

family ties

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One Family's Story:

Loving Tough: When the Family Drives the Team

By Joan and Doug Maynard

When our son was younger and experiencing behavioral problems, we wished for a wraparound program for support. He had had run-ins with the law, a psychiatric hospitalization, was truant from school, and was very difficult at home (to say the least). We had little or no control over him or his behavior. Of course, at times our son could appear perfectly normal or typical, so he was puzzling even to professionals, whether educators, therapists or counselors. Our main therapist commented that we virtually had to do "Zen Parenting" with our son whom he likened to a "rolling hairball." In any case, the county did not deem him to be at "institutional risk," and therefore he did not qualify for case management and the related services and support.

What were we to do? We decided to see what we could do ourselves to assemble a wraparound team. It would be family-driven. Indeed, it had to be family driven because it was never going to happen otherwise. But before saying how we managed to get a team, let us say more about our son and why we were desperate for collective help.

Joe (not his real name) lives in the moment, does not understand emotional experiences of others, and is unable to modulate his own affect, especially anger. His thinking is categorical and rigidly so. If he had trouble one day with a teacher, that person would be, in his way of thinking, condemned forever. Joe would not entertain that he might have generated or at least contributed to the trouble, or that the teacher might have been having a bad day, or that it was only one incident and not the pattern. Or that the teacher, like us all, has some good

points and some bad points. Joe is an either-or person who might decide that he would never go back to class because the teacher, having corrected him on some relatively small thing, was unredeemable.

Over the years, we learned that Joe had an exceptional need to be in control of his

ing the reactions of others, including beloved friends and relatives, who observe us getting into Joe's world and thereby see us as ceding our responsibilities, when in fact this may have been the most responsible thing we could do. It was difficult and still is, and requires the utmost self-discipline.

Just as Joe requires having the reins in his own life, he also has an exceptional need for success. When he does not think he can do something, he will not try. When he knows he can do something – he acquires knowledge through osmosis, it seems – he does it, and perfectly. This may be hard to believe, but Joe did not learn to ride a bicycle. Only when he had observed extensively and felt comfortable enough would he mount the bike. Then he took off as if he had been practicing for years! No amount of encouragement, prodding, cajoling, or consequences would get him to try it before he had the confidence to get on the bike and stay upright. This characteristic pervades every new venture he undertakes, which may be why he tries so few and automatically says "no" to most new ideas.

Nevertheless, as a teenager, Joe went on four cross-country group biking adventures, averaging 80-90 miles a day for three weeks. Each trip was a 1500-mile journey. Joe is strong and also adept mechanically, so he was a good rider and given the chore of caring for other bikes. His unusually successful performance on these bike trips raised his self-esteem immeasurably for weeks after they were completed, and that gave us further insight into his need for such experiences. Because of Joe's emotional make-up, however, the lead-up to these trips was sheer torture. That's a story for another time, except to say that every year for

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***“Tough love
is appropriate for
some children.
It did not work
with Joe.”***

daily life. He would not easily follow or take direction. But we discovered that if we could start from Joe's own perspective, his own logic, his concrete understandings, we often could make considerable movement in a mutually satisfactory direction, whether it was just getting ready for school or going out to dinner or talking about the day. We called this "getting into Joe's world." That always was and still is the proverbial thing that is easier said than done. It is extraordinarily difficult to give up your own expectations, desires, and views and enter in the first place into those of your child. We are the PARENTS, after all!! Getting into Joe's world means again and again and again letting go of our own feelings of entitlement, our own need for control, our rights not only as parents but also as the grownups. It means ignor-

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four years, his inability to handle usual pre-travel anxieties (the change in routine) almost undermined the very possibility for his own enjoyment and accomplishment.

Our difficulties, then, included knowing how to work with a child whose emotions and emotional understandings were underdeveloped, who demanded uncompromised control over his own life, who required others to get into his world before he could get into theirs, and who desperately needed success but who could sabotage himself at almost every turn. We simply could not handle these difficulties on our own. We needed others, who themselves would be somewhat quirky, or at least trained to appreciate quiriness. Fortunately, we found those who could perceive Joe's differences and work with them, if not embrace them. We searched, we called, we were referred, and eventually we found professionals for our team who were prepared to deal with our unusual son. These were therapists who admitted they didn't have all the answers and who were able to respect us as the experts on our child even when we felt deeply incompetent. At one point the professionals on our team consisted of the county social worker, her

supervisor, a community program probation worker, our son's therapist, his anger management counselor, and his special education teacher. In addition, we gratefully accepted the help of the mother of one of his peers. This mom saw our struggles, liked Joe, and was naturally talented at engaging him. We also encouraged a mentoring relationship between Joe and a former school playground supervisor who befriended Joe and, after he finished his degree and moved out of state, blessedly stayed in contact by email and telephone with him. Our daughter (Joe's sister) finished college and moved away when Joe was just entering high school, but she also contributed unwavering love and support. We had family friends whose shoulders we could cry on.

