

A Conceptual Framework for Service Planning for Children and Families

**Children's Board
of Hillsborough County, Florida**

Children's Board of Hillsborough County Board of Directors

Leo Diaz, Ed.D., Chair

The Honorable Carolyn Brickley, Vice Chair

Charles "Chip" Taylor, Treasurer

The Honorable F. Dennis Alvarez

The Honorable Colleen Bevis

Earl Lennard, Ph.D.

The Honorable Larry Lumpee

Robert Nixon, Ph.D.

The Honorable Jim Norman

The Honorable Francis Williams

by

Deborah Ruggs, Ph.D.
Marty Coulter, Dr. P.H.
Luanne Panacek, Ed.D.
William Stone, M.S.

Section I

Introducing Resiliency Framework

The Children's Board of Hillsborough County (CBHC) began this document with a desire to develop a user-friendly publication to describe the resiliency framework theory. The Children's Board offers this document as a guideline for the planning and delivery of children's services. The framework was developed for the community of caretakers with the intent of assisting them in favorably impacting the lives of the children and families of Hillsborough County.

Why Do This Project?

In the past, there was an emphasis on collecting risk data, for example: 22 percent of all children under the age of 6 in Hillsborough County were born into poverty; 16 percent of non-white babies in this county die before age one (Kids Count 1994).

More recently, there has been a shift toward recognition of strengths, assets, or protective factors in planning and service delivery. Some of the most promising programs have shown that change toward more favorable outcomes is possible to achieve on a county-wide basis. From the Healthy Start program, which began tracking infant mortality in Hillsborough County in 1990, we have learned that:

- There has been a decline in child deaths from 1992 to 1994.
- Similarly, low birthweight infants have shown a decline since the Healthy Start program went into effect in 1992.

County data collected from The Spring, a Hillsborough domestic violence center, has shown a dramatic reduction in Hillsborough domestic homicides.

In 1994, The Spring joined forces with city and county police, judges and the State Attorney's office to address the problem of domestic homicides.

- In 1994, 34 countable domestic homicides were reported in Hillsborough County.
- In 1995, 20 domestic homicides were reported in Hillsborough County.
- As of December of 1996, only six domestic homicides were reported for Hillsborough County.

Goals

By promoting the use of a resiliency framework by the community of providers, the Children's Board hopes to achieve the following goals:

- Unite the community of caretakers through the use of a common philosophy for understanding and planning for the needs of children and families.
- Build community capacity by promoting consensus on a set of outcomes understood by the community.
- Help families and children develop their full capacity by supporting them while allowing them to help themselves.

Resiliency Framework in a Nutshell

Resiliency framework has arisen because other theories failed to account for all of the data and other observations of human behavior. For years, researchers have tried to account for how children who grow up in the same or similar environment could be so different; how children exposed to the same risk factors could have different outcomes; and what factors placed children at risk.

Resiliency is the potential for youth to develop into healthy, productive, competent adults despite experiences of severe stress and adversity. It is a quality that characterizes children who, though exposed to significant stress and adversity, do not succumb to the failures predicted for them. It has been defined as the innate, self-righting mechanism within every person that is engaged in active, on-going adaptation to his or her environment. Other terms for resiliency are positive coping, persistence, adaptation and long-term success despite adverse circumstances.

The framework is systemic in that children are part of families and should be treated in the context of a family setting. Systemic in that services, programs and communities compose a network of care addressing nutritional, health, mental health and social welfare needs, with each component affecting the productivity of all other components. Families enter the system arbitrarily. They come to a place to get a specific service, but families and children have multiple needs that extend beyond the program providing the point of entry to the system.

The Components of Resiliency Theory

The resiliency framework is composed of several key components. The four components are as follows:

Developmental Process is a systematic approach to gaining knowledge about human beings. Human life span is seen as fluid and changing. Needs and crises may vary predictably depending upon the developmental stage of the individual.

Outcomes are goals by which progress is measured. They serve as a catalyst for individual, family, and community change.

Risk Factors are factors associated with poor outcomes. They threaten or prevent positive outcomes within a child, family or community.

Protective Factors are factors that are associated with positive outcomes. These factors serve to diminish the impact of stress and generate growth. Protective factors may be internal to the child, such as personality characteristics; family strengths, such as a one-on-one mentoring relationship between a parent and a child; or community-based, such as the presence of a strong neighborhood association.

The next section covers each component in detail. The third section defines specific examples of risk and protective factors based on developmental stages.

The framework is systemic in that children are part of families and should be treated in the context of a family setting.

Defining the Components

Developmental Process

Families' needs are different when their child is a newborn versus an adolescent. A developmental perspective allows us to look at the risks and potential protective factors that are specific to various stages of growth. When examining resiliency from a developmental perspective, several concepts are extremely useful. (Staudinger & Baltes, 1993)

Multi-directional Development Children develop physically, cognitively, emotionally in predictable stages. These areas of development, called domains, can be characterized by gains, losses or stability. The growth within each domain may or may not keep pace with the other domains. For example, a child may be physically mature yet cognitively slow, or cognitively normal yet emotionally immature.

Plasticity The range and limits of development are partly determined by genetics but actual development may vary depending upon an individual's experiences. Plasticity refers to the change potential of individuals that can be determined by internal and external resources. This is sometimes referred to as an indicator of adaptive abilities.

