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Rethinking interventions:

Addressing the mental health needs of vulnerable children and youth through intergenerational community

Niranjan Karnik, PhD

Assistant Professor of Psychiatry & Behavioral Neuroscience
The University of Chicago Pritzker School of Medicine

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609 W. University Avenue, Champaign, Illinois 61820
voice/message: 217.363.3080 • fax: 217.363.3082 • www.generationsofhope.org

GHDC WHITE PAPER

With intergenerational relationships at their core, Generations of Hope Communities (GHCs) are pioneering a new approach to mental health services. They do this primarily in two ways – by providing the kinds of support that all children need for healthy development, and by providing more targeted mental health services from within the community. This paper reviews current intervention strategies and examines how the GHC approach innovatively addresses the mental health needs of vulnerable children and youth through intergenerational community.

Forms of Intervention

The current social welfare and intervention systems in the United States largely rely on a simple model of care. These systems, regardless of their locus of control (local, state or federal), take as a starting point that experienced professionals should and can provide care and support for individuals and families. From this premise many effective and empirically-based models of care have emerged. These interventions are largely provider-driven and rely on professional expertise in order to be effective.

Recent years have seen a surge in the number and quality of interventions available to mental health providers. Cognitive behavioral therapy, motivational interviewing, and dialectical behavior therapy are all techniques that have shown promise in the clinical sphere. Medications have likewise been studied to address specific conditions, and their widespread usage has led some to question whether other modes of intervention are being neglected [1].

The field of what has been termed “sociotherapy” has also seen key advances [1]. From the use of Assertive Community Treatment (ACT) [2, 3] to the development of Parent Management Training (PMT) [4-6], the empirical tools developed to address behavioral and psychiatric issues among youth and families have grown. ACT uses an intensive case management model to address the needs of the chronically mental ill, and those who are high utilizers of medical and psychiatric emergency services. ACT teams are constituted of multiple professional disciplines and draw expertise from psychologists, psychiatrists, therapists, and social workers. These professionals meet regularly and support case managers in implementing specific goals to reduce hospitalizations. In contrast, PMT is a treatment strategy that teaches parents and guardians to set appropriate limits for children who present with disruptive behaviors. PMT has repeatedly been shown to reduce disruptive behavior patterns, and lead to better family functioning and social stability.

More recently, attempts have been made to establish treatments that target certain underserved populations including children in foster care and ethnic minorities with mental health problems. These interventions have built on prior intervention research to develop new models for the empirical treatment of vulnerable groups. Multidimensional Treatment Foster Care (MTFC) uses an array of techniques to help high-risk foster and delinquent youth [5, 7-11]. The techniques used include intensive case management, individual therapy, social skills training, educational supports, and close supervision for a period of 6-9 months. This approach has been empirically shown to reduce recidivism, improve academic and social outcomes, and address psychiatric and substance use disorders. Supervisors and clinical staff in the MTFC model are accessible 24/7, and these programs rely on their expertise as a means to support foster families. The researchers who developed MTFC have conducted several controlled studies and have published their results documenting the success of this approach [5, 7, 10, 12].

Another notable program that is underway is the Community Partners in Care (CPIC) program in Los Angeles [13]. Supported through a combined effort of UCLA, RAND, NIMH and the Robert Wood Johnson Foundation, the program uses a community-based collaborative model to address depression among high-risk ethnic communities in the greater Los Angeles area. The model seeks to displace the decision-making and control of programmatic functions from the university or tertiary care center, and instead empowers local communities to enter into a partnership with agencies to screen, treat and support individuals (largely adults) with depression. The program is currently pursuing a research arm between the CPIC collaboration model and a more traditional resource-based intervention with empirically proven treatment toolkits provided to participating agencies.

An overarching framework which sits above all of these types of interventions is the SAMHSA-led Communities that Care (CTC) program. This initiative seeks to feed empirically proven interventions to communities across the country to address the needs of children and youth. The model invites communities to participate in a locally-driven process of identifying needs, gathering data, and then taking this information and selecting appropriate interventions and prevention techniques to help foster positive youth development and prevent the onset of substance abuse, delinquency, teen pregnancy and truancy. The model draws on over 50 empirically proven treatments, interventions and public health strategies over which the community-based deliberative model is built. The initial findings from the Community Youth Development Study, that examined the CTC, found that community-based interventions using evidence-based techniques can produce positive results which lower rates of substance use and delinquency [14].

