Principles to Practice:
Guidelines for Oregon's State Incentive Grant (SIG)Project

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Introduction

In 2004, the Department of Human Services Addictions and Mental Health Division, contracted with the Northwest Early Childhood Institute, a Division of the Hearing and Speech Institute, to develop a report citing the research underlying key principles and recommendations for implementing these principles in non-traditional behavioral health settings for children 0-6 and their families. The key principles come from the literature for the Starting Early Starting Smart (SESS) approach and recommendations from the advisory committee for the State Incentive Grant for Early Childhood Prevention, which funded this project. The SESS approach, utilized by four demonstration projects in Oregon, integrates traditional behavioral health services into easily accessible, non-threatening settings where parents naturally and regularly take their young children.

The work of the demonstration projects required collaboration across agencies and a plan to sustain the changes beyond the funding period. This entailed engagement of staff members who provide direct services, supervisory personnel, and administrators in their roles within their own agency and across agencies. The examples in this document follow the conceptual framework described in "Assessing the Necessary Agency and System Support" which outlines the necessary conditions for successful implementation and mutual accountability in individualized support/service planning or wraparound. (Koroloff, N., Schutte, K., and Walker, Janet S. (2003). Focal Point: A National Bulletin on Family Support and Children's Mental Health: Quality and Fidelity in Wraparound, 17(2), p. 8-11).

The examples in this document are intended to support local community planning efforts to develop systems of care for young children and their families. The cited articles, generally published within the last 10 years, provide a base for each principle. For some principles, the wealth of literature is qualitative rather than quantitative, while other works provide examples of how the principle is implanted in practice. In some cases, no article was found that focused specifically on the principle; rather they were defined within the context of a larger examination. Some principles are held more strongly by one discipline (e.g., special education, social work, medicine, mental health) than another, and the literature reflects this. The time and resources available for this project allowed for a limited, rather than comprehensive, literature search.

Principle 1 - Facilitated Care Coordination

Facilitated care coordination ensures that services for a family are delivered in a comprehensive, organized manner, with communication between all the different people, agencies, and systems that may be involved. Rather than forcing the family to navigate many different systems, one central person, sometimes called a case manager or family advocate, becomes the link between the families and the services they need, regardless of system (medical, educational, social service). A continuing supportive relationship with the family is crucial, as care coordination involves the family becoming an equal partner with providers in all decision making. Decisions, then, are not made in isolation, but with the input of all involved parties, thus providing comprehensive care for children and families.

Principles into Practice

Direct Service Level	A family advocate based out of a pediatric clinic accompanies a family with developmental concerns to their initial referral to Early Intervention services.
Intra-Agency/Supervisory Level	The family advocate works with staff to revise intake paperwork to be more family-friendly and development-focused.
Inter/Intra-Systems Level	Monthly meetings—including representatives of the pediatric clinic, Early Intervention, the regional Medicaid/WIC offices, community mental health, and DHS—are held to review collaborative processes and make protocol decisions to facilitate connections between each agency.

<u>Sources consulted/Further exploration:</u>

American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. (2002). Policy statement: the medical home. *Pediatrics, 110,* 184–186.

Brown, T. (2000). *Care coordination for children with special health care needs and their families in the new millennium: Principles, goals and recommendations developed by the AMCHP Working Group on Care Coordination* (HRSA Info. Ctr. MCHM081). Washington, DC: Association of Maternal and Child Health Programs.

Strickland, B., McPherson, M., Weissman, G., Van Dyck, P., Zhihuan J., Huang, P., et al. (2004). Access to the medical home: Results of the National Survey of Children with Special Health Care Needs. *Pediatrics, 113*(5 Suppl), 1485-1492.

The Public Health Foundation (2002). *Healthy people 2010 toolkit: A field guide to health planning*. Retrieved September 8, 2006, from http://www.healthypeople.gov/ state/toolkit/default.htm.