Reserve Capacity An individual's current potential to develop in any domain refers to his or her baseline. Resources can be increased at any developmental stage thereby increasing the probability that further resources will be taken advantage of at future developmental stages. This self-perpetuating motion is referred to as reserve capacity. Developmentally, it is increasing resources, thereby increasing performance, which in turn may increase resources and so forth. Individual interventions or resources have the potential to increase through development or range of plasticity, hence, the effect of rising above any genetic or environmental limits. In essence, this is the theoretical definition of resiliency.

Outcomes

Outcomes are defined as positive measurable goals. Outcomes can sometimes be confusing. C. Bruner likens outcomes to various snapshots of child and family well-being. But the problem with snapshots is... "Each snapshot may suggest a potential solution. At best, however, this is akin to deciding as a group to purchase an automobile by each group member taking responsibility for buying an individual part...which is much more expensive than purchasing the whole automobile, and still requires someone to assemble it, and risks having parts ordered by different people that do not fit together." (Bruner, 1993)

Similarly, community goals or outcomes can often be confused with individual program goals. Using Bruner's analogy, program goals are the individual parts that fit together to form the community outcomes. It may take multiple programs to achieve one desired community outcome. For example, if the community outcome is a decrease in early infant mortality or an increase in healthy births, specific program results may focus on prenatal care, teen births, births to mothers with low education, births to unmarried mothers, substance use during pregnancy or any other results that add up to increased

Plasticity refers to the change potential of individuals which can be determined by internal and external resources.

Typically, when referring to outcomes, the Children's Board is referring to community outcomes.

overall infant health.

Typically, when referring to outcomes, the Children's Board is referring to community outcomes. Looking at community outcomes is one way that the Children's Board can gauge its own impact on the community.

Establishing a mutually agreed upon set of community outcomes is central to mobilizing a community and requires several considerations. First, there must be a core group of involved stakeholders, a critical mass of individuals who have the power and influence to make relevant decisions. These stakeholders must be committed to reform and have sufficient standing in the community to keep all interested parties informed of decisions. Because outcomes can range from client satisfaction to number of child deaths, these stakeholders must take responsibility for achieving an agreed upon list of achievable outcomes.

Outcome planning is a new focus for most governing bodies. It is a switch from measuring inputs to rewarding outputs. "Organizations that measure the results of their work...even if they do not link funding or rewards to those results...find that the information transforms them," or, "What gets measured gets done" (Osborne & Gaebler, 1992).

Once a set of outcomes is agreed upon, governing bodies are freed up to focus on steering toward the goal. Failure is recognizable and, therefore, more easily corrected. Results can be demonstrated to the public.

There are many different reasons why individual agencies are reluctant to measure their own performance based upon outcomes. Some of those reasons have to do with the difficulties of measurement. Other reasons have to do with apprehension of negative publicity and results. What evaluators have learned from experience is that rarely does the measurement of outcomes involve only one outcome and results are typically mixed, often referred to as strengths and weaknesses.

Fostering Resiliency

When offering services to families in need, interventions that are most effective work on eliminating risk while, at the same time, promoting and building on protective factors. The two strategies, reducing risk and increasing protective factors, require different delivery tactics. It is important to remember that resiliency is a capacity that develops over time as a result of child and environmental interactions. Some interventions, whether aimed at reducing risk or increasing protective factors, are building developmental capacity to interact with the world in a positive and competent way.

One example of looking at risk and protective factors in a real situation is the physical health of a child. Whooping cough is a risk to most children. However, there is a widely distributed immunization for this disease. This is the protective factor. A more complex example is single parenting as a risk factor. Single parenting may be a risk factor for a variety of reasons. Some of these may relate to stresses on the parent/child relationship. While one approach to the issue might be to encourage women to delay childbearing until there are two parents involved, another might be to help encourage fathers to be involved with their babies. Therefore, the relationship between the single parent and the child can be strengthened, adding a protective factor.

Risk Factors

Risk factors are associated with negative outcomes and have been previously identified in the literature. Having four or more of these stresses or risk factors in a child's life substantially increases the likelihood of negative outcomes. Examples of risk factors or stresses are:

- Poverty
- Poor infant-mother attachment
- Difficult temperament
- Parental instability
- Parental substance abuse
- Negative or non-existent parent-child relationships
- Out-of-home placement
- Neglect and abuse
- Violence

When resiliency was first studied, it was founded on research of the development of medical or psychological pathology. Researchers focused on which childhood disorders developed as a result of biological or psychological deficits in an individual's environment. Resiliency was created as a theory when attempts were made to explain the absence of pathology in individuals who thrived when deficits in the environment still occurred.

Protective Factors

Researchers have documented three areas of resources that contribute to resiliency. These are the individual child, the family and the larger social environment or community.

The Individual

Resiliency studies have examined individual personality factors which protect children at risk. The most commonly identified factors are:

Social Competence The ability to establish and maintain positive, caring relationships, maintain a sense of humor and communicate compassion and empathy. This also includes the ability to find an environment that supports one's own development, such as a church group, youth group or friend. As a young infant the child who exhibits an easy temperament is more appealing to adults, which leads to more positive attention.

