

5151

FAMILIES AND SCHOOLS TOGETHER (FAST)

FINAL REPORT FOR

OHD/ACF/DHSS GRANT #90-PD-165

JANUARY 1993

Submitted by:

Lynn McDonald, ACSW, Ph.D.
Principal Investigator
FAST Program Originator/Developer

Family Service
128 East Olin Avenue, Suite **100**
Madison, WI 53713
(608) 25 1-76 11

TABLE OF CONTENTS

Policy **Implication Analysis**
Families and **Schools** Together (FAST) Executive Summary
1989-1992 Grant #90-PD-165

I. Families and Schools Together - Overview

- A. Introduction
- B. Target Population
- c. Project Services
- D. Coordination of Services and Community Outreach
- E. Family Involvement
- F. Project Staff
- G. Barriers and Facilitators to Project Services
- H. Client Outcomes and Project Evaluation
- I. Project Replication

II. FAST as a Collaborative Prevention Strategy

- A. Introduction
- B. The FAST Program
- C.** Collaboration in the FAST Program
- D. FAST Collaboration as a Challenge for Systems
- E. Collaborative FAST Training Approach
- F. Summary

III. FAST as an Empowerment Strategy for Parents

- A. Introduction
- B. Concept of Empowerment
- C. The Families and Schools Together (FAST) Program
- D. FAST Program into Policy: Empowerment Stories
- E. FAST Participant Profiles

IV. FAST as a Multi-Family Prevention Strategy

- A. Introduction
- B. Collaboration with Schools
- C. Analyzing the Family-School System
- D. Multi-Family Eight-Week Group Curriculum
- E. Family Therapy Principles
- F. Profile of Children At-Risk, Families, Schools/Communities
- G. Evaluation
- H. Conclusion

V. FAST as a Community Mental Health Prevention Strategy

- A. Introduction
- B. Description of FAST Program for Two Goals
- C. Evaluation
- D. Results
- E. Summary

VI. FAST Curriculum Adaptation: Grades Four through Six

- A. Introduction
- B. Teacher Reports to Parents
- C. Weekly Themes
- D. The Routine FAST Agenda
- E. Family Time
- F. FAST Club/Rids' Play
- G. Parent Buddy Time and Group
- H. One-to-One Quality Time: Detour Communication
- I. Alcohol and Other Drug Session

VII. FAST Identification and Recruitment Strategies

- A. Identification of FAST Families
- B. Recruitment of FAST Families
- C. Incentives
- D. School Disclosure
- E. Mental Health Recruitment

VIII. FAST Evaluation

- A. Limits of Data Collection
- B. Procedures
- C. Measures
- D. Results

IX. FAST Replication Evaluation - Thirty Wisconsin Sites

- A. Introduction
- B. Wisconsin Statewide FAST Program Evaluation Results
- C. FAST Experimental Comparison Study

X. FASTWORKS Evaluation

- A. Introduction of Survey Instrument
- B. Parents' Remarks
- C. Impact

Bibliography

Appendix

POLICY IMPLICATION ANALYSIS
FAMILIES AND SCHOOLS TOGETHER (FAST) EXECUTIVE SUMMARY
19894992 GRANT #90-PD-165

In 1989-92, the U.S. Government, Administration of Children and Families, Department of Health and Human Services, through the Office of Human Development, awarded a **three-year** grant totalling \$150,000 to Dr. Lynn McDonald of Family Service in Madison, Wisconsin, to adapt and further develop a prevention/early intervention program for at-risk youth. The program is called Families and Schools Together (FAST), and is a collaborative, whole family approach. This executive summary reviews the outcomes of this award and proposes that: 1) OHD fund national dissemination and replication of FAST for three years; and 2) the Clinton administration consider FAST as a program using youth service volunteers for prevention service to the American children.

OHD/ACF Grant Application Summary: FAST will prevent pre-teen problems within educational systems through a family-based, collaborative project. Schools and families are in crisis. The rate of failure among students at-risk, many of whom have alcohol, drug, mental health, abuse/neglect, and other family problems, is high and increasing. The project will:

1. Identify, motivate, support, empower, and serve at-risk families.
2. Develop a close affiliation and collaboration between schools, community agencies, community leaders, and families.
3. Develop a permanent fund.

In order to accomplish these objectives, the project will draw from the most successful motivational and educational efforts in the entire human service field. The project will develop, evaluate, and disseminate in written, audio/visual, and oral form a model which, if successful, will intervene in families where the risks of failure are very high and the ability to access help

is now very low.

FAST Program Goals: FAST uses a collaborative team to **run** multi-family groups of elementary school aged children at-risk for school failure, delinquency, and substance abuse. The goal of FAST is to empower parents to be their own child's primary prevention agent. The program supports the whole family in order to increase the at-risk child's chances of success. Rather than an educational program, FAST builds positive bonds and strengthens relationships between a mother and her child, amongst whole family units, between mothers who are in similar circumstances, and between parents and professionals in the community.

FAST Evaluation: The evaluation outcomes showed: 1) increased functioning of children as reported by parents and teachers in the areas of self-esteem, attention span, conduct disorder problems, and hyperactivity; 2) increased family cohesiveness; 3) increased parent involvement in schools; 4) increased community involvement and support networks of stressed and isolated families; 5) increased collaborative relationships; and 6) empowerment of parents.

Statistically significant improvements in the mental health of the at-risk children have been documented by teachers and parents of over **400** children/families at thirty sites using standardized quantitative instruments, comparing scores pre and post FAST. The children's scores jumped an average of 20 to 25% over the eight-week period. In a small experimental study, the results were similarly positive when comparing FAST to a randomly assigned control group. Longitudinal, quantitative data on the children are being collected now with an OSAP grant. FASTWORKS three-year follow-up showed 16% of parents went into alcohol treatment, 27% went into counseling, 40% went on to further education, 16% obtained full-time jobs, 32%

became involved in **PTO's**, and 35% became more involved in community centers.

FAST Funding: Since 1988, the local FAST program has been funded by United Way of Dane County, the Madison Community Foundation, the City of Madison, Madison Metropolitan School District and Chapter I funds, the State of Wisconsin Department of Public Instruction, Drug Free Schools monies, the Department of Health and Human Services, Alcohol and Drug Prevention Unit, and the three year (1989- 1992) **OHD/ACF/DHSS** funding for program development. In 1990, Wisconsin Assembly Bill 122 was passed to allocate \$1,000,000 per year for replicating FAST across the state. This happened with support both from a Republican governor and a Democratic legislature. With three successive years of state funding, there **are** certified FAST programs in over forty school districts in Wisconsin. In 1991, the Office of Substance Abuse Prevention (**OSAP**), U.S. Government, awarded FAST a five-year, **\$1,300,000** high-risk youth grant to evaluate FAST longitudinally. to adapt FAST to preschool, Head Start, and middle school, and to develop the follow-up program.

FAST National Dissemination: In 1992. FAST grew to be in seventy schools/communities in six states: Wisconsin, Illinois. Iowa, Kansas. Michigan. and Delaware. In the last eighteen months, there have been over 800 requests for information about FAST from outside the state of Wisconsin. These requests have come from **across** the United States.

FAST has been featured in several nationally distributed professional newsletters: National Association of Family-Based Services; Family Resource Coalition; American Association of Marriage and Family Therapists; Brown University Family Therapy Newsletter;

National Association of Social Work; Social Work in Education; and National Organization of School Student Assistance Programs. FAST has also been presented at several national conferences: National Organization of School Student Assistance Program, National Association of School Administrators, National Association of School Board Members, Family Service Bi-Annual National meetings, and Family Resource Coalition. The chapters in this grant report were prepared in the form of articles to be submitted to appropriate journals for further dissemination.

Awards for FAST: FAST has been honored by several national competitive processes as an effective prevention/early intervention program:

- 1990: U.S. OSAP Exemplary Program Award (150 nominations, ten awards).
- 1991: United Way published a list of 100 outstanding programs **nationally** for children families; FAST was one of them (out of **2000**).
- 1992: CSR identified FAST as one of the top youth prevention/early intervention programs funded by Office of Human Development, ACF (**60** nominations, six awards).
- 1992: Department of Justice and University of Utah identified FAST as one of the excellent delinquency prevention programs (500 nominations, twenty awards).
- 1992: ABT, under contract to President's Drug Advisory Council, identified FAST as one of the top ten drug prevention programs for Office of National Drug Control Policy.
- 1992: Harvard/Ford Foundation Innovations Award identified FAST as one of seventy-five semi-finalists out of 1600 applicants for innovative programs becoming state policies.
- 1992: American Institute on Research identified top inner-city substance abuse prevention programs, under contract to the Pew Foundation and the Office of Justice (500 nominations. seven awards).
- 1992: Family Resource Coalition identified FAST as one of thirty model family support programs.

National Dissemination of FAST: Although Family Service of Madison, Wisconsin has provided a home for this rapidly expanding FAST program, the Family Service Board has decided that the

national dissemination of FAST is not encompassed by the mission of the agency. The local, not-for-profit mental health agency has a mission to serve people under stress in Dane County, Wisconsin.

Beginning February 1, 1993, the Dewitt-Wallace Foundation has awarded a three-year, \$625,000 grant for national replication and evaluation of FAST in six new states. The Mott Foundation also awarded a one-year, \$75,000 grant for training six additional cities. These grants **were** to Dr. Lynn McDonald at Family Service America, a not-for-profit umbrella organization for almost **300** private sector family service agencies across the United States.

Each of these agencies are committed to supporting families under stress with professional expertise. Family Service America publishes a journal entitled Families in Society; the organization has a presence at national professional meetings; and it has a mission to advocate nationally for exemplary service to families under stress. Family Service America also has professional regional consultants who travel regularly across the U.S. to provide membership support services. Family Service America is pleased to be the home to the FAST National Dissemination project.

RECOMMENDATIONS:

1. **ACF/OHDmatch** foundation dollars to replicate FAST **nationally: \$700,000 over three years. This would disseminate nationally an innovative; exemplary prevention program underwritten by OHD/ACF for children, families, schools, and communities.**
2. **FAST be considered by the Clinton administration for a national model which could**

incorporate youth service into its dissemination. Youth could be trained to help run **this** program **and** help **staff** it as a volunteer service to **their** country to help at-risk youth **succeed** in schools while empowering parents into being the primary prevention agent for their own child. This could be funded in part through Department of Education Chapter I funds as a parent involvement program for disadvantaged youth (annual allocation nationally is 6.9 billion dollars).

This report is submitted by
Lynn McDonald, ACSW, Ph.D.
Family Service
128 East Olin Avenue, Suite 100
Madison, WI 53713
(608) **251-7611**

I. **Families and Schools Together** - Overview*

A. Introduction

Families and Schools Together (FAST) is a statewide collaborative early intervention project offered by a service agency in conjunction with local public elementary schools in Madison, Wisconsin. The collaboration is supervised by Family Service and includes the Madison Metropolitan School District and other schools around the state; the Prevention and Intervention Center for Alcohol and Drug Abuse (**PICADA**); and the FAST Parent Advisory Councils (**PACs**), composed of parents who have graduated from the FAST program. In the future, a newly formed State Advisory Board also will provide FAST will planning services and guidance.

The parent agency, Family Service, is a multi-service, private, non-profit, mental health agency located in Madison, Wisconsin. The agency's mission is to strengthen individuals and families under **stress** and to foster caring, responsible relationships by providing a range of counseling and therapeutic support services. In addition to FAST, Family Service provides individual, marital, couple, group, and family counseling; financial counseling; a spousal abuse prevention program; and a Families in Transition program.

FAST is a school-based, family-focused project designed to provide at-risk elementary school-aged children with services to increase their self-esteem, improve their school performance, and strengthen the family unit. The four goals of FAST are: 1) enhance family functioning; 2) prevent the target child from experiencing school failure; 3) prevent alcohol and other drug abuse by the child and **family**; and 4) reduce the stress that parents and children

*This chapter was published by **OHD/ACF/DHSS** in a June 1992 publication describing six case studies on exemplary prevention/early intervention programs funded by **OHD/ACF**, and reviewed and site visited by CSR.

experience from daily life situations. The program has the additional goal of developing partnerships among mental health agencies, alcohol and drug abuse programs, individual schools, and families. FAST provides weekly multi-family group meetings, support services such as transportation and food, and a graduation ceremony for all families successfully completing the project. For two years following participation in FAST, graduated families attend monthly meetings called FASTWORKS, an acronym standing for Families and Schools Together, Working, Organizing, Relaxing, Knowing, Sharing.

FAST is guided by the agency's philosophy that respectful relationships among school staff, parents, and children are vital to children's success in school. FAST aims to minimize the risks children experience by improving the bonds "within the family, between the family and the school, and between the child and the school."

