fights were sometimes violent, and the children were also violent with each other and their peers. DSS became involved when staff at the children's school and the children's therapists filed reports alleging abuse and neglect. Melissa's interactions with DSS were antagonistic and non-productive. Melissa acknowledged that during the time before ICP, her moods were very bad. Things were so stressful that her moods affected her ability to parent, and she was not able to appreciate the effect of her depression and irritability on her children.

The children were also struggling. School attendance and performance were poor. Melissa was unable to advocate for the special education services her children needed. All of the children were showing significant emotional and behavioral problems. They were violent with each other and with their peers. Sean had been diagnosed with Major Depression and Oppositional Defiant Disorder, and Kate had been diagnosed with Attention Deficit Disorder with a question of Bipolar Disorder. Kate had also needed to be hospitalized for suicidality. It was difficult for Melissa and Sherman to get the children to their needed counseling and psychopharmacology appointments regularly due to the level of chaos and disorganization in their lives.

ICP Becomes Involved

Melissa and her family were referred to ICP in May 1998. Both DSS and Melissa's mental health providers initiated the referral. After being referred to ICP through DSS, the family began to make realistic goals for their future. Goals included, consolidating and decreasing debt, finding safe and adequate housing, educational and vocational guidance, medication management, treatment for mental health and substance abuse issues, entitlements acquisition, increasing parenting skills, and addressing the children's educational and mental health needs.

Melissa recalled that she was initially suspicious of her ICP case manager, assuming her to be like DSS workers. However, in a short time she realized that ICP was different. ICP worked hard to find the family housing. They made several referrals to supported housing programs, however, the family's financial limitations, and Melissa's commitment to keeping the family pets, made this impossible. As a result, the family was forced to live in a hotel temporarily. Melissa recalled that she was very grateful that ICP helped finance storage of their furniture.

Melissa's ICP case manager was very concerned about Melissa and Sherman's ability to care for their children appropriately under such difficult circumstances; and about the entire family sharing a single, hotel room. The case manager felt that DSS involvement and support were needed for Melissa and her family at this time, and requested DSS involvement. DSS did not agree. DSS determined that because ICP was involved, the children were safe, and that they could "close the case." ICP continued to be

concerned, and worked with Melissa to arrange temporary placement for Maria and Kate with Melissa's mother in a nearby county. Melissa's ICP case manager was able to persuade Melissa that placement was in the best interests of her children and family at this time. Sean, the youngest child, remained with his parents in the hotel.

In addition to housing, ICP worked with Melissa on other goals. Referrals were made for individual counseling, family counseling, parenting classes, GED preparation, and vocational training. ICP also provided assistance with tax preparation, and arranged for additional child services through existing child mental health structures. Melissa completed a substance abuse treatment program that she did not want to attend. She also attended parenting classes, successfully got her GED and began a vocational training program. The family participated in many ICP recreational activities and benefited from ICP's tradition of providing gifts and food for the entire family during the holiday season.

The Family Today

Both ICP staff and Melissa report that Melissa and her family have made good progress in many areas. Melissa was able to find an apartment that would allow the family pets. Melissa's daughters returned to live with their parents in this new apartment, although it was small for a family of five. Shortly after their return there were concerns about inappropriate sexual activity between Maria and Sean. With the support of her ICP case manager, Melissa was again able to realize that her parenting abilities were limited, and that she was better able to parent two rather than three children. It was also clear that Maria had functioned better while in her grandmother's custody, and all agreed that she should return there to live. Maria remains with her grandmother today, is doing well, and has regular contact with her family. Since our interview with Melissa, she has agreed to give up the family pets for more appropriate family housing. With ICP support, Melissa has completed applications for housing support and is currently on several waitlists for better housing.

Sherman is employed, and the family's financial strain has decreased. The family's debts are consolidated, and have been paid down with ICP support. Melissa says that she still struggles with feeling depressed, but has developed coping strategies, such as poetry writing, which provides her great satisfaction and a sense of self-esteem. Family communication has improved overall, and family members offer support to one another by talking.

Melissa feels she is blossoming as a parent. She is very organized and creative. She is focused on safety and teaching manners, and is better able to get her children to their counseling sessions. She enjoys her children's good health and good looks, and loves to see them excited and happy in their own accomplishments. She still struggles at times with her own short-temper with her children, but has learned to call the right people for support when she needs it. She often relies on her case manager to help her in moments of irritability and anger. Her case manager reports that Melissa has learned to accept her limitations as a parent, and to ask for support when appropriate.

Melissa's children are also doing better, though they continue to struggle with their own emotional and behavioral problems. Maria is thriving in her grandmother's custody, and has regular visits with Melissa, Sherman, and her siblings. Kate and Sean live at home, and attend individual counseling regularly. Melissa has learned to be a better advocate for her children. She was able to work with the school to get the special education services to which they were entitled. Both Kate and Sean have educational plans that meet their needs and are showing much better attendance and performance in school.

What Made the Difference?

Melissa remembers that the thing that distinguished ICP from other service providers with whom she had worked, was that they were "real people" who showed real concern, and that this genuineness led to "results." ICP case managers were non-judgmental and honest. They did not make false promises and were "one hundred percent fair." They identified problems/issues and addressed each individually. It was critical to Melissa that the ICP case manager was available by phone when needed during a crisis, and provided expertise and support at the same time. Stated succinctly by Melissa, "Through the power of

people, changes can be made." According to Melissa's ICP case manager, assisting Melissa with tax preparation, and an SSDI application, so that she could be eligible for entitlements was also an important factor in the family's success. Prior to ICP involvement, Melissa and Sherman had not filed taxes appropriately and were therefore unable to receive multiple needed benefits. Increases in family income as a result of this support have made a critical difference.

Cost of Services

The graphs for Melissa's family reflect the costs of case management and Respite services (see *Figure 12*). These costs rose initially, but are currently decreasing. DSS costs reflect costs associated with investigation of abuse and neglect, and were low overall because DSS determined that they could terminate involvement after ICP became involved. It is difficult to predict what would have happened had ICP not become involved with Melissa and her family. However, it seems likely that without ICP, family stressors would have exceeded family coping. DSS involvement would have been necessary according to DSS's own assessment of the situation. ICP was able to arrange for "kin care" for Melissa's oldest daughter, and avoid potentially expensive foster care and/or residential treatment. It seems likely that ICP involvement has saved DSS from long-term and costly involvement with Melissa and her family.

Individualized Service Mix (Not all services were in place at the same time)

This list identifies services used by Melissa, Sherman, Maria, Kate, and Sean since working with ICP. Some services are provided directly by ICP while others were secured by ICP through referrals

