# Creating a Service System That Builds Resiliency

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## CONCLUSION

As the concept of the stress resilient child has emerged clearly from careful research, we have arrived finally at a rational approach to the vexing problem of serving high risk youth. It is clear that this nation and the world suffers from burgeoning numbers of troubled youth. Traditional approaches in mental health, juvenile justice, education and social services have largely failed to reach this population. The idea of instilling protective factors and ameliorating risks, by using real relationships with trained mentors, has proven appeal to children and families and promises improved outcomes over traditional approaches.

## The Theory of Risk and Resiliency

During the past 25 years, a number of researchers have completed longitudinal developmental studies of large groups of children growing up in community settings (Garmezy, et al 1984, Rae-Grant, et al 1988, Rutter 1985,l Werner and Smith 1982, Wyman, et al 1991). Within these groups of children, many characteristics of the children and families were examined, and the life course of the child was charted into adulthood. These large studies contained hundreds of children with outcomes varying from successful to extremely poor. In looking at the characteristics of children with different outcomes, the researchers have identified consistent risk factors which are often associated with the development of negative outcomes, such as school failure, psychiatric illness, criminal involvement, vocational instability, and poor social relationships later in life. The risk factors which have been repeatedly identified are presented in Table 1.

### TABLE I:

### PSYCHOSOCIAL RISK FACTORS

| A. IN THE CHILD | B. FAMILY CHARACTERISTICS | C. FAMILY/EXPERIENTIAL |
|---|---|---|
| *Fetal drug/alcohol effects* | *Poverty* | *Poor infant attachment to mother* |
| *Premature birth or complications* | *Large family, 4 or more children* | *Long term absence of caregiver in infancy* |
| *"Difficult" temperament* | *Siblings within 2 years of child* | *Witness to extreme conflict, violence* |
| *Shy temperament* | *Parent with mental illness* | *Substantiated neglect* |

| | | |
|---|---|---|
| *Neurologic impairment* | *Parent with substance abuse* | *Separation/divorce/single parent* |
| *Low IQ <80* | *Parent with criminality* | *Negative parent-child relationship* |
| *Chronic medical disorder* | | *Sexual abuse* |
| *Psychiatric disorder* | | *Physical abuse* |
| *Repeated aggression* | | *Removal from home* |
| *Substance abuse* | | *Frequent family moves* |
| *Delinquency* | | *Teen pregnancy* |
| *Academic failure* | | |

Risk factors do not invariably lead to problems in the lives of children, but rather increase the probability that such problems will arise. In studying a multicultural group of children in Hawaii, Werner (1982) found that for a child to have four or more risk factors substantially increased the likelihood of later negative psychosocial outcomes. Interestingly the studies show that it is less significant ***which*** risk factors are present, but ***how many*** are present in life of a child. This suggests that when these risk factors accumulate in the life of a child, there is a tendency towards the whole range of negative outcomes, regardless of which specific risk factors are operative. It follows that the damaging effects of multiple risk factors apply across gender, race, culture and disability category. This is supported by studies in a variety of socioeconomic and demographic populations.

Many of these risk factors have been known for many years to lead to a variety to poor life outcomes. For example, low socioeconomic status (SES) is strongly linked to poor psychosocial outcome. Likewise, substance abuse or specific psychiatric illnesses have well-studied natural histories and devastating effects. What is less obvious, and has been studied only more recently, is that a certain number of children have successful outcomes in life, despite having many of these risk factors. These survivors of risk are labeled "resilient" children. In studying resilient children and their families, researchers are beginning to identify important features which seem to confer protection against the poor outcomes usually associated with living with many risk factors. These so-called "protective factors" protect no matter what the child's diagnosis, disability, or experiential risks. Studies also show that the greater the number of risk factors a child possesses, the greater number of protective factors he or she needs to promote a positive outcome.

Specific protective factors have been repeatedly identified by different studies of resilient children. Garmezy (1984) noted that protective factors seem to fall into three general categories: qualities of the child, characteristics of the family, and support from outside the family. The specific protective factors identified in various studies are listed in Table II. Note that some protective factors, such as "easy" temperament type or secure infant-mother attachment, constitute the opposite extreme of corresponding risk factors, while many children fall somewhere in between.

