FAMILY PROCESS

The Family Empowerment Program: An Interdisciplinary Approach to Working with Multi-Stressed Urban Families

ELIZABETH N. CLEEK, PSY.D.*
MATT WOFSY, LCSW*,[1]
NANCY BOYD-FRANKLIN, PH.D.†
BRIAN MUNDY, LMSW*
TAMIKA J. HOWELL, LCSW, M.A.‡

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The family empowerment program (FEP) is a multi-systemic family therapy program that partners multi-stressed families with an interdisciplinary resource team while remaining attached to a "traditional" mental health clinic. The rationale for this model is that far too often, families presenting at community mental health centers struggle with multiple psychosocial forces, for example problems with housing, domestic violence, child care, entitlements, racism, substance abuse, and foster care, as well as chronic medical and psychiatric illnesses, that exacerbate symptoms and impact traditional service delivery and access to effective treatment. Thus, families often experience fragmented care and are involved with multiple systems with contradictory and competing agendas. As a result, services frequently fail to harness the family's inherent strengths. The FEP partners the family with a unified team that includes representatives from Entitlements Services, Family Support and Parent Advocacy, and Clinical Staff from the agency's Outpatient Mental Health Clinic practicing from a strength-based family therapy perspective. The goal of the FEP is to support the family in achieving their goals. This is accomplished through co-construction of a service plan

*Program Design, Evaluation, & Systems Implementation, Institute for Community Living, Inc., New York, NY.
†Graduate School of Applied and Professional Psychology, Rutgers University, New Brunswick, New Jersey.
‡Community Health Services, Harlem United, New York, NY.
Correspondence concerning this article should be address to Elizabeth N. Cleek, Institute for Community Living, Inc., 40 Rector St., 8th floor, New York, NY. E-mail: elizabeth.cleek@iclinc.net.
[1]Authors are noted alphabetically to reflect equal authorship.
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that addresses the family's needs in an efficient and coherent manner—emphasizing family strengths and competencies and supporting family self-sufficiency.

Keywords: Urban; Multi-stressed; Interdisciplinary; Parent advocate; Family intervention

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Families presenting at public mental health centers in inner-city communities often struggle with multiple psychosocial forces that interfere with their use of inherent capacities and access to effective treatment—all of which challenges providers to go outside the bounds of traditional service delivery. Psychosocial forces often include homelessness, poverty, domestic violence, child abuse, foster care, substance abuse, racism, and other forms of discrimination, which may create a sense of hopelessness. Such families repeatedly interact with multiple outside systems, such as child welfare agencies, foster care agencies, family court, public assistance programs, law enforcement, schools, and shelters. These systems may have contradictory agendas and often fail to coordinate their priorities and services. This impedes each system's effectiveness and creates a sense of confusion, fragmentation, and futility in the family (Micucci, 1998). Insofar as these systems and services focus on individual people and problems, they fail to activate the inherent strengths, competencies, and healing capacities of the family and the community (Minuchin, Colapinto, & Minuchin, 2006).

LOCAL AND NATIONAL CONTEXT

Initiatives in national and local mental health policy have moved the agenda forward for an integrated and coordinated approach to service delivery. In July 2003, the President's New Freedom Commission on Mental Health set a new standard for the delivery of evidence-based and best practices in the public mental health service arena. Enumerated in the Commission's report (2003) were a series of *Goals for a Transformed Mental Health System*. Among these were the elimination of disparities in access to excellent mental health care, and that care is consumer and family driven. Consistent with this report is a trend emerging at the state level, wherein state funding across the country has become increasingly contingent upon a system's capacity to deliver evidence-based and best-practice programming with documented outcomes (e.g., Carpinello et al., 2002; New York State Office of Mental Health, 2001; Oregon Senate Bill 267, 2005; Minnesota Department of Human Services, 2010). The accountable care model (US Department of Health & Human Services, 2011), which highlights integrative partnerships among medical and behavioral health providers, and which will transform payment mechanisms (Jarvis & Alexander, 2011), is emerging in health care policy and highlights another application of coordinated care interventions.