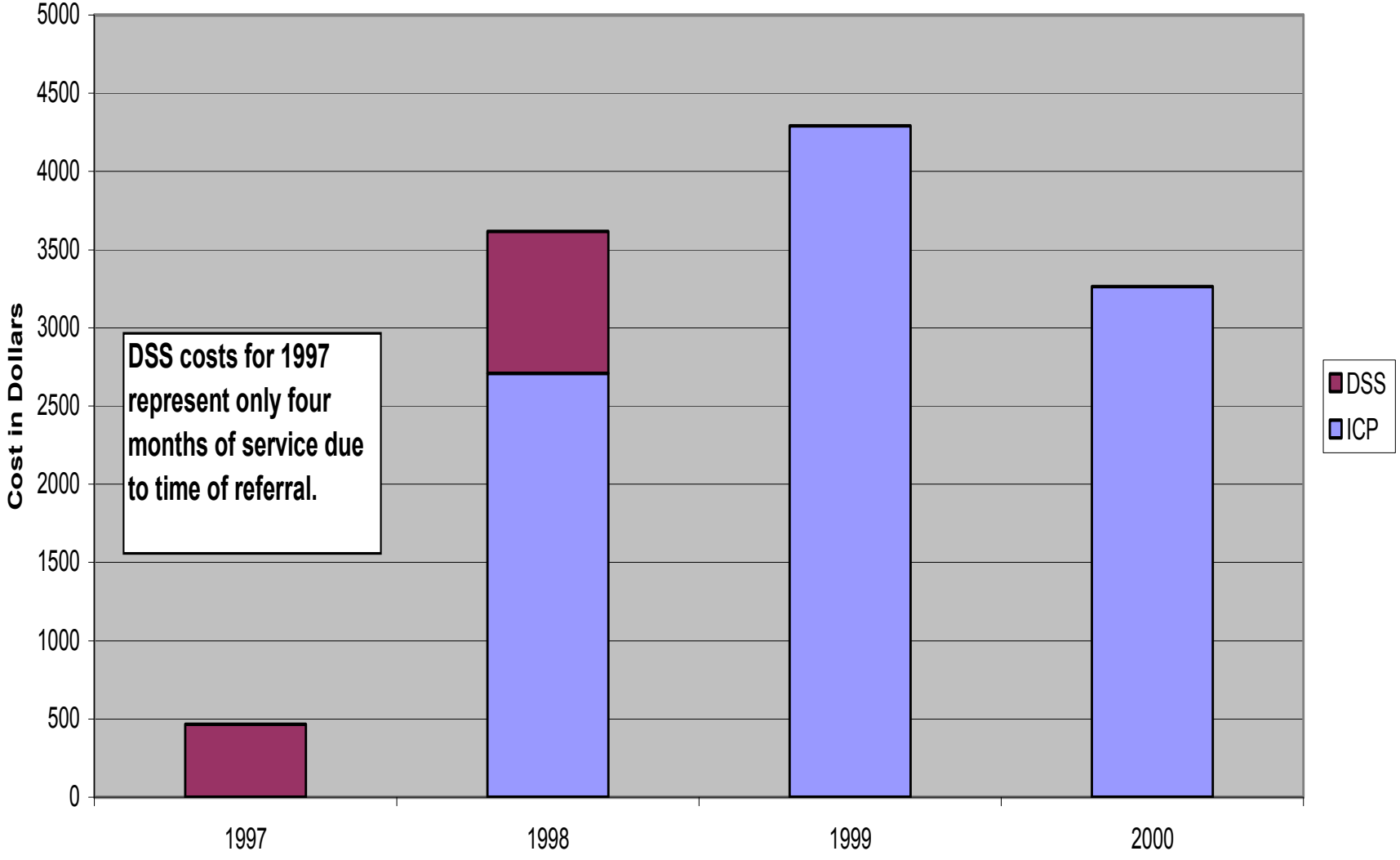
Case management*
Liaison with other services agency (school, DSS)*
Budgeting and finances*
Entitlement counseling*
In-home parent consultant*
Respite*
Transportation*
Crisis Helpline*
Crisis funds (utility payments)*
Funding for special activities (e.g., holiday and birthday gifts, summer camp)*
Family Recreation*
Art Therapy*
Housing
Vocational and Educational services
Legal Advocacy
Medical Management
Medication Management
Individual Therapy
Family Therapy
Behavior Modification

* Identifies direct ICP service

MELISSA AND HER FAMILY
PROGRESS REPORT

Areas of Progress	At Time Of Admission To ICP	November 2000	Trends
Psychiatric Hospitalization Status	No hospitalizations	No hospitalizations	Same
Employment/ Education Status	Unemployed	Temporarily employed. Currently unemployed	Same
Housing Status	Evicted from home. Living in a motel room	Secured apartment to accommodate family	Improved
Social Support Network	Support from friends and family	Support from friends and family	Same
Mental Health & Medical Care	Inadequate access and utilization of mental health services.	Access to and regular utilization of adult and child mental health services, parenting services, and early intervention services.	Improved
Parenting	Concerns related to physical abuse and neglect.	Continuing concerns related to abuse and neglect.	Same
Custody Status	DSS protective investigation.	Custody maintained for two children. One child placed by family with grandparents.	Improved
School Attendance & Child Behavioral Functioning	Poor attendance, serious emotional and behavioral problems including suicidality.	Attendance improved due to collaboration between school and ICP case manager. Behavioral and emotional problems continue but are improved.	Improved

FIGURE 12
Melissa and Her Family: Total Adjusted Costs



Meet Janet and Her Family

Janet is the mother of four children, Heather (25 years old), Matt (24 years old), Michelle (12 years old), and Jessie (8 years old). Janet lives with Dennis, her husband of two years, her two youngest children, Michelle and Jessie, and two of her grandchildren, Joshua (6 years old) and Rachel (3 years old). Joshua and Rachel have lived with Janet and her family since 1999, when their mother was incarcerated. The family enjoys barbecuing, getting ice cream, and going to the mall. Janet's close friend Suzanne spends a lot of time with the family.

Signs of Family Struggle/ Pre-ICP

Janet is diagnosed with Bipolar Disorder and has also been diagnosed with Major Depression with psychotic features. Janet's first psychiatric hospitalization was at age 17. She has a history of substance abuse and suicide attempts that have resulted in hospitalizations, most recently in 1995. Janet has also been hospitalized due to complications from Hepatitis C. Janet has a history of abusive relationships, including two years with Jessie's father.

Janet's children also have mental health issues. Jessie is diagnosed with Bipolar Disorder and ADHD. He is aggressive, hyperactive and difficult to deal with. Michelle does not have a psychiatric diagnosis, but can be aggressive and violent, both verbally and physically. Both children had issues with sexually inappropriate behavior in the past.

Janet is trained as a certified nursing assistant, but was unemployed in the period before ICP became involved. The family's main sources of income were SSI, SSDI, and child support. She also received food stamps, Section 8, and Medicaid, but struggled to make ends meet. Janet continually felt overwhelmed with her daily housekeeping and child rearing tasks. To cope, Janet would hide in her bedroom, leaving Michelle to do the family's laundry, prepare meals, and bathe the younger children. As Janet related, "I was withdrawn, and not active in my kids' lives. I would seclude myself when I came home from work." Janet would "cycle" with her therapy and medications, going off and on depending on her moods. Janet worried about her mental stability: "I was overwhelmed, stressed, and disorganized. I would pace and wring my hands. I would blow small situations way out of proportion."

DSS filed numerous reports on this family related to issues of domestic violence, and child neglect and abuse. Janet's DSS caseworker described the home as, "crisis-oriented, oftentimes disorganized and chaotic. Janet could not organize herself, she had trouble keeping appointments for herself and for Jessie, and was unable to secure the appropriate services for her family." By the fall of 1995, DSS was ready to remove Janet's children from the home.

ICP Becomes Involved

Janet and her family were referred to ICP in December of 1995 by Janet's therapist and her DSS preventive worker. DSS agreed to allow the children to remain in the home *only if* the family worked with ICP, and remained under ICP's supervision. This arrangement was made possible by the honest and trusting relationship between ICP and DSS built up over years of working together with other families.

Upon intake, Janet and her ICP case manager identified goals for the family including getting vocational training to help Janet return to work, learning budgeting skills and financial management strategies, and increasing social opportunities for Janet. Goals for the children included securing an educational advocate to help with Jessie's behavioral problems in school, finding therapists for Jessie and Michelle, and providing Respite for socialization. To support Janet in her parenting role, her ICP case manager helped Janet register for parenting classes, and spent time with Janet and her children modeling appropriate parenting behaviors, and child activities. ICP educated Janet about her mental illness, and brainstormed around coping mechanisms to help during difficult times.

The Family Today

Today, Janet is more in control of her life and is better able to enjoy time with her family. She returned to work full-time, as a case manager at a homeless shelter. While it is challenging working outside the home with four small children, Janet loves her work and enjoys her newly found financial

independence. She has created a budget for family expenses, applied for and received SSDI entitlements for Jessie, and no longer requires representative payee services through a former family friend. Janet attends Hudson House, a local psychosocial rehabilitation clubhouse that provides her with an opportunity to socialize. In addition, Janet makes time for herself, and relaxes with aromatherapy baths and inspirational readings.

Janet is more active and interested in her children's lives. She no longer isolates herself from her family, and is better able to take care of her own needs. Janet is working on listening better to her children, and improving her coping skills, so as not to become overwhelmed. Janet explains her new strategies for working with Jessie's behavioral problems: "They (ICP) assisted me with the strengths and techniques to deal with Jessie's behavior. For example, how to choose your battles, how to stay firm, how to be assertive, how to speak my mind – they gave me the tools. I even use these skills in my workplace." Janet also relies on the Crisis Helpline when she needs extra support.