**TABLE II**

## PSYCHOSOCIAL PROTECTIVE FACTORS

| QUALITIES OF THE CHILD | FAMILY CHARACTERISTICS | SOCIAL SUPPORT FROM OUTSIDE THE FAMILY |
|---|---|---|
| *Positive, "easy" temperament type* | Lives at home | Adult mentor for child outside immediate family |
| *Autonomy and independence as a toddler* | Secure mother-infant attachment | Extra adult help for caretaker of family |
| *High hopes and expectations for the future* | Warm relationship with a parent | Support for child from friends |
| *Internal locus of control as a teenager* | Inductive, consistent discipline by parents | Support for child from a mentor at school |
| *Interpersonally engaging, "likable"* | Perception that parents care | Support for family from church |
| *Sense of humor* | Established routines in the home | Support for family from work place |
| *Empathy* | | |
| *Perceived competencies* | | |
| *Above average intelligence, IQ>100* | | |
| *Good reader* | | |
| *Gets along with others* | | |
| *Problem solving skills in school age* | | |

As study after study recognizes these same risks and protective factors, researchers are calling for clinicians and service systems to shift from traditional approaches to establish new intervention efforts to prevent risks and promote protective factors (Rutter 1987, Werner 1989, Offord 1992). Pilot programs which pursue this direction show promise. For example, school-based programs teaching social skills and problem-solving can at least temporarily improve the functional level of high risk children (Shure and Spivak, 1988). Also, programs in intensive probation, which essentially allow mentoring of juvenile offenders by probation workers with low case loads, have lower rates of recidivism. Further, in-home support services, such as Family Preservation programs and in-home outreach child abuse prevention programs, capitalize on promoting goals which serve as protective factors against risk. Recent evaluations of the big Brother/big Sister program of mentoring high risk youth show significant improvements in school attendance, decreased entry into substance abuse, and improvements in family relationships, with decreased behavioral problems overall (Tierney, 1995). Such pronounced positive effects outstrip many of the traditional treatment efforts of mental health and delinquency rehabilitation. Despite these successes, many

human service delivery systems remain oblivious to targeting interventions directly to reduce risk by promoting protective factors.

## Building a Comprehensive Mental Health System Based on Promoting Resiliency

It is not entirely certain that high risk children and families can improve functioning simply by "forcing" protective factors on them. After all, the resilient children of the previously mentioned studies were naturally resilient, enveloping protective factors without the assistance of human services agencies. While a naturally resilient child may have the social skills to engage a caring adult to serve as a mentor, another high risk child may be more likely to evade or reject caring adults who seek to mentor them. Nonetheless, the experience of field workers with high risk youth reveals that the children and families who do manage to improve their lot do so by the acquisition of some of the above-mentioned protective factors. Occasionally, the turnaround is seen as a direct result of the determined intervention of our service system, but is probably more often a result of natural forces in the child or family's life. To the extent that a service system can duplicate the growth of protective factors in the lives of high risk individuals, it can also expect to improve long range outcomes. In order to take a true "strengths-based approach" to treatment, the ideal mental health system should go beyond disability and diagnosis-specific approaches, and actively assess and promote protective factors. In this way, the general psychosocial benefits of acquiring protective factors would augment traditional therapies.

Any overview of traditional public sector mental health services makes it immediately clear that many interventions fall short of meeting the needs of high risk children. For example, weekly clinic-based individual or family therapy, group therapies, and structured treatment programs are often under-utilized in the absence of providing in-home supports or one-to-one mentor relationships, which could facilitate access to such services. The traditional behavioral modification approaches used so widely in special education and mental health programs most often fail to generalize to the child's natural environment, and are therefore probably less important than building competence and confidence, or providing a child with an enduring relationship with a caring adult. Family therapy should provide real logistical support to overwhelmed parents, foster positively in parent-child relationships, and assist in the development of household consistency. The many problems of high risk children and families frustrate our traditional techniques of therapy and service delivery, but where resiliency theory is applied to deliver know protective factors, we can begin to see positive outcomes in the lives of people who are otherwise difficult to serve.