FAST receives funding from the State of Wisconsin through a legislative allocation from the Department of Public Instruction (DPI). The project also receives funding from Dane County, the city of Madison, and the United Way of Dane County, as well as from area corporations, foundations, and individual donors. Sliding fee scales and clients' health insurance also help sustain the project.

B. Target Population

"The school recruitment is unique and essential to our program. The school sends home notes - reminders of meetings - with the kids. The kids love the meetings. They get food, playtime, attention, prizes. The kids drag their parent to the meetings....We've used strategic planning to square the effects of the program....It's a win-win program"
- FAST staff member

FAST targets elementary school children who have been identified by their teachers as

being at-risk of school failure, juvenile delinquency, and substance abuse in adolescence, Clients are referred to FAST in one of two ways. First, parents may refer themselves to the project, particularly in schools that have sponsored previous FAST groups. However, **self-referral** does not automatically result in inclusion in the project, and the school must verify the family's need for the project. Second, and more commonly, FAST invites families to participate in the project based on a teacher identifying their child as being at-risk of experiencing a range of maladaptive behavior problems in the future.

Teachers screen their students for risk by using a checklist to assess children's academic level; school attendance; classroom behaviors; attention span; social responsiveness; consistency of daily work; and levels of sensitivity, depression, and preoccupation. The results of each screening instrument are reviewed by a panel of teachers, guidance and counseling staff, and the school principal to determine which families will be referred to FAST. In some cases, the school social worker, psychologist, or learning disability specialist will also be asked to attend the panel meeting.

After a child is identified as being at-risk, the school contacts the parents to obtain a signed release form and describe why the child has been referred to FAST. A FAST staff member and a parent who has graduated from the project schedule a home visit with prospective families to discuss the project. The aim of **the** home visit is to establish a rapport between FAST staff and parents and to highlight the potential benefits of the project for their children and family.

FAST families are described as characteristically "...**hard-to-reach**; they **are typically** poor, experience a high degree of environmental stress, and are disaffiliated from schools and

community services.” Of the families participating in Madison, approximately 80% are single parent, mother-run households; 80% have a history of substance abuse; and 90% receive some type of government aid.

Compiled statewide data on FAST indicate that 97% of the children identified by the project as at-risk **are** between five and ten years old and 62% are male. 81% of the children are Caucasian, 11% **are** African American, and 7% are Native American, Hispanic, or Asian/Pacific Islander. 50% of FAST households have no adult male involved with the family, 15% have no telephone, and 22% have no transportation. FAST staff point out, however, that while these families face **difficult** situations, most of them care deeply about the welfare of their children and are willing to make every effort to help their children succeed.

C. Project Services

FAST Meeting Agenda

Dinner
FAST Song
Scribbles
Feelings Charades
Parent Talk/Kids' Play
Special Play
Lottery
"RAIN" Closing Ritual

FAST families attend eight multi-family group sessions that meet once a week at the children's school. Session focus on family communication and are based on the principles of family therapy, using techniques **from child** psychiatry and group work theory. Meetings follow a uniform agenda that includes opening and closing rituals, structured family activities, parent education, and parent-child play therapy for children identified as at-risk. Each eight-week

session serves eight to twelve families and may have as many as forty project participants.

The parent-child play therapy, called “Special Play”, is the central component of FAST program services. In Special **Play**, parents learn in a supervised group setting how to provide directed play therapy for their own **children**. This activity is designed to teach parents to focus their attention on their children in ways that help build children’s self-esteem and enhance family communication. Parents **are** encouraged to continue Special Play in the evenings after FAST sessions.

Sessions also include parents only group discussion time. In this project component, parents are educated about topics relevant to parenting and family development such as substance abuse, family communication, stress management, and parenting skills. The session that focuses on substance abuse is conducted by an alcohol and other drug (AOD) specialist and highlights the importance of setting clear rules and expectations about drug use to help parents take charge of drug prevention in their households.

To ensure that families continue to attend group meetings, FAST offers a variety of incentives, such as transportation, a hot meal, and babysitting for infants and small children. Each week, one family is responsible for “hosting” the hot meal and is given twenty-five dollars from FAST. In some locations, FAST has connections with local food banks to help **families** prepare the weekly meal. In addition to the meal, each meeting includes a lottery in which a **family** wins a gift bag filled with needed items that have been donated by local businesses. Each family wins the lottery at least once during the eight weeks. The contents of the bag are catered to each family’s needs.

At the end of the eight-week session, families graduate from the project in a traditional

graduation ceremony. Invitations are sent to families, certificates are presented to project participants, and the ceremony is followed by a reception to honor graduates' achievements. School teachers, psychologists, and other staff **also are** invited to attend. FAST participants report feelings of pride and self-respect during the graduation ceremony, which is **considered** a highlight of the project.

After families have graduated from FAST, they join FASTWORKS, the second phase of the FAST program. FASTWORKS is a series of parent-organized family support meetings that are scheduled once a month for two years in an effort to continue and extend the social network established during FAST. Families who have graduated from the same school's FAST program become members of the same local FASTWORKS network. FASTWORKS groups organize family outings such as picnics and trips to the zoo. They also conduct periodic group meetings using the FAST program agenda. Monthly meetings are arranged by a graduated parent who is participating in a local FAST PAC.

Over 200 families are currently participating in the FAST eight-week program. This figure includes over 200 at-risk children, over 350 parents, and approximately **500** siblings. Statewide. FAST employs approximately 108 trained professionals to work with families.

D. Coordination of Services and Community Outreach

Since FAST is a collaborative project, extensive coordination of services has been required throughout all phases of project development and implementation. The contributions of Family Service have been vital to FAST in every phase. Family Service organized the project,

providing administrative office space, staff time, and funding. Family Service still supervises FAST and many FAST staff **are** full-time employees of the parent agency. **While** the relationship between Family Service and FAST is less integrated now than during the **project** development phase, it is no less important to project operations. Further, Family Service continues to provide FAST with office space, staff, and a range of support services.

The cooperation of the state DPI and the local school districts has been essential to the maintenance of FAST. This collaborative relationship began during a United Way funded pilot project between Family Service and the Madison Metropolitan School District, and expanded when more funding became available. Local schools throughout the state cooperate with FAST by providing space for weekly meetings, screening children to identify those at-risk, contacting families to refer them to FAST, and providing school staff to co-facilitate FAST weekly meetings.

“Collaborations are built building block by building block...They involve changes in thinking, they involve commitment. [We must] accept that a home-school partnership is necessary for the academic, social, emotional, and physical development of children. This is a shared responsibility. [We need to] make a commitment to children at-risk who we have predicted [have] futures which may not positive...[We have to] respect the authority of the parents. Schools aren't experts who know more than parent [know] about their own children...The keystone is to think about what we know about people...To help people give one another safety, security, stability, belonging, and love.”

***- Student Services Administrator
Madison Metropolitan School District***

FAST relies upon the following organizations for support and services:

PICADA, a drug prevention program. directs prevention and intervention activities at two FAST evening meetings per session and provides information and referrals for alcohol and other drug services when necessary.

PACs provide FAST with ongoing support and guidance. Each FAST session is co-facilitated by one PAC representative who serves as a model of successful completion of the project. In addition, PAC members supervise the FASTWORKS component of the project which provides ongoing support and **aftercare**.

The Madison Community Foundation (**MCF**) developed and tested FAST activities to ensure their developmental appropriateness. Representatives of MCF remain active in FAST through participation in the State Advisory Board.

FAST's State Advisory Board was formed last year to advocate for FAST, maintain collaborative relationships, and protect the quality of the project. The board is made up of representatives of all agencies involved in the FAST collaboration and members of state and local government.

E. Family Involvement

Family involvement plays a key role in the FAST program; individual and family services are provided for parents, children identified as at-risk, siblings, and other household members. Parent participation is integral to FAST since its primary goal is to train parents to be service providers for their own involvement in FAST and FASTWORKS. In meetings, parents focus on family interactions and learn how to play with their children to encourage their children's development. Parents support each other in emotional and concrete ways through sharing rides, babysitters, problems, and feelings. Many parents choose to give service to the project following their graduation and may recruit other parents to participate, run monthly FASTWORKS meetings, or become involved in **PACs**.

F. Project Staff

The staff of FAST includes administrative and direct service professionals from each of the service systems involved in the FAST collaboration. The administrative supervisory staff

includes the executive director and a family therapist from Family Service, **PICADA's** manager of community programs, the FAST project director, two FAST co-managers (one in charge of statewide information requests and the other in charge of Parent-Liaisons, **PACs**, and **FASTWORKS**), and three FAST service delivery team leaders (one is also in charge of national information requests and the other is also in charge of public relations).

Direct service delivery is conducted by FAST school-site teams. School-site teams are trained together and have a minimum of four professionals per team, including a mental health professional from FAST or Family Service, an AOD professional from PICADA, a school professional from the host school, and a parent-liaison from a FAST PAC. Parent-liaisons are parents who have graduated from FAST's eight-week session and are paid, part-time members of the FAST staff. Parent-liaisons attend weekly sessions, contact each parent to check in during the week, and provide transportation to and from meetings.

FAST also **relies** on volunteers who help out at each weekly meeting. Volunteers assist host families in preparing and cleaning up hot meals, supplement paid childcare workers providing services during meetings. or assist in group activities. Volunteers have included school staff. adolescent siblings of younger children. students, or adolescent children of project staff.

G. Barriers and Facilitators to Project Services

FAST staff reported several factors that were particularly helpful during the development and implementation of the project. The factor most often cited as facilitating project services was collaboration between the different service systems. particularly the school system. As a FAST staff member explained:

“Integrating services during planning and keeping with that has been really important to the program Collaboration occurs between everyone at all levels - joint planning, joint meetings, joint recruitment of families, co-facilitation of family meetings. This integration makes [the program] work Kids need all the players to be involved; in FAST, they are. And the schools were especially important. If there had been no cooperative schools, there would have been no program”

Gaining the cooperation of participating schools was not always an easy task, and FAST staff mentioned several barriers that needed to be overcome before the project could be implemented. **As** one staff member explained:

“There was some distrust across the human service sector - not personal to the program, just a distrust of a family agency getting involved with the schools. Schools see themselves as self-sufficient service providers. They aren’t used to working with other agencies...But the program has a commitment to interdisciplinary services, nothing could make us quit that. The cooperation is built into the program, you must have a collaborative partnership.”

To overcome this barrier, FAST made the extra money and training the schools receive from the project contingent on the school’s active participation in the collaborative team. Project staff noted that it was helpful to find one person in each school who believe in the project and who would talk to other school staff in support of the project. Once schools agreed to become involved in FAST, they were cooperative and supportive of the project.

FAST staff reported that the project’s effectiveness also was enhanced by its comprehensive recruitment procedures. Considerable time was devoted to refining the recruitment strategy and FAST staff reported that a number of well-accepted recruitment techniques were ineffective and acted as a barrier to recruitment. For example, announcements in parent newsletters and fliers sent home with students were too impersonal and went mostly unnoticed and unanswered. Informing parents at school meetings and parent-teacher association

conference was also ineffective, because the parents who need FAST the most were usually wary of the school and did not attend these school functions. Some of the approaches reported by FAST staff as being helpful during recruitment were the following:

- Enlist the help of the parents who have been involved in FAST to recruit new parents. This conveys that the project is credible and values parental participation.
- Recruit parents using home visits, not in a school setting or by telephone. Parents are most at ease in a familiar environment.
- Listen to what parents have to say. Take fifteen minutes to break the ice and make a personal connection; be honest, open, and treat parents with respect.

Concerns about continued funding of FAST have prompted an ongoing search for alternative funding sources. As the FAST manual suggests, funding should come from both the lead agency and collaborative agencies, with each site securing funding for its own participation. At the time of this visit, however, no solution or guarantee was apparent. The State Advisory Board will help ease some of these concerns, however, as representatives from each service system are included on the Board and the Board is charged with the responsibility of safeguarding the collaboration.

Project staff also related concerns that the recent expansion of FAST to more sites statewide has resulted in an increased burden of FAST staff. Subsequently, a number of FAST staff have resigned and the majority of staff are newly hired. It was not uncommon for staff at all levels to report working beyond their paid staff hours and several staff mentioned that they often worked twenty to thirty hours each week for FAST, in addition to twenty to thirty hours each for Family Service, PICADA, or their school. In response to this problem, FAST is exploring ways to reduce the burden on staff and is closely monitoring expansion at new sites.