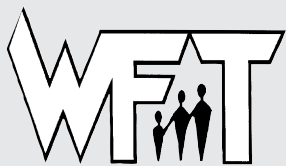
Tough love is appropriate for some children. It did not work with Joe. We opted for a different strategy: *love tough*. Our goal was simple: In the face of damage to our home, angry outbursts of invectiveness directed toward us, and what seemed like concerted efforts to prove that he was utterly unworthy, we committed to do everything in our power to keep him home, in school, and on track until he could reach adulthood, at whatever age that would be. He was at high risk for being put in a restrictive environment and we knew that that placement for him would be counterproductive. We insisted, with all our energy, in looking for the often microscopic increments of growth and progress. We insisted on loving him despite it all. We have made many mistakes trying to raise our son but loving tough was not one.

In December of 2003, after our son turned 18, we invited many of the players mentioned above to join us for an entire Saturday morning at our house. We were led by a skilled facilitator and an artist in a process entitled "PATH: Planning Alternative Tomorrows with Hope." With Joe present, we labored to create a practical, visual and colorful plan. We started with our son's big vision (goal), and working backwards, determined what needed to be accomplished within a year, six months, one month and the next week if that goal was to be realized. Coaches were assigned for each task with others assigned to check up on the coaches. At the end everyone signed the plan and committed to help our son in the ways they had said they would.

We are pleased to report that our son accomplished many of the goals on the PATH during the following year: He completed his High School Equivalency Diploma, obtained his Driver's License, stayed out of further

legal trouble, and continued with anger management classes. Although currently unemployed, he did hold a job for seven months, and was able to live away from home. He is looking hard for a new job and we are hopeful. At twenty, Joe has a ways to go toward that elusive goal of adulthood, but we try to forget his chronological age and mark his progress in terms that are appropriate to his unique development and inner spirit. We have seen progress and we are still able to call some of the team members on his behalf. Better yet, he seeks their help on his own.

It takes huge amounts of energy and effort to assemble a family-driven team, and we are thankful for those who have responded to our sometimes faltering initiatives. They include the psychologist who did extensive evaluation and helped us in therapy sessions of our own to begin to understand our child; the therapists and psychiatrists who took what we knew about our son and worked with that knowledge rather than discounting it, and also were creatively able to relate to Joe in very important ways; the teachers, principals, and special education instructors who didn't view us as bad parents and worked hard on Joe's behalf; the social service and juvenile justice officials who saw a good kid even when he wasn't behaving well; and the friends and relatives who somehow understood what our challenges have been and have given their unwavering support. Because they respected us, and allowed us to drive the team, we were able to love tough.



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We would appreciate knowing what kinds of articles you would like to see included in future issues. Please feel free to send your comments or suggestions about this newsletter to:

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Volume & Issue

OK, we admit it, our newsletter volume number has been incorrect for, say, 10 years. The problem started when the volume number was incremented with each issue in 1996. We further complicated matters when we used the same volume number for one issue in 2004 and all of 2005. Not that all this matters to most of you, but here's what we're going to do to correct things. Technically, our newsletters in 2006 should be Volume 20. So, despite having used that volume number (Issue 1 in 2004; Issues 2-5 in 2005), we're going to stick with Volume 20 in 2006. Due to budget limitations, we anticipate we will only be able to publish two issues in 2006, and they will be identified as Issues 6 and 7. Hope this clears things up for the librarians on our mailing list!

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Need for a Definition of Family-Driven Care

By Gary M. Blau, Trina W. Osher,
David M. Osher

In 2003, the President's New Freedom Commission on Mental Health issued "Achieving the Promise: Transforming Mental Health Care in America." Goal 2 of that report calls for "consumer and family driven care." The report cites research showing that hope and self-determination play a key role in recovery. The Commissioners insisted that families "must stand at the center of the system of care." They also said that the needs of children, youth, and families must "drive the care and services that are provided."

The report did not say what family driven care should look like. But, it did make five recommendations giving clues about what they meant.

1. Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
2. Involve consumers and families fully in orienting the mental health system toward recovery.
3. Align relevant Federal programs to improve access and accountability for mental health services.
4. Create a Comprehensive State Mental Health Plan.
5. Protect and enhance the rights of people with mental illnesses.

At its spring 2004 meeting, the Council for Collaboration and Coordination (the CCC) asked the Federation of Families for Children's Mental Health to help develop a clear definition of the term "family-driven". The authors of this article took on this task.

Why Promote Family-Driven Care?

Families, youth consumers, and family oriented practitioners echo the findings and recommendations of the Commission. They know that outcomes are better when families have a key voice in decision-making.

"Consumers and families told the Commission that having hope and the opportunity to regain control of their lives was vital to their recovery."

Families know what works for them. Therefore, it makes sense that they drive service delivery decisions. Their experience is holistic. In other words, they do not have a mental health part, a child welfare part, a juvenile justice part, and so forth. Families focus on the concrete challenges that they face all day and every day. Families also know their strengths and their limitations. Families know the difficulties they face. Families can see change in how they or their child are doing on a daily basis. They know how a program, agency, or system works (or doesn't work) for them. Most importantly, without family comfort and buy-in, children and youth won't participate in services. Also, family voices are listened to by politicians and public officials. Their passion and persistence are necessary to transform mental health services.

Providing family-driven care requires a major change in how people think and act. There must be administrative support to change behaviors and relationships. Developing, promoting, and supporting a commonly accepted definition of family-driven care is a necessary step in helping people change how they think and act.