Ziring, P.R. (1999). Care coordination: integrating health and related systems of care for children with special health care needs. *Pediatrics, 104*(4), 978-81.

Principle 2 - Co-location of Services

Families involved in multiple systems often have trouble accessing services. By physically locating agencies (or their representatives) in the same place, families can take advantage of "one-stop shopping," getting several needs met at one time. Planning should take into consideration ease of transit for families with young children and hours that match families' availability.

Principles into Practice

Direct Service Level	A family brings their child in for a health check-up. Afterwards, the family will go down the hall to the Medicaid satellite office.
Intra-Agency/Supervisory Level	Representative from various agencies take turns hosting training sessions for everyone represented in the center to keep open lines of communication and facilitate mutual understanding.
Inter/Intra-Systems Level	The center is sponsored jointly by a local hospital and community non-profit, who collaborate to pursue grants and fundraising opportunities.

Sources consulted/Further exploration:

Roberts, R.N., Behl, D.D. & Akers, A.L. (1996). Community-level service integration within home visiting programs. *Topics in Early Childhood Special Education, 16*, 302-321.

Rosman, E. A., Yoshikawa, H., & Knitzer, J. (2002). Towards an understanding of the impact of welfare reform on children with disabilities and their families: Setting a research and policy agenda. Social Policy Report, 16(4). Retrieved September 14, 2006, from http://www.srcd.org/Documents/Publications/SPR/spr16-4.pdf.

Principle 3 - Comprehensive Service Array

Programs develop and make available to families a broad spectrum of services and resources. These services and resources should address all aspects of a child's development (physical, mental, and emotional), as well as the needs of the entire family (housing and job assistance, counseling, child care). While they may be located in different places, the services are all offered under the umbrella of the parent agency to make them simple for families to access.

Principles into Practice

Direct Service Level	A local family center offers developmental screening and therapy, as well as medical and dental check-ups. Families are also helped to access mental health specialists, nutritionists, and counselors for housing and job assistance.
Intra-Agency/Supervisory Level	An advisory group of service providers and parents meets periodically to evaluate the services being delivered—are they the right services being delivered in the right way?
Inter/Intra-Systems Level	People and agencies involved work together to create a universal system for meeting administrative needs such as billing, intake, and records.

<u>Sources consulted/Further exploration:</u>

Greenwald, L., Siegel, M., & Greenwald, R. (2006). Kindering Center: A comprehensive Early Intervention community-based program model. *Infants & Young Children: An Interdisciplinary Journal of Special Care Practices, 19*(3), 190-202.

Katz, M., Urkin, J., Bar David, Y., Cohen, A. H., Warshawsky, S. & Barak, N. (2005). Child health care centres: an academic model for comprehensive child health care in the community. *Child: Care, Health and Development, 31*(2), 217–222.

Ryan, C.S., McCall, R.B., Robinson, D.R., Groark, C.J., Mulvey, L., & Plemons, B.W. (2002). Benefits of the Comprehensive Child Development program as a function of AFDC receipt and SES. *Child Development, 73*(1), 315-328.

Trivette, P.S. & Thompson-Drew, C. (2003). Implementing a school-based health center: The Winstom-Salem Forsyth County experience. *Psychology in the Schools, 40*(3), 289-296.

Principle 4 - Cross-Agency Collaboration

Many families have needs more complex than any one person, system, or discipline can address. Involvement with multiple systems can result in duplicate or conflicting services, as well as unmet needs that fall through the cracks. Cross-agency collaboration ensures that families' needs are met by building partnerships at all levels. Participants in collaboration share a common goal: to work together to develop methods for solving problems and improving services to children and families. To that end, they must also "acknowledge their interdependence and share risks, resources, responsibilities, and rewards" (Himmelman, 1993).