Staff and project participants cited a number of improvements that could be made in

project services and directions that the FAST **program** could take in the future. Some of these suggestions are the following: (a) recruit and hire more role models of different racial and **ethnic** designations; (b) extension sessions longer than eight weeks; (c) develop a FAST program for youth who are older than the current target population; and (d) offer school orientations to **non-**school staff and facilitators to familiarize them with school settings.

H. Client Outcomes and Project Evaluation

Examples of Desired Client Outcomes

Changes in Children:

- *Reduced attention problems*
Reduced behavior problems
Increased self-esteem
Increased appropriate behaviors

Changes in Families:

- Improved communication*
Improved connections with an informal support network
Increased feelings of closeness
Improved interactions between FAST staff and parents

The FAST program monitors clients' success through assessing a number of changes made in the families* and target children's interactions and behaviors. Family and child functioning are measured using three pre and post-project instruments that assess children's functioning and level of parental empowerment. Data from these instruments suggest that FAST sessions increase family cohesiveness, improve the target child's **behaviors,** and increase parents' confidence in their parenting skills.

Overall, parents report enormous levels of satisfaction, success, and learning from their FAST experiences. Quantitative measures from parents and teachers show children's risk-related

behaviors. As one parent reported, “This week, I learned that my children grew **ears...When I** talked to them they actually heard what I said!” Other parents told similar stories after participating in the project, commenting that FAST “helps change the way you look at the **situation...You** learn to take time to look at your kids and watch and listen. And you realize you aren’t alone.”

FAST’s commitment to project evaluation is one of the project’s strongest components. Each FAST site is required to collect four types of data and to submit these figures to FAST’s central office in Madison for analysis. The types of data collected by the project include demographic information about participants’ life situations and backgrounds, information about the group process including observations of FAST groups, rates of project participation, and information about the appropriateness and effectiveness of curriculum materials. FAST uses these data to prepare a report on each individual school site, on multiple sites within each school district, and on state programs synthesizing FAST program operations. The preliminary statewide evaluation report was presented to the State Advisory Board on March 16, 1991.

To improve project analyses, FAST is refining its evaluation strategy to include a control group design. As one staff member explained:

“We will be doing our first random assignment research project this spring after the school assessment. We need to address researchers who argue that teachers are attributing improvements to kids in the program whether or not those improvements happen. Well, we say who cares! If teachers think that the kids are doing better, it’s a good chance the kids begin to think so too and, in fact, do better. We know it works. Kids get better. But now we’ll begin collecting data on it.”

I. Project Replication*

FAST has had extraordinary success replicating the project. In three years of project operation, FAST has expanded from running **groups** at three sites to over thirty sites statewide. The bulk of this expansion occurred during the last state funding period when FAST encouraged local schools to apply for DPI funds. Although FAST management expected six grants **to** be awarded, twelve schools were funded to begin FAST groups in Madison alone. This expansion added to **that of the** previous year when FAST added twenty new sites to **the** project statewide, virtually tripling the size of the project in a short period of time.

Part of FAST's successful replication is due to the cost effectiveness of the project. Project costs for the eight-week FAST project each year is approximately \$800 per targeted child or approximately \$40,000 per school to run FAST groups. The effectiveness of this low cost, short-term intervention has made it particularly appealing to various funding sources.

*These are **direct** quotes **from** the CSR report for **OHD/ACF** (1992) **and** are now dated. **FAST** is now in **seventy** sites in six states.

FAST has expanded in scope in addition to its expanse in size and has begun to modify training and curriculum materials to be appropriate for working with fourth to sixth graders, sixth to eighth graders, and multi-ethnic or predominantly Hispanic children and youth. In addition, FAST staff are refining the project evaluation to better monitor **the** effectiveness of various services **with** different populations.

To maintain **the** project's quality, replication has been accompanied by extensive training and consultation from experienced FAST staff. FAST requires potential replication sites to attend training as a team comprised of a school representative, a mental health organization representative, and a drug prevention representative. If an interested parent is available, they are

also asked to attend training.

Training involves three phases. In Phase I, the team attends two days of training in Madison to help team members establish a collaborative style. Teams are trained in family and systems therapy and **are** taught strategies for recruiting and retaining clients and implementing project services. Teams meet with graduated FAST families, observe a FAST session, and are educated about the research underlying each curricular component.

Phase II begins as teams recruit families at their program sites. Once the local team is ready to begin programming, a FAST trainer will make a one to two-day site visit to provide assistance and feedback to the team just prior to the beginning of services. In addition, trainers return to the site to observe the first session led by the drug prevention specialist from the site team and again to attend the project's first graduation ceremony.

In Phase III of training, the new site team returns to the FAST **office** to present a written report about project implementation. Teams also learn about other sites' experiences and share strategies that have been effective in implementing services. Once this process is completed, each site **team** becomes FAST certified as accredited trainers for the project. This is done in an effort to decentralize training and keep FAST programs less dependent on the Madison sites for training. FAST developed three sites across the state to be training centers. They began functioning during the summer of 1991. Additional efforts also are being directed toward developing a written assistance package for establishing FASTWORKS groups. Long-term training goals include a statewide trainers conference to update and upgrade training and a newsletter to keep sites informed about new developments and FAST activities.

FAST sites adhere to project guidelines set by the Madison office. As one staff member

explained:

*"All the sites are ecstatic about how the **program** is working in their community. **Madison** provides training, guidance, **support**, and **encouragement**...Of course, we want the program to spread, but we don't want it to spread too quickly or without guidance. We're **afraid** it won't be **taken as a whole** - and it needs to be done as a whole. So, the only thing we hope, the only advice we have, is that they do the program exactly like ours at least once through before they **try** and **tailor** it to their **community**...This is not a free-standing curriculum, it's a process."*

II. FAST as a Collaborative Prevention Strategy*

A. Introduction

All institutions dealing with children are being besieged with the impact of poverty on America's children. This paper describes a collaborative response to this challenge: a prevention/early intervention program called Families and Schools Together (FAST). FAST was funded by **OHD/ACF** grant **#90-PD-165**. The collaborative FAST team is made up of a consumer/parent, a school professional, and two community-based, not-for-profit agency professionals: a clinical social worker and a drug counselor. The school targets five to nine year old children identified as at-risk. Then, the FAST team invites the at-risk child's whole family to voluntarily participate in a multi-family group, eight-week experience. The approach is based on family therapy principles and works to build connections to increase parent involvement and help those at-risk children to succeed. This paper describes the collaborative components of the FAST program, the challenges of that collaboration on the systems, and the collaborative training being offered. The FAST program **began** in 1988; in 1990, it was funded at one million dollars per year as a state policy in Wisconsin. By 1992, it has won several national awards, and functions in over seventy schools in six states.

Collaboration is a popular concept of the 1990's. New collaborative efforts (i.e. structurally non-affiliated groups working together to bring about change) represent one of the few positive outcomes of the recession. The partnerships being formed in various combinations across the United States are novel and varying. but they make good sense, and often cause the layman to wonder why this has not happened before. For example, recently the mayor's **office**

*This chapter has been **submitted** to Families in Society for publication; authors **are Lynn McDonald and Steph** Billingham.

was **meeting** with the school superintendent, the director of county social services and with the United Way director to plan local services for the **first** time. These collaborative planning efforts are being funded by federal dollars, state dollars, United Way dollars, etc.

Elizabeth **Schorr**, in her book Within Our Reach, has underlined several basic principles shared by existing effective approaches to helping disadvantaged families. One of these is collaboration. In a keynote address at the National Association of Family-Based Services in Missouri in December, 1991, Ms. Schorr congratulated the bureaucracies which are changing to facilitate cross-bureaucratic collaboration. However, she expressed concern that the recent move towards collaborative planning efforts, although excellent beginnings, did not bring the effectiveness of collaboration into the service delivery sector. It is in face-to-face contacts with clients that the collaborative approach really produces an impact, she argued.

In the summer of 1987, the Family Service agency in Madison, Wisconsin initiated a joint venture with a local elementary school (Lowell Elementary School) to address the issues of children at-risk for school failure, drug, and mental health problems among adolescents. The agency and school together obtained funding from both the United Way of Dane County and Wisconsin Department of Health and Human Services, Alcohol and Other Drug Section to implement the FAST program.

FAST exemplifies a recent national movement towards cooperation across sectors of the human services community. At all levels of practice, human service professionals are confronted by massive societal problems that effect contemporary youth and families, especially those families struggling under burdens of low-income, sexism, and racism. Current statistics reveal

that about 25% of the nation's children will not graduate from high school, despite our renewed emphasis on the importance of public education. Among minority children, children who reside in **inner** cities, and the children of lower socioeconomic status, drop-out rates range from 40% to **60%** (Wehlage, Rutter, Smith, Lesko, and Fernandez, 1990). Alcohol and other drug abuse also take a heavy toll on the potential of the nation's youth.

The growing recognition of the inadequacy of current strategies has fueled a search for new approaches. In recent years, innovative coalition of agencies, institutions, and families have often succeeded where traditional approaches have failed. These success stories have so dramatically demonstrated the effectiveness and efficiency of collaboration that the concept has rapidly won enthusiastic acceptance from many diverse sources. Collaborative partnerships simply make good methodological sense.

In this paper, a collaborative program called Families and Schools Together (FAST) will be briefly described. Unlike many other new programs, FAST is collaborative at the planning level, the funding level, the administering level, the training level, and the service delivery level. The focus of this paper will be on how the FAST program is collaborative, what the challenges are of the collaborative process, and what the benefits are of collaborating in this program.

B. The FAST Program

The goal of the FAST program is to bring families into partnerships with schools for the sake of the children (see McDonald. et al. 1991 for a full program description). Schools complain that there is **insufficient** parent involvement, but often do not have the resources needed to adequately reach out successfully to the parents. Unfortunately, some teachers stereotype

certain **parents** as uncaring, and certain parents characterize schools as unwelcoming. In **FAST**, **the** assumption is that in order to achieve parent-school cooperation, there must be a bridging process involving community-based agencies (such as Family Service agencies). FAST targets at-risk children of uninvolved, hard-to-reach families, and uses a collaborative team (which includes parent graduates of the FAST program, two community-based agency professionals, and a school representative) to create a bridge to bring the families and the schools together on a positive level. The FAST team reaches out to the whole family by making a home visit, and offers a free, voluntary, eight-week multi-family program. **Often** as many as twelve whole families graduate from the program. There are multiple incentives for participation. The group is not didactic, but experiential. Structured activities build relationships among family units, between a parent and the at-risk child, between parent and parent, and with parents and community service providers. Positive connections are formed through the program while having fun.

Upon graduation from FAST, referrals are made to appropriate clinical **services** (e.g., support and advocacy for meeting basic needs, substance abuse treatment centers, psychotherapy, family therapy, or other community resources). A two-year follow-up commitment is made for monthly sessions open to all FAST graduates. A Parent Advisory Council runs the follow-up sessions, with a small budget and professional staff **support**.

Most families that have participated in FAST to date are single parent families (mostly mothers) living on inadequate incomes with high levels of parental stresses and demands. Many participating parents also are functionally isolated (60% of the initial FAST families had no transportation vehicle, and 40% had no telephone). and lack of opportunities to provide or receive

support from other parents. FAST proactively involves parents in a supportive network of relationships with peers and service providers, and thereby buffers the effects of stress and undergirds the family system. A programmatic goal of FAST and the follow-up program is to build and provide organizational support for ongoing social networks that can service as a sustaining resource over time to families under chronic or periodic stress.

During each weekly FAST session, each parent is brought together with their at-risk child for fifteen uninterrupted minutes of quality time. Parents are coached as they play with their child to be non-judgmental and non-directive. This variation of play therapy conducted by the cathected parent is a published child psychiatry technique developed by Dr. Kate Kogan (1975, 1978). This is the core of the program and the impact on the child's functioning is attributed to this protected, positive interaction with the child and his mother.

Although lower income and less educated parents and parents who are stressed and isolated are most subject to risk factors for the development of child problems in school and elsewhere, these same parents often have less access to supportive resources for families such as parent education (Clark and Baker, 1983; Rios and Gutierrez, 1986; Dumas and Wahler, 1980) or parent-led support groups and prevention efforts (Klitzner et al, 1990). Real life pressures including time demands, job demands, childcare responsibilities, and lack of transportation make it difficult for families to become meaningfully involved in traditional programming like parent education. FAST offers multiple incentives and assistance to attract the **families** of at-risk children. These incentives both reduce obstacles to coming to FAST meetings, and provide material and emotional rewards for the families, since the programmatic features alone are unlikely to motivate many families who are unfamiliar with the program.

n

Collaborative teams enhanced the initial participation rates in **FAST**:

- Of those targeted by the schools, only 40% initially agreed to be visited at home by a FAST staff person. This may reflect the initial level of distrust which existed in the neighborhood towards the school.
- Of those home visited, 80% attended at least one session. The home visit to invite the whole family was made by the community-based agency professional with the FAST parent graduate. The non-school, community-based representatives may have deflected some of the anti-school sentiment, and contributed to the home visit resulting in this high level of attendance.