Working Definition of Family-Driven Care

The Definition

Family-driven means families have a pri-

mary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- ✓ Choosing supports, services, and providers;
- ✓ Setting goals;
- ✓ Designing and implementing programs;
- ✓ Monitoring outcomes;
- ✓ Partnering in funding decisions; and
- ✓ Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

Guiding Principles of Family-Driven Care

1. Families and youth are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning for individual children and their families.
2. Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes.
3. Families and youth are organized to collectively use their knowledge and skills as a force for systems transformation.
4. Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
5. Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports.
6. Providers take the initiative to change practice from provider-driven to family-driven.
7. Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.
8. Efforts to change community attitudes focus on removing barriers and discrimination created by stigma.
9. Communities embrace, value, and celebrate the diverse cultures of their children, youth, and families.

Families and providers both need help to:

- view the decision making process differently;
- to act and interact in new ways;
- to feel comfortable with shared responsibility for decision making; and
- to own and believe in a family-driven approach as the right way of working together.

Family-Driven Care *Continued from page 3*

10. Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes.

Characteristics of Family-Driven Care

1. Family and youth experiences, their visions and goals, their perceptions of strengths and needs, and their guidance about what will make them comfortable steer decision making about all aspects of service and system design, operation, and evaluation.
2. Family-run organizations receive resources and funds to support and sustain the infrastructure that is essential to insure an independent family voice in their communities, states, tribes, territories, and the nation.
3. Meetings and service provision happen in culturally and linguistically competent environments where family and youth voices are heard and valued, everyone is respected and trusted, and it is safe for everyone to speak honestly.
4. Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority, responsibility, and control with them.
5. Families and youth have access to useful, usable, and understandable information and data, as well as sound professional expertise so they have good information to make decisions.
6. Funding mechanisms allow families and youth to have choices.
7. All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

Putting Families Behind the Wheel

The term “family-driven care” can be thought of as a road trip. Picture a comfortable car or minivan filled with good traveling companions. The main passenger is a child who has a mental health need. The driver is the child’s family. The rest of the passengers have been invited along because they know a lot about child development, education, health, family support, psychology, literacy, housing, employment, and other things families need to have a good quality of life. The family knows where it wants to go but needs

help choosing a good route and getting there safely. The traveling companions share what they know and discuss all the options together

with the driver. Then the family takes the wheel, and drives the car along the chosen

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TIPS For SUCCESS

System partners have a responsibility to ensure that families have practical opportunities to get the training they need to drive safely!!

Ways to Take the Wheel – at the start

- Ask/explain about the steps ahead and what to expect along the way.
- Ask/tell about including other agencies involved with your child and family and getting relevant information from them (such as an Individualized Education Program (IEP)).
- Ask for/offer referrals for services to meet your child’s needs.
- Ask for/give explanations of all options and ask for the support your family would need to make things work for your child.
- Request/offer services that teach your child how to adapt successfully in their schools and communities.

Ways to Take the Wheel – as things move along

- Find out/tell about all opportunities to participate in planning and advocate for your child’s and your family’s services and supports.
- Talk/connect with professionals to learn the evidence about the kinds of treatments, services, and supports that can help achieve your goals.
- Seek/offer opportunities to develop new skills to build (or rebuild) and sustain good relationships with your child.
- Insist on making/provide discharge and aftercare plans for reintegration into the community at the outset of out-of-home care.
- Ask/offer for help to find the right services and providers and funding to pay for them.

Ways to Take the Wheel – sustaining gains

- Request/provide services that support your child’s gains and will help insure they continue to adapt successfully in their schools and communities.
- Ask/offer for supports that can help your family cope with the stress at home – including support for siblings.
- Seek/offer services that promote wellness and resilience.
- Insist on/provide services that build on your child’s and family’s strengths and counter balance risk factors.

Ways to Take the Wheel – at a Judicial Proceeding

- Find/provide a family advocate attached to the court or other knowledgeable and trustworthy person who can help you learn what you need to know and prepare for court.
- Ask/provide for a description of the courtroom and the court proceedings beforehand – including any security measures you are likely to encounter.
- Get/offer help to prepare any statements you wish to make during the proceeding.
- Request/provide transportation, child care, and qualified, professional translators (if necessary) so you can fully participate in the hearing.

Counting the Grass

by Jo Pelishek

I chuckled to myself knowing my husband's patience had taken a hit when he told our son to go outside and count the grass. Moments later, my endurance also took a dive while trying to cope with this same 18-year-old version of "The Mask" whirling through our home. His goofy, high-pitched voice in a sing-song chant, "Dad is funny, Dad is funny, Dad is funny... I love my sister, I love my sister, I..." at toxic volume – while our son jumped, pranced, and leaped. Add to that the obsessive affection and all "Mask" qualities but the green face were present. It was just another day of living with a child who has a variety of disabilities, including, sometimes, the inability to match his mood to the moment. He was flying high. Some say he's autistic. Some call him hyper, others call him bipolar. Some call him undisciplined. We call him "Karl."

You may see us in town, but chances are you'll hear us first. As Karl ambles alongside

me in the local stores, holding my hand or trying to hug me as we walk, you might hear this big kid saying loudly, "I LOVE you, Mommy." Karl may argue with me about Spiderman pencils or get angry that he can't have a bottle of pop. If he knows you from school or church, he'll announce it for all to hear. You are his "best" friend. He may even run to you with a greeting or hug, not meaning to knock you over or cause a scene. Don't be embarrassed. Our family has already lived through enough embarrassing moments to last a lifetime. It goes with the package. Families with disabilities often feel conspicuous, which is a challenge.