Principles into Practice

Direct Service Level	Staff at a relief nursery use their connection with a local housing program to support a homeless family.
Intra-Agency/Supervisory Level	Professional development requirements for relief nursery staff includes "shadowing" days at other service providers to learn their programs.
Inter/Intra-Systems Level	Agencies within a community form a Collaboration Council which provides training by pairing up staff from different agencies to make connections and plan procedures for inter-agency referrals.

Sources consulted/Further exploration:

Gill, S. (2004). Multi-agency collaboration: The challenges for CAMHS. *Child & Adolescent Mental Health, 9*(4). 156-161.

Himmelman, A.T. (1993). *Helping each other help others: Principles and practices of collaboration* (ARCH Factsheet No. 25). Chapel Hill, NC: ARCH National Resource Center.

Hodges, S., Hernandez, M., & Nesman, T. (2003). A developmental framework for collaboration in child-serving agencies. *Journal of Child and Family Studies, 12*(3), 291-306.

Principle 5 - Culturally Appropriate Services

Culturally appropriate services require that service providers—and the programs and systems to which they belong—understand and respect families' unique needs and strengths specific to their background and culture (which may include factors such as race, ethnicity, religion, education, and socioeconomic status). True cultural competence is not just to be found in isolated actions, but in the beliefs held by individuals and systems that value differences while promoting inclusiveness.

Principles into Practice

Direct Service Level	A teacher in a day care invites parents to bring in different types of food, clothing, or books that reflect their particular traditions.
Intra-Agency/Supervisory Level	A panel, made up of parents and community members, meets regularly to review current practices in the day care and provide feedback and training (e.g., they might suggest that the monthly newsletters are available in multiple languages or that they be replaced by a monthly "open house" to facilitate parent-teacher communication).
Inter/Intra-Systems Level	The day care connects with a local college to provide on-site ESL classes in the evening.

<u>Sources consulted/Further exploration:</u>

Briggs, H., Briggs, A., & Leary, J. (2005). Promoting culturally competent systems of care through statewide family advocacy networks. *Best Practices in Mental Health: An International Journal, 1*(2), 77-79.

Briscoe, R., Smith, A., & McClain, G. (2003). Implementing culturally competent research practices: Identifying strengths of African-American communities, families, and children. *Focal Point: A National Bulletin on Family Support and Children's Mental Health, 17*(1), 10–16.

Cartledge, G., Kea, C., & Simmons-Reed, E. (2002). Serving culturally diverse children with serious emotional disturbance and their families. *Journal of Child and Family Studies, 11*(1), 113–126.

Center for Mental Health Services, Substance Abuse and Mental Health Administration. (1997). *Cultural competence standards: In managed mental health care for four underserved/underrepresented racial/ethnic groups.* Rockville, MD: Author.

Davis, T. S., Johnson, T. K., Barraza, F., & Rodriguez, B. A. (2002). Cultural competence assessment in systems of care: A concept mapping alternative. *Focal Point: A National Bulletin on Family Support and Children's Mental Health, 16*(2), 31–34.

Principle 6 - Enduring, Sufficient Dosage

In order to have a lasting impact and affect change, service providers must determine a family's needs, and then provide services at a level appropriate to the individual family. The question that must be asked is, "In order to meet this family's needs, how much intervention do they need, how often do they need it, and for how long?" Also factored into the equation should be the time it takes to build a trust with families and the opportunity for follow-up services once the family is out of crisis.

Principles into Practice

Direct Service Level	A family advocate conducts a needs assessment on a family in crisis. Based on the results, she decides to meet with the family twice a week and accompany them as they begin services. After three months, the family has stable housing, has found support through a local church group, and is attending counseling regularly. The family advocate pulls back to twice monthly visits.
Intra-Agency/Supervisory Level	Supervisors adjust schedules to allow for flexible service delivery by staff. Staff are supported in determining what they need to provide for individual families, and not held to any one-size-fits-all standard.
Inter/Intra-Systems Level	The Board of Directors works with a lobbyist to advocate for increased funding to allow for the intensity of services needed by their agency.