Consistent with the trends noted above, the Institute for Community Living (ICL) designed and implemented the family empowerment program (FEP). ICL, a New York City based not-for-profit corporation, assists over 9,000 adults, children, and families through a broad array of programs and services to meet the specialized needs of New Yorkers, including housing with supports, outpatient mental health clinics, commu-

nity support and outreach services, and healthcare services. The FEP, sited in East New York Brooklyn in a building that houses many ICL resources including an outpatient mental health clinic, an entitlements counselor, and the Brooklyn Family Resource Center, engages representatives from each of these to better support families in responding to the myriad of psycho-social forces that those in this inner-city neighborhood often experience. FEP was developed in accordance with Kazdin's (1997) recommendation that blueprints for effective treatments meet the needs of the population served and follow strong theoretical underpinnings, and incorporates best practices within a flexible service structure, enabling it to deliver theoretically sound interventions in a manner that is sensitive to the cultural context of families served (Waldegrave, 2005).

A PROACTIVE RESPONSE TO FRAGMENTATION OF CARE

The ICL FEP is comprised of an interdisciplinary team that partners with multi-stressed urban families to address the needs most essential to the family being served. The team is comprised of the family along with ICL staff from collaborative programs, including: parent advocates, family therapists, an entitlements specialist, and agency administrators. Additionally, other involved parties such as specialist consultants, outside providers, and family-identified support personnel regularly attend meetings in support of family goals (Figure 1).

The FEP model is driven by a threefold focus on engaging the entire family in treatment, the implementation of strength-based family therapy interventions, and the linkage with a multi-disciplinary resource team that assists the family in transferring the principles, insights, and skills developed in the family session to their experiences within the naturally occurring community (Boyd-Franklin & Bry, 2000; Imber-Black, 1988). As a result, rather than being pulled in many directions, families experience the maximal benefit of the array of services offered.

Through the multiple perspectives represented on the team, the family is better able to address a broad range of mental health and concrete concerns. By balancing family needs and strengths with systemic priorities, the team is better able to prioritize family concerns and thus stabilize family functioning while coordinating services. Three core elements lie at the core of this model's success:

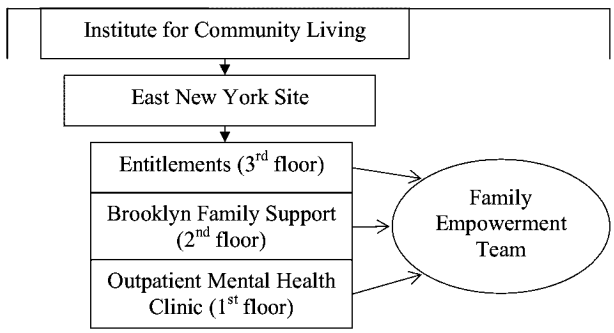

FIGURE 1. Composition of Family Empowerment Program Team in East New York, Brooklyn

- involvement of parent advocates;
- response to the concrete service needs of the family through entitlements, counseling, and advocacy; and
- family therapy informed by the evidence-based brief strategic family therapy (BSFT) (Szapocznik, Hervis, & Schwartz, 2003).

Central to all of the FEPs' interventions is the involvement of the parent advocates from ICL's Brooklyn Family Resource Center. The advocates are parents who have sought mental health services for their children and their families, and serve as flexible resources to families of children with emotional and behavioral challenges (Burns, Hoagwood & Mrazek, 1999). Advocates offer support and education that stems from their own experience navigating the system on behalf of their own children. Through the Brooklyn Family Resource Center, they provide a wide array of local wisdom and assistance, such as attending school and court meetings along with the family, offering program funded respite monies in times of crisis, and/or providing after-school parent and child mentoring programs. The local wisdom and lived experience of parent advocates has enhanced the larger service system and provides a new dimension of support to families. Though research is limited, early outcomes suggest that family advocate involvement increases the likelihood that families engage in treatment (McKay, Gopalan, Franco et al., 2010). Ireys, Devet, and Sakwa (2002), in their discussion of Family Support Programs, highlight the concept of "weak ties"—"small social groups or networks ...[which] can themselves be linked by an acquaintance relationship to different social groups" (p. 155).