Most people are discreetly curious, but supportive. For those who wonder why we don't leave Karl home, I have an answer. First, of course, is the fact that he wants to be a part of the community in which he lives, and has both that right and privilege, as do you. Second, even on the days we'd prefer to leave him, there are few supports available to families like ours. And with no relatives

nearby, you – our community, school, church, neighbors – become our family.

So next time you see us, or a family like ours, please give us a smile rather than a smirk. And when children are fussing and screaming at the checkout counter or in the cart, don't assume parents have been too lenient or the child spoiled. Rather than becoming impatient or disgusted, offer that child a smile and give the parents an understanding look. You may just be providing the highlight of their day, or even week.

And if you observe a teenager-almost-adult wandering around with eyes peeled to the ground, not to worry. He may have been told to go outside...to count the grass!

Family-Driven Care *Continued from page 4*

route. The driver gets help along way if it is needed. At the end of the trip, everyone celebrates their success together.

This image of a journey was presented to the New Freedom Commission by the Federation of Families for Children's Mental Health. The image has been used to help families and professionals understand how to apply the definition of family-driven care in their everyday lives in the real world. Some practical strategies for taking the wheel have been developed to get folks started on their own journey (see TIPS for SUCCESS in this newsletter).

Gary M. Blau, Ph.D., is Chief of the Child, Adolescent and Family Branch, Center for Mental Health Services, United States Department of Health and Human Services.

Trina W. Osher, M.S., is Co-Director of Policy & Research at the Federation of Families for Children's Mental Health.

David M. Osher, Ph.D., is Director of the Center for Effective Collaboration and Practice in Washington, D.C.

Web References on Family-Driven Care

www.ffcmh.org/systems_whatism.htm - Working definition and tools

www.tapartnership.org/advisors/family/the_family_page.asp - Webinar and supporting documents – follow links under Defining Family Driven Care to view the PowerPoint slides for the Webinar; view the definition of family-driven care; read the story "Journey to Family-Driven Policy;" or post a message to the discussion board

www.mentalhealthcommission.gov/reports/FinalReport/toc.html - Achieving the Promise: Report of the President's Commission on Mental Health

www.systemsofcare.samhsa.gov - A website providing information about the mental health of children, youth and families. A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families.

Ian

*Smart, curious, kind
and sometimes rude*

Brother of Lydia

*Lover of Mom, TV and
computer and video games*

*Who feels Happy, Angry,
Funny and Sad*

*Who needs more love and
less conversation*

*Who gives Unwanted books,
toys, VHS tapes and games*

*Who fears storms, death and
loud noises*

*Who would like to go to
Tokyo, England and get a
2000-inch TV screen*

*Written by Ian Pavelko,
a 6th grade student with Autism.*



Meet the Advocate: Ann Hager

Senior Family Advocate, Western Region

1) Why do you work for WFT?

I work for WFT to help give a voice to a very underserved population. My experiences as a Mom of five sons - two with developmental and mental health differences - gives me a unique perspective and the ability to relate to other families.

2) What's your favorite thing about being a Family Advocate?

My favorite thing is when a parent realizes that other families have had similar experiences. They usually say, "I thought I was all alone," or, "I thought my son/daughter was the only one who did something like that." I also love working with parents and then watching them successfully advocate for their child.

3) If you had one thing to tell parents, what would it be?

Have hope, never give up on your child. Never forget your child is a child first and foremost; the disease of mental illness is secondary.

4) What has helped you cope?

We have had a horrific year with our kids but just when I think

things can get no worse, I get a phone call from a parent with a situation that makes mine look trivial. It helps me keep things in perspective. Humor and prayer are also a huge part of my coping mechanisms.

5) What are some things you like to do outside of work?

On weekends our whole family plays a medieval live action role play game. For two hours every Saturday I am transformed into my medieval persona and live in a fantasy world, casting spells, escaping Barbarians, avoiding monsters and just having fun. I also enjoy reading mysteries, doing cross stitch and when possible, going on motorcycle rides with my hubby.