<u>Sources consulted/Further exploration:</u>

Barnett, D.W., Daly, E.J., Jones, K.M., & Lentz, E.F. (2004). Response to intervention: Empirically based special service decisions from single-case designs of increasing and decreasing intensity. *Journal of Special Education, 38*(2), 66-79.

Kumpfer, K. L. (1999). *Strengthening America's Families: Exemplary Parenting and Family Strategies for Delinquency Prevention*. U.S. Dept. of Justice, University of Utah.

Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., Morrisey-Kane, E., et al. (2003). What works in prevention. *American Psychologist, 58*(8), 449-456.

Principle 7 - Family-Centered Services & Family Involvement

In order to truly empower families, individuals and agencies must recognize them as an essential partner in service delivery. Families need to have a voice in what services they want and how they want them provided, and service providers must respect that voice and recognize the value of family input. As each family is unique, providers need to seek out and welcome the differing belief systems and preferences of the families they serve. In order to truly provide family-centered services on an agency- or program-wide scale, families should also be involved in policy and program development and decisions.

Principles into Practice

Direct Service Level	Families who come to a pediatric clinic are provided with a list of available services. A family advocate goes through the list and listens to what the family identifies as main needs or concerns and that becomes the starting point for all future service delivery.
Intra-Agency/Supervisory Level	Weekly parent groups are hosted and moderated by a neutral person (i.e., from outside the agency) to encourage honest feedback without fear of retribution. These groups also provide parents opportunities to connect with other families in similar situations.
Inter/Intra-Systems Level	Parent support organizations are represented on a state-wide panel at a policy planning conference.

<u>Sources consulted/Further exploration:</u>

Corrigan, D., & Bishop, K.K. (1997). Creating family-centered integrated service systems and interprofessional educational programs to implement them. *Social Work in Education, 19*(3), 149-163.

King, G., Kertoy, M., King, S., Law, M., Rosenbaum, P., & Hurley, P. (2003). A measure of parents' and service providers' beliefs about participation in family-centered services. *Children's Health Care, 32*(3), 191-215.

Shannon, P. (2004). Barriers to family-centered services to infants and toddlers with developmental delays. *Social Work, 49*(2), 301-308.

Strickland, B., McPherson, M., Weissman, G., Van Dyck, P., Zhihuan, J., & Huang, P. (2004). Access to the medical home: Results of the National Survey of Children with Special Health Care Needs. *Pediatrics, 113*(Suppl. May), 1485-1492.

Wehman, T. (1998). Family-centered early intervention services: Factors contributing to increased parent involvement and participation. *Focus on Autism & Other Developmental Disabilities, 13*(2), 80-87.

Principle 8 - Holistic Perspective

A holistic perspective (sometimes referred to as an ecological perspective) involves seeing each person not just as a unique individual, but also as a part of something larger: a child is part of a family, who is part of a community, who is part of a cultural or socio-economic group. Each of these levels impacts the other (i.e., a baby's temperament affects the family dynamic; a cultural belief affects how a parent seeks help). Rather than examine a problem, concern, or behavior in isolation, a holistic perspective looks at all of the possible influences, internal and external, to better understand how to provide services.

Principles into Practice

Direct Service Level	A preschool teacher concerned with a child's refusal to eat at snack considers the possible reasons at different levels: individual (physical—the child has feeding issues, behavioral—the child is testing boundaries), family (the child is not used to sitting in a chair for meals, because the family sits on mats on the floor), and cultural (the child usually eats food specific to her culture and is unfamiliar with the snack being served).
Intra-Agency/Supervisory Level	The preschool's policies provide staff with methods of gathering information about the child's life outside of school.
Inter/Intra-Systems Level	University classes focus on training students to recognize different levels of influence in assessing children and families' needs.

<u>Sources consulted/Further exploration:</u>

Corcoran, J., & Nichols-Casebolt, A. (2004). Risk and resilience ecological framework for assessment and goal formulation. *Child and Adolescent Social Work Journal, 21*(3), 211-235.