It should be noted that existing mental health programs are clearly helpful for lower risk children. For families who are able to regularly access services and have either motivation for involvement, or children who are easily engaged, traditional systems of care are at least effective, if not widely available. Viable service options for moderate and low risk children will be discussed, but differ little from well-known models of mental health care continuums. It is the persistent inability of traditional systems to adequately serve high risk children and families which is discussed in detail. Described below is a model of a child and family mental health system based on a full assessment of risk and protective factors, and targeted interventions aimed at promoting resiliency in high risk populations.

## Initial Assessment In A Resiliency-Building System Of Care

Traditional admission assessment tools serve to direct treatment services towards specific disability groups. This approach has limited utility in high risk children and families because conventional mental health treatment plans do not account for the myriad of treatment obstacles existing in such families. By including a full resiliency assessment which characterizes not only mental health issues, but a broad range of known psychosocial risk and protective factors, a more sensible treatment approach can be implemented. Beyond making a specific diagnosis, an assessment of all the factors relevant to resiliency allows treatment planning to address ongoing risk factors, identify existing strengths, and build protective factors where they are lacking. The Brief Resiliency checklist, or BRC, (Sanchez and Vance, 1995) is an initial assessment instrument designed to inventory all of the significant risk and protective factors in a child and family, for planning and monitoring purposes.

This assessment technique results in classification of levels of risk in a child and family. A low risk child can be best characterized as an individual whose protective factors outweigh risk factors. This individual's presenting problems are likely mild or episodic, and with short-term counseling or therapy he or she will likely be able to overcome the problem in a relatively short time. This child has sufficient skills, social support, and mentors in his/her life, as well as a home environment which is safe and nurturing. Compliance and follow-through with conventional treatment recommendations are likely.

A moderate risk child can be characterized as an individual with a slight net risk score, but considerable protective factors to work with. This child has sufficient protective factors that he/she could benefit from, if mobilized, and can probably be maintained in a community-based treatment program. Also, this child may have within his/her natural support system individuals with whom they already have a trusting relationship ;who can serve in the mentor role. Natural mentors may be enlisted for training or support if desired. Their living situation usually has enough strengths that it can be both maintained and strengthened by promoting additional protective factors.

A high risk child is a child whose risk factors greatly outweigh his or her protective factors. Traditionally, this child either does not benefit from or does not access traditional psychotherapy, nor can he/she successfully access and/or be maintained in most treatment and community based program alternatives. For these individuals and their families the most productive form of treatment can be provided through mentor figures and intensive outreach. However, since this profile does not bond easily with others, a paid mentor may be key in beginning the treatment. In addition, since many of these children come from chaotic environments, providing safe and therapeutic residential options are also an essential aspect of treatment. Assertive outreach is absolutely required, with a need for in-home services.

The impact of viewing children from a perspective of their relative resiliency will have direct implications in determining treatment strategies and interventions identified for each child. Resiliency theory suggests that certain services have a greater chance of success based on promoting protective factors to buffer against the risk factors. Traditionally, mental health service systems have prescribed psychotherapy or traditionally accepted configurations of services to the high risk population only to discover that the child and his/her family have problems accessing these services in a consistent manner. As a result, much effort goes into making a plan that quickly fails. Therefore, by prescribing treatment based on an individual's specific risk factors and

delivering this treatment with outreach by mentors, useful services can be assertively delivered in a more cost effective manner. When traditional clinic-based psychotherapy is effective, it is usually because a child and his/her family are low to moderate risk, and therefore able to internalize the information obtained in treatment. Those who are high risk are far less adaptive and therefore, by identifying the specific treatment services most likely to be effective with high, moderate, and low risk children, one can reduce making inappropriate referrals, better target treatment goals, and truly develop a more appropriate continuum of services. (See Table III)

**TABLE III**

**TREATMENT SERVICE OPTIONS BY RISKS CATEGORY**

| **LOW RISK:** | **MODERATE RISK:** | **HIGH RISK** |
|---|---|---|
| *Individual therapy* | *Case management* | *Secure residential* |
| *Respite services* | *Family preservation* | *Paid mentors for child and/or family* |
| *Family therapy* | *Sex abuse treatment* | *Residential outdoor camp* |
| *Family training sessions* | *School-based crisis stabilization* | *Therapeutic home* |
| *Parent support groups* | *Volunteer mentor* | *Respite services* |
| *Client support groups* | *After school program* | *Intensive team* |
| | *Community-based recreation* | *Day treatment* |
| | *Vocational services* | *Crisis services* |
| | *Individual therapy* | *Clinical oversight* |
| | *Family therapy* | |
| | *In-home parent training* | |