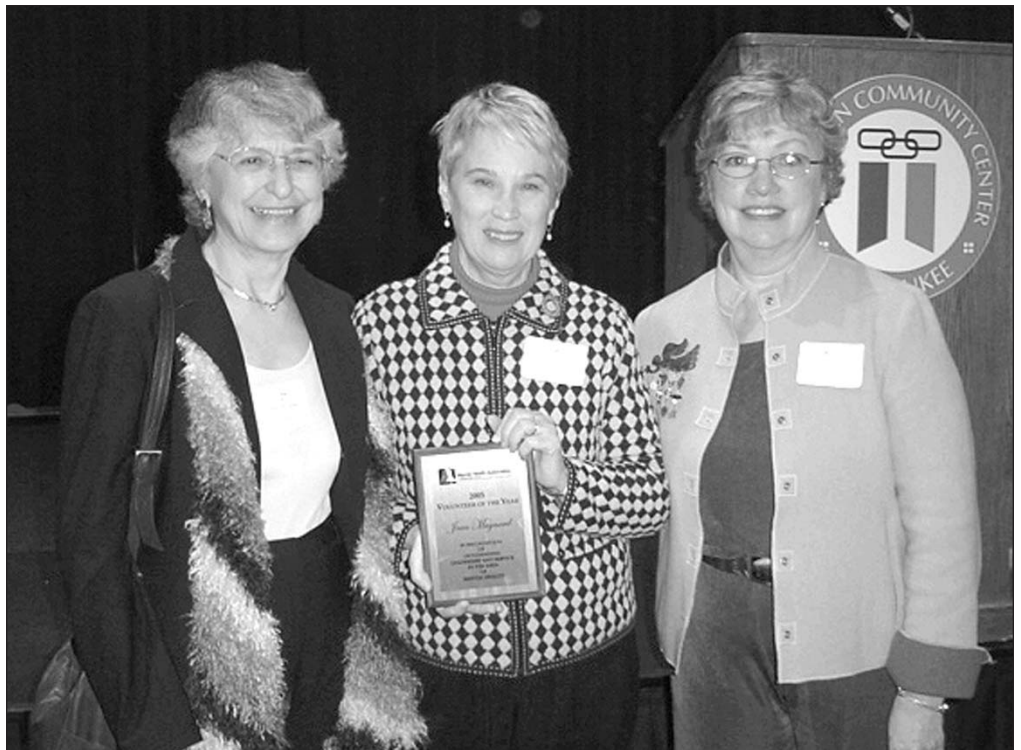
6) How have your child-rearing experiences affected your outlook?

I have lived through what many of the parents I work with are going through. I can relate to them from my perspective as a mom. I cannot imagine doing this job if I did not have children with an emotional, behavioral or mental health difference. I like to think I give those other parents hope that they too can support their child and work with all the systems our families are involved with, to help their child reach his or her full potential.

WFT Staff Member Honored

Joan Maynard, Wisconsin Family Ties' Information and Referral Coordinator, was honored by the Mental Health Association (MHA) of Milwaukee County with the 2005 Volunteer of the Year Award in recognition of "outstanding leadership and service in the area of mental health." The award was given at the Association's annual awards luncheon held in Milwaukee on December 13, 2005.

In introducing Joan to the attendees Lisa Roehl, MHA's Director of Programs, stated, "Joan has generously given her time and wisdom to the editing and facilitation of a day-long training session designed to reduce mental health stigma in schools for pupil service personnel and classroom teachers called Eliminating Barriers to Learning. Joan co-facilitated three such training sessions in the past year. Her experience as an educator, community resources expert, and parent was invaluable to the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration, the Mental Health Association, and Wisconsin United for Mental Health."



Joan Maynard, center, is honored by Lucy Rosenberg, MHA Board President, left, and Martha Rasmus, MHA President & CEO.

Family Fun Day

Coming July 11th!

It's time to think warm weather and sunny skies as Wisconsin Family Ties' annual Family Fun Day will be held on Tuesday, July 11. The location is the same as last year – Mt. Olympus Water & Theme Park in Wisconsin Dells.

This is the eleventh year WFT will host Family Fun Day for families that include children with mental, emotional or behavioral disorders. We know how important it is for families to have this day to relax – to soak up the sun, swim, ride water slides, and bounce in the wave pool. We know how much we all need this day!

Due to rising costs to Wisconsin Family Ties over the past five years, it is necessary for us to increase the price of a ticket from \$10 to \$11. The ticket will cover the outdoor and indoor water parks and a picnic lunch. An upgrade to use the entire theme park

will be available for \$7.00 at the gate. This upgrade is available only to those who have pre-purchased Family Fun Day tickets. We know you'll get your money's worth come rain or shine! If the weather fails to cooperate, we will use the indoor water park.

So plan to join us again, or join us for the first time. Please complete the form below and mail it to us with your check now. Please don't wait until the last minute! The last day we'll be able to send tickets is July 7. We look forward to having you join us for Family Fun Day on July 11!

Mt. Olympus Water and Theme Park is at 1701 Wisconsin Dells Parkway. Enter at the sign for the Treasure Island Resort. After parking, meet us at the Group Sales building (it has a blue awning) beginning at 9 a.m. The outdoor park is open until 7 p.m. and the indoor park closes at 10 p.m.



Family Fun Day Ticket Request

Please complete (print clearly), detach and mail with payment to: WFT, 16 N. Carroll, Ste. 640, Madison WI 53703

MUST BE RECEIVED IN OUR OFFICE NO LATER THAN FRIDAY, JULY 7.

First Name _____ Last Name: _____

Address: _____ City: _____ State _____ Zip: _____

Phone: _____ Number of Tickets Requested: _____ (ages 3 to adult \$11/ticket)

_____ (ages 2 and under free)

Payment by Personal Check, Money Order or Cashier's Check Only

The Importance of Taking a Strength-Based Perspective

By *Mary Beth Hewitt*

Many times when I am doing a consultation, staff members can tell me everything that a child does wrong. “He NEVER sits still.” “She’s ALWAYS talking.” “He NEVER does any work.” When I ask what the child does right, I am frequently met with blank stares. Along the same vein, adults can also tell me what the child does not like. He’s not interested in reading, rewards, etc. However, when I inquire as to what he/she does like, the blank stares return. Do not get me wrong, I used to sit with consultants and expand on all the problem behaviors of my students, too. It was easy to talk about the problems the child created because they were so obvious. You have probably heard that the squeaky wheel gets the grease. Well, let’s face it; you NOTICE when kids are misbehaving. You also know what the child does not like because he or she tells you, saying things like “I don’t care” or “this is stupid.”