Problem-solving Skills The ability to make decisions, solicit help from others and recognize alternative ways to solve problems and resolve conflicts.

Autonomy The ability to act independently and exert some control over one's environment. This also includes a sense of identity and detachment from others who exhibit risky or dysfunctional behaviors.

Belief in Future The ability to see a bright future for oneself, to be optimistic and to set and work toward educational and personal goals is perhaps most critical of all the internal resources listed.

*...four or more ...
risk factors in a child's
life ... increases the
likelihood of negative
outcomes.*

...strong infant-parent bonds protect children from later maladaptive behaviors.

The Family

Resilient children generally come from homes that are organized, warm and offer emotional support as well as limits.

Strong Attachment to Caregiver One of the most important protective factors is the bond between a child and the primary caregiver or parent. Researchers have shown that strong infant-parent bonds protect children from later maladaptive behaviors. Children with secure attachments as infants show positive benefits such as healthy social relationships, better emotional and cognitive functioning, and stable relationships later in life. More recently, research has shown that abused children may be more likely to overcome the lasting effects of abuse if an early attachment to a caregiver was secure.

High Expectations for Child's Behavior Families who reward success and ignore failure or help the child to understand that failure is part of life promote self-esteem in their children.

Meaningful Opportunities to Participate Children who are valued in families are given opportunities to contribute to the families' overall well-being. Whether carrying groceries or aiding families in financial crises, no child is too young to contribute something to the running of a household.

The Community

Communities offer other opportunities outside of the family to increase a child's and family's internal and external resources through positive and meaningful interactions between the child and others. Community interventions, which have worked well in the past, contain some or all of the following (Brooks, 1994):

Encourage Contributions Children and families are encouraged and are provided with opportunities to contribute to their school or community. This builds self-respect and fosters attachment to the community.

Enhancing Decision-Making Skills Providing children with the opportunities to make sound choices and to problem-solve is one way to build the internal resources of children.

Encouragement and Positive Feedback Words and actions that help children to feel genuinely special, expressed in a positive way, are energizing and demonstrate the existence of people who accept and believe in them.

Developing Self-Discipline Essential to developing high self-esteem is a sense of self-discipline.

Dealing with Mistakes and Failure For children at-risk, the fear of making a mistake or being embarrassed is a barrier to development. Furthermore, children from abusive homes often are taught to keep to themselves and not divulge any detail about their home life. Being in an environment where they are accepted and feel free to take risks is a big step toward fostering resilience in children.

The next section identifies five developmental stages: prenatal (conception to age 1), early childhood (2 to 5), school-age (6 to 12), early adolescence (13 to 15), and young adults (16 to 18). The goal of these sections is give examples rather than to provide an exhaustive list of risk and protective factors identified with each stage.

Being in an environment where they are accepted and feel free to take risks is a big step toward fostering resilience in children.

Section III

Developmental Stages

Prenatal to Age 1: Examples of Risk Factors

In the prenatal stage, numerous risks and protective factors are associated with the family and specifically with the mother. It is helpful to cluster the maternal risks into three categories: social/environmental, medical and behavioral. All three categories of risk are closely related. Examples of risk factors that are viewed as single determinants of poor birth outcomes, such as drug use during pregnancy, do not operate in isolation. Mothers who use drugs also tend to smoke, consume alcohol, lack nutritious diets and otherwise neglect their health. They are less likely to seek prenatal care, which, if sought, can potentially protect even high-risk mothers and increase the likelihood of healthy births. A discussion follows of some of the more powerful risk factors.

Alcohol and drug use during pregnancy is a significant problem. Fetal alcohol syndrome results in retarded growth, malformed facial features, poor neurological coordination and mental retardation (Edmondson, 1994). Alcohol use among women in childbearing years has escalated over the past 15 years. It is estimated that one in six women during their childbearing years may drink enough to harm their unborn children (Edmondson, 1994). Alcohol use is also an indicator of other substance abuse (Healthy Start, 1994).

HIV infection rates among young men and women are rapidly increasing. In the 15- to 24-year-old age group, HIV is the third leading cause of death. In the 25- to 34-year-old age group, HIV is the leading cause of death (HRS, 1994). Most children born to women with HIV have an eight percent chance of contracting AIDS if the mother is

| Prenatal to Age 1: Examples of Risk Factors | | |
|--|---|--|
| Child | Family | Community |
| <ul style="list-style-type: none"> • congenital anomalies • pre-maturity • perinatal conditions • HIV • low birthweight | <p>Social/Environmental</p> <ul style="list-style-type: none"> • poverty <p>Medical</p> <ul style="list-style-type: none"> • poor maternal health • STI/HIV <p>Behavioral</p> <ul style="list-style-type: none"> • age of mother < 17 or > 40 • tobacco use • alcohol use • substance abuse | <ul style="list-style-type: none"> • inaccessible & unaffordable health care • no prenatal care • no well-baby screenings |

treated with AZT during pregnancy. The risk increases to 25 to 30 percent if the mother does not receive preventive care with AZT (Florida Department of Health and Rehabilitative Services Health Office, 1994).