Jessie and Michelle are doing well in school. Jessie's behavior has greatly improved, and he has strengthened his social and motor skills, and problem solving abilities. Michelle excels academically, and is on the honor roll. Jessie's behavior at home has also improved, but is still problematic. "Jessie used to have a lot of behavior problems, until I learned about behavior-modification. His behavior has improved since ICP became involved and with all the counseling, all the negative things have become positive. But sometimes, he has trouble with authority." Michelle, however, has had a challenging year after being sexually assaulted by a family member while on vacation. Michelle is dealing with this trauma as well as could be expected, and Janet and her ICP case manager together are coordinating services and supports for Michelle, including the needed physical examinations, psychological evaluations, therapy, and support groups. Both Michelle and Jessie go to individual therapy, are involved in art therapy, and participate in the Big Brothers/Big Sisters program.

Janet recently remarried but is having difficulties with her new husband, Dennis. Since their marriage 18 months ago, they have already separated once. Dennis is emotionally abusive and refuses to seek help. While he provides financial support, his abusive behavior creates a lot of tension in the house. Janet relates, "I need help with my co-dependency, and being in this abusive relationship. I need counseling and need encouragement to do this. I have talked a lot with [my ICP case manager] about my situation." During this challenging time, ICP has "been there" for Janet to provide the support she needs.

DSS was able to close "Janet's case" in 1999, after five years of involvement with Janet's family. According to her DSS caseworker, "ICP's involvement was the key to closing out this case."

<u>What Made the Difference?</u>

Janet is clear about why ICP works for her and her family. In part, ICP helps with the practical, day-to-day tasks in life that can be overwhelming. For example, ICP transports Jessie to and from therapy appointments, or takes Janet to job interviews. "ICP does not just encourage you to get help; they go with you when you need them." Equally important, ICP forms genuine, sincere, and lasting relationships with families. "They listen to me as an individual. They give me the space to grow from my illness. They are more concerned about me as an individual than as a participant in the program." ICP believes that all families should be treated with respect, courtesy, and compassion. Janet recalled an experience of running into her ICP case manager at a local fair. Janet expected the case manager to pay no attention to her since they were "off the clock," but instead "[the case manager] stopped and talked to me like a normal person – I didn't expect this."

Janet described a level of honesty and trust in her interactions with ICP that she doesn't have with DSS. "ICP is like Mother Hubbard, and makes sure the cupboard is never bare. I could never tell DSS I didn't have food, but I could tell ICP." With ICP, Janet feels "like I'm part of a family. I would rather deal with ICP than DSS where I'm just a number." DSS is quick to acknowledge the importance of ICP in their work. For Janet and her family, ICP provided a range of necessary services DSS could not provide, including managing <u>all</u> family members mental health needs, providing crisis intervention, supporting day-to-day functioning, and helping to plan for the family's future. The DSS caseworker believes that ICP "fills the gap" of missing services: "ICP is willing to get down and dirty and do a lot of

the leg work that no one else has time to do." Janet's DSS worker also agreed that Janet's relationship with ICP is different than her relationship with DSS: "DSS clients really see ICP as an advocate. They see ICP workers differently than DSS workers; they really trust ICP and see ICP as there for them." DSS also sees ICP as a partner in serving families, and acknowledges their vital role both for the families and for DSS. "ICP provides oversight of a family. By knowing someone else is involved, we (DSS) can be available to other families." In other words, DSS can serve more families *because* ICP is involved – ICP "frees up" DSS time and resources for other families.

Finally, ICP is flexible and responsive. They do whatever it takes to support a family. For Janet and her family, they helped her buy a new car, provided food and gifts during the holidays, and supported Janet closely after the death of her father, Janet says it best: "I've come a long way and I owe it to ICP. They're the backbone, they put everything in place."

Cost of Services

As can be seen in the cost graph (see *Figure 13*), as ICP became involved with Janet and her family, DSS was able to decrease services and the costs of involvement. The intensive family case management model used by ICP could provide support for both Janet's parenting skills development and with managing Jessie's behavioral problems. As a result, ICP expenditures even during their most costly year (1999) were never greater than DSS costs during their most costly years (1996/1997). Thus, the *entire family* was served for less than a parent and single child served by DSS. ICP has been able to decrease costs as Janet and her family have became more independent and resilient.

An Individualized Service Mix (Not all services were in place at the same time)

This list identifies services used by Janet, Michelle, Jessie, Joshua and Rachel since working with ICP. Some services are provided directly by ICP while others were secured by ICP through referrals.

Case management*
Liaison with other service agencies (i.e., special education, clinical, DSS, SSI) *
Supported educational services
Budgeting and financial management*
Entitlements counseling*
In-home clinical consultation*
Respite*
Crisis Helpline*
Transportation*
Crisis funds*
Funding for special activities (i.e., holidays)*
Family Recreation*
Art therapy*
Parenting support groups
Parenting classes
Parent aide
Legal advocacy
Vocational needs assessment
Hudson House (psychiatric support program)
Support groups
Mental health clinic
Medication management
Medical management

* Identifies direct ICP service.

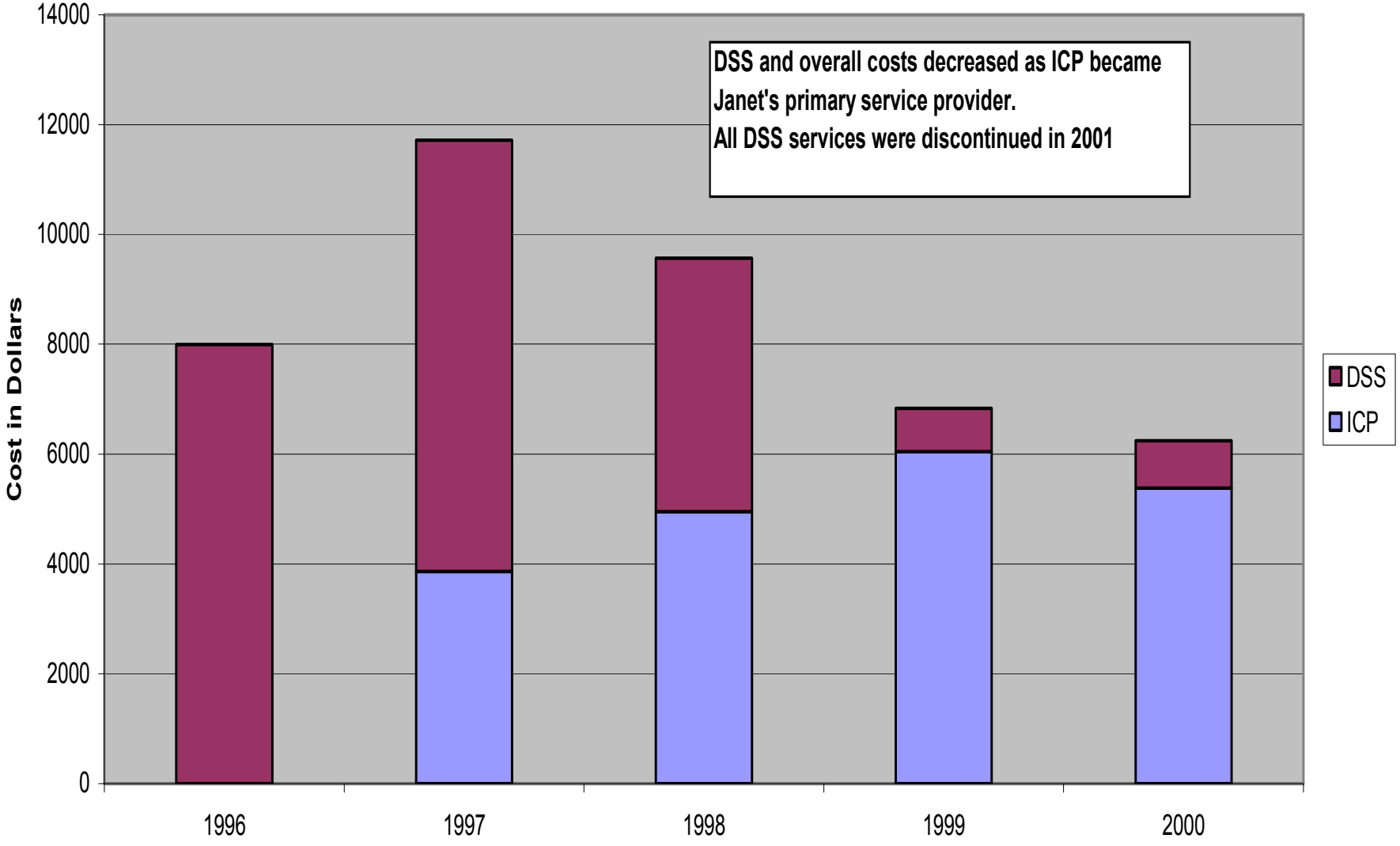
Psychiatric evaluation
Medication evaluation
Individual therapy (for Janet, Michelle, and Jessie)
Family therapy
Rape crisis services
Educational advocate
Behavior modification
Big Brothers/Big Sisters