Developing Additional Models of Intervention

MTFC and CPIC are beginning points in a shifting set of interventions available to communities through programs like the CTC. There is a need to have more and varied interventions since it is unlikely that any single intervention will be applicable to all communities or the social problems that they address. Present models address specific targets such as juvenile delinquency, adolescent substance misuse, and major mood disorders among adults.

Consideration should be given to models which could address multiple social problems, and if possible position community members who have needs simultaneously as recipients and providers of intervention. Such an approach, having clients cast in a dual role, has some well-documented antecedents in the research literature [15-17]. It also builds a dyadic relationship between members of the community who have needs by providing them a role in contributing to the community in a meaningful way.

A New Intervention Model

A Generations of Hope Community (GHC) is an intentionally created, geographically contiguous intergenerational neighborhood, where some of the residents are facing a specific social problem around which the entire community organizes. The practices and policies of a GHC implement a strategy known as Intergenerational Community as Intervention (ICI). The distinctive ICI strategy facilitates and supports naturally emergent alliances, relationships, and enduring commitments across generational lines. The ultimate goal of the ICI strategy is to restore the role of community as the first line of intervention — of service and support to its members.

The ICI strategy is largely implemented by those who are traditionally considered social problems (the elderly, vulnerable youth and their over-burdened families). In doing so, the GHC model grows even more robust by reducing the stigma of labels and instead empowering individuals and families to help each other – the social problems become part of the solution. The ICI strategy posits that committed community members (from at least three generations: youth, parents, seniors) can support one another if given an appropriate amount of initial assistance, and an intentional purpose which drives them toward a common goal [18, 19]. In a GHC, ordinary people of all ages and vulnerabilities care for one another in ways, and to a degree, that goes beyond the scope of traditional interventions. It is these caring relationships that shift the initial focus of problem-solving from professional service providers to the members of the community.

Generations of Hope, a nonprofit corporation created Hope Meadows, the first GHC. It has found over its 16 years of operation that older adults provide indispensable support to vulnerable parents, children and youth who, in turn, become instrumental in promoting the well-being of the elders as they age. At Hope Meadows the common goal is to support youth from foster care in their transition to permanent adoptive homes and after their adoption. All of the families, seniors and staff are committed to this goal, and lend their experience and talents to accomplish it. As a consequence of this shared purpose, the community became a functional system that now is largely self-supportive and generative.

Components of the ICI Strategy

There are several elements that contribute to the positive interventional aspects of the ICI strategy and enable it to address the mental health needs of youth and families while also playing a role in the prevention and/or amelioration of psychiatric and substance use disorders. Following are six key components of this new intervention strategy.

1. Seniors and Families as Front-Line Responders

The ICI strategy provides an important context in which professional providers are displaced slightly to make room for family and community members to initially respond to the needs of others in the community. The community and professionals occupy complementary positions with regard to the individuals who need help and support. The community members, by virtue of living in this unique community, support one another and act as essential psychosocial supports extending to the point of intervening. There are professionals (e.g., social worker and therapist) who are employed by Generations of Hope and work within the community. They help facilitate the community's ability to solve problems; they also provide the services that they would provide in ordinary practice, with the advantage of seeing the children in their everyday world and receiving relevant information from community members who are a part of that world. When necessary, they consult with or refer to professionals in the broader community.

It is important to note that this re-configuration of intervention, with seniors and neighborhood families as front-line responders, is a process and not an established pattern for the community at the outset. Instead it emerges gradually over time through a process of community empowerment, education, and support. Professional service providers play an essential role and continue to remain a part of the process over time.

In traditional service delivery models, it is easy to see the directionality and structure of service. Providers with expertise and training provide care and services to individuals with defined needs

(Figure 1). For example, a therapist might provide parent management training to the guardians of a child in foster care who presents with disruptive behaviors. In this scenario, the therapist would meet with the family for a number of sessions and educate them about the approach to dealing with this child. Should a crisis occur during times outside of the session, the family might call the therapist for assistance. If available the therapist may offer some guidance over the phone or ask them to come to the office for an urgent consultation. The directionality of the intervention is clearly from the provider to the family, and takes place largely in the context of the therapist's office.

The ICI strategy changes this dynamic by positioning the provider in the role of a consultant and putting a small cadre of seniors or neighborhood families in the immediate location around the index family (Figure 2). This structure better reflects the dynamics of the residential community where seniors and neighborhood families are on-site. In a Generations of Hope Community seniors and other parents are the people that families and children turn to first for help and support. The realities of office-based ambulatory care are limited when compared to the potential of neighbors and friends in the community that can provide support and advice at crucial times. Such psychosocial supports have long been recognized as essential aspects of medical and psychiatric care, but rarely have programs been built to enhance and draw specifically on this aspect of support.