**The Role of Mentors for High Risk Youth and Families**

The role of the mentor is crucial in this approach to treating high risk children. This approach capitalizes on existing outcome studies that have placed a high premium on the impact of an adult mentor on children with multiple risks. One of the consistent findings in studies of resilient high risk children is that those who did well nearly always had a long term relationship with a caring adult outside the immediate family to provide support and guidance (Werner 1982). High risk children have difficulty in cultivating relationships and internalizing protective factors through traditional methods such as psychotherapy, mentors become crucial to providing successful treatment. When asked, most high risk children say they prefer relationships with mentors to those with helping professionals. With proper clinical supervision and specific strategies for promoting protective factors, a trusting adult relationship can be maximized to deliver treatment in a way that is more acceptable to this population. Likewise, most high risk families which produce resilient children

have some support from outside the family; from adults who helped in child rearing, respite, and provided other social support. Therefore, much of what we hope to "deliver" to high risk kids and families should be done by clinically supervised, paraprofessional mentors.

It is quite often the case that high risk youth have serious mental health needs that could benefit from interventions such as medications, individual or group therapies. It can be exceedingly difficult to persuade and engage these children and families to accept services. One important role of trained mentors is to attempt to link their clients to such services as needed. This function may range from ensuring medication compliance to transporting to appointments or support groups. Careful and frequent clinical oversight must be provided to mentors to provide guidance, strategies and support in this difficult job.

In order for this approach to work in the public sector, there must exist a large pool of personnel who could be clinically matched to a child or family, to act as mentors and instill protective factors into a child's life in daily interaction. The key to these interactions is the existence of a sustained relationship over time that can allow the child to internalize the skills of getting along with others, conflict resolution, empathy, hopes for the future, and other protective factors. Implementation of mentioned care requires that mentors be trained, clinically supervised, and adequately compensated. This compensation must be geared to motivate longevity with the child through incremental increases in pay or periodic bonuses based on years of service with a high risk.

In addition, a separate family support mentor can also be identified to work with the families of at risk children. The role of the family support mentor is to work in the home to promote the specific protective factors which have been identified in the families of resilient children (See Table II). Family Preservation programs have been building key protective factors into high risk families for years. By using the mentor approach with families, one can address a child not only individually but also within his/her most crucial environment. In the same manner that high risk children are resistant to traditional disability based treatment services, their families are often equally resistant to participating in these same programs. The mentor has the advantage of being able to build a relationship through being identified as an outreach support to the family's daily function. Note that resiliency studies show that great protection is provided for high risk families by the simple support of an outside adult to give help in child care and household functioning. Protection can also be provided by promoting positive attachments, setting up household routines and training parents in positive discipline. In the context of a caring relationship, in home mentors should also be trained to identify special needs in the parents, and encourage high risk parents to build their own self-esteem intensive training, natural skills, and clinical supervision.

## The Role of Clinicians in a Resiliency-Building System of Care

In working with high risk populations, a clinician rarely has the luxury of conducting regular psychotherapy except in highly restrictive settings, where there is a "captive population." It is far more common for clinicians to be frustrated by canceled appointments, no-shows, or "resistant" children and families. Further, there is little evidence to suggest that intensive psychotherapy is beneficial to very many high risk children. The net result is that traditional clinical efforts with high risk children are highly inefficient.

In a system based on fostering protective factors, clinicians play a vital role in diagnosis, resiliency assessment, training, supervision, and consultation. Initial assessment of a child's risk factors, protective factors, and biopsychosocial formulation will be guided by clinical expertise. An understanding of how specific risk factors demand targeted protective interventions is required knowledge for clinical oversight. Each mentor for a child or family should obtain regular ongoing clinical supervision for devising strategies and receiving clinical support for their activities. In situations where brief, directed psychotherapeutic interventions or medication are required, mentors would facilitate logistics and engage in persuasion of resistant children or families to use the clinicians.