Prenatal to Age 1: Examples of Protective Factors

A healthy mother is much more likely to deliver a healthy baby. Receiving comprehensive prenatal care throughout pregnancy reduces the factors associated with babies born with low birthweight, prematurity or congenital disabilities. Comprehensive prenatal care is one of the primary measures for preventing an array of poor outcomes. Comprehensive prenatal care addresses more than traditional medical care. It also includes:

- Early and continual risk assessment
- Health education and promotion
- Medical and psycho-social support
- Follow-up care and services

Pregnancy outcomes can be effectively addressed with the combined prenatal efforts of public and private health and human services systems.

Other protective factors serve to reduce the number of mothers who are teens. Successful programs aimed at teens focus on increasing a young women’s belief that she has a future other than motherhood. By delaying motherhood and staying in school,

| Prenatal to Age 1: Examples of Protective Factors | | |
|--|--|--|
| Child | Family | Community |
| <ul style="list-style-type: none"> • attachment to caregiver • good health • adequate nutrition • normal fetal development | <ul style="list-style-type: none"> • social supports • family supports | <ul style="list-style-type: none"> • comprehensive prenatal care throughout pregnancy |

young women have opportunities to develop marketable skills which later will serve as a protective factors against poverty both for them and their children.

Programs that focus on prevention and strengthening family resources have been extremely successful in reducing the number of premature births, low birthweight babies, and infant deaths. Several of these programs have received national acclaim. For a discussion of these programs and others see “Within Our Reach” by L. Schorr (1989).

Early Childhood Age 2 to 5: Examples of Risk Factors

The preschool period has its own developmental agenda. At this stage, children are still very dependent on adults. At the same time, they are changing rapidly and seeking greater independence from parents and caregivers. It is a vital time for learning, and this learning occurs primarily through play. Play contributes to children's development by enabling them to learn about objects, each other and the adult world. In addition, play encourages the development of skills and drives that cannot be taught through direct instruction. In their newly found freedom and sense of discovery, toddlers and young children are particularly at risk for injuries. Children at this stage do not have the capacity to think through consequences before completing their actions.

The leading cause of death for this age group in Hillsborough County is death by drowning (Hazinski, Francescutti, Lapidus, Micik, & Rivara, 1993). Florida and California have extremely high numbers of swimming pools. In the late 1980s, the Consumer Product Safety Commission did a study of swimming pool accidents. Their data revealed:

- 75 percent of the children who drowned in swimming pools were under the age of 3.
- 65 percent of the drownings occurred at the victim's own home.
- 33 percent of the accidents occurred in pools of relatives or friends.
- Fewer than two percent of the pool drownings occurred on property where the child didn't live or belong.

| Early Childhood Age 2 to 5: Examples of Risk Factors | | |
|--|---|--|
| Child | Family | Community |
| <ul style="list-style-type: none"> • no car safety seat • unmonitored swimming | <ul style="list-style-type: none"> • inattentive care giving | <ul style="list-style-type: none"> • lack of community education • environmental hazards • unfenced pools or swimming area • unsafe play equipment |

The American Academy of Pediatrics does not believe formal swimming lessons should occur until age 3. Early swimming lessons don't make children better swimmers and they don't waterproof them. Children who have had lessons may be at greater risk around water than other children because they feel safe and comfortable in it. Also, because their parents, under the impression their children can swim if they have to, are lulled into a false sense of security (Eisenberg, Murkoff, Hathaway, 1994).

Nationally, the leading cause of death for this age group is auto accidents. Seventy percent of all vehicular deaths in this age group occurred because the child was not properly secured in an approved safety seat or a safety belt was not in use (Centers for Disease Control and Prevention, 1991). Parents and caregivers need to understand the need for a child safety seat and how to use it properly. For example, all child safety seats come with weight and height limits. Seats sized for young children should not be placed

in a seat where an air bag deploys. The safest place for all child safety seats is in the middle of the back seat.

Finally, while this section has primarily focused on physical aspects of risk factors in this age group, it should be noted that additional emotional examples are prevalent as well.

Early Childhood Age 2 to 5: Examples of Protective Factors

Well-child health care appointments are successful in identifying and preventing health problems. Immunizations are a primary source of prevention. When a child visits a clinic or pediatrician’s office, screening can take place simultaneously for health, nutrition, development, physical or congenital abnormalities and hearing and speech, and immunizations can be given. In addition to development of the child, the parent-child relationship, which is critical to assure positive emotional and cognitive development, can be assessed by the practitioner.

| Early Childhood Age 2 to 5: Examples of Protective Factors | | |
|--|---|---|
| Child | Family | Community |
| <ul style="list-style-type: none"> • adequate nutrition • immunizations • parent/child attachment | <ul style="list-style-type: none"> • responsive and stable care giving • safety precautions | <ul style="list-style-type: none"> • information and laws on safety • advocate groups for child protection • preventive medical care and treatment |

Many, if not most, injuries can be prevented with appropriate information and equipment, for instance, using car safety seats, bicycle helmets and, most importantly for Hillsborough County, swimming pool barriers or fences. There are federally approved guidelines for all three types of equipment. However, only car safety seats and, as of January 1997, bicycle helmets are required in Florida.

School Age 6 to 12: Examples of Risk Factors

Children in first to sixth grades are more difficult to characterize than children in other age groups because they make such rapid changes during these years. The child who completes elementary school is very different from the one who entered first grade six years earlier.