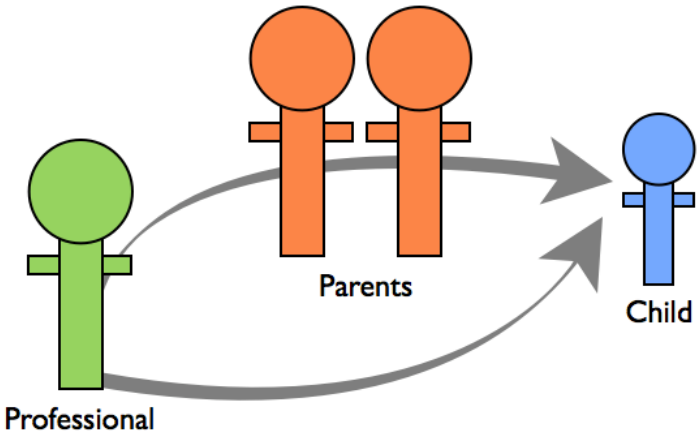

Figure 1: Traditional Service Model

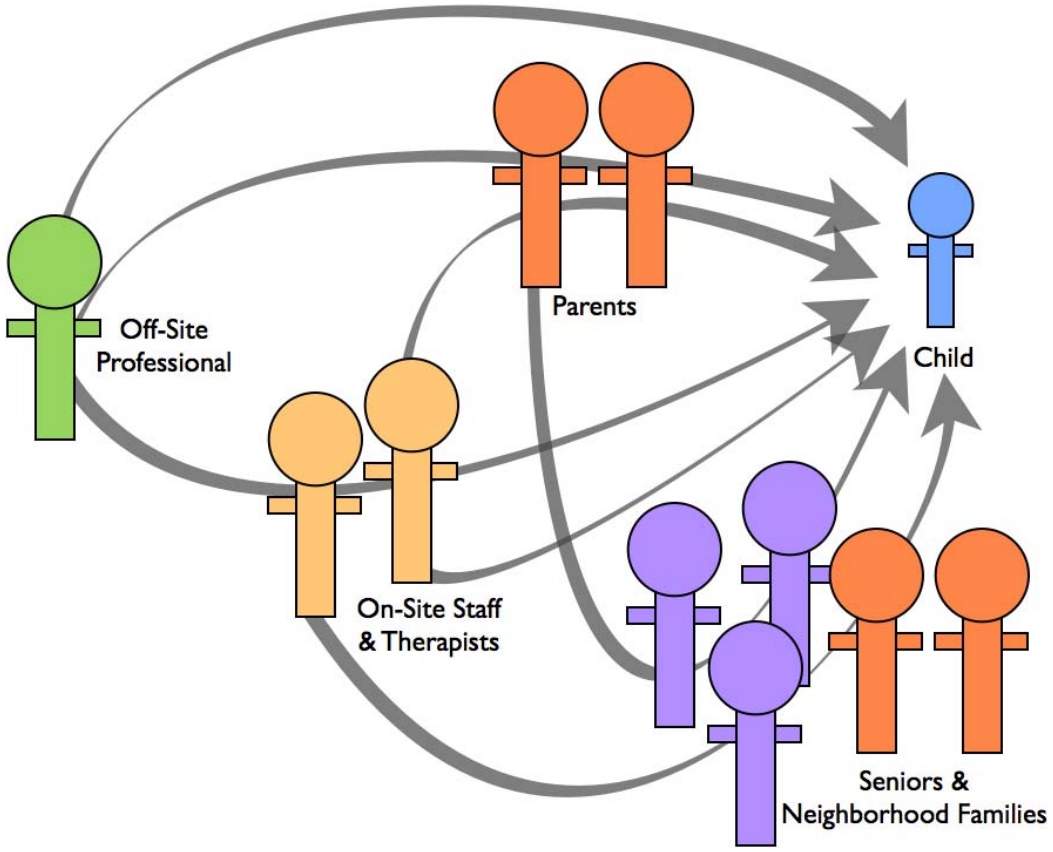

Figure 2: Generations of Hope ICI Strategy Model

In the example outlined above, the family would work simultaneously with the GHC therapist and community members to problem solve and address the behaviors of the child. In addition to using parent management training, at a time of crisis, the parent might turn to a neighbor or senior citizen in the community for assistance. It may be something as simple as this other person sitting with the child until the tantrum ends so that the parent can take a short walk to draw themselves back together, or enlisting the support to help address the safety of the child so that they don't hurt themselves or others by throwing objects or hitting people. Clearly if the behaviors go beyond the ability of the families and seniors to address them, then immediate involvement of GHC professionals is indicated and the involvement of outside professionals may become necessary. But in the event that the community can address the situation, then the therapist(s) would be informed of the events the next day or at the next appointment.