Pelchat, D., & Lefebvre, H. (2004). A holistic intervention programme for families with a child with a disability. *Journal of Advanced Nursing, 48*(2), 124-131.

Prilleltensky, I., & Nelson, G. (2000). Promoting child and family wellness: Priorities for psychological and social interventions. *Journal of Community & Applied Social Psychology, 10*(2), 85-105.

Principle 9 - Individually Tailored Services

Recognizing that each individual, family, and situation is unique, service providers need to be able to modify their services to meet families' needs in a way that will work for the families. Goals should be set in response to a family's concerns, wants, and needs, not according to externally-imposed expectations. Services and interventions should not be predetermined, but developed in collaboration with the family according to the specific circumstances and people involved. This may mean that agencies need to change their methods or create new services as needed.

Principles into Practice

Direct Service Level	An early interventionist works with a toddler in an empty preschool classroom. Although visits are typically done in the home, Mom prefers to meet after her older son's preschool class rather than worry about guests in her often-chaotic home.
Intra-Agency/Supervisory Level	Supervisors support staff decisions to stray from the "typical" way of doing things if it meets the family's needs.
Inter/Intra-Systems Level	Federal documents, such as Individualized Family Service Plans, allow for flexibility within their required components.

Sources consulted/Further exploration:

Browne, J.V., Langlois, A., Ross, E.S., & Smith-Sharp, S. (2001). An interim Individualized Family Service Plan for use in the Intensive Care Nursery. *Infants & Young Children: An Interdisciplinary Journal of Special Care Practices, 14*(2), 19-33.

Burchard, J. D. & Clarke, R. T. (1990). The role of individualized care in a service delivery system for children and adolescents with severely maladjusted behavior. *Journal of Mental Health Administration, 17,* 48-60.

Clark, H. B., Prange, M. E., Lee, B., Boyd, L. A., McDonald, B. A., & Stewart, E. S. (1994). Improving adjustment outcomes for foster children with emotional and behavioral disorders: Early findings from a controlled study on individualized services. *Journal of Emotional and Behavioral Disorders, 2*, 207-218.

Ray, J., Stromwall, L.K., Neumiller, S., & Roloff, M. (1998). A community response to tragedy: Individualized services for families. *Child & Adolescent Social Work Journal, 15*(1), 39-54.

VanDenBerg, J. E. (1993). Integration of individualized mental health services into the system of care for children and adolescents. *Administration and Policy in Mental Health, 20*, 247-257.

Principle 10 - Integrated Services; Integration into Operations

Integrated services pulls together the ideas of comprehensive service array, facilitated care coordination, and co-location of services. A variety of different services are provided and coordinated at the same location, which makes it easier for a family to access all needed services. However, the complexity of coordinating services requires strong managerial and programming skills on the part of administrators.

Principles into Practice

Direct Service Level	A relief nursery provides not only respite care and therapeutic day care for children, but also offers substance abuse counseling, job and housing assistance, mental health service for children and adults, and early intervention services. A staff nurse practitioner provides physical health check-ups and immunizations as needed. Family advocates provide case management of the different services accessed by each family.
Intra-Agency/Supervisory Level	Training focuses on the agency's integrated model; staff work to learn how to approach services in a way different from their particular field (e.g., a medical model).
Inter/Intra-Systems Level	Intake and billing for all services are done through the single agency. The nursery coordinates with a variety of private insurance companies and public assistance for billing for various services.

Sources consulted/Further exploration:

Burns, B.J., & Goldman, S.K. (Eds.). (1999). *Promising practices in wraparound for children with serious emotional disturbances and their families: Systems of care.* Washington, DC: American Institutes for Research Center for Effective Collaboration and Practice.