From the time children are 6 years old until at least age 12, they spend between six and eight hours a day in school for approximately 180 days a year. In addition to learning

basic subjects such as math and reading, children are expected to learn social skills, problem-solving, athletic skills, good work habits and respect for other cultures.

All too often a pattern of school failure begins in the early primary grades. The pattern of failure may include disruptive behavior, disaffection towards school and retention in one or more grades. It is recognizable by sixth grade and is a good predictor of who will

| School Age 6 to 12: Examples of Risk Factors | | |
|--|---|--|
| Child | Family | Community |
| <ul style="list-style-type: none"> • lack of friends, social isolation • labeled by school system • chronic mobility of school placements | <ul style="list-style-type: none"> • loss of parents by incarceration, divorce, abandonment, or death • instability, chronic mobility • family violence • parents have negative attitude toward education | <ul style="list-style-type: none"> • lack of neighborhood organizations • norms supporting negative behavior • lack of after-school supervision |

drop out in high school. Those factors most notable for school failure are truancy and poor academic progress. Other risk factors are delinquency, disciplinary problems in school, being two or more years behind grade level, and pregnancy (Carnahan, 1994). Family risk factors of school failure are: single-parent family, large family, parent dropped out of school or parent in jail.

Finally, in addition to in-school issues, children in this age group are often faced with issues related to family substance abuse or the early onset of alcohol and other drug abuse.

School Age 6 to 12: Examples of Protective Factors

According to Carnahan (1994), school programs that successfully prevent school failure and future drop out have three principles. First, successful programs are individualized. These programs recognize that school failure is caused by many factors,

| School Age 6 to 12: Examples of Protective Factors | | |
|--|--|--|
| Child | Family | Community |
| <ul style="list-style-type: none"> • attachment to school • positive attitude toward authority • involved in positive activities in or out of school • trust in adults | <ul style="list-style-type: none"> • clear limits set by parents • involvement in school | <ul style="list-style-type: none"> • child care or after-school supervision • norms for positive behaviors • positive role models |

too numerous to put into a simple formula for predicting school failure. Individualized programs might include individualized treatment planning teams or down-sizing classrooms, or a broad range of interventions. Secondly, successful programs target subgroups of at-risk children. For example, pregnant adolescents or inner-city gang members. Finally, successful programs focus on relationships. Some ways to do this are through a mentoring program or a coaching approach to teaching. These programs recognize that children are successful in school because of good quality relationships with school personnel.

Early Adolescence Age 13-15: Examples of Risk Factors

The early teenage period is a time of vacillation between childhood and adolescence. Children in this age group are beginning to think more abstractly, and their problem-solving capabilities are growing rapidly. Most early adolescents are now able to integrate many different factors in understanding concepts and problem-solving. This is a time of

| Early Adolescence Age 13-15: Examples of Risk Factors | | |
|---|--|--|
| Child | Family | Community |
| <ul style="list-style-type: none"> • history of failure • antisocial behavior • alienation • destructive coping behaviors such as drug use and suicidal ideation • pregnancy • negative peer identification and attachments | <ul style="list-style-type: none"> • domestic violence • family history of problem behaviors • negative attitude toward school or authority | <ul style="list-style-type: none"> • availability of drugs or guns • norms favorable toward drugs, guns and violence |

experimentation with many new behaviors and roles. It can be a very frightening period in their lives. At this stage, it is common to take risks in order to experience new behaviors and feel a part of a peer social group.

Florida is above the national average in number of firearm deaths for youths. Firearm related homicide deaths are the highest for the 14- to 24-year-old age group. This includes homicide, suicide and unintentional deaths (Injuries in Florida Mortality Facts, 1994). Nationally, the second leading cause of death for children is homicide, with firearms implicated in many of these deaths (Zins, Garcia, Tuchfarber, Clark, and Laurence, 1994).

Early Adolescence Age 13-15: Examples of Protective Factors

It is important for adolescents to feel that they are supported and loved by their parents and families as they experiment with limits of acceptable new behaviors. Meaningful involvement in the community is one of their greatest needs. Adolescents need a community that cares for them, allows them to grow into their new freedom, and most importantly, encourages their contribution to the community.

Successful outcomes for youth in early adolescent years include positive personal growth and development, as well as continued involvement and successful performance

| Early Adolescence Age 13 to 15: Protective Factors | | |
|---|--|---|
| Child | Family | Community |
| <ul style="list-style-type: none"> • sense of self-worth and esteem • good social skills • positive peer relationships • decision-making skills • concern and caring for others • affiliations with groups or organizations | <ul style="list-style-type: none"> • internal harmony • coping skills • parenting skills/ communication • emotional availability • responsive care giving • strong positive values | <ul style="list-style-type: none"> • opportunities for community involvement • recognition of youths' contributions • positive places for youth to associate • structured youth activities • church membership |

in academic programs. Adolescents also need to develop and practice social competency, problem-solving skills and skills that involve acting autonomously. A sense of purpose and hope for the future is critical. Meaningful relationships with peers and adults provide supportive and caring environments in the community, the school and the home.