This approach allows the team clinician to conduct therapy sessions only with children for whom the service is appropriate. The emphasis is no longer on providing psychotherapy to all identified patients, many of whom have a low probability of success, but rather to provide clinical consultation, education, and training to mentors and parents who are spending considerable hours with the child. This modification to the clinician's role will expand the productivity of the service system, in that it will reduce the high number of canceled appointments while allowing the clinician to provide a greater number of training's and consultations in the group modality. In addition, the clinician will be able to supervise the daily treatment of a greater number of clients through assigned mentors. This strategy will also be fiscally sound because most clinical psychoeducational activities and paraprofessional services are billable under public reimbursement programs. Therefore, while clinicians once could only manage a small caseload for individual and family therapy, they can now clinically manage a larger staff of mentors while improving the quality of care.

## General Interventions for Treatment

It is readily apparent that the interventions directed by a risk/resiliency model will be primarily the promotion of protective factors in high risk children and their families. Clearly, the effects of caring relationships in particular can have wide-ranging, positive impact on high risk clients. The important roles of mentors and clinicians have been clarified. In order to sensibly guide specific interventions, risk factors must be somewhat understood with respect to their mechanism of risk. In other words, how do specific risk factors create the problems that they do?

The research indicates that the specific risk factor is less important than the total number of risk factors. Despite this, risk factors seem to fall into general categories, much like protective factors (see Table II). It is also clear that certain risk factors dictate specific interventions, for example certain medications for psychiatric illnesses, etc.

In looking at Table I, all of the risk factors can be seen to be related to general risk areas: neurobiologic, social-relational problems family instability, lack of family attention or social drift. It becomes clearer now that the areas of protective factors in Table II are well suited to counter the mechanisms of risk in the general risk areas. For example, developing social skills will impact on social/relational problems. Enhancing family risk areas. For example, developing social skills will impact on social/relational problems. Enhancing family function will counter family instability. Developing competencies and confidence will decrease social drift. Providing social support will temper the effect of lack of family attention. Neurobiologic disadvantage will sometimes respond to

medical/psychiatric intervention, but often must be addressed by enhancing other protective factors. The general impact of protective factors on risk factors is seen in Figure I.

**FIGURE I**

**IMPACTING ON RISK: PROMOTING PROTECTIVE FACTORS**

| Risk Factors | Vehicle for Change | Protective Factors |
|---|---|---|
| Social/Relational Problems | Mentors<br>Clinician | Social Skill Enhancement |
| Social Drift | Mentors<br>Teachers | Competencies/Confidence |
| Family Instability | Mentors<br>Clinician | Family Enhancement |
| Lack of Family Attention | Mentors<br>Clergy<br>School<br>Employer<br>Extended Family | Social Support |

## Specific Treatment Interventions

As described and diagrammed above, general areas of risk can only be impacted by the promotion of protective factors. These protective factors must be delivered to the child and family by designated adults, committed to helping over an extended period of time. Much of the failure of services to high risk children results from the mistaken belief that they can respond to brief, intensive interventions as low and moderate risk children can. Relapses to poor outcome often occur when a seemingly "stable" child is dropped from someone's caseload, or staff turnover occurs, disrupting a developing relationship with the child. It is only by building trust into a relationship overtime that specific protective interventions can be accomplished. This reality requires the system to have incentives for longevity in working with high risk children and their families.

The role of the mentor in providing support for the child and for the family has been described above in general terms. It is evident from research on high risk children and families that they prefer informal and personal attachments to impersonal interactions with agencies (Werner, 1992). The goal of service agencies then becomes the location and enhancement of a child or families' informal supports, or the direct provision of such support in as natural and personal a manner as possible. Specific interventions for mentors, either natural or agency-based, are described in detail below.

## DEVELOPMENT OF TRUST

As noted in the discussion of risk factors, and well known to workers with high risk children and families, the breakdown of positive social interactions in the child and family has devastating effects on the development of helpful relationships. Hostility or apathy can prevail, resulting in chasing others away, or causing them to give up. This is the first and most important obstacle to overcome, or all other attempts at intervention will likely fail. Simply put, the development of a trusting relationship involves not being scared away or giving up on a particular family or child. The effort usually involves repeated visits, rejecting rejection, creative ways of offering assistance and stubborn determination. While this often results in frustration, the aspiring mentor must understand that trust comes hard to high risk children, mainly because trust has been broken with them so often. Nearly every child or family, when faced with the inescapable caring of a person who will persist through thick or thin, will eventually come to accept a mentor's help.