The seniors and families in the community function as a useful source of support and intervention that providers can draw on to help a family or child that is struggling. In one example at Hope Meadows, a youth was constantly getting into fights during recess, lunch, and

physical education. Everyday for six months, various seniors would attend each of these school sessions, helping the youth to get control of his behavior when necessary and helping his classmates to come to appreciate his positive qualities.

2. Restoring Attachment

One of the key challenges facing youth who have had exposure to the social welfare system is the loss of attachment to adults. Attachment is the process by which young children develop healthy and appropriate nurturing relationships with adults that enable them to enter the world as functional participants. Good attachment is the cornerstone to psychiatric stability and promotes resiliency. Studies of children in foster care have found a relationship between foster parents' sense of attachment and their commitment to the children [20, 21]. Lack of attachment and placement instability leads to increased oppositional and disruptive behaviors in the child [22]. More recently investigators have found preliminary evidence to suggest that good attachment can lead to a mitigation of the biological consequences of early life adversity [23-25], and potentially lead to better long-term outcomes.

The GHC model, using the ICI strategy, restores attachment not only through placement in families who are open to creating new bonds, but also by leveraging their roles as supports and confidants to parents as well as grandparents to the children in the community. The inclusion of seniors as a seemingly unlimited supply of grandparent relationships creates a web of attachment bonds that both parents and youth can rely on and draw on at times of stress and need, and also to share happy moments and successes. To date the nature of grandparent roles and their significance in the attachment process and mental health has yet to be well studied or examined in the academic literature. The lessons from this aspect of the program may have significant impacts and transferability to other contexts.

3. Active Listening

The ICI strategy fosters a therapeutic environment by not only providing psychosocial support in a more traditional sense, but by also using "active listening" [26]. Active listening is a process by which the listener uses minimal encouragements and instead paraphrases, labels emotions, mirrors the individuals that they are listening to, engages in open-ended questions, and uses "I" statements. These techniques help the speaker better understand the degree to which the listener is engaged, and allow for better reciprocal relationships between speaker and listener.

In the GHC model, seniors practice active listening encouraging the youth to tell their stories. Many of the children come from highly traumatized backgrounds, and are often hesitant to share their stories with their new foster-adoptive parents. The seniors in the course of their routine

contact with the children through their volunteer roles as tutors, sitters, companions, and neighbors become “safe” people with whom to share their stories. The seniors engage in active listening through some of the techniques outlined above. It is also their status as elders who have seen more of the world that makes them individuals who can be the repository for the stories (both good and bad) that the children have to share.

Children and youth who have faced early life traumas like those in the foster care, juvenile justice, and welfare systems often have fears about the impacts and effects their personal trauma narratives might have on others. Research has shown that young children often feel that the stories themselves will hurt other people as the traumas hurt them [27,30]. Adolescents often perceive that traumatic stories will somehow ruin or hurt their present placement (e.g., adoptive, foster), and cause people around them to see them as damaged or problematic.

In addition to addressing trauma, active listening can be used to help youth deal with a specific (relatively small or isolated) incident such as a fight with a sibling or parent, or having a bad day at school. It can also be used to help a child build a positive sense of self. Seniors who engage in active listening serve an essential role in bridging these feelings, and opening an avenue toward a more therapeutic approach. In the ICI strategy, what may start as a series of friendly conversations over a tutoring session can easily delve into deep traumas and the past. It is at this point that the seniors can appropriately draw on professionals within the community to support the therapeutic work and encourage that child or teen to work more closely with the available therapists to explore some of these issues. Often seniors describe this part of the work as some of the most challenging and simultaneously fulfilling aspects of what they do. When they encourage the youth to speak to a therapist or facilitate a discussion about the past with their parents, they often and appropriately take the standpoint that we will work through this together and that they love them regardless of what they have been through in the past. And perhaps most importantly they tell the children that what happened to them was not their fault.