Young Adults Age 16-18: Examples of Risk Factors

Young adults in the 16- to 18-year-old category share at least one characteristic with children in the 2- to 5-year-old category, they are in danger of dying in car accidents. Males are twice as likely to die as females (Injuries in Florida Mortality Facts, 1994).

| Young Adults Age 16-18: Examples of Risk Factors | | |
|--|---|---|
| Child | Family | Community |
| <ul style="list-style-type: none"> • dropping out of school • no plans for after graduation • not employed • pregnancy | <ul style="list-style-type: none"> • history of mental illness • uninvolved in child's life | <ul style="list-style-type: none"> • gangs • norms that do not favor higher education |

Teenagers have the lowest rate of safety belt use and the highest rate of fatal crashes (National Highway Traffic Safety Administration, US. Department of Transportation, 1991). Often alcohol is a contributing factor (Insurance Institute for Highway Safety, 1991).

A risk factor that imposes serious consequences is pregnancy. Kids Count data from 1993 reveals that 7.6 percent of all teens in Hillsborough ages 15 to 19 give birth. The rate for white teens was 6.2 percent and the rate for nonwhite teens was 11.8 percent. The damaging effects to the mother are too numerous to mention in this short space. Moreover the damage to the next generation is profound, repeating the cycle of poverty, neglect and hopelessness.

Young Adults Age 16-18: Examples of Protective Factors

Graduation from high school as a teen is certainly a good predictor of favorable outcomes. In a study of high-risk children, tracked from birth to 32 years, Werner (1993) found that resilient children who went on to graduate from high school eventually achieve the same or equal educational and vocational accomplishments as their low-risk counterparts who had grown up in a more affluent and enriched environment. These individuals had overcome tremendous personal obstacles early in life, but had made the most of their individual or environmental resources.

Furthermore, mentoring programs such as Big Brother/Big Sisters have shown effectiveness in promoting resiliency in young adults, especially in minority

| Young Adults Age 16 to 18: Protective Factors | | |
|--|--|--|
| Child | Family | Community |
| <ul style="list-style-type: none"> • employed • belief in future • abstains from sex, alcohol, drugs • church membership | <ul style="list-style-type: none"> • teen part of decision making • teen valued by other family members • teen looked up to by younger siblings | <ul style="list-style-type: none"> • opportunities for employment • input into decision making |

underprivileged populations. In a recent national evaluation of Big Brother Big/Sisters, those teens randomly assigned to the Big Brother/Big Sisters group were 46 percent less likely to start using drugs, 27 percent less likely to drink, and skipped half as many days of school as the wait list group. In addition, after 18 months, the Big Brother/Big Sisters group showed gains in academic performance (Bernard, 1996).

References

- Benard, B. (1996). Mentoring: New study shows the power of relationship to make a difference. *Resiliency in Action*, 1(4), 7-12.
- Bruner, C. (1993). A framework for developing and holding comprehensive reform efforts accountable for improving child outcomes. Available from C. Bruner, Child and Family Policy Center, 100 Court Ave., Suite 312, Des Moines, IA 50309.
- Carnahan, S. (1994). Preventing school failure and dropout. In R.F. Simeonsson (Ed.). *Risk Resilience & Prevention: Promoting the Well-Being of All Children*. (pp. 103-124). Paul H. Brookes Publishing Co.
- Centers for Disease Control and Prevention. (1990). Child passenger restraint use and motor-vehicle-related fatalities among children - United States, 1982-1990. *Morbidity and Mortality Weekly Report*, 40(34), 600-602.
- Edmondson, R. (1994). Drug use and pregnancy. In R.F. Simeonsson (Ed.). *Risk Resilience & Prevention: Promoting the Well-Being of All Children*. (pp. 151-168). Paul H. Brookes Publishing Co.
- Eisenberg, A., Murkoff, H.E., & Hathaway, S.E. (1994). *What to Expect: The Toddler Years*. New York: Workman Publishing.
- Florida Department of Health and Rehabilitative Services Health Office. (1994). *Seroprevalence study of child-bearing women, conducted between October 1993 and March 1994*. Tallahassee, FL: Author.
- Florida KIDS COUNT(1994). *Key Facts about Children: A report on the status of Florida's children*. Tallahassee, FL: Author.
- Hazinski, M., Francescutti, L., Lapidus, G.D., Micik, S., & Rivara, F.P. (1993). *Pediatric injury prevention, Annals of Emergency Medicine*, 22(2), 456-467.
- Healthy Start Coalition of Hillsborough County. (1994). *Prenatal and infant health care service delivery plan update: Hillsborough County 1994-1995*. Tampa, FL: Author.
- HRS. (1994). *Injuries in Florida 1994 Mortality Facts*. Florida Injury Prevention and Control Program, HRS - Office of Health Promotion and Wellness, 1317 Winewood Blvd. HSH, Tallahassee, FL 32399-0700.
- Insurance Institute for Highway Safety. (1991). *Fatality fact, 1991 edition*. Arlington, VA: Author.
- KIDS COUNT. (1994). *Kids Count Data Book: state profiles of child well-being*. Baltimore MD: Author.
- National Highway Traffic Safety Administration, US Department of Transportation. (1991). *Occupant protection trends in 19 cities*. Washington, DC: Author.
- Osborne, D. & Gaebler, T. (1993). *Reinventing Government*. New York, NY: Plume.
- Schorr, L.B. & Schorr, D. (1988). *Within Our Reach: Breaking the Cycle of Disadvantage*. New York, NY: Anchor Book.
- The Spring. (1996). *Tampa Tribune*, Monday, Dec. 9. High cost of domestic violence.
- Werner, E.E. (1993). Risk, resilience, and recovery: Perspectives from the Kauai longitudinal study. *Development and Psychopathology*, 5, 503-515.
- Zins, J.E., Garcia, V.F., Tuchfarber, B.S., Clark, K.M., & Laurence, S.C. (1994). Preventing injury in children and adolescents. In R.F. Simeonsson (Ed.). *Risk Resilience & Prevention: Promoting the Well-Being of All Children*. (pp. 183-202). Paul H. Brookes Publishing Co.