Ragan, M. (2003). *Building Better Human Service Systems: Integrating Services for Income Support and Related Programs*. Albany, NY: Nelson A. Rockefeller Institute of Government Center for the Study of the States. (ERIC Document Reproduction Service No. ED481351)

Howell, J.C., Kelly, M.R., Palmer, J., & Mangum, R.L. (2004). Integrating child welfare, juvenile justice, and other agencies in a continuum of service. *Child Welfare, 83*(2), 143-156.

Principle 11 - Multidisciplinary Teams

In order to effectively deliver comprehensive and collaborative services to families, providers from various disciplines need to work together with the family—and with each other. Multidisciplinary teams (or MDTs) bring together the different providers involved with a family (and the family itself) to make program and service decisions, offer case management assistance, and ensure coordination of care. As members of a team, participants are able to provide more inclusive and effective care to families, while gaining support from each other. They also have the opportunity to learn about disciplines other than their own, which gives them skills for future work.

Principles into Practice

Direct Service Level	An MDT meets to discuss a child who lives with his mother in an A&D treatment center and is having feeding issues. This particular family's team includes a family advocate, a pediatric nurse practitioner, an early intervention specialist, an occupational therapist, a feeding specialist, an early childhood mental health therapist, a social worker, and a substance-abuse specialist.
Intra-Agency/Supervisory Level	Members of different disciplines host training sessions for other team members to share expertise and break down barriers.
Inter/Intra-Systems Level	Training programs include time for students to practice working on MDTs, focusing on listening and collaboration skills.

<u>Sources consulted/Further exploration:</u>

Bell, L., & Feldman, L. (1999). A comparison of multi-disciplinary groups in the UK and New Jersey. *Child Abuse Review, 8*(5), 314-324.

Blatt, S.D., & Saletsky, R.D. (1997). A comprehensive, multidisciplinary approach to providing health care for children in out-of-home care. *Child Welfare, 76*(2), 331-347.

Chatoor, I., Kerzner, B., Zorc, L., Persinger, M. Simenson, R., & Mrazek, D. (1992). Two-year-old twins refuse to eat: A multidisciplinary approach to diagnosis and treatment. *Infant Mental Health Journal, 13*(3), 252-268.

Lowe, F., & O'Hara, S. (2000). Multi-disciplinary team working in practice: Managing the transition. *Journal of Interprofessional Care, 14*(3), 269-279.

Nicholson, D., Artz, S., Armitage, A., & Fagan, J. (2000). Working relationships and outcomes in multidisciplinary collaborative practice settings. *Child & Youth Care Forum, 29*(1). 39-73.

Principle 12 - Mutually Beneficial Relationships

If families are to be partners in their own care, providers and families must engage in mutually beneficial relationships. As families need to trust, listen to, and respect providers, so must providers trust, listen to, and respect families. Both family and provider need to appreciate the other's expertise and experience. That same trust, respect, and appreciation must also be present in the professional relationships within agencies or programs, especially among disciplines. How are relationships with clients informing practice and educating staff? How are relationships among professional partners impacting the work with families?

Principles into Practice

Direct Service Level	A mother is offended by the way material was presented at a lecture sponsored by her child's early intervention program. She shares her frustration with her home visitor, who listens without judging or defending the speaker.
Intra-Agency/Supervisory Level	The home visitor takes the mother's feedback back to the agency, to the person responsible for hiring the speaker.
Inter/Intra-Systems Level	The early intervention agency contacts the speaker's agency and sets up a meeting to discuss future presentations to avoid the problem in the future.

<u>Sources consulted/Further exploration:</u>

Drake, B. (1994). Relationship competencies in child welfare services. *Social Work, 39*(5), 595-602.

Wehman, T. (1998). Family-centered early intervention services: Factors contributing to increased parent involvement and participation. *Focus on Autism & Other Developmental Disabilities, 13*(2), 80-87.

Principle 12 - Prevention/Early Intervention Strategies

Agencies use programs, policies, interventions, and services that have been proven effective through research and widely accepted as "best practice." These are not a set list of commandments, but rather a growing and changing body of recommendations.