Of those who attended one session, 80% completed the eight-week program. This is considered to be related to the positive programming of FAST, once people got there, they enjoyed themselves. This is probably hue of most good programs.

- Over time, with additional training, and with the positive reputation of the program, these have all improved. Now 80% of those targeted agree to a home visit by the FAST staff. The collaborative team seems to help bridge the distance between the parents and the school with a positive shared experience.

Over a short two-month period, attitudes change, children's behavior improves, and parents become more involved with their child and with school (McDonald and Billingham, 1992). FAST begins with the parent's hope for their child. By respecting the parent and providing support to the parents so that they can become the prevention agent for their own child, parents feel empowered. In FAST, they have a voice and a responsibility in facilitating the program. Soon after graduation. they frequently get involved in community events, employment, and ongoing education. Communities which have been trained in this collaborative approach have been effective in increasing parent involvement in over seventy schools in six states. Although FAST has served low-income families, primarily, it has also been popular with suburban, middle-class, intact families. FAST multi-family groups have taken place in rural areas, small cities, and large inner-city ghettos. FAST has worked effectively with intact families, divorced families, three generation families, and single parent families. It has served

Spanish-speaking families, African American families, Native American families, Asian American families, and European American families.

C. Collaboration in the FAST Program

To become trained and certified as a FAST program, **there** must be a minimum of four collaborative partners: a school professional, two community-based agency professional (a mental health/clinical social worker and a substance abuse counselor), and a consumer representative (a parent). There are four ways in which collaboration in FAST is considered innovative.

First, the FAST collaborative teaming is represented at every level of the program: at the service delivery level, in the training process to do FAST, at the planning and administering level of the local program, and at a state level for policy development and funding, i.e. the FAST Advisory Board. These multiple levels of collaboration distinguishes FAST from some initiatives which have gathered policymakers and planners into partnerships, but not the service providers.

Second, the collaborative partnerships in FAST cross over public/private sector lines. Specifically, with FAST, public schools work closely with private, not-for-profit, **community-**based agencies to produce change for at-risk children. There is an increasing recognition that the public schools cannot manage on their own the impact of the recession on the community and the family, **as** it plays out in the classroom. This recent openness to collaboration to address these issues is demonstrated in a 1989 guide for state action published under the title “Family Support, Education, and Involvement”. by the Council of Chief State School Officers, an organization of the heads of public education agencies from every state:

“The realities facing **today;s** families mean that they often do not have the time, resources, or skills for that kind of support or assistance. Schools must do more to position families to help their children in school.”

“Expanding school actions in family support, education, and involvement presents new sets of expectations and responsibilities for **schools and their staffs**. **Though some** may feel this adds to an already overburdened set of responsibilities for schools, the situation is such that the potential for the school to address basic family needs must be used. Much of the effort must be carried by schools in alliance with other service agencies. Much of the effort will require use of existing programs of community and adult education and will require **reshaping** traditional school/parent organizations and partnerships.”

However, the funding of such a process is not easy. In Wisconsin, when the state bill to replicate FAST was introduced, it encountered some controversy. First, there was resistance to public money being specifically allocated to a private sector, specific program, and so the wording of the legislation was to fund families and schools together program (with the name FAST lower-case). Second, the bill included an unprecedented component: public education monies could be used to pay for community-based agency participation. The Wisconsin School Board Association was quite interested in and supportive of the FAST proposal, in part because of its setting this legal precedent, i.e. financing a public/private collaboration with taxpayers' dollars (O and Kunelius. 1991).

The separate funding structures and procedures of the public vs. private (not-for-profit) sector has contributed to a great deal of misunderstanding. Schools, for example, do not separate out their overhead costs when describing the costs of a program. In contrast, a Family Service agency in proposing budgets for a program adds the actual cost of overhead to the budgeted costs. This difference alone has led to a suspicion by the public sector that profit from “inflated costs” might be taking place.

The third way in which FAST is innovative in its collaboration is that consumers and

providers are in partnership. The parent voice, as a consumer of FAST, is included **in the training**, implementation, and planning for **the** program. The effect on a group of professional of including a consumer of FAST at the discussion table is striking. **The** consumer presence **alters** the tone of the team. The parent/consumer perspective is respected as equal in the team; and, if invited to speak and listened to, it can increase the credibility of the FAST program. The consumer team member helps to remind the professionals to inquire **first** about the consumer experience, i.e. that of poverty, single parenthood, **ethnic** background, before deciding on a course of action. The value-based FAST program includes as the first of ten values, “the parent is the primary prevention agent for their own child”, and, as the tenth value, “all parents love their children and want the best for them.” Parental partnership with professionals is essential to the program’s success.

As a fourth feature of the collaborative team, FAST brings together a mental health social worker, a substance abuse counselor, and a school social worker/guidance counselor. Often MSW clinical social work graduates have never taken any academic courses on alcohol and other drug treatment issues, or courses on schools as institutions. This lack of training reduces **the** likelihood of their asking questions about drinking behaviors, i.e. breaking the “no talk” rule in families with alcoholic members, or of knowing the issues confronting their colleagues in the school systems. Funding of professional jobs underlines this separation of mental health from substance abuse from schools, so that these specialists are usually located in different agencies. The opportunity to work alongside one another and bring together their distinct areas of competence enriches each of them.

These four factors, the top to bottom levels of collaboration, the public/private transfer

of funds, the consumer/provider relationship, and the working relationships of social workers in mental health, drug counseling, and school counseling settings, have contributed to the effectiveness of FAST as a model prevention program.

D. FAST Collaboration as a Challenge for Systems

The FAST program has been developed and implemented as an innovative collaborative **venture, defining new roles and** relationships for the collaborative partners. The collaborative **team in the** FAST model includes representatives from the school, a local mental health agency, **a substance abuse** specialist, and a parent-liaison. Team members collaborate to define roles in accordance **with** their special strengths and organizational contexts. For example, mental health professionals collaborate with the schools in the identification and referral of the at-risk children, or a mental health professional may team with the parent-liaison from home visits and recruitment. Collaborative teams divide responsibilities for FAST curriculum components among their members so that all team members' responsibilities conform to their respective agency contexts, with parents as co-facilitators of the program.

FAST's parent empowerment goal is achieved in part by the inclusion of a parent representative on the collaborative team. Parents with some leadership experience, in Head Start, for example, make excellent parent representatives. FAST's involvement of parents also includes the program's recruitment efforts. program input. and parent advocacy, but the parent representative to the collaborative team has. in particular. necessitated some rethinking and new approaches to interactions among professionals. While all FAST teams to date have **confirmed** the importance of the parent-liaison to program success, the creation and maintenance of this

parent role has required extra effort, since most FAST parents lack the educational, professional, and agency affiliations that benefit other professionals.

While the strength of school-community collaboration brings new hope to prevention programs like FAST, the obstacles to collaboration across agency and disciplinary boundaries are well known. These may include training differences, salary and status differentials, conflicting organizational traditions, disputes over cost efficiency, language discrepancies, and “turf wars” (Jacobs, 1987).

The experience of the FAST program has been that collaborative strategies’ require a number of key ingredients to stand any chance of success. First, there must be a shared realization that current efforts directed towards FAST’s “target” problems **are** not working. **In** the case of the FAST program, it was clear to school personnel that a significant minority of students were not succeeding, and that a very high number of these students **were** from families who were not involved in the school community. Clear definition of an at-risk problem existed. From the **mental** health agency perspective, it was clear that while intensive therapy showed promise with some families, therapy was unavailable to others, or was simply too little and far too late. Agencies recognized that earlier, preemptive intervention might be successful, but also realized that such an approach could not be developed or implemented without the cooperation of the schools.

A second vital element to the success of a collaborative strategy is the involvement of people who have both the interest and the authority to try a new approach. Simple recognition that a current approach is not working does not necessarily translate into a willingness to try something new; and the enthusiastic support of any single agency representative may not produce

an enthusiastic collaborative partner if the representative does not have authority or persuasive **powers to secure the cooperation of the agency** he/she represents.

Third, a successful collaborative team often must develop broad, well-traveled lines of communications among the various partners. While communications among school, human service agencies, and other sectors often already exist due to state mandates and 'other reasons, these channels may be inadequate to support a collaborative service venture on the scale of FAST. Without active cross-system communications vehicles, many collaborative projects will fail. The FAST program encountered some thorny problems in the areas of confidentiality policies and funding, and these could have easily evolved into major conflicts without the existence of good cross-system communications.

The forces that have produced individual, **specialized human and social service** organizations are very strong. Organizational values and proprietary attitudes often are institutionalized within formal policies and procedures quite independent of **the** people who manage an organization and pursue its goals. The FAST program **continues to encounter** problems that can be traced directly to the separate origins and evolutions of its different partners. FAST has found that good communications foster new loyalties to the team and to the venture, which heads off many potential problems.

While collaboration quickly reveals diverse perspectives and orientations to service delivery, team members can be united by common values or missions that transcend or encompass disciplinary affiliations (**Childs**, 1987). FAST is explicit about program values and goals, which all collaborative partners must acknowledge. These values, **which** are asserted and discussed during the collaborative training process, include the belief that collaboration across

systems to address the needs of at-risk children is a necessary and important process.

E. Collaborative FAST Training Approach

The FAST program first began operating in 1988, and there was a commitment from the outset by Family Service in Madison, Wisconsin and the authors to share the technology for the program as soon as possible. Two training manuals totaling over 300 pages were drafted in 1989, published by Family Service in 1990, and revised in 1992. The Orientation and Training Manual includes sections describing: 1) the goals and values; 2) the basic program; 3) background information on research underlying the program; 4) **details** on evaluation; 5) details on grantwriting; 6) details on funding sources; 7) details on costs; 8) details on training; and 9) details on developing a collaborative team. The second volume, the FAST Program Workbook, accompanies the training process and goes step by step through how to execute the program

By 1992, the FAST program is in almost seventy schools in six states: Wisconsin, Illinois, Iowa, Michigan, Kansas, and Delaware. These communities have participated in a structured collaborative training process encompassing six and one-half days of training spread over a four-month period. The evaluation of thirty FAST replication sites indicates that the training has been successful in demonstrating statistically significant improvements of the children's behavior in school and at home; changes of 20% to 25% in just eight weeks in self-esteem, attention span, and conduct disorders (McDonald and Billingham, 1992).

In order to insure the collaborative teaming to do FAST, access to training is limited to those who come with the four basic partners. Thus, a collaborative team must be created prior to training with the minimum of four members: a consumer/parent, a school professional, and

two community-based representatives: a mental health/clinical social worker and an alcohol and **drug** counselor (from the not-for-profit sector). Teams can be comprised of up to ten members, **reflecting the** local community strengths and priorities. Often school principals and other administrators participate, as well as potential funders for the ongoing FAST program, such as school board members, Chapter I representatives, Drug-Free School or parent involvement dollars, and pupil services staff.

The goals of the training are the mastery of the concepts, the content, the delivery of the FAST program, and the building of an effective, problem-solving, communicative collaborative team. Manuals and procedures alone cannot accomplish this second, process oriented goal. Often the FAST team members have not met each other prior to the training, yet they will be expected to co-facilitate a complicated and challenging program. A FAST trainer is assigned to the community team for the entire six and one-half days. The trainer works to facilitate the team building among the collaborative team members. Exercises **are** constructed to maximize the likelihood of group connections being formed. An attempt is made to override the natural divisions which separate the individual team members from one another. These divisions include position power, education, experience, gender, race, age, and personalities. These **are** in addition to the divisions of public vs. private sector, the consumer vs. provider sector, the administrative vs. direct service practitioner, and the mental health counselor vs. drug counselor vs. guidance counselor.

Team training is conducted in three phases. In the first phase, the multi-disciplinary team attends a two day training to **introduce** the concepts and the content of the program. Team building is maximized by community specific, small group discussions led by the FAST trainer.

The content goals of this initial two-day phase are:

1. To review the FAST program and understand the research background and theory base.
2. To experientially walk through each step of the program curriculum.
3. To observe a FAST group, with actual FAST families, and hear about the program from the children and parent consumers.
4. To understand and discuss FAST program values.
5. To plan in detail how the program would be implemented at the local site, taking **into** consideration local facilities, resources, and other site-specific circumstances.