> "The concept of weak ties is integral to understanding the role of experienced peer or support partner. Parents of children with severe emotional or behavioral disorders report many unmet needs when working with traditional service providers. In some instances, a support partner may function as a weak tie by developing only an acquaintance relationship; yet within this relationship, the partner may link a parent to community resources, people, or institutions and thus serve as a relationship or social network bridge-builder." (Ireys et al., 2002, p. 155)

In keeping with this concept, and in addition to the individual linkage and support work noted above, the Brooklyn Family Resource Center advocates offer an array of workshops and support groups designed to promote an understanding of children's mental health issues, as well as to create a natural support network amongst parents. Examples of these services include single parent support groups, workshops on mental-health related topics, and pro-social gatherings such as trips to amusement parks and a monthly family night where dinner and activities are provided. Any family involved in the family empowerment program (FEP) can avail themselves of these offerings. In addition, it provides youth advocacy and mentoring activities that help keep children involved with meaningful activities, and enables them to become part of a larger pro-social peer community. Families attached to the Family Resource Center participate in a community where social support, trust, and connectedness are realized.

An entitlements specialist complements these services by offering expertise in the realms of finance, health care benefits, and housing. For instance, the entitlements specialist can support families by providing information on tenants' rights, supplying the family with an application for needed benefits, and assisting the family with

negotiating the complex bureaucratic system that often encumbers access. In agencies where this position does not exist, programs can draw on the expertise of experienced social workers who have worked with accessing entitlements, and/or cultivate expertise by enabling staff time to attend one of the many free trainings that exist around this issue.

The third component of FEP is family therapy informed by the evidence-based BSFT (Szapocznik, Hervis & Schwartz, 2003). ICL's family therapists were trained in BSFT when FEP was developed, and BSFT has informed the perspective by which the therapists and family work. The work begins by eliciting each family member's point of view, drawing out family strengths, and reframing the presenting problem as one that is rooted in family functioning (Szapocznik et al., 2003). This process is designed to identify symptomatic cycles and help the family achieve more adaptable patterns of relating by addressing communication, problem-solving, and conflict resolution (Szapocznik et al., 2003).

The three core components of the team (Family Advocacy, Entitlements Counseling, and Family Therapy) are implemented and coordinated in collaboration with the family to enhance internal family functioning and resiliency, and to create a more adaptive fit between the family and its naturally occurring environment. At any given time, the FEP team actively works with a caseload of approximately ten families. Over the last four years, 36 families who enrolled in the ICL mental health clinic have enrolled in the FEP, and reflect the diversity of the community.[1]

Families who present as multi-stressed and multi-system involved during the mental health clinic intake are informed of the FEP and its array of services. Should the family decide to participate in the FEP, they are matched with an advocate from the Brooklyn Family Resource Center, and an FEP team therapist is assigned. The therapist and the advocate meet with the family in order to further orient them to the FEP process, following which a first FEP meeting is scheduled.

The FEP is predicated on the idea that effective practice must reflect the translation of research to practice. For instance, the FEP's central activities are consistent with the principles of recovery, which include notions of first and second order change (Onken et al., 2007). By stabilizing environmental factors and concrete service needs (second order change), the FEP's integrated approach creates the conditions necessary for successful delivery of evidence informed treatment targeted to facilitate transformation within the family system (first order change). The combined effect of the clinical interventions, advocacy work, and concrete specialist services create a synergistic effect that also reflects a multi-systemic care coordination framework (Madsen, 1999). The model is influenced by System of Care (Stroul & Friedman, 1986) theory, which emphasizes that the child and family are central to the initiation and direction of the service process; that service delivery and coordination are localized and community-based; and that development and delivery of services are culturally relevant (Pires, 2002; Stroul & Friedman, 1986).

In order to identify and facilitate integration of cultural context into the clinical work, clinicians are trained from the outset of hire to be sensitive to clients' age, gender, and cultural issues. This process begins during the psychosocial assessment conducted at intake, when all clients are asked to complete a person-centered survey

[1]Forty-seven percent of families served by FEP have been Latino, 36% African-American, 8% Caribbean or of Caribbean-American descent, and 5% Caucasian.

specifically developed to identify cultural needs and background, as well as individually identified strengths, needs, interests, and goals. Cultural context must be integrated into clinical work, particularly in therapy for individuals and families from racially and ethnically diverse, low socio-economic backgrounds (Waldegrave, 2005). Boyd-Franklin (2003) also highlights this need along with the challenges that poor African-American families often face in relation to multi-systems involvement. In addition to the integration of cultural context in therapy, parent advocates from the Brooklyn Family Resource Center who are from the same cultural, racial, linguistic and socio-economic backgrounds as families participating in FEP often serve as "cultural bridges," and their involvement fosters a more seamless inclusion of cultural context in the service delivery system. At all times, hope, resiliency, and an emphasis on self-sufficiency within and among family members is the overarching framework that guides the FEP.