Principles into Practice

Direct Service Level	A preschool teacher consults her copy NAEYC's *Developmentally Appropriate Practices* when planning her classroom.
Intra-Agency/Supervisory Level	The Board of Directors reviews several proven programs before choosing a curriculum for the preschool.
Inter/Intra-Systems Level	Teachers and administrators are encouraged to join professional memberships to access up-to-date information on new promising practices.

Sources consulted/Further exploration:

Copple, C. & Bredekamp, S. (Eds.). (1997). *Developmentally appropriate practice in early childhood programs* (Rev. ed.). Washington, DC: National Association for the Education of Young Children.

Smokowski, P.R. (1998). Prevention and intervention strategies for promoting resilience in disadvantaged children. *Social Service Review, 72*(3), 337-365.

Center for Effective Collaboration and Practice website: http://cecp.air.org/

National Center for Mental Health Promotion and Youth Violence Prevention website: http://library.promoteprevent.org/browse.php?catid=116190

Promising Practices website: http://www.promisingpractices.net/about_site.asp

The Prevention Institute website:http://www.preventioninstitute.org/children.html

Principle 13 - Staff Training, Support, and Supervision

Agency staff needs more than a thorough orientation/training period and periodic attendance of topic-specific trainings. Training and support must be ongoing to ensure that professionals have continuous opportunities to learn and grow as they become more experienced or change job responsibilities. Reflective supervision, a collaborative dialogue between supervisor and staff, is one way to provide supervision such that staff can learn within the context of professional relationships. By sharing the problem-solving process (rather than a boss giving orders to a subordinate), the relationship between supervisor and staff is strengthened while the program's objectives are met.

Principles into Practice

Direct Service Level	A case manager feels overwhelmed by a particular family. During his weekly meeting with his supervisor, the two brainstorm about what has worked in the past and what strategies he might try. Later, the case manager remembers how supportive he felt by his supervisor and adopts a similar approach with his client.
Intra-Agency/Supervisory Level	The agency calendar includes several days set aside for training. Each year, the agency chooses a topic to focus on and offers several in-services, each building off the one previous.
Inter/Intra-Systems Level	Universities offer on-line professional development courses that providers can access at any time. Courses are designed to link together to provide continuous learning, instead of isolated classes.

Sources consulted/Further exploration:

Bertacchi, J. & T. Norman-Murch. (1999). Implementing reflective supervision in non-clinical settings: Challenges to practice. *Zero to Three 20*(1): 18-23.

Head Start Information and Publication Center. (2002). Reflective supervision. *Head Start Bulletin*. Retrieved November 1, 2006 from http://www.headstartinfo.org/publications/ hsbulletin73/hsb73_32.htm.

Zero to Three. (2003, February). Tips for Practitioners: Lessons Learned from Implementing Reflective Supervision. Retrieved November 1, 2006, from http://www.zerotothree.org /cpe/tip_2003_02.html.

Principle 14 - Strengths-Based Perspective

A strengths-based perspective stems from the idea that all individuals and families have strengths and resources that can be drawn upon. If professionals are to see families as partners, it must be recognized that families have assets that they contribute to the problem-solving process. These assets may be personal attributes, individual abilities, or connections within a culture or community. Sometimes the family may not be able to see their own strengths, and the service provider may need to help identify them. Strengths-based does not mean that problems are ignored, but that the focus shifts from the problem itself to how to use the family's strengths to help solve the problem.

Principles into Practice

Direct Service Level	A father who works full-time feels disconnected from his son's work with the early intervention team. The occupational therapist knows that Dad is a talented craftsman, and provides him with ideas of adaptive materials he could make to use at home with his son.
Intra-Agency/Supervisory Level	All program paperwork (intake forms, progress notes, referral forms, etc.) is designed to help identify family strengths, rather than simply talking about concerns/problems.
Inter/Intra-Systems Level	A community clinic serving a rural population has trouble getting people to attend parenting classes. Recognizing the community's strong faith, the clinic works in partnership with local churches to offer classes in a familiar place, where volunteers from the church provide childcare.