The second phase of training occurs on-site. Each FAST trainer visits his/her team's home site three separate times during an eight-week program period. The trainers observe, coach, and provide feedback; all completely individualized to the local community. This stage is essential to the successful start-up of the complex program,

Finally, all of the community groups convene at a FAST training center at the conclusion of their first eight-week sessions to review their FAST group experiences and to prepare for FASTWORKS and independence from the trainers.

While many programs have attempted to serve children and families with a multi-disciplinary approach, not all have been as successful as FAST. Effective collaboration is not an easily acquired goal, but the FAST experience suggests that legislative mandates, funding restrictions, and the control of access to training and certification can all contribute to this important process.

F. Summary

FAST targets children who are at-risk in elementary schools, using a collaborative

approach and a whole-family methodology. Because FAST is a prevention program rather than a treatment program, some mental health and family service agencies may not initially accept the program as part of their customary operations. The program's experience challenges the **resistance in several** ways:

FAST succeeds in linking hard-to-reach families to mental health **treatment** services, which the families then use.

The collaborative structure of FAST increases interagency referrals. **The** program helps **staff** from mental health agencies, substance abuse treatment centers, and local schools to get to know each other.

A thorough program evaluation of FAST to date has **confirmed** clinical changes in the functioning of the at-risk children, as measured by teachers and parents before and after the eight-week session using standardized quantitative methods (McDonald et al, 1991; McDonald and Billingham, 1992).

FAST is very **fundable** at this time: United Way, city, county, state, and federal dollars (Chapter I, Carl Perkins, At-Risk OSAP monies) have all funded FAST.

FAST has been described as a program that strengthens families, prevents drop-outs, prevents substance abuse, prevents delinquency, and serves as a transition from Head Start to the public schools. It is a very positive program. FAST makes everyone feel good: the children, the families, the professional staff, the volunteers, the **funders**, and the media.

III. FAST as an Empowerment Strategy for Parents*

A. Introduction

Prevention as a concept is often entirely left out of social workers' repertoires or vocabularies, Social workers did not do "lightweight work"; we did work at the "deep end." We work with families of children who were delinquents, substance abusers, emotionally disturbed, victims of abuse and neglect, or severely **developmentally** disabled. We work with homeless, seriously mentally **ill**, hospitalized patients. However, with the savage inequities of the last twelve years, the destruction of the nation's infrastructure and the resulting loss of the safety net for children and families, social workers **must** use our bag of "deep end" tricks of the trade into the prevention arena. Rather than sit by as people helplessly say, "we have lost a generation of children." As clinical social workers, we have the technology to bring to bear in the arena of early intervention, and the socially responsible time to do so is now.

Empowerment. on the other hand. is a **popular** social work concept. However, it is suspect when such a term appeals to both Democrats and Republicans. Is this a term supporting "pull yourself up by your own bootstraps?" Is there not a risk of implying that a victim of the recession, who is a single mother with three children and two jobs, should take on the responsibility herself of becoming empowered, and then be less dependent on the "System".... How is it that the word is acceptable when the number of children living in poverty is greater than at any time since the Depression?

We describe a program in this paper. funded by OHD/ACF grant **#90-PD-165**, that strives to achieve consumer empowerment is actually professionally challenging, is complex, and is

***This** chapter is a draft of a paper **which I** intend **to** submit **to** Social Work, **co-authored** by Lynn McDonald Carla Jensen, **Stella Payton**, **Stephe** Billingham. and David Hansey.

costly in terms of time and resources. Empowerment is a value-based approach which takes an exactness of professional practice.

In this paper, I will describe a multi-family group prevention/early intervention program based on social work principles and practices, and **illustrate** with case examples the impact of the empowerment on the lives of graduates of the program. Only four years old, this program called Families and Schools Together (FAST) has already been replicated in seventy communities in six states. There seems to be a need for such a bag of “deep end” tricks.

B. Concept of Empowerment

The integrated practice model of social work (Parsons, Hernandez and Jorgensen, 1988) suggests that “both prevention and habilitation are optional intervention points, because social workers are educators and mobilizers of resources, not specialized therapists.” I resist this dichotomy and suggest that as a specialized therapist, I can use that expertise to share with the educators and mobilizers of resources what to do that will work best. The integrated practice model identifies practice principles as “promotion of competency, normalization, and empowerment. These practice strategies include differential role taking, teaching problem-solving models, networking, team building, and mutual aid and self help.” I suggest that these are sound principles and practices, and that the specifics of how to achieve these can best be delineated by the clinical social workers. Integrated practice models of social **work** should integrate the expertise of clinical social work with community-based practice. Prevention is an excellent arena for this to take place, and empowerment is a fine example of bringing the principle and technology together to alleviate the circumstances of the feminization of poverty. According to

The FAST co-facilitators organize **the** group of ten to twelve families at a time, and the volunteers and visitors (often sixty people) to make the transitions smoothly. Usually several rooms are involved, and a lot of people get up and walk around during the two and an half hour FAST session. All family unit time is done at separate family tables spread around the room, **and marked by a family flag and a family picture.** The level of chaos diminishes after **the** first session **during which brief interactional guidelines are given for each activity.** The families quickly become familiar with the routine and with the instructions and can proceed independently **through various activities.** **The only time the co-facilitators split up is during the parent vs. child** time, and then the family therapist and **the** consumer/parent facilitate the adult group time. **The** instructions for the exercises are simple. They are listed below:

- Flag: To parent: have your family make a family flag. Make sure each family members puts something on it.
- Meals: To children: come with us (staff) to **fill** a plate of food for your mother, and let her just rest at the family table: she needs a break. She works hard being a mother; now let's treat her specially. Then, after you serve her, we'll help you get a plate of food for yourself (parents hear this).
- Music: Everyone gets taught the FAST song together; often we add on. To a parent: ask one of your children to think of a song that we **all** know, and then can your family table lead us all in singing it please?
- Scribbles: To parent: Have one of your children count the number of folks at your family table. and tell that child to come up to us and get **the** right number of papers and pencils.
To parent: Now have each member of your family draw on a piece of paper, but don't let anyone peek at each other's **drawing.**
To parent: Now have each person in your family take a turn to show their picture, and invite each person to ask the drawer a question about their picture. Do not allow criticism.
- Feelings Charades: To parent: have each person in your family come up to the front and pick up a card and return to your family table.
To parent: have each member of your family act out the feeling on the

card that they picked, and let everybody guess it.

- Kids' Time:** To children: go on out and play; the grown-ups will stay and talk.
- Buddy Tie:** To parents: please buddy up with another person; just review your day with each other, and no giving advice, just listen.
- Adult Group:** To parents: My name is Lynn, I have two children - Ruth, age **fifteen**, and Ben, age eleven. My stress level is about seven. Who's next?
- Special Play:** To parent: spend **fifteen** minutes of one-to-one time playing with your child. During this time, do not boss, do not teach, and do not judge. You can follow his lead, and describe what he does or mimic him, **but** do not teach, boss, or judge.
- Lottery:** To parents: the lottery is fixed. Each family will win once. Don't tell your children that it is fixed; you can say you **are** sure they will win, but you do not know when.
To everyone: remember, if you have the winning ticket, you win for your whole family and everyone comes up together.
To the winning parent: you also win the chance to host a meal for all of us next week; here is forty dollars cash, please **plan** the menu, shop, prepare, and cook the meal. Thank you.
- Announcements/Rain:** To parents: can you help get your kids into a big group circle?
To everyone: are there any announcements of good things that anyone wants to share? Are there any birthdays to sing for?
To everyone: now we are going to do an ending exercise that sounds **like** rain. Don't use your mouth, just your eyes to see what to do next; pass it around the circle.

E. Family Therapy Principles

These instructions maximize the probability that certain family strengthening enactments will occur. These enactments are based on family therapy premises that certain types of experiences can only enhance family functioning. Rather than prescribing specific enactments for individual situations of individual families, FAST proactively prescribes the same enactments for all families of this particular state of family life-cycle functioning, i.e., having a five to nine

year old.

The following family-systems principles **are** undergirded in the structured FAST multi-family process:

1. Clearly **defining** the family boundaries in relation to outsiders.
2. Empowering the parental executive sub-system with support.
3. **Clarifying** the hierarchy.
4. Bringing order to chaos with foreshadowing, rules, and routine.
5. Facilitating expression of empathic familial responses and broadening the range of expressed affect in the family.
6. Structuring communication to include each person having a turn to talk and to be listened to, and inquiring of each other in turns.
7. Differentiating individuals in the family.
8. Combatting disengagement and promoting cohesion within **the** family.
9. Creating family rituals with repeated sharing experiences.
10. Challenging shared family beliefs by enabling families to experience themselves as winners, as hosts for the group meal, and as having power to successfully initiate activities.

In these ways, the FAST multi-family program builds bonds and positive connections with various combinations relevant to the child's optimal functioning. The programmed activities promote relationships: 1) between the parent and the at-risk child; 2) within the family unit as a whole; 3) between adult **dyads**; 4) among the adult group; 5) between parents and **community-**based professionals; 6) among the whole group of participants; and, **finally** 7) between families and schools together.

F. Profile of Children At-Risk, Families, Schools/Communities

Profile of Children At-Risk (see table):

Elementary schools designate the children they wish to target for FAST according to their own procedures and processes. Teachers are usually involved, and they **are** asked to identify children who may as adolescents become school drop-outs, delinquents, and involved in substance abuse. Typically, the children have been boys, about eight years old, who are behind in school, apathetic, hypersensitive, unpredictable, depressed, have conduct problems in class, and a short attention span. They are two standard deviations above the norm for problems.

Profile of Parents of Children At-Risk:

Typically, they have been single mothers with marginal income or on welfare. Sixty percent have no car and forty percent have no telephone. They **are stressed**, socially isolated, depleted, and depressed. In many cases, there is a family history of substance abuse. They score within normal range on family cohesion scales.

Profiles of Schools/Communities which have done FAST:

FAST programs have been held in suburban, urban, and rural schools/communities. They have been in inner-city ghetto neighborhoods and in communities where it is miles between each farmhouse. These multi-family groups have been held with various family forms: intact families; divorced families including both biological parents; three generation families; single parent families; and single parents with boyfriends and roommates included. FAST has been used with all middle class families. all lower class families, and a mix of social class families. Groups have been held with a **mix of** races. as well as with families which were all African American, all Spanish-speaking American. all Native American, all European American, and all

Asian America.

G. Evaluation

Because FAST has been funded by grant applications which get reviewed, because schools like concrete numbers, and because it helps clinical practice to have a feedback loop for **self-**correction or self-congratulation, there is a heavy emphasis on evaluation in the FAST program. However, this evaluation was not part of a research program in a university setting. Clinical staff at Family Service in Madison, Wisconsin, a small, not-for-profit mental health agency, conducted it. Although the multi-family approach is based on many clinical researchers' published findings and on theoretically sound assumptions, the evaluative attempt has been to document the impact of the program on children and families.

Of those whom the schools initially referred, only forty percent agreed to a home visit by a FAST staff person. Of those initially home visited, eighty percent went to one session. Of those who went to one session, eighty percent completed the eight-week program. Of those **who** complete the eight-week program, twenty-five percent regularly attend the follow-up monthly meetings, and fifty percent attend at least one a year. These rates have all been improved upon over time with parent graduates doing recruitment, careful use of incentives, reputation of the program, being positive, and training of staff more thoroughly. Communities/schools trained to do FAST always do **better** on their rates of involvement, than these initial rates.

A brief summary of the outcomes on the children are outlined below. The full evaluative process and results are described elsewhere (McDonald and Billingham, submitted; McDonald and Billingham, 1992; McDonald, et al. 1992). **Pre/post** data from teachers and parents on 400

children and their families **from** thirty trained FAST sites have been analyzed. Standardly used instruments with established validity and reliability have shown overall increases in child functioning of twenty-five percent, after the eight-week multi-family program. This included **sub-**scales of attention span, conduct disorder, anxiety withdrawal, socialized aggression, and motor excess. In addition, at one site, an experimental design with random assignment to FAST vs. no FAST was completed. The parents with FAST reported a forty percent improvement, with no FAST a twelve percent improvement. on child functioning measures. Statistically significant improvements in family cohesion, and parent involvement in the schools were also demonstrated. Longitudinal assessment is now taking place. Families give the FAST program a 9.5 out of ten, and recommend it to their friends. Children seem proud to be in it, and they force their parents to attend.

H. Conclusion

Donna Purcell, the President of a State School Board Association, is quoted as saying:

“We must remember the most important partners in education are the parents and the family; they must become involved in planning and supporting their children’s education. Engaging parents in the process and making them feel wanted and comfortable in the school environment are two of the most tangible and effective results of the program. Helping at-risk students and parents become successful helps the school become successful.” (O and Kunelius. 1991. p. 26)

Recently, a school superintendent from a rural community told me this story: two years ago, their school wanted to construct an addition to the building; to get money for that, they had a referendum. a vote in the community. It was voted down. Then they began the FAST program. This spring, they held the referendum again and it passed. They attribute the change to FAST, and have decided to build a Parent Room onto the school as well.