The manner in which the component parts of the FEP work together in assisting families with stabilizing external systems and internal functioning is illustrated in the following case example.[2]

The Smiths, an African-American family, entered the shelter system following their move to New York City. Due to a history of substance abuse, Mr. and Mrs. Smith were referred for specialized counseling. Upon hearing their account of current use, the clinician reported the family to the city's child welfare agency. The child welfare case was opened and soon after, the Smith's 8-year-old daughter, Pam, became violent in the community and was hospitalized. Pam remained on the psychiatric unit for 6 weeks and was classified by hospital staff as "severely emotionally disturbed." At discharge, the hospital referred her for case management and outpatient mental health services. Child Welfare also referred the family to a preventive service agency. In addition, Child Welfare arranged for the Smiths to receive family services and early intervention for their toddlers. Thus, all of the adults and children in the family were involved with different agencies and receiving treatment at different programs. Despite the influx of services, the Smiths were challenged in that the family was at risk for losing their Section 8 Housing and Public Assistance.

The FEP was a good fit for this family in that it addresses the diverse needs of children and families by enhancing and coordinating the multiple services in which families are involved, in conjunction with a family-centered and strength-based approach. For the Smiths who were engaged with multiple providers and systems, the FEP could help structure all the various "helpers" and work to ensure that the Smiths were guiding the single agenda.

At the time of intake into ICL's clinic, the Smiths were working with service providers spread across three different boroughs of New York City. In one day, the family could be expected to attend a public assistance meeting at 10:00 a.m. in one borough, a home visit scheduled at 1:00 p.m. in a second, and a medical appointment in a third. These expectations inadvertently set this family up for failure, as it was impossible to satisfy all of them. A second complication was that three different therapists, with diverse goals, were working with members of this family. Although the three children were seen by the same therapist for family therapy, Mrs. Smith was referred for individual therapy at a second agency, and the whole family was mandated to attend

[2]Identifying characteristics have been changed to ensure confidentiality.

family therapy sessions at a third agency. All of this, combined with daily involvement with a parent advocate, resulted in extreme role confusion, fragmentation, and inefficiency for family members and providers alike.

Due to their multi-systems involvement, the therapist informed Mr. and Mrs. Smith about the FEP team. The family decided to participate. At the first meeting that the family attended, and in response to the family's chief concern that services were too fragmented and that they felt they were being set up for failure, a collaborative decision was first made to transfer the children's and mother's cases to a single family-centered clinician at one agency. Second, Mr. and Mrs. Smith were linked to a parent advocate who was of the same racial and socio-economic background. This was done at the request of the family and in order to help mitigate the healthy suspiciousness that the Smith family expressed during the intake at the clinic. Third, a linkage was established between the family and the FEP's Entitlements Specialist, who supported them in negotiating the Section 8 and Public Assistance processes; and last, the family decided whom they wanted to participate in future meetings. The monthly FEP meeting acted as a consistent venue for the family to effectively communicate with and pull together self-identified resources. These initial meetings became a platform for Mr. and Mrs. Smith to increasingly take ownership of the helping process. For example, though Mr. and Mrs. Smith were actively encouraged from the beginning to participate, it was not until the second and third meetings that Mr. and Mrs. Smith increasingly contributed agenda items and verbalized concerns. When Mr. Smith was not able to attend a meeting, he initiated calling in from work. The collaborative work of the family and providers mobilized the strengths, wisdom, and resiliency inherent to the family. The family gained the strength and support they needed to positively impact change in their lives.

MULTI-SYSTEMIC COLLABORATION

First and foremost the Smiths are a family—one in which each member was in distress. An immediate concern was to alleviate this distress through the provision of concrete services. The tension experienced by the family over competing, albeit necessary, appointments was addressed through monthly team meetings at which Mrs. Smith, the internal FEP team, and relevant outside providers and supports were able to meet together and engage in a mutual exchange of ideas, identify target goals and objectives, and coordinate service delivery. Through this process, and through daily contact with the Smiths' parent advocate, Mrs. Smith became increasingly confident and hopeful about her family's future and achieved a sense of ownership of the process. This was evidenced when Mrs. Smith increasingly came to the meeting with an agenda, identifying areas for discussion, posing questions to service providers, and establishing priorities for the team. Mrs. Smith also began to present as less depressed, both through her ability to focus the FEP agenda and through her increased range of expression and care in her appearance. Mr. Smith maintained sobriety and employment, and parent advocacy also guided family involvement in workshops on parent training and support groups. Entitlements assistance was provided to help stabilize the family in terms of their housing and finances.