4. Shared Narratives

In the process of active listening, the seniors and youth begin to construct a new shared narrative. The importance of narratives cannot be stressed enough – they are the stories we tell ourselves and others about ourselves. They are the context through which we make sense of our lives. A small corpus of research has emerged in recent years to better define and demonstrate the importance of narrative [27-29].

Children who are exposed to violence and trauma at an early age often lack the verbal and language skills to describe these events. These traumas then become experienced as a series of

feeling and sensations that become associated with the memory of the trauma [27]. This is very much in line with what we understand about the nature of all emotional experiences for children. For example, a child suffering from anxiety might report stomach aches or headaches because that is where they feel the experience and where it localizes. The child mental health professional is charged with ascertaining when the pain is somatic and when it is psychic. But the reality is that pain can often be experienced simultaneously.

These understandings about childhood trauma have informed adult practices especially those that focus on the effects of childhood trauma on adult psychopathology. Increasingly professionals now recognize that many adults with chronic pain, personality disorders and mood dysregulation may be experiencing some of the psychosomatic experiences that children face. There are studies underway to look at the potential of these early childhood traumas to essentially rewire the pain and mood pathways of the brain and make them more or less sensitive to particular environmental and social stimuli.

One therapeutic approach to children with early life stress is to help them to construct a narrative of their trauma experience as a means to a build psychological structure that can then be examined and worked with [30]. This moves the experience for the ephemeral feelings of the body to the concrete words, images and phrases that only language can yield. The words and images then become the conduit through which to try to address the trauma and learn new ways of coping with it.

The ICI strategy helps with this process by having an adjunctive approach. Here youth, families and seniors begin building a new shared narrative. Their narrative is one that is built on a shared sense of community, and positive interfamilial and intrafamilial experiences. The new narratives gradually displace the old in their primacy and salience, and begin to take more of a central role in the stories that the youth tell about themselves. It is not that the past is forgotten but instead that the present and future narratives begin to help push the past narratives some distance away from the everyday experiences of the youth and families.

5. Mutually Supportive Relationships

The extent to which the new relationships can create important bonds can be difficult to describe. The seniors, through their volunteer time and presence in the neighborhood, become instrumental and essential supports to the families in the GHC. The countervailing relationships begin to emerge slowly over time as the youth begin to support the seniors. The seniors face many life course transitions. From the onset of illnesses to the loss of a spouse, seniors in almost every community face challenges of how to “age well.” Aging well in community is an even harder

challenge especially if individuals are facing the loss of friends and neighbors around them that are contemporaneous in age.

This is where the ICI strategy comes to bear on this major social challenge; the youth of a GHC regularly draw on the support of the seniors, and then later are able to provide support to the seniors through keys transitions in their lives [31]. Several seniors at Hope Meadows have faced major medical problems that would have traditionally required intensive nursing care, but through the support of this community they were able to be maintained and cared for during their recovery. In addition, when a spouse dies it is often one of the most traumatic events in an individual's life. Statistics show a very high probability that the remaining spouse will die within one year of the first [32]. The youth of Hope Meadows provide an ongoing purpose and focus for the seniors to continue after the loss of their spouse. Multiple stories highlight these processes, where the youth come to care for, check on and look after the seniors of the community as they themselves go through the life course transitions of adolescence and young adulthood.

Every senior at Hope Meadows will insist that "we are here to help the kids." Few fully realize, however, that as they age and become less able to engage in their usual activities, they continue to provide an important secondary benefit: they offer the children an opportunity to "give back" some of what they have received and feel useful and important in the life of another person. Children who have been neglected and abused, as is the case for most who have come to Hope Meadows, often find it difficult to get beyond their own fears about having their basic needs met. Caring for seniors presents a unique learning opportunity for children – one of profound importance.

The intergenerational social model created in a GHC is essential for the formation of mutually supportive relationships. It provides children ongoing opportunities to engage in the kind of reciprocity so important to their development. It provides seniors with meaning and purpose until the end of their lives. Interdependence, the capacity to enjoy mutual support and caring in relationships can be conceived of as a major component of care and contribution to the well-being of others.

6. Undoing Labels and Creating a New Normativity

Finally, GHCs do the work that no professional or agency can truly achieve - this is the labor of undoing labels and creating a new normativity. Children and youth lose their designations as "foster" or "adopted" children, and simply emerge in this community as children. Families lose their labels as foster, adoptive or guardians, and gain the simplistic notion of being good families. And finally, seniors lose their labels of "retired" and instead find themselves being

called “grandma” or “grandpa” to a host of children who truly see them in these relational roles. The new ICI normativity that emerges eschews the official provider and institutional labels, and instead forefronts labels built from the local social networks that constitute the community.