JANET AND HER FAMILY
PROGRESS REPORT

Areas of Progress	At Time Of Admission To ICP	November 2000	Trends
Psychiatric Hospitalization Status	Multiple prior hospitalizations.	Two brief hospitalizations.	Improved
Employment/ Education Status	Unemployed	Supported employment and vocational training programs. Full-time employment with human service agency.	Improved
Housing Status	Section 8 housing.	Maintained appropriate Section 8 housing.	Same
Social Support Network	Neighborhood friendships and limited family support.	New friendships at work and in the community. Remarried.	Improved
Mental Health & Medical Care	Inadequate access and utilization of mental health services.	Access to and regular utilization of adult and child mental health services, parenting services, and early intervention services.	Improved
Parenting	Concerns regarding child neglect and abuse.	No further concerns of child neglect or abuse.	Improved
Custody Status	DSS preventive services. Risk of custody loss.	Custody maintained and gained custody of two grandchildren. DSS case closed.	Improved
School Attendance & Child Behavioral Functioning	Poor attendance of younger child due to emotional and behavioral problems.	Attendance is improved due to ongoing collaboration between school and ICP case manager. Behavior problems decreased.	Improved

FIGURE 13

Janet and Her Family: Total Adjusted Costs



Meet Sandy and Her Family

Sandy lives with her son Matt who is 9 years old. Sandy and Matt enjoy many activities together, including fishing, bike-riding, going to the park, and playing Frisbee. Sandy and Matt see Sandy's mother and aunt regularly. They often take Matt to family events and help Sandy with childcare when she needs it. Sandy also has a close friend with whom she goes out socially when she can afford it, and with whom she can trade childcare.

Family Challenges/ Pre-ICP

Sandy has a long history of depression and anxiety, and suicide attempts. She was hospitalized for the first time at the age of 16, after a drug overdose. Sandy also has a history of childhood trauma and domestic violence. She left Matt's father when Matt was three months old, and has struggled with homelessness since that time. Sandy acknowledges that she has had trouble with drug and alcohol abuse. She goes through periods of total abstinence, and then suffers a relapse.

In the year before Sandy became involved with ICP, Matt was hit by a truck while riding his bicycle. He suffered a head injury and began developing serious behavior problems shortly thereafter. He showed symptoms of Post-Traumatic Stress Disorder (e.g., anxiety), as well as difficulties with attention and impulse control. He had violent, explosive outbursts on a daily basis, and was hospitalized when he reported hearing voices telling him to hurt himself and others.

Sandy had a history of DSS involvement related to homelessness, suspected abuse and substance use problems. DSS became involved again when both the hospital, and the homeless shelter where Sandy were living were concerned about Sandy's ability to manage Matt's dangerous and self-injurious behaviors upon discharge from the hospital. Sandy did not welcome DSS involvement and the relationship between Sandy and DSS became very problematic. Sandy recalled that she felt completely overwhelmed during this period, and was not able to parent well. She was poor and homeless, and she could not manage her son's emotional and behavioral problems, or her own depression.

ICP Becomes Involved

Sandy was referred to ICP in April of 1999 by a caseworker at the homeless shelter where she was living. Matt was in the hospital at the time of referral. Sandy and her ICP case manager identified many goals for Sandy and her family. These goals included securing safe and affordable housing, accessing appropriate and adequate mental health services for both Sandy and Matt (discharge planning and SSI application for Matt), paying down Sandy's debt, and re-establishing credit and utility services. Sandy also wanted to receive vocational training, find employment, get a drivers' license and a car, and improve her parenting skills and relationship with her son.

Achieving these goals required access to and coordination of multiple services and providers. ICP helped Sandy find housing and secure a HUD subsidy to cover this expense. ICP participated in Matt's discharge planning, and arranged for referral and transportation to therapy and psychopharmacology appointments for Matt. In-home consultation services were provided to address parenting skills and behavior management issues upon Matt's return home. ICP also facilitated a referral to Wraparound services, – a child mental health program -- participated as a team member on Matt's Wraparound team, and accessed and coordinated many of the authorized services for Matt. The ICP case manager also helped Sandy to advocate for appropriate school services for Matt. Respite services were provided to offer Sandy a "break" from parenting, while also providing Matt with another positive role model. ICP intervened on Sandy's behalf with the telephone company. A payment plan was negotiated and Sandy was able to receive phone services while she paid down her bill debt. Sandy was referred to Hudson House, a local psychosocial rehabilitation center that provides vocational training and supported employment for adults with mental illness. In addition, ICP facilitated communication with DSS during several investigations of abuse and neglect. As a result, collaboration between Sandy and DSS improved greatly, and they were able to achieve common goals.

Sandy showed excellent progress during her first year of involvement with ICP. However, after this initial period, Sandy invited another woman and her daughter to live with her and Matt. This

relationship was problematic on many levels, and after the two women became involved in a physical fight, Sandy insisted that the woman leave her home. ICP helped Sandy to change the locks and secure a restraining order. These events were difficult for Matt, who became increasingly violent and out of control, and had to be hospitalized after a long period of no hospitalizations. During this same period, Sandy missed several appointments with her in-home consultant and ICP case-manager, and showed poor follow through on DSS requirements. As a result, ICP considered ending their involvement with Sandy. However, at her request, ICP agreed to continue to work with Sandy if she could keep regularly scheduled appointments with her ICP case manager, in-home consultant and outpatient mental health providers.

The Family Today

At the time of our interview, Sandy was "back on track" and was showing good progress. Therapy and medication help manage her depression much better, and she has some understanding of the impact of her depression on Matt. She recognizes that when she is down, she is not available to him to do the things he enjoys, and that she relies on him to "bring me up." She attends therapy with Matt, and is able to get him to all his appointments regularly.

According to her ICP case manager, Sandy's problem-solving and advocacy skills are much better. She makes better decisions and has more confidence in her parenting decisions. With the help of her ICP case manager, Sandy has been able to secure appropriate and adequate school services for Matt, who is showing improved behavior and academic performance. Since his school services have been in place, Matt has not had a single suspension. In addition to school-based services, Matt is receiving community-based case management and Wraparound services. Sandy reported that she has a good relationship with Matt's case-manager, and that she has participated in a parent-training course that she found extremely helpful. Both Sandy and her ICP case manager agree that Sandy is better able to handle Matt's emotional and behavioral issues. She is better able to de-escalate an outburst, and is able to ask for and receive help when she needs it. As a result, Matt and Sandy are able to enjoy a much more positive relationship, and can spend time doing the things they enjoy doing together, rather than engaging in conflict.

Sandy and Matt currently live in a two-bedroom, Section 8 house, on a quiet and safe street within walking distance to convenience shops and bus transportation. Sandy works as a full-time phlebotomist at a local hospital. Sandy loves her job, and is "very proud of doing what I do." She continues to receive "job coaching" from Hudson House, and recently received the "Employee of the Year" award from her colleagues at the hospital.

What Made the Difference?

According to both Sandy and her providers, the trusting and supportive relationship provided by ICP, the availability of the ICP caseworker, and the ability to provide flexible funding for a variety of crises and needs are the key components to success. DSS in particular recognizes that ICP can establish a rapport and trust with a family that they cannot, due to the generally antagonistic nature of their relationship with parents. In addition, ICP can be available to families, and understands the mental health issues and how they interface with child protection. The DSS worker for this family stated explicitly that ICP involvement allowed DSS to "do less", and that "DSS learns a lot about the families with whom they work from the ICP case manager." He also reported that on-going services would have been necessary for Sandy and Matt had ICP not been involved.