Although in some ways it is helpful to know what the child cannot do and what he does not like, focusing on it does little to solve the problem. We have a choice. We can stay stuck in the problem or we can look for the solution. Talking about what the child cannot do or does not like brings us no closer to finding out what he can do or what he does like. Nothing is ever fixed by looking at it and bemoaning the fact that it is broken or worthless. Imagine that you are working with an individual who has severe physical challenges, who can neither speak nor move his arms or legs in a coordinated manner. You are sitting with a consultant and say, “I don’t know what to do with him. He NEVER does his work. He is ALWAYS disrupting the class by flailing around.” Ridiculous, isn’t it? I find it interesting that when people look at individuals with extreme physical challenges, the focus shifts from what they cannot do, to what they can do. A person with cerebral palsy may not be able to speak or coordinate his/her hand movements but perhaps is able to track items with his/her eyes. A computer program is then developed that allows communication via eye-movement tracking. The people working with individuals with these types of disabilities are forced to focus on the client’s STRENGTHS rather than lamenting about the person’s weaknesses. They also focus on the factors that they (the staff members) can

control. Furthermore, they look at how the environment can adjust to meet the needs of the client rather than expecting the client to adapt to the environment. Many people have found that the same strength-based approach can help educators program for students with learning, emotional, and/or behavioral disabilities. A strength-based approach is an optimistic way of looking at a situation.

Beauty is in the Eye of the Beholder. So Is Misbehavior.

One day, I was observing in the classroom of a first year teacher. Before the class began, I sat down with her and she told me that her most pressing problem was a particular student, whom she said never did any work, was constantly seeking attention, was rude and defiant. The school psychologist had given her an observation checklist, which she wanted to complete, but had not had the time. She asked if I would watch the boy’s behavior. In the thirty minutes I observed, he sat in his seat, did his work, and paid attention for twenty-nine out of the thirty minutes. Once he got out of his seat to sharpen his pencil, and once he verbally stood up for a fellow classmate who was being teased, by saying, “Leave her alone. That’s not nice.” I viewed both of these as positive actions. Sharpening his pencil allowed him to keep working. Standing up for a classmate who was being teased was an act of courage.

I also noticed the teacher’s behavior. She stood at the front of the room and read from a worksheet, which the students were doing at their desks. In a thirty-minute period, she gave fifteen reprimands to various members of the group for off-task behavior and gave no recognition for positive behavior. She made three praise statements for right answers and seven reprimands for wrong answers. Interestingly, four of those reprimands for wrong answers were to one boy who was the most well behaved student.

After the students had left the room to go to another class, we had a chance to talk. “So, what do you think?” she asked. Thinking that perhaps I had observed the student in question on a particularly good day, I inquired, “Was that pretty typical behavior for him?” “Yes,” she replied, “I mean, sometimes he can be worse, but that was pretty typical. See how awful he is? He was off task, out of his seat, and was yelling at other students.”

You may wonder how two individuals can

look at the same student and have such very different perceptions. While she was gathering evidence on what the student was doing to reinforce her belief that he was behaving badly, I was looking at what the boy was doing to reinforce my belief that he must be doing something right. It all has to do with what you focus on. If you focus on the negative, the negative grows. If you focus on the positive, the positive grows. This is the critical difference between optimism and pessimism.

Why Do We Need Optimism?

If you view something as broken, useless, and beyond repair, you generally throw it away. It’s not worth your efforts to fix. However, if you view it as precious and valuable, you will go to great lengths to salvage it. We are talking about children here. They are far too valuable to throw away. Although I am writing about students with learning problems as well as behavioral disorders, I like this quote from Larry Brendtro and Arlin Ness, two leading experts in the field of strength-based interventions:

“Some might argue that optimism about anti-social youth is itself a thinking error, a Pollyanna illusion that nasty kids are really little cherubs. However, pessimism is seldom useful and often leads to feelings of powerlessness, frustration, and depression. In contrast, optimism feeds a sense of efficacy and motivates coping and adaptive behavior, even in the face of difficult odds.”

We need to assume an optimistic view in order for us to feel like we can make a difference in the lives of all of our children. Furthermore, if we want our children to be resilient and optimistic, we need to model it.

Going back to the teacher with whom I was consulting, I realized that I had to shift my focus from what she was doing incorrectly to what she was doing correctly. I will admit it is a lot easier to focus on what she was doing incorrectly. However, I knew that I could not help her if I only considered her weaknesses, any more than I could expect her to help her student if she focused on his. I had to shift my focus to what she was doing right:

1. She allowed a perfect stranger to come into her classroom;
2. She asked for help;

Strength-Based Perspective *Continued from page 8*

3. For 20 out of the 30 minutes, she did not issue any reprimands;
4. She gave some praise statements;
5. She had materials prepared.