The use of traditional social service language labels a child as an outsider, as different or perhaps even deviant. For many, the term foster child, for example, suggests that the child is damaged or at fault for his or her foster care status; or that s/he comes from a family that is abnormal, irresponsible, abusive and perhaps criminal. Although the child did nothing to earn the stigma attached to his or her foster status, the tendency to internalize labels is strong. The ICI strategy is designed to normalize life for everyone in the community. Here all children can be children without the burdens of a foster care label or any of the other labels that would serve to exclude them from full family and community life. Community members and staff avoid the use of unnecessary and stigmatizing jargon that sets children and families apart as “the other” and not “one of us.” Words that denote difference, or attempt to label or categorize, are abandoned in favor of more neutral terms; for example, the word person or individual is used instead of ward, client, patient, and case. Better yet, the actual names of people are used. At Hope Meadows the words foster or adoptive are usually avoided. Children or parents are not referred to as foster or adoptive. Children are not placed with foster parents; rather they live with the Smith family. When they are adopted, care is taken to assure that the Smith family is never asked if they have any children of “their own” or if Mrs. Smith is their “real” mother. What does it mean to be a real mother? What makes an adoptive mother any less real? As a result of this conscious effort to normalize language, often new residents, and even many of the children, do not know which children are adopted.

Given every effort to de-stigmatize language in a GHC, language related to place also is normalized. Traditional social service terms such as placement, beds, slots and campus are not used because they (like the label “foster”) impose hierarchy, assign blame, create shame and, by doing so, reinforce existing power inequities. At GHCs, families live in homes in a neighborhood, not in cottages on a campus. These homes are indistinguishable from adjacent houses that are not part of the program, and there are no physical markers to indicate that the neighborhood or the residents are any different from their neighbors. This deliberate effort to normalize the physical setting of GHCs has resulted in a special place. According to Gurwitt, “…there is nothing institutional about Hope Meadows, not even a hint that, in the eyes of the state of Illinois, it is a private ‘facility.’ Because it is not. It is a neighborhood” [33 p.4].

Without hurtful labels, new stories are being written where the children are simply children with the same needs and desires as other children. They are not viewed as “different” or “other.” The

stories that unfold result in memories of inclusion not exclusion, of being cared for not rejected, of friendships and belonging not loneliness and isolation.

Next Steps

To date the ICI strategy has been used successfully for 16 years at Hope Meadows in Rantoul, Illinois with a focus on children adopted from the foster care system. A second site has broken ground in Portland, Oregon to build a GHC for foster children in that region. Other populations that could and should be addressed using this model are: youth exiting the juvenile justice system, homeless and street youth, families facing substance misuse challenges, developmentally disabled youth and adults, and refugees or unaccompanied minors. Simultaneously, it is important to keep in mind that seniors are also a target population of any GHC, and derive significant advantages from living in an intentional intergenerational community.

Next steps involve using intervention and outcomes research methods to examine the various elements of the ICI strategy outlined above. To date most of the data that has been analyzed is qualitative and anecdotal, and there is a need to follow a structured method for analyzing the interactions and effects of the ICI strategy. The challenge in pursing this research agenda is that GHCs employ a complex, multi-layered approach with many component parts and interventions taking place simultaneously. In essence, they must all be studied together to see the full effects that this community has on the lives of its members. The GHC model using the ICI strategy has much promise. As the efforts to replicate the model begin, it is equally important to conduct the research that carefully examines the model as it is being used in communities across the country.

Two broad structural and cultural shifts make this moment one of the best opportunities to examine and more broadly disseminate the GHC model. The recently passed health care reform now opens a set of new possibilities to expand coverage for individuals, but it is equally clear that we need to consider new models of care. Instead of relying only on technology-based medicine, we need to look for ways to leverage local resources, and try to ascertain how to thoughtfully use health care professionals within broader contexts of intervention by and for communities that care for each other. Second, the recent downturn in the global economy has forced people to look at their own communities, and the values that draw them together. The GHC model draws on what works best in our local communities, and empowers them to search for ways to create solutions to some of our most recalcitrant social problems. In this way, GHCs using the ICI strategy can address the mental health needs of some of the most vulnerable children and youth in our communities.

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