## BEYOND TRUST WITH THE HIGH RISK CHILD

Once a trusting relationship is established with a child or family, a number of protective factors can be promoted. These protective factors vary depending on the age of the child, the nature of the family and what specified risk factors are present. Nonetheless, the mentor-child relationship remains a place where valuable, protective lessons can be learned. (See Figure 2).

## FIGURE 2

## INTERVENTIONS FOR A CHILD'S MENTOR

By building a trusting relationship over time, a child's mentor can affect:

- Interpersonal Problem Solving
- Empathy Building
- Getting Along with Others
- Increase "likeability"
- Develop competencies
- Sense of humor
- Broaden social supports
- Internal locus of control
- Positive hopes and expectations
- Facilitate clinical interventions
- Crisis support

Within the relationship of mentor and child, conflicts will naturally arise in the course of shared experiences. Resolving an interpersonal conflict involves problem solving skills and coming to understand the other's feelings; the development of empathy. Mentors should be trained and supervised in the art of conflict resolution which can then be taught to the child to enhance his/her ability to get along with others, another important protective factor.

Mentors are challenged to notice and reinforce "likable" behaviors, competencies, and sense of humor. Noticing these, pointing them out to the child, and modeling them will result in the growth of these protective factors. Developing these skills will result in more positive social interactions and growth of a child's social support network.

Sharing emotional experiences serves to strengthen any relationship. Mentors are asked to share and create emotionally charged experiences with each high risk child in order to strengthen the attachment. Crisis intervention by the mentor offers the opportunity to teach problem solving and repair important relationships. It also allows the mentor to show the child that he/she is in control of his/her impulses and decisions; that there are choices in life. This is critical to developing a sense of internal focus of control, or control over one's destiny.

Activities which seem simple may provide great opportunities to instill protective factors. Helping a child to develop competencies such as reading skills, basketball or fishing can build his/her confidence while sharing positive emotional experiences to strengthen the relationship. By noticing and pointing out to the child his/her growing abilities, the child begins to perceive competencies and develop skills for a lifetime. It is often within the setting of competency building experiences that hopes and expectations for the future arise. Anything from homework to yard work can be shared and used as a competency builder. Activities can be used as a way of interacting positively with peers and gaining friends and self esteem. Finally, acquiring a competency can demonstrate to a child that they have the power to change themselves; that they have an internal locus of control.

Helping a child or family to identify and accept the problems they need to work on is an important role of the mentor. This will sometimes involve breaking through denial, stressing the relationship. If it serves to eventually lead to problem-solving together, the relationship is enhanced.

In reality, these are the very processes which occur naturally for children who are lucky enough to have a caring adult mentor in their lives. Through development of trust, navigating through crisis, sharing positive experiences and providing good counsel, children are steered towards positive outcomes. As mental health providers we can supply mentors to high risk children in an attempt to duplicate the natural mentoring process.

## Mentors in the Family

One of the most important functions of agency-based mentors is to become acquainted with the high risk family. Aside from the need to promote protective factors in the family, this allows the mentor to understand literally "where the child is coming from," and why he/she may be the way they are. At times the child's mentor may be able to intervene directly to help the family, or an

additional "family support mentor" may be needed. Within very little difference, the same process of trust building must occur with the family as occurs with the high risk child. (See Figure 3).

## FIGURE 3

## INTERVENTIONS FOR A FAMILY SUPPORT MENTOR

By developing a trusting, helping relationship over time, a family mentor may help:

- Provision of Help/Support
- Improve Parent-Child Attachments
- Increase Parental Warmth
- Establish Household Routines
- Teach Positive Discipline Practices
- Broaden Social Supports
- Facilitate Interactions with Agencies
- Provide Crisis Support

Trust building with a family often starts immediately as some burden of responsibility is lifted when a child's mentor begins to "lend a hand." Remember that a significant protective factor for high risk families is the simple provision of extra help for the primary caretaker in the family. If a family support mentor offers some "real" help in child care, transportation, household duties, etc., it begins to ease the stress on overburdened families. Again, little else can be done with a high risk family until they come to trust and see a mentor as truly helpful.