Annotated Bibliography for Resiliency Theory

All research articles are available from your Children's Board Hillsborough County. Contact our Resource Library by:

Phone: **(813) 229-2884**; Fax: **(813) 228-8122** ; Internet Email: **library@childrensboard.org**

Brooks, R.B. (1994). Children at risk: Fostering resilience and hope. *American Journal of Orthopsychiatry*, 64(4), 545-553.

A succinct write-up of the domains of resilience. See pages 550 to 552 for the underlying principles of intervention strategies reporting success.

Bruner, C. (1993). *A framework for developing and holding comprehensive reform efforts accountable for improving child outcomes*. Available from C. Bruner, Child and Family Policy Center, 100 Court Ave., Suite 312, Des Moines, IA 50309.

A work-in-progress that offers a discussion from the community perspective of how to begin a accountable system of care. The document covers material such as service reform strategies, core beliefs of a resiliency-focused system, and implementation strategies.

Carnahan, S. (1994). Preventing school failure and drop-out. In R.F. Simeonsson (Ed.). *Risk Resilience & Prevention: Promoting the Well-Being of All Children*. (pp. 103-124). Paul H. Brookes Publishing Co.

Discusses the importance of personalizing school drop-out programs. Goes over risk factors for child, and family, and community. Discussion on principles of successful programs to prevent school drop-out and failure.

Improved Outcomes for Children Project. (1993). *A framework for improving outcomes for children and families*. Available from the Center for Social Policy.

One of the original, if not the original framework. This document is a "must read" for anyone attempting to implement the resiliency framework. Goes into detail about community involvement and action steps.

Georgia Policy Council for Children and Families, (1994). *On behalf of our children: A framework for improving results*. Available from the Georgia Policy Council for Children and Families.

A document somewhat similar to the Children's Board document. An example of what a core group of stakeholders can produce in the way of priorities and planning. This document lays it out for the providers.

Kolbo, J. R. (1996). Risk and resilience among children exposed to family violence. *Violence and Victims*, 11 (2), 113-128.

A study was done on 60 children (30 males and 30 females) referred to treatment for exposure to family violence. A parent completed a Conflict Tactics Scale measure of violence. Other measures collected were a socioeconomic index, stability, support, I.Q. of the child, children's behavioral and emotional functioning. Study demonstrated exposure to violence was negatively correlated to the child's self-worth and positively correlated to behavior problems. Other interesting correlations are noted.

Linquanti, R. (1992). Using community-wide collaboration to foster resiliency in kids: A conceptual framework. Available from ERIC Document Reproduction Service, 7420 Fullerton Road, Suite 110, Springfield, VA 22153-2852.

Article focuses on community collaboration as a way to implement resilience programs. Describes resiliency framework from community perspective. Tools, models, and programs are highlighted.

Luthar, S.S., & Zigler, E. (1991). Vulnerability and competence: A review of research on resilience in childhood. *American Journal of Orthopsychiatry*, 61, 6-22.

This article reviews the literature on resilience from a developmental psychopathology perspective. The authors point out what they perceive as the major flaws in previous research. Three interactive models of resiliency are described in brief. Also covers the literature on three major domains of protective factors or moderator variables, disposition attributes, family cohesion, external social supports.

Osborne, D. & Gaebler, T. (1993). *Reinventing Government*. New York, NY: Plume.

This book addresses programs that have recently implemented results-oriented governing. The authors go over one example after another of clear and effective programs that happen to be publicly owned. See section 5 on funding outcomes not inputs, p. 138.

Schorr, L.B. & Schorr, D. (1988). *Within Our Reach: Breaking the Cycle of Disadvantage*. New York, NY: Anchor Books.

If looking for examples of programs that have implemented resiliency theory, this is the book to start with. Although the authors cover the need for reform, they also cover much ground with descriptions of positive and effective programs. The book is nicely personalized, including many case studies. Teen pregnancy and infant health care are extensively covered.

Staudinger, U.M., Marsiske, M., & Baltes, P.B. (1993). Resilience and levels of reserve capacity in later adulthood: Perspectives from life-span theory. *Development and Psychopathology*, 5, 541-566.

Although this article focuses on resilience in the elderly, the developmental definitions are applicable for childhood as well. The impact is that resiliency is not a static entity but will continue to accumulate throughout the life span.

Werner, Emmy E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry*, 59(1), 72-81.