Sandy was grateful to ICP for support with housing and employment, and for helping her to gain the skills and services she needed to function more independently. She reported that she still turns to ICP for a "pep talk" and advice. According to Sandy, ICP helped her to see that "there are better ways to do things" with Matt. An important element in her experience with ICP was recognizing that "it was not shameful to ask for help." She readily acknowledged that she "could not have done this without ICP. I would not have been able to do it on my own." She stated further that ICP provides "assurance and support. They are there if I need them, if I fall back or can't do it on my own."

Cost of Services

The graph for Sandy and her family reflect the cost of Case Management and Respite services (see *Figure 14*). Total costs increased for both DSS and ICP during the two years of Sandy's involvement with ICP. However, examination of costs by service indicates that the increase in costs for ICP reflects the addition of Respite services. Case management costs for ICP actually decreased for this period. DSS costs reflect investigation of abuse and neglect costs only. ICP involvement allowed DSS to avoid any other expenses such as childcare or Respite for Sandy and Matt. Overall, costs for this family were kept low as a result of ICP involvement.

Individualized Service Mix (Not all services were in place at the same time)

This list identifies services used by Sandy and Matt since working with ICP. Some services are provided directly by ICP while others were secured by ICP through referrals.

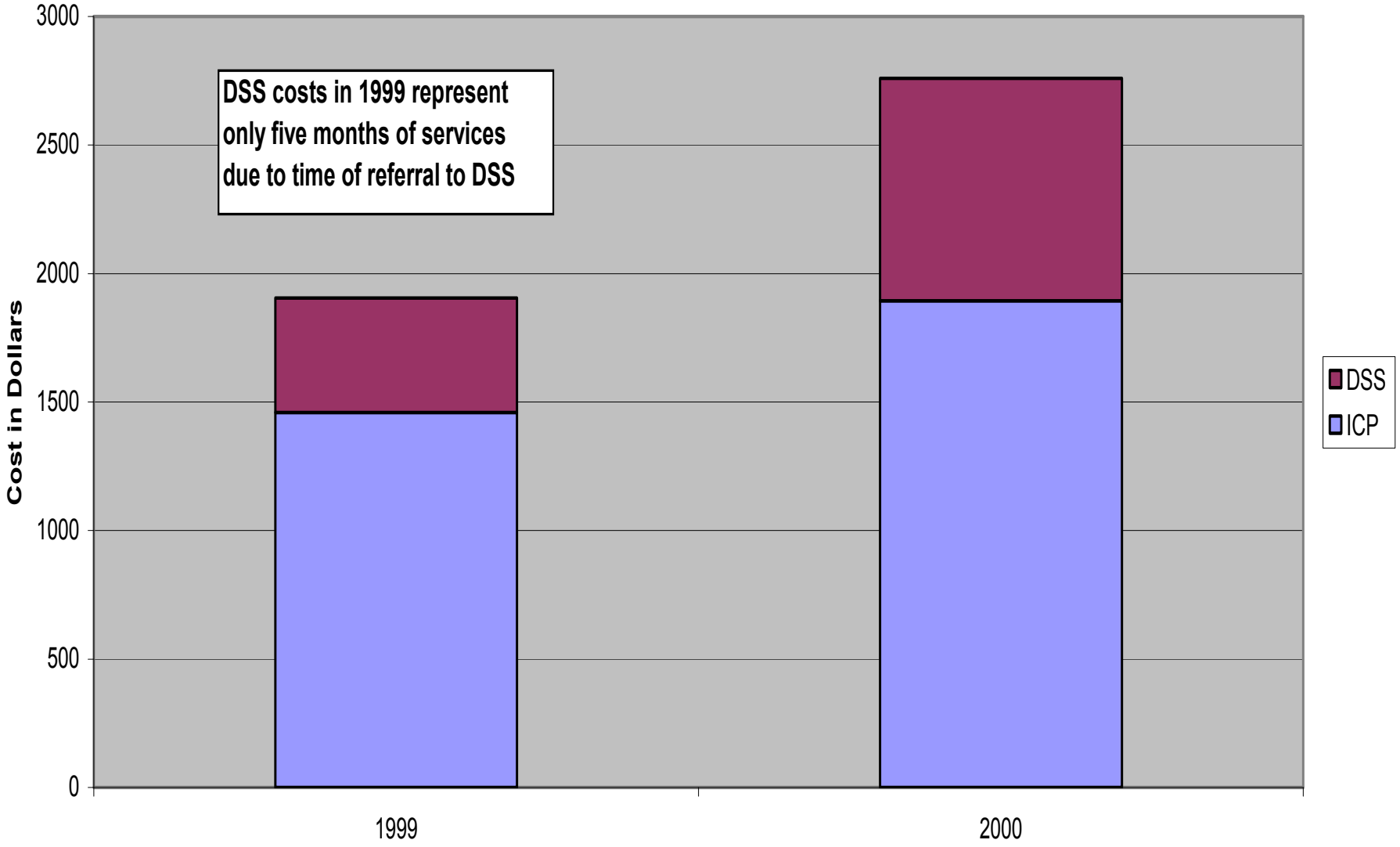
Case Management*
Housing (HUD/Section 8)*
Liaison with other services agency (DSS, OMH, and inpatient hospital for Matt)*
Budgeting and finances*
Crisis funds (utility payments)*
Entitlement counseling*
In-home parent consultant*
Respite*
Crisis Helpline*
Transportation*
Funding for special activities (e.g., holiday and birthday gifts, summer camp)*
Family Recreation*
Art therapy*
Educational and vocational services: Welfare to Work program
Medication Management
Outpatient psychotherapy
Outpatient psychopharmacology
Behavior modification
Child Mental Health Case Management
Inpatient psychiatric treatment for child
Individual Therapy and SSI for Child

* Identifies services provided directly by ICP

SANDY AND HER FAMILY
PROGRESS REPORT

Areas of Progress	At Time Of Admission To ICP	November 2000	Trends
Psychiatric Hospitalization Status	One hospitalization.	No new hospitalizations.	Somewhat Improved
Employment/ Education Status	Unemployed	Supported employment and vocational training programs. Phlebotomy certificate received. Full-time employment at local hospital.	Improved
Housing Status	Homeless	Subsidized housing in safe neighborhood.	Improved
Social Support Network	One close friend. Limited family support.	New friendships through work. Improved relationship with family.	Somewhat Improved
Mental Health & Medical Care	Poor access to mental health and substance abuse treatment for depression and anxiety.	Access to mental health treatment for parent and child.	Improved
Parenting	Poor behavior management skills; overwhelmed by child behavior problems.	Parenting classes attended. Parenting skills greatly improved.	Improved
Custody Status	Child protective investigation.	Custody maintained.	Improved
School Attendance & Child Behavioral Functioning	Poor attendance due to behavioral problems and multiple hospitalizations. Safety issues with child at home (fire setting, threatening parent). Child in hospital.	Attendance improved due to enhanced coordination of school and community services. Hospitalizations decreased. Child behavior improved and safety concerns decreased. Child hospitalizations have decreased.	Improved

FIGURE 14
Sandy and Her Family: Total Costs



SUMMARY AND CONCLUSIONS

The current study used family study and file extraction methodologies to describe The Invisible Children's Project, an innovative program for parents with mental illness and their children. Program practices and key ingredients were documented with respect to critical family and cost outcomes. Data collected from parents, ICP case managers, and DSS caseworkers revealed that parents with mental illness and their children receiving family-centered case management services from ICP showed improvement across multiple outcomes. Improvement was reported by parents, ICP case managers, and DSS workers. DSS workers stated unequivocally that children were returned home, or maintained in the home as a direct result of ICP involvement. While service costs increased for families, the benefits were great. Access to and utilization of appropriate and needed services increased greatly. Parent and agency goals were achieved, and more expensive, disruptive, and potentially damaging out of home placements, e.g., hospitalization and residential care or foster care, were avoided.

Services and Key Ingredients

ICP was described by parents, ICP case managers, and DSS caseworkers as family-centered and strengths-based. The family is considered the "unit of service" and service plans and goals include all family members. Results across families converged to reveal "key ingredients" with respect to family satisfaction and functional outcomes. Parents, ICP case managers and DSS workers showed great consistency in identifying key ingredients (see Table 1). Although consistent, informant groups also showed divergence in emphasis. All study informant groups identified *five* essential components of ICP case management that distinguished ICP from other service providers in general and DSS in particular, and that were related to improved parent and child outcomes. These ingredients were 1) the high level of availability of ICP case managers; 2) strengths-based, non-judgmental approaches; 3) a trusting relationship; 4) emotional support; and 5) liaison activities between parents and DSS.