Family empowerment program team meetings facilitate communication and greater understanding and synchronization among providers who often are siloed in

different systems—for example family advocates, clinicians, and child welfare staff, together with the family. While coordination of care is an essential feature of the FEP team, it is the synergistic interplay among the family members, parent advocates, clinicians, and entitlements specialists that is the most powerful element of this multi-systemic intervention. Within this interplay, a family-centered framework, open and respectful dialog, empathic resonance, and appropriate boundary-setting create the conditions conducive to learning, skill acquisition, collaboration, and follow-through. In the case of the Smiths, the initial emphasis was on establishing mutual priorities in the face of multi-systemic demands, such as facilitating the family's involvement in a monthly family night, engaging their older daughter in an after-school mentoring group at the Family Resource Center, and advocating for the family at school meetings. These supports bolstered social connectedness and the Smiths' capacity to navigate multiple service systems. The level of direct involvement and support provided by the FEP team enables families to sustain their involvement in the sometimes emotionally demanding family therapy process, while building empowerment and family self-confidence.

BENCHMARKS OF POSITIVE OUTCOME

At the third monthly team meeting including the Smiths and their service providers internal and external to ICL, Mr. Smith was unable to participate due to his job, but provided Mrs. Smith with a list of questions. At this meeting, the family's progress was immediately apparent. Mrs. Smith confidently relayed her husband's questions, and asked for clarification about specific aspects related to the family's case status. Mrs. Smith maintained consistent eye-contact throughout the meeting. The family successfully secured housing and medical benefits, and was regularly attending all therapy appointments; in addition, multiple providers working with the family were engaged in ongoing collaboration. The team members reflected their observations of family progress, and Mrs. Smith echoed this sentiment. Pam was engaged in treatment, her aggression levels had decreased, and school attendance, homework completion, and behavior had improved for all of the children in the family. In addition, the family had been present consistently for weekly home visits with providers. The children were attending school/preschool regularly and were exhibiting improved behavioral functioning in the classroom.

For the Smith family, the multi-systemic intervention described in this paper resulted in the following outcomes—which are consistent with the outcomes associated with other families who choose to utilize the FEP—as assessed by both professional observation and family feedback[3]:

- Increased Coordination of Services.
- Greater Access to Concrete Services for example food stamps, disability, housing, and legal aid.

[3]The FEP team also has preliminary data reflecting symptom improvement from standardized outcome measures such as the Strengths and Difficulties Questionnaire (Goodman, 1999) for children and the Outcomes Questionnaire (Lambert et al., 2003; Wells, Burlingame, Lambert, Hoag, & Hope, 1996) for adults that is consistent with this anecdotal evidence. These data continue to be collected and analyzed and will be reported in a future paper.

- Increased Daily Living Skills such as Hygiene and Time Management.
- Improved Parenting and Household Management.
- Decreased Experience of Mental Health Symptoms.
- Family Preservation.
- Family Ownership of Change Process.
- Access to Needed Family Resources via Emergency Funding Provided by City and/or State Contracts.
- Increased Attendance at Family Therapy Sessions.
- Increased Involvement of Important Persons in the Family's Lives, for example Ministers, coaches, other family members, etc.

Future steps of the FEP involve synthesizing data from more diagnosis-specific outcomes measures, formally integrating family feedback, and incorporating legal and housing support.

CONCLUSION

The FEP is an evolving intervention that adapts the latest research (Carpinello et al., 2002; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Kazdin, 2008; Szapocznik et al., 2003; Minuchin et al., 2006) to the clinical needs of the families served and the training needs of the participating staff. Its unique blend of multi-disciplinary input provides a context that seeks to foster change in both the external and internal domains of multi-stressed urban families. While pulling together the component parts of a system that has an inherent complexity, there is simplicity in utilizing existing resources within a system in order to partner with families and match their expressed needs. By reducing barriers that interfere with engagement and treatment retention, and developing partnerships among system members, staff feel empowered to provide clinically sound and culturally sensitive services that are responsive to the family's needs, and families are able to own and direct their involvement and benefit from the supportive capacity of each.

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