Classic outcome study on resiliency. Emmy Werner tracked 201 individuals from birth to the age of 32. This is a powerful and well done study with positive implications for all children who experience stresses or risks early in life.

Zins, J.E., Garcia, V.F., Tuchfarber, B.S., Clark, K.M., & Laurence, S.C. (1994). Preventing injury in children and adolescents. In R.F. Simeonsson (Ed.). *Risk Resilience & Prevention: Promoting the Well-Being of All Children*. (pp. 183-202). Paul H. Brookes Publishing Co.

Covers national statistics on major causes of injury and accidental death of children. Also presents a discussion of intervention components.

The Framework - A Brief Historical Perspective

The Children's Board of Hillsborough County welcomes the opportunity to share its Conceptual Framework for Service Planning with you. Like most publications of this kind, it has not been the work of one individual but rather a collaborative effort by many. The Board is pleased to have had so much community involvement in developing this particular document. It represents the labor of a number of committees, task forces and work groups. The Framework presents the best effort of these participants to provide a concise and meaningful guide for the planning of effective services for children and families.

The initial goal of the Children's Board in developing this publication was to provide the community with a master plan that would guide the planning, development and implementation of all children's services for Hillsborough County. It would identify all existing services as well as gaps in services that needed to be addressed.

While developing a master plan for children's services could be perceived as a worthy goal, it proved to be a daunting task. This is a large community with a diverse population and many types of human or social services. Some of these services are issue-specific while others are more comprehensive. Some services exist in one area and might not serve another. In some instances, that service may be needed elsewhere and others it may not. In addition, what would be helpful in planning services for one child, family, neighborhood or group might not be helpful to another. Statistical data gathering also proved to be difficult. Information sources often used different data collection methods and time periods. This sometimes made data out-of-date or irrelevant for another's planning purposes.

It also became clear as the Board pursued this project that while children, families, neighborhood and groups have needs, they also have many strengths and assets. Resiliency theory, the concept that provides the underpinnings of the Framework, recognizes this. The work also identifies those protective factors that enable children, families and communities to weather life's storms and to achieve stability no matter what challenges are presented. Replicating these successes is one of the major objectives the Board hopes to facilitate by publishing and sharing this work with our community.

As you use this publication in your planning, the Board would like to hear from you. Has it been helpful? In what ways did it guide your planning efforts? How can we improve upon it?

The Board wants to learn from your efforts how it can enhance or improve the services available to the children and families of our community by using the theory on which the Framework is built. Sharing this knowledge will make each success cumulative and will help to further improve services throughout the community. Working together we can, over time, develop that master plan that will enhance the lives of all our community's children and families. This has been the dream of social service providers, the Board and the community, and we can all make it a reality.

ACKNOWLEDGMENTS

The Children's Board would also like to take this opportunity to thank each person identified here for their assistance with this publication through its many stages of development and to acknowledge their participation.

| | | |
|------------------|-----------------------|--------------------|
| Vickie Adelson | Robert Friedman | Alexandra Mitchell |
| Pam Apisa | Adrienne Garcia | Jane Murphy |
| Ann Ashcraft | Kenneth Gaughan | Amparo Nunez |
| Debra Bara | Rosa Greenbaum | Terry O'Conner |
| Donna Bardwell | Pat Grosz | Luanne Panacek |
| Debbie Belk | Christine Grovenstein | Cecilia Peredo |
| Dottie Berger | Betty Gulitz | Kay Perrin |
| Colleen Bevis | Rose Marie Guntert | Gail Potter |
| Shelley Blood | Barbara Hammock | Mary Redmond |
| Jane Boles | JoAnne Harvey | Randy Remmel |
| Faye Bowman | Ed Howell | Mike Resnik |
| Debra Braman | Joyce James | Mirta Rivera |
| Richard Briscoe | Evan Joran | Roy Robinson |
| Joel Brooks | Lize Kalashian | Pat Russell |
| Judy Brophy | Steve LaBour | Susan Schneider |
| Karen Brown | Marlene Lalota | Lisa Scott |
| Richard Brown | Marsha Lane | Walter Sickles |
| Donna Casella | Marsha Lewis-Brown | Bob Sleczkowski |
| Anna Chairetakis | Jack Lockett | Diane Smith |
| Jim Counts | Lory Maddox | Jeanne Smith |
| Mariane Crochet | Michael Maher | Leonard Speed |
| John Curran | Sadye Martin | Leisa Stanley |
| Bobbi Davis | Ed McBride | Linda Stoller |
| Ann Dawson | Gwen McClain | Joe Tagliarini |
| Linda Delapenha | Beth McDonald | Charles Taylor |
| Leo Diaz | Brian McEwen | Chet Tharpe |
| Regina Downum | Yvonne McKitrick | Renee Warmack |
| Jim Boyle | Lydia Medrano | Rick Weibley |
| Barry Drew | Adele Meissner | Susan Weitzel |
| Joan Dye | Marilyn Merida | Kathy Wellman |
| Reggie Earl | Will Michaels | Shirley Woodward |
| Margaret Fender | Clem Miller | Ellen Zinzeleta |
| Beth Formica | Dan Miller | |

**A Conceptual Framework
for Service Planning
for Children and Families**