Study participants spoke at length about the centrality of the relationship between the ICP case manager and the parent and family. The ability of the ICP case manager to engender parents' trust, and the consequent acceptance of support and intervention were identified as critical to improved functioning for parents and to family reunification or preservation. This trust was related fundamentally to the *family-centered, strengths-based* approach utilized by ICP, and the availability of the case manager. Parents, ICP case managers, and DSS workers also recognized that ICP involvement as a liaison between parents and DSS improved the relationships between parents and DSS workers by facilitating communication, clarifying expectations, and reducing antagonism. ICP involvement allowed DSS workers to have access to more information about families, including both strengths and risk factors, and helped families understand and comply with DSS requirements, factors critical to maintaining children in the home, and DSS's ability to "close the case."

In addition to these common ingredients, informant groups emphasized other key ingredients. Parents highlighted the accountability and reliability of the case manager, and the concrete assistance made possible by flexible funding. ICP case managers emphasized referral and access to, and coordination of multiple services. DSS workers identified the case managers' mental health expertise as a critical factor in family success in the DSS system. A full list of the shared and non-shared key ingredients by informant group is displayed in *Table 1*.

In summary, it is clear that family-centered, strengths-based practices distinguished ICP from other services available to parents with mental illness. These practices were highly valued by both consumers and providers that work with ICP. Parents with mental illness reported that these practices improved their overall functioning and self-esteem, and helped them maintain custody of their children. DSS workers echoed this testimony. Each DSS worker interviewed for the current study stated unequivocally that the children involved could not have been returned home or maintained in the home without ICP intervention and support. DSS workers readily acknowledged that ICP involvement allowed DSS to "close cases" that would otherwise not be closed, and to redirect resources to other needy families. Family-centered, strengths-based services proved to be a powerful and precious resource for the

parents with mental illness interviewed for the current study, as well as for the child welfare system and providers that worked with them.

Table 1. Shared and non-shared key ingredients across informants

Informant	Key ingredients of ICP case management *
Parent	• **Availability of case manager** • **Strengths-based, non-judgmental approach** • **Trusting relationship** • **Emotional Support** • **Liaison with DSS** • Flexible funds to provide concrete support (e.g. utility bills, furniture, holiday presents)
ICP Case Manager	• **Availability of case manager** • **Strengths-based approach** • **Trusting relationship** • **Emotional support** • **Liaison with DSS** • Crisis management • Comprehensive services coordination • Referral and access to services • Role modeling
DSS Caseworker	• **Availability of case manager** • **Strengths-based approach** • **Trusting relationship** • **Emotional support** • **Liaison with DSS** • Sharing of critical information about family strengths and risks • Mental health expertise and knowledge

* Bold text reflects ingredients identified by all three informants.

Policy Implications and Recommendations

Findings of the current evaluation have important policy implications.

- Family-centered case management services meet the needs of both adults with mental illness who are parents and their children, who may have, or may be at risk of developing psychosocial problems themselves.
- Family case management services require the integration of adult- and child-focused service sectors and systems, e.g., mental health, child welfare, public health, housing, educational/vocational services, early intervention, etc..
- Organizational, administrative, and financial mechanisms must support and facilitate the coordination and integration of adult and child services, and the collaboration of direct service providers.
- Providers from all service sectors need to be educated about the prevalence of parenthood among adults with mental illness, their goals, strengths and challenges in caring for children, and the benefits of appropriate and adequate supports and services for all family members.

- Providers must be encouraged to consider the strengths and resources, needs and goals of clients as family members, in the context of family life, rather than as individuals living in isolation.
- The number of families assigned to a provider must allow the provider to be accessible and supportive to family members, sometimes as often as daily. Provider availability and dependability are essential for parents with mental illness to establish meaningful and useful relationships.
- Flexible funds must be available to allow for the purchase of appropriate formal and informal (e.g. summer camp) services for all family members regardless of agency or service system affiliation; and to support families during times of financial crisis.
- Programs and services need to be documented and manualized to allow for rigorous evaluation with respect to specific and meaningful outcomes, and to facilitate the development of evidence-based practices for families in which a parent has a mental illness. Replication of successful programs is needed to evaluate practices in different communities and with diverse samples of parents and families. Technical and financial assistance for programs will be necessary to support such development and evaluation.

REFERENCES

Achenbach, T.M. (1991). Manual for the Child Behavior Checklist/4-18 and 1991 Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Allen, R.I., Petr, C.G., & Brown, B.F.C. (1995). Family-Centered Behavior Scale and User's Manual. Lawrence, KS: University of Kansas Beach Center on Families and Disability.

Epstein, M.H., & Sharma, J.M. (1998). Behavioral and Emotional Rating Scale: A Strength-based Approach to Assessment. Austin, TX: PRO-ED, Inc.

Nicholson, J., Biebel, K., Hinden, B., Henry, A., & Stier, L. (2001). Critical issues for parents with mental illness and their families. Rockville, MD: Substance Abuse and Mental Health Services Administration/Center for Mental Health Services.

FIGURES 2-6

FIGURE 2
Behavioral and Emotional Rating Scale (BERS)
Number of Children with Average or Above Average Strengths

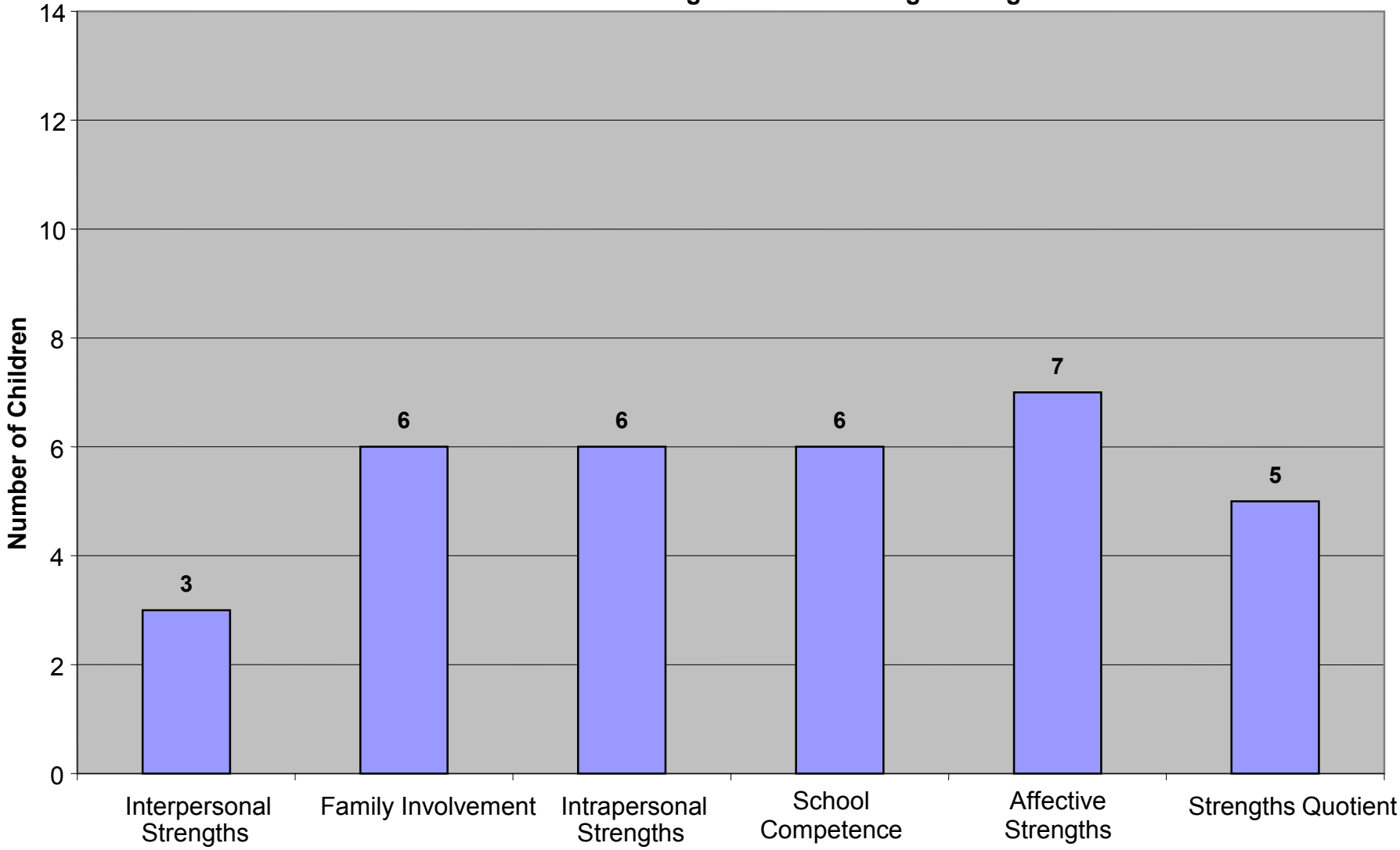


FIGURE 3
CBCL Competence Scales
Number of Children in Borderline Clinical or Clinical Range