Once a relationship is established with the family, other protective factors can be promoted. Parent-child attachments and warmth can be improved by helping parents to see the positive in a child, and helping to create mutually enjoyable activities. Mentors should be trained to notice and comment on opportunities for parents and children to see positive features in each other. Many parents of high risk children are simply too stressed or never were taught to be positive, warm parents. In a real way, the family support mentor's role is to teach parental competence.

Important protective factors also include the establishment of consistent household routines and discipline in the family system. These functions have been taught by in-home family workers for many years. Establishments of routines, children's chores and predictability in the home are challenges that can only be met if adequate support and oversight are provided by the family support mentor. It should be understood that simple interventions, such as a regular dinnertime and minimal household chore expectations can have a dramatic positive impact on high-risk homes. Again, it is unlikely that brief interventions will have lasting impact. It will involve a long term relationship with the family to assure the benefits of this protective factor.

Consistent and inductive discipline practices are often absent from high risk families, and if parents can be taught certain techniques it will confer protection on their children. Inductive discipline involves the agreement of the family as to what rules are necessary for the family and what are reasonable consequences for breaking the rules. Inductive discipline also allows for flexibility in given situations to account for compromise and discussion.

Consistency arises from the predictable use of consequences and clear expectations over a period of time. These techniques are well known to in-home workers and would be enforced by family support mentors.

Family support mentors, like child mentors, must be available to families in crisis. It is in crisis that the most can be learned about prelims in the family's function, and the greatest opportunities for change arise. Identification of specific problems such as substance abuse or psychiatric illness can lead to referral, by the mentor, of the family member to appropriate services.

## ENLISTING SOCIAL SUPPORT

The ultimate goal of any social service intervention is to promote self-sufficiency. Likewise, a primary goal of child and family support mentors is to work to identify natural mentors and support systems in the community. For high risks populations, natural supports such as extended family, friends, school personnel, churches, and employers will likely need a degree of guidance and oversight by agency-based mentors in how best to work with a given family. There are real reasons why such social supports didn't arise on their own; the tendency on both sides is to reject or give up. Mentors will persist in promoting the support of these natural social contacts, because the protective benefits can be tremendous for the high risk family.

## OTHER APPLICATION OF RESILIENCY THEORY:

There is mounting evidence in a number of intervention/prevention programs that high risk youth respond to strategies which provide or instill protective factors. Programs providing mentors for at-risk children (Big Brothers, intensive probation program, Communities in Schools, and others), are achieving predictable success. It is not surprising that such programs have a positive effect on children, many of whom are from single parent homes with absent father-figures and overburdened mothers. Simple provision of attention and caring by an adult is likely to be of help. While much of the role of these mentors is intuitive, and emerges naturally in the relationship with the child, it would enhance the function of mentors to focus their interventions in the realm of known protective factors.

Intervention and prevention programs which have targeted known protective factors are showing great promise. Interpersonal problem solving instruction is known to decrease aggression among school children, probably by enhancing problem solving skills and increasing the child's ability to "get along" with others. Peer mediation and other conflict resolution approaches, now being applied in schools and community settings, are showing promise by teaching these same skills to older children. A number of successful recreational, fine arts, and scholastic enhancement programs seem to be delivering competencies to high risk children, thus conferring protection to enhance psychosocial functioning.

Despite the widespread and growing use of such interventions, it is not clear that they are guided by a full appreciation of resiliency theory. For example, mentors could go beyond providing a supportive relationship to teaching humor, empathy, helping the child to create a vision of their future, or tutoring in reading. While these skills seem far removed from the issues which brought the mentor and child together, it is like that they would serve to protect the child. Mentors should be

aware of the range of protective factors which would likely be of most use to a child and family, and focus the work accordingly.

It is well known that high risk children often tend to be involved with multiple agencies. Working in the public sector reveals that children most at risk have mental health problems, court involvement, social services needs, school problems and even medical health needs. Focusing the interventions of all these agencies on instilling protective factors is a practical approach that would clarify the efforts of agencies and avoid duplication of services. Clearly, depending on the particular child, the expertise or experience of a mentor might best be enlisted from mental health, juvenile justice or other background. For example, what better mentor for a child with sickle-cell anemia and other risk factors, than a mentor who has coped with a chronic illness in their own life? Likewise, many court-involved youth view their parole officers as mentors. The tasks of such mentored relationships should remain focused on the development and tribulations of the relationship, and instilling known protective factors.

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