A school principal from a small community told me that three weeks after their FAST graduation, where she had given out FAST diplomas, the father of one of the **at-risk** children died **suddenly**. Before FAST, she continued, that family had been **totally** isolated from the **community**. **All** of the FAST families got together and prepared food for the funeral. The **principal was invited to the funeral**. After the funeral, the at-risk **child** pulled **his** out-of-town aunt and uncle over to the principal, and said proudly, “I want you to meet my principal.”

Another school principal told a group of relatives and guests at the FAST graduation, “Schools should be about **the** four R’s: Reading, Writing, Arithmetic, and Relationships. FAST is about building relationships.”

A school social worker told me that an at-risk children who had been everyone’s concern now dropped by her office to say “hi” or would shout at her in the hallway, “see you at the next FAST meeting.”

These stories from the school hierarchy are about something that is changing and can be changed. In the **1990’s**, maybe it can be said that the technology of family therapy can be packaged, taught, and used by minimally trained collaborative team for large numbers of families simultaneously in a prevention/early intervention format. It is obviously no substitute for therapy, but it can give support to families. give them a taste of positive familial interactions, and actually motivate them to want therapy. **If** they decide they want therapy, they now know someone who does it, or who could refer them.

Parents want the best for their children. and schools want to teach those children. Family therapy techniques can be used to **enter** into a conflicted, disengaged system by building on the positive, common ground. FAST can offer effective alternative strategies to those involved.

V. FAST as Community Mental Health Prevention Strategy*

A. Introduction

The current status of children in the U.S. is very bad according to many different measures, including poverty, neglect, abuse, school failure, delinquency, and substance abuse (Children's Defense Fund, 1992). There are multiple stresses which accompany poverty: e.g., living in substandard, overcrowded housing; safety and health hazards; insufficient nutritious food; overstimulation or understimulation; and often the inaccessibility of the major caretaker, either physically or emotionally. Political indicators do not show any immediate possibility of a fair redistribution of wealth to address the needs of these children. Therefore, as caring clinicians, we **are left** with the question: is there anything else which can be done to ameliorate the impact of the poverty on the mental health of children?

Werner and Smith (1984) did longitudinal research on children of chronic poverty and identified factors which over time correlated with survival **and** successful coping. These included protective factors in the child (such as active, good-natured, autonomous, and positive **self**-concept), as well as major sources of support in the caregiving environment. Twelve characteristics of the caregiving environment helped to increase the likelihood of young adult competence, despite growing up in a context of chronic poverty. These were:

1. Four or fewer children spaced more than two years apart;
2. Much attention paid to infant during the first year;
3. Positive parent-child relationship in early childhood;
4. Additional caretakers **besides** mother;

*This chapter is a draft of a paper which will be **submitted** to Journal of Hospital and Community Psychiatry by co-authors Lynn McDonald and **Stephe** Billingham.

5. Care by siblings and grandparents;
6. Mother has some steady employment outside of household;
7. Availability of kin and neighbors for emotional support;
8. Structure and rules in household;
9. Shared values - a sense of family coherence;
10. **Close** peer friends;
11. Availability of counsel by teachers, and or ministers;
12. Access to special services (e.g., health, education, social services).

Work summarizing research on resilience (**Nieman**, 1988) identifies that the number and types of chronic and acute stresses in the child's past and current context are counterbalanced by the availability of the parent for parenting, and the availability of alternative social supports to the child.

If one perceives the parent under as the most natural and appropriate resource to the child who is under duress, then early intervention would involve supporting the parent as the primary prevention agent for their own child. By supporting the parent, and coaching the parent as they interact with their child, one could increase the level of parental accessibility to the child, and this. in turn. would increase the coping of the child. For young children, this would especially be true: the parent would be a critical buffer to the chronic and acute stressors on a child's well-being.

Mothers, however, who **are** low-income and depressed, often vacillate between neglect and emotional abuse. **UNLESS** their depression is counteracted by another adult friend/lover/relative to whom they **turn** for support on a daily basis, their own worries and

concerns diminish their psychological maternal availability (**Belle**, 1983). Other researchers have **similarly** pointed out that single mothers with little education and marginal income, who experience a great deal of stress, are at-risk for increased neglect and abuse towards **their** children. Egeland et al (1983) show in a longitudinal study which correlated many factors **with** child abuse, that such risk factors correlated with abusive behavior significantly more when the mothers were socially isolated. Wahler (1978) underlined this interaction between parents and isolation by reporting that behavioral parenting programs were less likely to be effective over time **with** single, low-income mothers who had no support network.

In this paper, we describe Families and Schools Together (FAST), a prevention/early intervention program designed to increase the protective factors available to children under stress. This program was funded by federal **OHD/ACF** grant **#90-PD-165**. The FAST program applies to relevant theory and empirical findings from child psychiatry, family therapy, group work, and stress and social support studies to achieve this. Two central goals of the program are 1) to increase the social connectedness between the child and his/her parent, and 2) to increase the parents' social connectedness to other adults, i.e., to parents in the neighborhood, to people at the child's school, and to people at community-based agencies.

These two goals address separate dimensions of functioning, and distinct methods and techniques are needed to achieve each of them. It is the assumption of the program that the first goal can only be achieved if the second goal is achieved. But the second goal alone does not lead inevitably to the achievement of the first goal. In other words, mothers under stress, who are socially isolated, are more at-risk of abusive behavior towards their children. However, social connectedness alone does not sufficiently address the parent-child interaction to support the

mental health of the child who is under stress.

Follow the program description as it relates to those two goals, the initial program evaluation data are presented, using the child's mental health indicators as the relevant outcome measure.

B. Description of FAST Program for Two Goals

FAST is a collaborative prevention/early intervention program for five to nine year old school children involving the whole family. The process begins with teacher identification of children in the classroom showing behaviors which concern the teacher. This could include underfunctioning, unpredictable performance, out of control episodes, and/or withdrawn and being teased, overreactive, etc. Following a signed release from the **parent** to the school, the collaborative team visits the home for recruitment, eight weeks of evening multi-family meetings are held, graduation takes place. and ongoing monthly FASTWORKS sessions begin as the follow-up component of the program. Also, referral to appropriate resources takes place, and evaluation of the impact of this program on the mental health of the child and the closeness of the family take place (see flow chart).

GOAL 1: INCREASE SOCIAL CONNECTEDNESS BETWEEN THE CHILD AND PARENT:

In the FAST program, up to twelve whole families are assembled at one time, for weekly meetings and then monthly meetings. Sessions usually last about two and one-half hours. During each session, fifteen minutes is set aside for the parent to play one-to-one time with **the** at-risk child. This fifteen minutes of "quality time" is the **core** of the FAST program and it is called "Special Play."

This technique is the foundation of the whole program and FAST parent graduates teach it to new parents, **Parents** are **asked** to do this with their at-risk child each meeting in front of **staff**; and staff asks them to do it for fifteen minutes each day at home as “homework.” There are four simple rules for the parents as they provide the one-to-one time their child needs:

1. DO NOT BOSS;
2. DO NOT TEACH;
3. DO NOT JUDGE (OR CRITICIZE);
4. FOLLOW THE CHILD’S LEAD.

It is called “Special Play” because kids like to play and this approach helps parents to relate to their children on the children’s terms.

“Special Play” was developed and researched as an intervention with child patients in a child psychiatry clinic having varied presenting complaints (**Kogan**, 1975, 1978). Dr. **Kogan**, at University of Washington, Department of Psychiatry, in Seattle Washington, investigated coaching parents through a one-way mirror as they played with their identified patient child. Her National Institute of Mental Health funded clinical studies determined that in only eight weeks of daily one-to-one time with their parent, the child’s behavior dramatically improved. The coaching was done on an individualized basis. once a week. In a relatively brief period of time, parents demonstrated recognizable change in their interactional behaviors. Her video tapes **allow** one to see gradual reduction in parental directives, decreases in their attempts to teach the child something, while also increasing their verbal tracing of the child’s initiatives. **Essentially**, the desired parental interaction is a form of play therapy, non-judgmental and non-directive, with full, uninterrupted attention focused towards whatever the child does. For a young child, there is

nothing that could be more valued than a positive, attentive, playful time with one's own parent.

Kogan's creative work challenges the notion that a trained professional doing play therapy is the preferred approach to child psychiatric intervention. A stumbling block for this may have been the issues of interpreting the play of the child, and supporting the child's play as a form of mastery over traumatic past events. Kogan deletes the powerful interpretative component, but replaces it with the power of the ongoing connected relationship of the child with their parent. Parents with psychopathology and addictions, as well as busyness and preoccupations, have been able to apply the interactional rules. By establishing a teachable-to-parents mode of play therapy, and tracking its impact on the improved symptoms of the child, Kogan demonstrated that parents can be systematically included in the available resource pool to help their troubled **child**.

Behaviorists have long recognized **parents** as a resource, and have documented major behavioral changes in children with the consistent delivery of contingent reinforcers by trained parents. Having taught these behavioral parenting classes for years, and written a manual on how to run these classes (McDonald et al, 1974), I am struck by the indirectness of the approach and by the clinicians' trust that the parents would carry out the lessons correctly and report back on their homework assignments accurately. Unlike the many effective behavioral parenting classes and manuals, Kogan uses a direct coaching approach to the parent-child dyad as it interacts. This allows for immediate corrective, as well as positive, feedback to the parent. In Kogan's training, as well as in FAST, there are eight weekly sessions in which the parents **are** directly observed playing with their child, which provides the coaches multiple opportunities for comments. The parents' new behavioral repertoire is in turn reinforced by the natural consequences of the child's immediately observable uplifted affect and improved behavior. This feedback loop empowers

parents to feel effective with their own child and to take full credit for the child's changes.

In FAST, this **technique** is removed **from** the one-way mirror, individualized coaching of the **parent's** interactions with their child, and into a mass service delivery format. Kogan's lessons are valuable to all busy parents of young children, and have been shared in practice demonstrations with many families across the United States. In churches and Boy Scout family nights, "Special Play" has been explained and then coached in vivo with thirty-five and forty parent-child dyads at one sitting, by one coach. In the FAST sessions, during "Special Play" time, twelve to fifteen parent-child dyads play in a large open area, and the FAST staff (usually four) moves about the room, stopping here and there to watch the interactive play, and to then whisper privately into each parent's ear corrections, praise, and encouragement. The technology seems transferable, the approach is teachable, and large numbers of parents at a time can benefit.

The transfer of behavior modification approaches to large parent groups was also effective. The monitoring built into an individual approach, however, was missing from the group format, risking that stressed-out parents could misuse the information they learn. Parents who are out of control with their children can become overreliant on time-outs and contingent aversives. In a multi-family approach such as FAST, there is some comfort in the sharing **ONLY** of a positive technology: coaching "Special Play" can only improve a parent-child relationship. Even if it is done sporadically, it will still improve the relationship, but at a slower rate.

The **first** goal of promoting social connectedness between the parent and the at-risk child is achieved by practicing a technique which can be **used** on a daily basis for one-to-one positive contact with an undistracted, uninterrupted, beloved mother. There remains a major problem: even if "Special Play" is teachable and coachable, how can one expect or even persuade a

stressed and isolated parent to do this quality time on a daily basis. This leads us to the second **goal.**

GOAL 2: BUILDING SOCIAL CONNECTIONS OF THE PARENT TO OTHER PARENTS, THE SCHOOL, AND COMMUNITY-BASED AGENCIES.

In order for a parent who is busy, stressed, depleted, and isolate to do “Special Play” successfully, their own personal needs must first be addressed. FAST provides a structure which maximizes the likelihood that the parent will have eaten with her family; sung songs as a group; laughed and conversed with her own family members; had individual time talking with another adult parent; spent adult group time talking with several parents: and had access to professionals if there were any urgent issues to be dealt with BEFORE she is invited to do “Special Play” with her at-risk child. Meanwhile, to also optimize the success of the dyadic “Special Play” interaction for the parent, the child has had his needs attended to: he has eaten with his family; sung songs as a group; laughed and conversed with his own family unit; and had one hour of supervised running and playing time with other children and their siblings from his school and community.

The program makes a commitment to reduce the obstacles which inhibit parents and children from having positive. uninterrupted one-to-one time with one another. Incentive prizes are given for attendance, transportation is provided. infant care is provided, meals are provided, fun activities are structured for the family unit. adults have respite from the children for one hour and meet the other parents, and the active children are given good exercise. Then, an uninterrupted private time of fifteen minutes is provided, during which “Special Play” takes place. The routine, which is the same each week for eight weeks, is quickly apprehended.