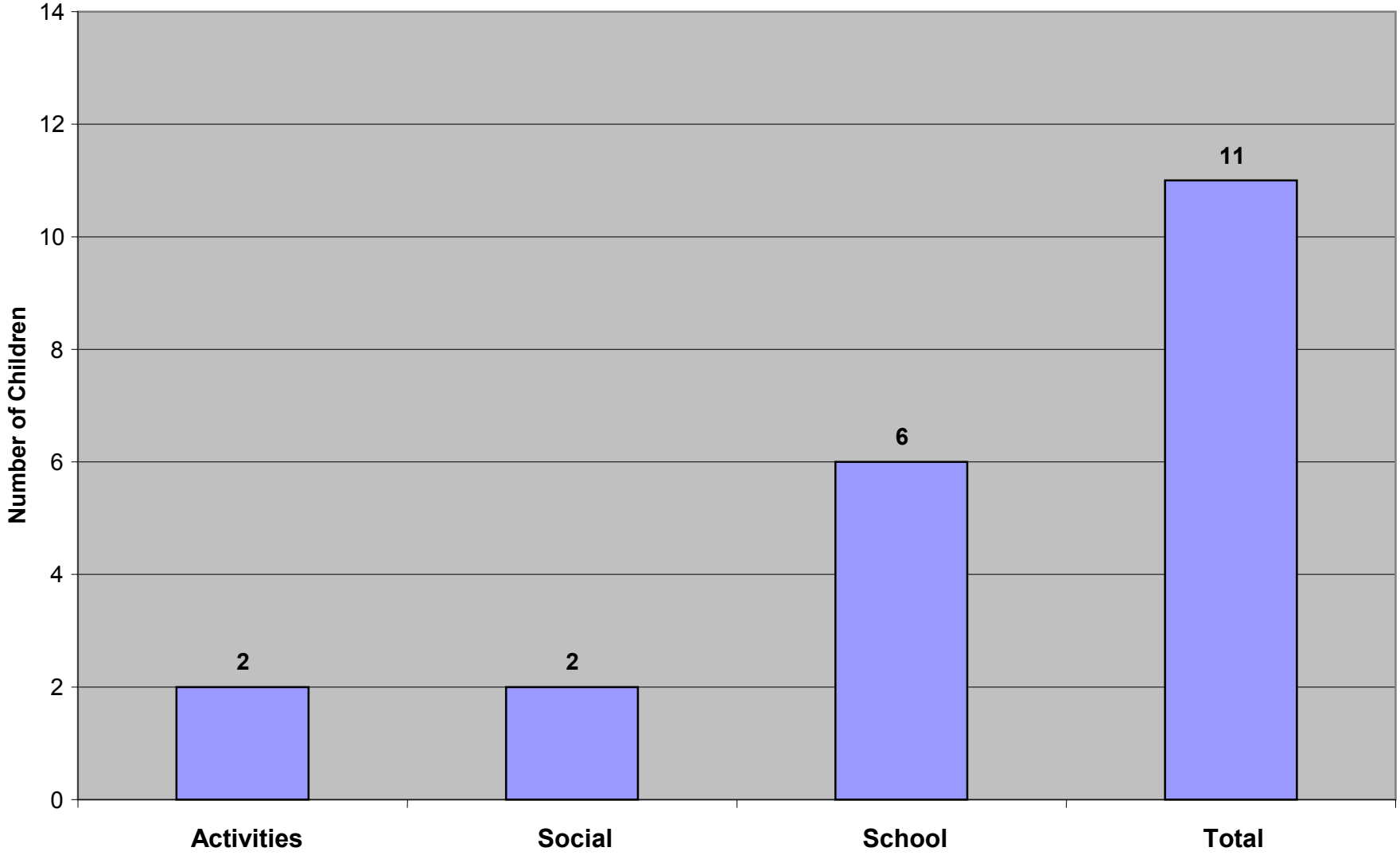


FIGURE 4
CBCL Narrow-Band Problem Syndromes
Number of Children in Borderline Clinical or Clinical Range

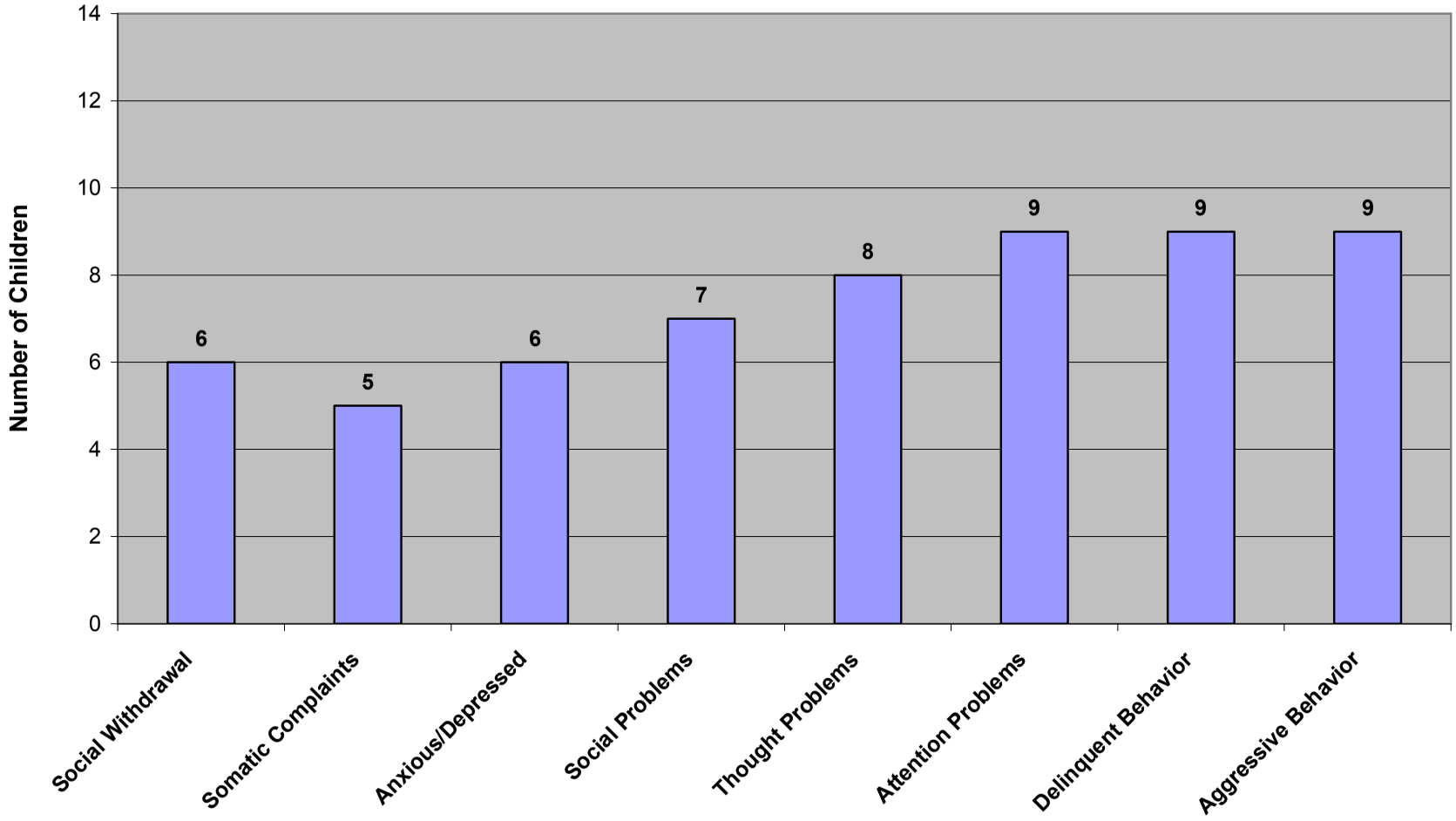


FIGURE 5
CBCL Broad-Band Syndromes
Number of Children in Borderline Clinical or Clinical Range