<u>Sources consulted/Further exploration:</u>

Early, T. J., & GlenMaye, L. F. (2000). Valuing families: Social work practice with families from a strengths perspective. *Social Work. 45,* 118-129.

Powell D. S., & Batsche, C. J. (1997). A strength-based approach in support of multi-risk families: Principles and issues. *Topics in Early Childhood Special Education, 17,* 1-26.

Weick, A. and Saleeby, D. (1995). Supporting family strengths: Orienting policy and practice toward the 21st century. *Families in Society: The Journal of Contemporary Human Services, 76,* 141–149.

Principle 15 - Use of Non-Traditional Settings

Service delivery takes place where families feel most comfortable. This often means that services are provided in places that are not thought of as mental health settings. Instead, providers meet the families in local or community settings, such as churches, community centers, outreach clinics, child care programs, schools, etc. Using non-traditional settings for service delivery helps reduce the stigma of receiving mental health or other services. It is also generally more convenient for the family and gives service providers a chance to see the child/family in their own environment.

Principles into Practice

Direct Service Level	A mother brings her child to a relief nursery. While he is in class, Mom is able to meet with her substance abuse counselor down the hall.
Intra-Agency/Supervisory Level	The relief nursery makes it a policy to set aside a few small offices for confidential meetings and encourages parents and professionals to use them.
Inter/Intra-Systems Level	The nursery makes other local programs (D&A, domestic violence, early intervention) aware of the nursery's willingness to be used as a service delivery setting.

<u>Sources consulted/Further exploration:</u>

Edlefsen, M., & Baird, M. (1994). Making it work: Preventative mental health care for disadvantaged preschoolers. *Social Work 39*(5), 566-573.

Shanok, R. S., Welton, S. J., & Lapidus, C. (1989). Group therapy for preschool children: A transdisciplinary school-based program. *Child and Adolescent Social Work Journal, 6*, 72-95.

Editors Note regarding revisions:

The focus for each of the principles was three-fold: 1) to revise the draft definitions to be clearer and more user-friendly, 2) to provide examples of how the principle might look at the different levels of implementation, and 3) to find research that indicated an evidence base for each principle. Unexpectedly, most of my time went into that last objective, and the search led to some unexpected results.

To that end, I tried to find articles published in scientific journals that studied each principle within in the context of a study or survey that would show that the principle led to better outcomes or improved results for families. I couldn't find this for many of the principles. I don't think this necessarily means that each of these cannot be called "evidence-based principles," but that we should be cautious about how we are using and defining "evidence-based" when we are discussing something as inexact as a "principle."

For some of the principles, I found a wealth of literature, even if it tended to be more qualitative than quantitative. Many works cited are examples of how a particular principle is being implanted in practice. (Interestingly, many of the articles regarding implementation that I found were not based out of the United States, but from the UK or Australia) For some principles, I couldn't find any article that focused on that specific idea, but was able to list a few places where the principles were well-defined within the context of a larger examination. It also became apparent that some of these principles were held more strongly by one discipline (e.g., special education, social work, medicine, mental health) than another, and the literature available reflects this. Similarly, some literature, especially in the mental health field, addressed some of these issues solely looking at adults, not children and families, and I did not include these articles.

Finally, it is also well-worth noting the limitations of what follows. Obviously, time was a large factor. It's entirely possible that there are dozens of rigorous studies about each of these that I was just unable to find in the time that I could allot to each principle. I needed to put some limits on my searching, and so mainly confined myself to articles written in the last 10 years. I used OHSU's library to search for articles, and was therefore limited to what they had available that I could access full-text over the Web. In no way can this be considered a comprehensive review of available literature, and the implications of a lack of research on any particular principle need to be qualified by this disclaimer.