I said, “You really care about this boy.” “I do,” she replied and continued, “He is homeless and doesn’t have much stability in his life. I really want him to do well, and I’m very concerned about him. I don’t know what to do. I feel like I’m failing him. I’m constantly yelling at him.” I said, “It must be awful for you to care so much and yet the only way you know how to get his attention is by yelling at him.” “It is,” she said as she broke into tears. “I wish I knew what else to do.” I asked, “Would you like some suggestions?” and she responded affirmatively. At this point, she was willing to listen to my observations about this boy and behavioral indications that he was doing some things correctly. This was the beginning of a supportive relationship. Later that year, I saw this teacher again and she was beaming. This boy had now become her star pupil!

Because I chose to see this teacher as being committed, open-minded, caring, receptive, brave, and honest, I wanted to help her. I wonder if I had seen her as being negative, rigid, and domineering if I would have felt the same way. Taking an optimistic view does not mean you do not address problems. It means that you look for what you are able to nourish in order to overcome those problems.

The Power of Labels

The way you label something will make a big difference in the way you approach it. To paraphrase Ross Greene (1990) in *The Explosive Child*, your interpretation will drive your intervention. This is particularly important when it comes to describing students’ behaviors. Labels are evidence of our interpretation. Our interpretation of the behavior can lead us to either want to disconnect and discard or reconnect and nurture.

There is a great deal of research on the dehumanizing and debilitating effects of negative labeling. As I was doing some research in preparation for writing this article, I came across a study about a woman who taught her class about how discrimination and prejudice starts (WGBH Educational Foundation, 1985). The class

was divided into the “blue eyes” and the “brown eyes.” The students were told that blue eyes were good and that brown eyes were inferior. In less than one day, the performance level of the students with brown eyes dropped. Although she was trying to teach about racial prejudice, I couldn’t help but make the connection to all forms of prejudice. There is a great deal of prejudice against students with emotional and behavioral disabilities. I think this was most evident to me when I was teaching a group of 2nd graders about students with emotional disabilities. One young boy raised his hand and asked, “Are we talking about the handicapped kids or the bad kids?”

Likewise, I hear the pessimism of adults working with students with behavioral disorders in comments such as “The apple doesn’t fall far from the tree,” “What do you expect? His father is in jail,” “He lives in a trailer park,” “He’s from a broken home.” These comments are not information sharing; they are indictments. How do we expect kids to be hopeful and persistent, if the adults in their world are mired in feelings of hopelessness?

Behaviors of Strength-Based Teachers

Why are some people successful working with kids although others have given up on them? I believe it is because they take an optimistic view and engage in eight behaviors that go along with a strength-based focus. As you read the examples that follow, note your attitude for each. Do you notice that when something is phrased negatively, you feel depressed and defeated, while when the same situation is described positively you feel hopeful and energized? I truly believe that all teachers start out wanting to and believing they can make a positive difference in the lives of all of their students. However, years of being exposed to negative reports and focusing on a student’s weaknesses and misbehaviors have taken their toll. Teachers and parents can recapture the feeling that they can make a positive difference in the lives of ALL students by focusing on the positive.

- **Focus on what the student can do.** **Rather than**, “He cannot attend to a task for more than five minutes,” try, “He can attend to a task for 5 minutes.”
- **Make accurate and realistic appraisals.** **Rather than**, “He is always out of his

seat,” try, “He stayed in his seat for 28 out of 30 minutes.”

- **Look for and give credit for evidence of progress. Don’t minimize or discount the positive.** **Rather than**, “He must have been in a good mood because he worked longer today, but that won’t last,” try, “He worked steadily for 10 minutes.”
- **Positively reframe behavior.** **Rather than**, “She is constantly interfering in issues that don’t concern her,” try, “She is aware of injustice and stands up for those she believes are being mistreated.”
- **Look for the ‘silver lining’ in a student’s behavior and start there.** **Rather than**, “He screams to get your attention when something is hard,” try, “He recognizes when he needs help and lets people know it.”
- **Work with the factors that you can control.** **Rather than**, “There aren’t enough aides to help him when he needs a scribe,” try, “I can modify the activity so that he can work in a cooperative team and another student can take the notes.”
- **Look at the whole picture. It is as important to focus on factors that are present when the misbehavior does not occur as when it does.** **Rather than**, “When she is asked to read aloud in the classroom she throws her books,” try, “When she is reading to younger students she is calm and attentive to their needs.”
- **Be aware of the labels that you use and the projections that you make.** **Rather than**, “He is stubborn and hard-boiled. He’ll end up in jail. What do you expect? He comes from a bad neighborhood,” try, “He is determined, resolute, and courageous. He has leadership potential.”

Copied with permission from: Reclaiming Children and Youth, Edited by Nicholas J. Long and Larry K. Brendtro, Issue 14:1, No Disposable Kids, Spring 2005, Mary Beth Hewitt.

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New Legislation Puts Parents in Driver's Seat

Parents Now Can Make Decisions to Treat

A significant step forward for Wisconsin children and families occurred on May 23, 2006, when Governor Jim Doyle signed Senate Bill 226 into law as Wisconsin Act 444. Act 444 makes parents the primary decision-makers for mental health treatment of their children until they reach age 18. Previously, minors age 14 or above could refuse mental health treatment and sign themselves out of treatment, despite their parents' wishes.