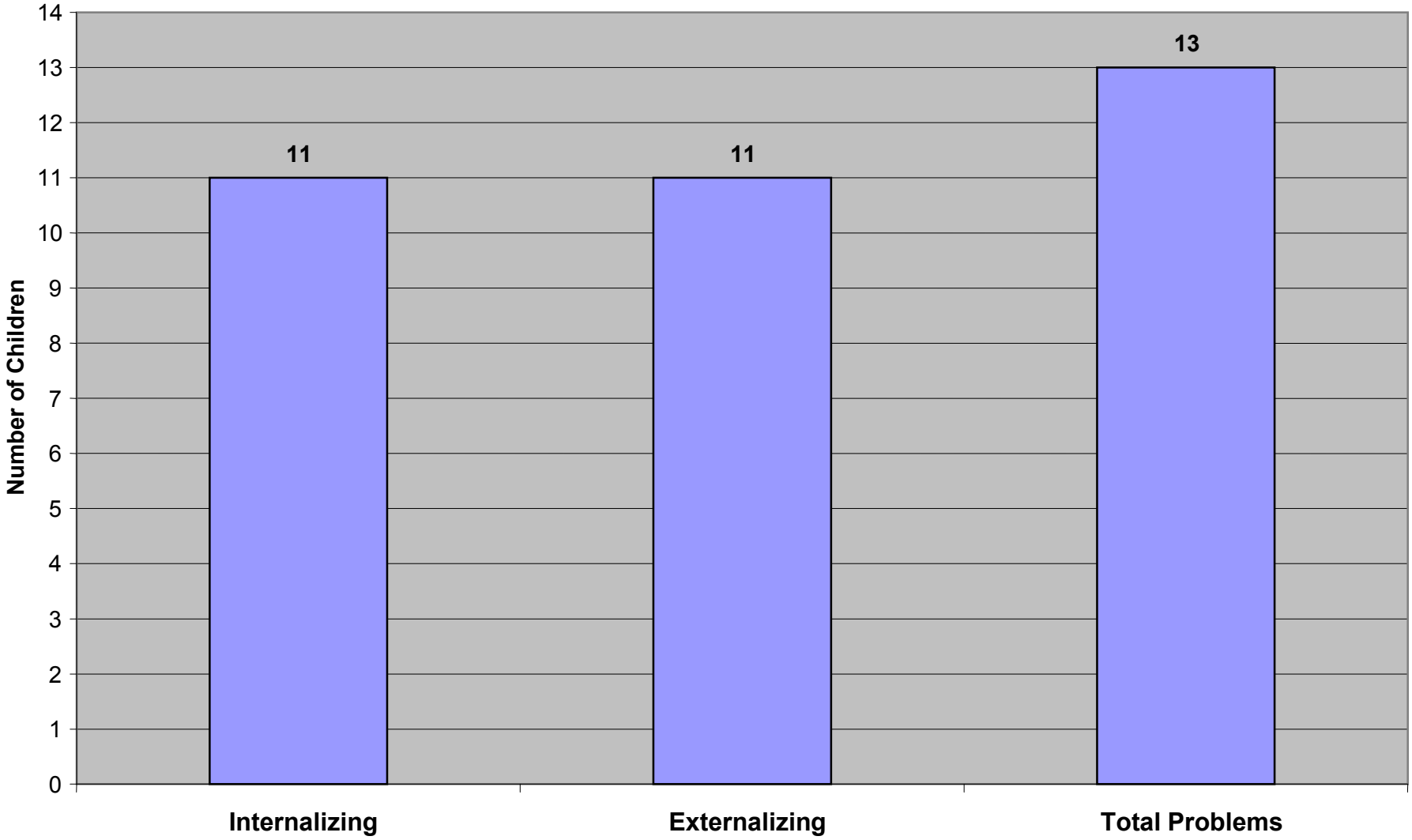
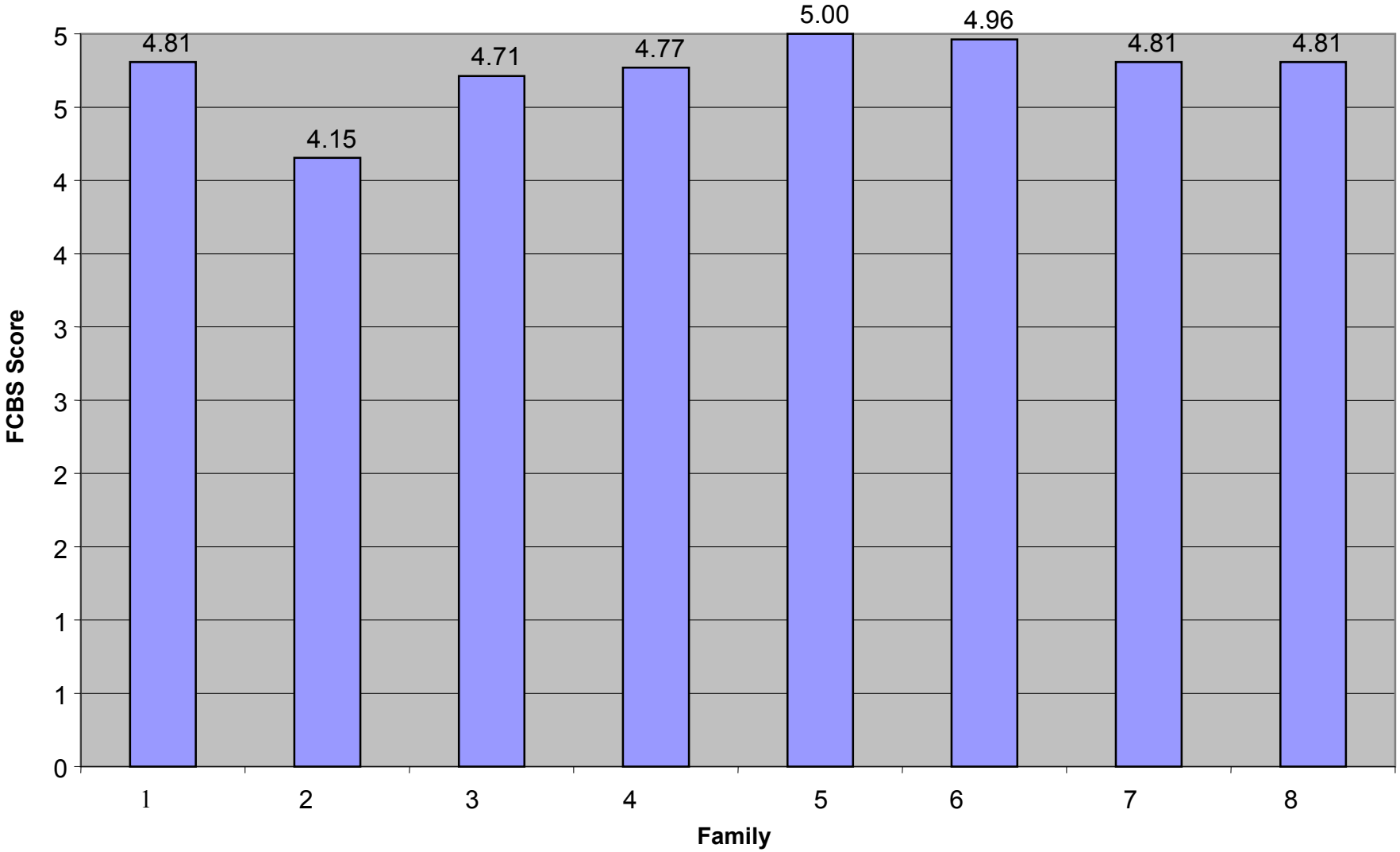



FIGURE 6
Family Centered Behavior Scale
Average Overall Score