FAST is a valued-based program. It is assumed that all parents love their children and want the best possible **future** for them. Obstacles can interrupt that demonstration of that love; support is needed by all parents to show that love. It is assumed that excessive stresses and social isolation undermine one's coping skills, no matter who one is. There is a non-hierarchical assumption of respect for the hard work and the challenge of parenting in today's world. FAST takes on responsibility of overcoming the obstacles and providing the support for many families at a time, in order to insure that the at-risk child has access to their parents' full and positive attention.

Rather than teaching these values and skills, parents experience the respect and they experience the social connectedness. For example, social connectedness with other parents and with community-based professionals is structured into the program in several ways. First, the part of the collaborative FAST team which recruits the families, includes a paid parent/consumer representative. A home visit to invite parents to voluntarily participate in the FAST program is conducted by a FAST team consisting of a FAST parent graduate and a mental health professional, working as equals. The invitation is made at the families' homes at their convenience.

Second, the entire FAST collaborative **team** co-facilitates each of the eight-week sessions. This team is made up of the FAST parent the mental health professional from a **community-**based agency, a drug counselor from a community-based agency, and a school professional (e.g., school social worker. school psychologist). **There** are many opportunities at the multi-family sessions to informally chat with the FAST team: these casual encounters are meant to break down formal hierarchical social distance between consumers and providers and to facilitate a human

connection. The anticipation is that **later**, if a referral to a community service is needed, the parent will be more likely to follow through because of these casual encounters with the System at FAST.

Third, at each FAST session, there is a structured fifteen minute period for adults to pair up, called "Buddy **Time**", to review the hassles of the day: do not give advice, just listen. This **insures** that married couples or live-in partners have a chance to check in with each other. For those participants without partners, this one-to-one adult talking time which both reduces stress and promotes the building of new friendships.

Fourth, the structured forty-five minute time with the adult group is not didactic; it is a time to talk and listen to one another, to touch base, to make connections, and to share common experiences in a group environment. The co-facilitators of the adult group **are** the mental health therapist and the parent staff. Their intent is to facilitate the development of the group's interdependence. Over the eight weeks, the group gets intimate, intense, and begins to help each other (exchanging addresses, etc.). Touching base with the group becomes a major incentive for ongoing participation in the monthly follow-up sessions. Because the parents are all voluntary participants and all have children of the same age, attending the same school, from the same neighborhood (with exceptions of bussed children), there are many immediate commonalities which can support the creation of a supportive network for parents. The intensive successful parent groups have developed with mixed groups, as well as African American groups, Native American groups, Spanish American groups, and Asian American groups. The common experiences of stressful living, parenting, and social isolationism to override some of the familiar obstacles in building effective parent support groups, i.e., social class differences, ethnic

differences, gender differences.

Fifth, the graduation ceremony on the eighth week is built up as an event. Everyone is encouraged to invite guests to celebrate their family achievement. Grandparents and other relatives, neighbors, teachers, principals, bus drivers, school board members, superintendents, elected officials, etc. have all been invited to graduation. People who might like to get involved in FAST **are** invited as well. The contributions of many volunteers **are** also acknowledged. For example, one church “adopted” a FAST program and provided volunteers to do transportation, clean up, and helping with supervision of the children’s play time. The social connections begin to reach beyond the parent-child dyad, the family unit, the multi-family group, and the collaborative team. Outsiders are invited to this positive culmination of recognized hard work.

Finally, group leaders of the eight sessions are encouraged to become members of the Parent Advisory Council (**PAC**) for FASTWORKS. This PAC receives a budget and plans and runs (with FAST staff support) monthly follow-up sessions for two years. A FAST Leadership Family Camp has been held two summers for PAC families to reward the whole family for their leadership role, and to train parents in leadership skills. PAC parents have frequently reached beyond the FAST program to become generic leaders of their home communities; however, they continue to identify themselves as FAST families.

Thus, social connections are structured in FAST to maximize the likelihood that parents of at-risk children will not be socially isolated. The support of the various connections is related to the second goal and nurtures the nurturer. so the he/she can, in turn, nurture the at-risk child.

C. Evaluation

In this section, two separate evaluations of FAST are reported. The first is on thirty communities/school districts which were trained to do the FAST program, and in which a **pre/post** assessment of the children was conducted by the teachers and the parents. The second is of a single FAST site, staffed by Family Service, in the Middleton, Wisconsin school district. In this evaluation, results are of an experimental study with random assignment to FAST vs. **non-FAST**. In both evaluations, the assessment is of the eight-week program.

Wisconsin Statewide FAST Replication Evaluation:

Many communities/schools/families have been trained to do FAST in the United States. The data presented in this paper are from thirty school district replication sites in Wisconsin. Each one had a collaborative **team** of professionals from the elementary school, a local mental health agency, an alcohol and other drug abuse specialist, and a parent-liaison. Each was evaluating its first FAST group. as a part of the training process to learn the program.

SAMPLE I: The sample sizes vary by how much the site participated in the evaluation process. The average age of the FAST children (**N=596**) was 7.8 years of age, and ninety-three percent of the at-risk children participating were between the ages of five and ten years old. Sixty-six percent of the at-risk children were male. Ethnically, eighty-three percent of the children were white, seven percent were African American, and ten percent were Asian, Native, or Hispanic American. Eighty-five percent of the families had at least one other child in the family in addition to the identified child at-risk (for 467 families, the average number of children at home was 2.6).

Fifty percent of the FAST households had no adult male “father figure” involved with the family. **Thirteen percent of the families in FAST (N=581) had no telephone by which they could be reached by schools.** Twenty percent of the **families had no transportation to come to schools for meetings.** Of those reporting, **sixteen percent of the mothers (N=423) and twenty-four percent of the fathers (N=300) had not graduated from high school.** (These rates were likely to be **underestimates, because of the sensitivity of identifying oneself as a school drop-out. Also Graduate Equivalency Degrees and parents who reported twelve years of school were counted as high school graduates).** **Of families that agreed during recruitment to attend at least one meeting, eight-five percent graduated from their FAST program with consistent attendance and participation (N=212).**

SAMPLE II: In this random assignment comparison study (N=17), all children were in grades Kindergarten through third grade. Eighty-five percent of the children were White American, sixty percent were male, and forty percent were from single parent families. The school served a predominantly middle-class neighborhood. (See table on next page).

DESIGN I: These thirty replication sites did not choose to conduct experimentally designed evaluations, with random assignment. Rather, they chose to have parents and teachers assess the at-risk child in a **pre/post** evaluation of the target children’s and families’ participation in the FAST program. Measures were administered within two weeks prior to and following the initial FAST eight-week group. Parents completed the evaluation packet during a home visit following their consent to participate in the program, with instructions on instrument completion, and non-directive reading of questions as needed. Classroom teachers were given their own evaluation packets and completed them individually and on their own time when time permitted,

but still within the two-week window. All evaluation packets were coded to insure the confidentiality of the child and family members. All protocols **were** gathered and submitted to the FAST Program Evaluator housed at Family Service. Parents were assured that this information was not introduced into their child's school file and any information provided back to school staff and made available to funding sources was and is always in aggregate form. This manner of data collection has allowed FAST to obtain a high percentage of compliance for completion of the questionnaires even though the parents involved tend to be distrustful of school and community agency staff.

DESIGN II: Efforts at establishing comparison groups in school settings to date have been very difficult. School staff and parents alike have not been receptive to additional evaluation beyond the children and families involved in the FAST program. In addition, resources for funding comparison group data collection have been limited. Although support and consultation for a comparison evaluation design were offered to all FAST schools implementing the program in collaboration or training with Family Service in Madison, Wisconsin, it was not until Spring, 1991 that the first school district negotiated an experimental design with random assignment to condition.

The pool of at-risk children eligible for FAST was generated using school district criteria and then the at-risk children were randomly assigned to FAST recruitment or to the control condition. Parents in the waiting list comparison group were contacted by mail and offered twenty-five dollars for the completion of the evaluation questionnaires before and after the **eight-** week treatment period. an amount **roughly** equal to the tangible incentives (guaranteed prizes) received by parents participating in the FAST program. (Funding for this was sponsored by the

American Institute for Research, which had recognized FAST as a model program for inner-city alcohol and drug prevention under contract from the Pew Foundation). Approximately fifty percent of the pool in the control condition agreed to participate in the evaluation.

TABLE

FAST EVALUATION

TARGET CHILD	THIRTY SCHOOL REPLICATION	SINGLE SITE EXPERIMENTAL STUDY
	N=596	N=17
Age	7.8 years	K-3 grade
Gender	66% male	60% male
Race	85% white 7% black 10% other	85% white 15% black
FAMILY		
Marital status	50% single parents	40% single parents
Telephone	13% none	N/A
Transportation	20% none	N/A
Education	16% no high school	N/A

Measures:

There are three measures which were selected for these evaluations: 1) The Social Insularity **Subscale** of the Parenting Stress Inventory (PSI), 2) the Family Adaptability and Cohesion Evaluation Scale (FACES-III), and 3) the Quay-Peterson Revised Behavior Problem Checklist (RBPC). They are described below:

1) (PSI) Social Insularity Sub-scale of the Parenting Stress Inventory (Abidin, 1986):

The sixth revision of the PSI is used in the study. The normative group was approximately ninety-two percent white, and primarily working and middle class, drawn from clients at small pediatric clinics. The Social Isolation sub-scale of the PSI consists of seven questions which tap parents' (mothers') perceptions of social support. Higher scores indicate isolation from sources of emotional supports. Higher scores indicate isolation from sources of emotional supports. Social isolation of parents has been linked to breakdowns in parenting and negative child behaviors. For two standardization samples, internal reliability coefficients were $r=.70$ and $r=.78$.

Three month **test/re-test** coefficients for the total PSI are reported to be **.88**.

2) (FACES-III) Family Adaptability and Cohesion Evaluation Scale (Olson, 1986):

This twenty item questionnaire has scales for family cohesion which is the emotional bonding between family members, and adaptability, the family flexibility under stress. FACES-III has well established reliability, validity, and standardized norms. High family cohesion has been show to buffer the deleterious effects of stressful life events and circumstances on children.

3) (RBPC) Quay-Peterson Revised Behavior Problem Checklist (Quay & Peterson, 1987):

The RBPC is a well-standardized, empirically derived eighty-nine item behavior rating scale with acceptable psychometric qualities of reliability and validity. The RBPC Manual provides normative data for both teacher and **parent** ratings, making the test attractive for a family and school program evaluation. Scores are obtained on six sub-scales including Conduct Disorder, Socialized Aggression, Attention Problems, Anxiety Withdrawal, Psychotic Behavior, and Motor Tension-Excess. Nine-week stability coefficients of teachers' ratings of elementary school children were established. The RBPC has been used in many settings with parent and teacher ratings.

At referral, FAST children are one to two standard deviations above the established means for problem behaviors, placing them at approximately the eighty-five percent range for problem behaviors, relative to the standardized norms in the RBPC Manual. However, the scores did not reach the "clinic" sample means. and indicate risk status rather than seriously **emotionally** disturbed.

D. Results

In both evaluations, the RBPC show statistically significant improvements for the children who participated in FAST.

Thirty School Replication Evaluation:

Paired T-Test Comparisons were made of teachers' ratings (**N=408**) and parents' ratings (**N=358**) **pre/post** FAST on the RBPC. FAST graduates show significant reductions in behavior problems after completing the FAST eight-week multi-family group, as shown in the accompanying tables. Parents record highly statistically significant decreases in each of the six separate scales of problem behaviors on the RBPC. These reflect overall improvement in the at-risk child's mental health functioning of twenty to twenty-five percent.

In a statewide sample of 332 families, families reported significantly improved levels of family cohesiveness after participating in FAST (see Table). There were no changes in adaptability scores. Social isolation scores improved statistically significantly (**N=68**).

Experimental Study Evaluation:

In this study, FAST was shown to reduce child behavior problems as rated by parents, beyond the effects of natural maturation or other influences. FAST parents (**N=7**) reported significant decreases in aggregate child problem behaviors (total RBPC), compared to non-FAST parents (**N=10**). FAST children significantly reduced behavior problems over the initial phase of FAST, compared to other at-risk children from the same school, but who were not in the FAST program. Total RBPC scores for FAST graduates decreased forty percent compared to the twelve percent decrease of the control group.