In a press release, State Senator Carol Roessler, who introduced the legislation, stated, "There are many parents who have been forced to watch their child self-destruct because he or she did not recognize the need for mental health treatment. Parents in this situation felt helpless and frustrated that they could not help their child in the same way the law allowed them to when their child

suffered from a physical illness."

All that has changed with the passage of this important legislation. Under Act 444, if an adolescent refuses treatment, their parent or guardian may permit treatment on their behalf.

Act 444 will help ensure that adolescents requiring mental health treatment can obtain services early in the course of their illness. Research has shown that early intervention is crucial for positive long-term outcomes.

With a landmark 2005 study finding that half of all lifetime cases of mental illness begin by age 14, treatment during adolescence is of paramount importance.

Many WFT families worked diligently to get this legislation passed, contacting their legislators and testifying before legislative committees. Wisconsin Family Ties thanks those families for their efforts, and Sen. Roessler for her perseverance in introducing this legislation.

Governor Doyle Proclaims Children's Mental Health Week

Governor Jim Doyle recently issued a proclamation declaring May 7-13, 2006, as Children's Mental Health Week. The proclamation highlights the prevalence of children's mental health disorders, the challenges faced by families, and the responsibility placed upon our state and local communities to provide appropriate services and supports. For a copy of the proclamation, visit the Wisconsin Family Ties website (www.wifamilyties.org) or email the WFT office at info@wifamilyties.org.

Conferences & Workshops

Jun 21-22 – Learning Through Learning: Influencing the Developing Mind through Knowledge of the Science of Brain Development

Waukesha Co Technical College, Pewaukee. Advanced training on early childhood brain development. Contact Jeanne Erickson at (608) 284-0580, ext. 301 or jerickson@wccf.org. To register online visit www.wccf.org and click on Learning Through Learning.

Jul 12-15 – Training Institutes 2006: Developing Local Systems of Care – Family-Driven, Youth-Guided Services to Improve Outcomes

Gaylord Palms Resort & Convention Center, Orlando, FL. For more info, call (202) 687-5000 or email institutes_2006@comcast.net. Website: gucchd.georgetown.edu.

Jul 27 – Neurobiology of Addiction and Behavior: Making Sense of the Mystery

Jul 28 – Adolescent and Gender Issues of Substance Abuse from a Brain Perspective

Nicolet Area Technical College, Rhinelander. Presented by Flo Hilliard. Contact The Human Service Center in Rhinelander for more information and registration.

Jul 31-Aug 2 – Best Practices in Inclusion Conference (Special Education)

Westwood Conference Center, Wausau. Visit dpi.wi.gov/sped/doc/inclusionconf.doc for more information and registration materials, or contact Marge Schenk, (608) 267-9176.

Sep 28-29 – Crisis Intervention Conference

Ho-Chunk Casino Hotel and Convention Center, Wisconsin Dells. For more info, call (800) 898-9472 or visit www.uwsp.edu/conted and click on Conferences.

Oct 4 - Statewide Respite Conference

Holiday Inn Express Convention Center, Janesville. For info, call (608) 758-0956.

Oct 20-21, Dec 8-9, Jan 19-20, Feb 16-17, Mar 16-17 – Statewide YIPPE Training

Wintergreen Resort & Conference Center, Wisconsin Dells. YIPPE stands for Youth in Partnership with Parents for Empowerment. This training is for parents and youth (14-21) who want to learn in a unique way about the transition process. Contact Martha De Young at (608) 742-8814, ext 255 or deyoungm@cesa5.k12.wi.us. Registration deadline is Sept 1; space is limited.

Oct 26-28 – 18th Annual CHADD International Conference

Hyatt Regency O'Hare, Chicago. For more info, visit www.chadd.org or contact conference@chadd.org or (800) 233-4050.

Dec 1-3 – Federation of Families for Children's Mental Health Conference: Improving Outcomes Through Practice-based Evidence

Hyatt Regency at Union Station, St. Louis. For info, call (919) 477-3677 or visit www.ffcmh.org.

WFT Seeks Board Members

Wisconsin Family Ties is looking for individuals to serve on the organization's Board of Directors. The board makes critical decisions concerning the future of WFT and meets on a Saturday four times per year. Board members are volunteers and serve a two-year term. According to our bylaws, the majority of the board must be parents of children with mental, emotional or behavioral disorders.

This is a great way to contribute to the health and wellbeing of thousands of families throughout our state! Training is available, so if you have an interest, there's really no excuse. If you would like more information or an application, please contact the Wisconsin Family Ties office at (800) 422-7145 or by email at info@wifamilyties.org.

Send us your family story!

Have you ever been touched or moved by one of the family stories in this newsletter? Has one of our stories given you support or advice, or helped you to feel like you are not alone? Most of us appreciate hearing from another parent who has "been there." That is why we would like to hear from you! Please send us a story about your special child and what has helped you cope, even thrive. Other parents will benefit from sharing your struggles and triumphs.

Don't worry about writing style. We will be happy to edit your story for print. You may also remain anonymous if you wish. Stories can be up to 1500 words. Stories can be sent by email or snail mail. Check the back of this newsletter for contact information.

“We make a living by what we get, we make a life by what we give.”

–Sir Winston Churchill (1874 - 1965)

family ties

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