TABLE I	FAST (N=7) means SD.	NON-FAST (N= 10) means SD.
RBPC Total: Pre	43.4	33.0
RBPC Total: Post	26.7	28.0

Using a repeated measures **ANOVA** design, this condition by time interaction effect is significant at **P=< .068**. This level of significance is acceptable because it is remarkable to demonstrated any effects in such a small sample, due to the limited statistical power in such tests. Reductions of sub-scale scores for the FAST group were statistically significant in **paired** T-Tests, reflecting the general pattern described with the large sample.

E. Summary

To really help children in the United States, one should fiercely advocate for a decent standard of living for everyone, and all that it entails. As a compromise, the many problems facing children in 1993 can be better coped with if a child has positive social connections. FAST offers a compromise temporary solution to children under stress of poverty and other negative life circumstances. FAST brings the parent to the child as a resource by coaching the parent in a novel technique, while supporting the parent with multiple levels of adult social connections. There are some data to suggest the short-term effectiveness of the program, and the effectiveness of training collaborative teams to conduct the program in other sites. Longitudinal studies are now being carried out under a grant from OSAP. Until those data are analyzed, there are only survey reports from parents to support the long-term impact of FAST on the mental health of children. The survey results are included in the evaluation section.

VI. FAST Curriculum Adaptation: Grades Four through Six*

A. Introduction

The FAST curriculum has been shown to be highly effective in altering both classroom and home behaviors of identified children and in improving their self-esteem. FAST has also demonstrated improvements in various aspects of family functioning including increased feelings of family cohesion, more positive parent-child interactions and more comfort in working with school personnel.

The curriculum has been adapted to be developmentally appropriate for youth in grades four through six (approximately ages nine to twelve) with the help of the **Westside** Elementary School, Sun Prairie, Wisconsin, which served as the pilot site.

Although the specific activities and structure of some FAST sessions may differ from other FAST groups, the goals, values and collaborative partners remain the same for all adaptations of FAST. This adaptation was a result of the **OHD/ACF** grant **#90-PD-165**.

Youth in the nine to twelve year age group present an interesting challenge in designing activities that will meet differing levels of cognitive and social development. According to Piaget's categories of cognitive development (Flavell, 1977). some of these youth will still be in the concrete-operational stage. while others will be moving into the more abstract thinking of the formal operational stage when children develop deductive reasoning.

The components of the fourth-sixth grade curriculum adaptation are structured to support the FAST program goals in a way that is more appropriate for youth in this age group. Although the basic meeting structure **remains** the same, activities are varied from week to week to provide

*This chapter will become **part** of a FAST Manual on nine to twelve year **olds**. It was co-authored by Lynn McDonald, Carolyn Regan. and FAST staff at Sun Prairie Schools in Wisconsin.

different types of stimulation for the families and to meet the different developmental needs of the youth in the group.

B. Teacher Reports to Parents

In preparation for the group, the school representative on the FAST team should meet with the main teacher who has each identified youth in class. The teacher needs to **fill** out a Quay-Peterson pre and post FAST. They also must be asked to assess the range of the student's work for one week, so that they can identify the top level of work the student is performing. Before every FAST group meeting, the teacher is asked to prepare a brief report on the attached form regarding "My Week in School." Help may need to be given to teachers to show them how to find positive qualities in the youth. The teachers are to be commended for their support of their students, families and the FAST program (Blechman, 1981).

We have found this positive communication from the teacher to have many positive effects on both the student and the parent. These are then handed to the youth to give the parent during One-to-One time where they can then discuss the information on the form. This provides a structure for both parent and youth and facilitates "detour communication."

C. Weekly Themes

Each of the 8 week sessions is centered around a "theme" for the week. The theme can be used to provide a focus for parents and youth to talk about during one-to-one time and/or can be used as a guide to activities during the FAST Club/Kids' Play time. The themes for each week are:

Week **One**: Family - Who are You as a Family? (Identity)

Week Two: Family - Togetherness (what do you do together?)

Week Three: Self

Week Four: Changes/ Seasons/ Feelings

Week Five: Natural Highs

Week Six: Communication

Week Seven: Friends

Week Eight: Winning as a Family

D. The Routine FAST Agenda

The following is the basic agenda for each of the 8 week groups:

- | | |
|--------------------------------------------------|------------|
| 1. Family Meal | 30 minutes |
| 2. FAST Song/Music | 15 minutes |
| 3. Family Time-see specific section for activity | 30 minutes |
| 4. Parent Buddy Time | 15 minutes |
| Parent Group | 40 minutes |
| Simultaneously | |
| FAST Club/Kids* Play | 55 minutes |
| 5. One-to-One Tie/Quality Time | 15 minutes |
| 6. Lottery | 10 minutes |
| 7. Announcements/Birthdays/Rain | 10 minutes |

E. Family Time

The activities that the family does during this time have been designed to support the FAST **goals**. **The** way that they do this is by:

1. Increasing positive communication and interactions.
2. Empowers parents to be in charge of their family.
3. Increases self-esteem in all family members.
4. Encourages the identification and sharing of feelings among family members.
5. Encourages creativity and individuation among family members.
6. Promotes empathy, and helps families communicate individual and family values to each other.

The activities utilized during family time change from week to week. Week one is a special week where the family spends this time creating a family symbol, usually a flag. Weeks two, four, six and eight the activity is the Family Game (Regan et al). Weeks three, five, seven the activities are fifteen minutes of Advanced Feeling Charades and **fifteen** minutes of Draw a Person. Instructions for all activities are attached.

F. FAST Club/Kids' Play

Following Family Time, the children and youth are separated into two groups, one with only the targeted FAST youths and one with the remaining children.

The group with the non-FAST target children is taken to a separate space for activities/play time. The targeted FAST youth form another group - the FAST Club. **Separate** facilitators are needed for each group.

The coordinator/facilitator for the FAST Club needs to be flexible and should have

experience in working with youth in this age range.

During the initial group meeting, the need for rules in sports, games, families, society and clubs are discussed. The group then establishes club rules. Some type of physical activity, i.e., basketball, should be built into every meeting of the FAST Club.

Every week at the end of this time, the youth that have participated in the FAST Club make buttons to symbolize the week's theme. They are given identical pictures that they can color with neon markers to individualize and which are then made into a button with a button maker. The buttons or badges start to help the group develop an identity that separates from the other children. Button makers are a one time investment for your program.

Before the club time ends, the youth are given a "home project" which could be worked on during one-to-one time. Every youth receives a blank Family Scrapbook (attached) which they are to work on every week and have completed by the end of the eight weeks. The scrapbook is another option **that** the youth and parent can work on together during one-to-one time.

Every week the FAST Club meets during this time.

- Week Two:
1. Physical activity.
 2. Weekly theme related activity - make paper bag puppets and act out a play of a family doing something together, in small groups.
 3. Make buttons.
 4. Home Project: Make a collage or write about things your family likes to do together.

- Week Three:
1. Physical activity
 2. Weekly theme related activity - Make T-Shirts, using fabric paints and plain, **white** T-Shirts.
 3. Make Buttons.
 4. Home Project: Make a self-portrait collage or write 10 responses to "Who I Am."

- Week Four:
1. Physical activity.
 2. Weekly theme related activity - divide into small groups and make **up** a skit about a season, and include feelings about the season and changes to act out.
 3. Make Buttons.
 4. Home Project: At least 3 days during the next week, write out at least 5 feelings you had during the day and explain what they were about or write a poem with 3 season words and 3 feeling words in it.
- Week Five:
1. Theme related activity - The group gets in a close circle with one person getting **in the** middle but leaving their space in the circle open and stating, "I like people who..." **and** fills in blank with a quality or object about people they like. All people **in** the circle who match the characteristic must move to the open space in the circle along with the person in the middle. Whoever does not get into a new space in the circle gets to be in the center.
 2. Make buttons.
 3. Home Project - discuss at least one alcohol related commercial at home.
- Week Six:
1. Physical activity.
 2. Play telephone. 1 person whispers a message about a topic to the next person who passes it on. The person at the end of the **line** says the message aloud.
 3. Make buttons and graduation invitations.
 4. Home Project - Write a secret note to parent to communicate appreciation, love, etc.
- Week Seven:
1. Physical activity.
 2. Make friendship bracelets.
 3. Make buttons.
 4. No home project - complete family scrapbook .
- Week Eight:
1. Physical activity.
 2. Pass a compliment - form a circle with one person in the center. Everyone goes around the circle saying a compliment about the person in the center. After all have gone. a new person moves into the center until all youth have been in the center.
 3. Make buttons.
 4. No home project.

G. Parent Buddy Time and Group

At the same time that the children and youth go for activity time, parents get some personal time of their own. The first fifteen minutes of this time is spent with one other parent in the group to discuss how the day is going. After fifteen minutes the parents then form a group. The group lasts for thirty minutes. The topics for the parent groups are as follows:

Week One: Introductions of group members. Introduce, and demonstrate and answer questions about “detour communication” and provide handouts. Give the parents each a chart to mark off when they did this at home.

Week Two: Follow on “detour communication,” answer questions, have group troubleshoot. Discuss **fun** and inexpensive family activities.

Week Three: Check in on detour communication. Discuss setting limits and discipline.

Week Four: Check in on detour communication. Discuss coping with stress.

Week Five: Discuss Alcohol and Drug presentation.

Week Six: Check in on detour communication. Discuss building self-esteem in themselves and their children.

Week Seven: Check in on detour communication. Discuss support systems.

Week Eight: Discuss FASTWORKS. Affirmations.

After parent group, the target child is brought back into the main room for One-to-One time.

H. One-to-One Quality Time: Detour Communication

Most nine to twelve year olds report wanting to **talk** more about things with their parents,

but complain that they are too busy or too critical. In FAST, the core experience is the quality one-to-one time spent with the parent and the at-risk child. **This** must be structured to maximize the success of the encounter. In order to reduce obstacles for successful contact, prior to the fifteen minutes, both parent and young person have had a meal, participation music, positive family activities, and peer group time. This helps to set both parties up for success. In addition, the actual encounter has instructions and rules to maximize its success in bringing the two together. Youth in this age range prefer less silence, make more interruptions, and like more equality of interactions than younger children (**Graziano**, 1981). Better school performance and attendance is also equated at this age with recognition from parents for school activities. These are some of the concepts included in the “detour communication” technique designed by Lynn McDonald.

The concept of one-to-one time is integral to the success of the FAST program. For this age group the goal is to help the youth and their parent to talk. When the youth is talking, the parent must follow these rules:

1. Don't Teach
2. Don't Boss
3. Don't Give Advice or Judge

To indirectly encourage the youth to talk, the parent should:

1. Provide a diverse **range** of non-verbal activities that the youth can do during this **time**.
2. Detour through another activity that they are both doing with their hands.
3. Start talking themselves about anything that comes to mind.

You might want to have materials such as modeling clay; silly putty; beads and string;

legos; puppets; nerf ball and basketball hoop; and materials with which to make a collage, i.e., magazines, glue, scissors, construction paper, etc.

I. Alcohol and Other Drug Session

During this session, held on week four or five, the normal meeting structure must be adjusted. The substance abuse portion of the session takes approximately forty-five minutes. You may need to shorten other activities, so the session still ends on time. Do not shorten the length of One-to-One time.

The AOD person on your team should be involved in the facilitation and presentation of this part of the session. The AOD person makes a brief presentation about some of the signs that indicate problems with alcohol and/or drugs and will help the families identify ways in which the media, especially television, promote and/or discourage the use of alcohol and drugs among youth. After this discussion, the families are asked to design and act out a television commercial discouraging the use of alcohol and/or drugs. They can move to different parts of the facility, if possible, to give them space to work out and practice their commercial. The time allocated for this is fifteen to twenty minutes. At the end of this time, the families come back to the main area and each family then acts out their “commercial” for the FAST group. The commercial is videotaped by FAST staff and given to the family as a gift.

If there is time, discussion can be held about the messages in the different commercials.

HOME **PROJECT/WEEK** TWO

Youth - Make a collage or write about things your family **likes** to do together.

HOME **PROJECT/WEEK** TWO

Parent - Make a list of things you enjoy doing as a family.

HOME PROJECT/WEEK THREE

Youth • Make a self-portrait collage OR write ten responses to “Who I Am.”

HOME PROJECT/WEEK THREE

Parent • Write ten responses to the “Who I am” and share them with your **son/daughter**.

HOME PROJECT/WEEK FOUR

Youth - At least three days during the next week, write out at least five feelings you had during the day and explain what they were about or write a poem with three season words and three feeling words in it.

HOME PROJECT/WEEK FOUR

Parent - Tell your youth how you feel three times this week.

HOME **PROJECT/WEEK** FIVE

Youth • Discuss at least one alcohol related commercial at home.

HOME **PROJECT/WEEK** FIVE

Parent • Discuss at least one alcohol related commercial at home.

HOME **PROJECT/WEEK SIX**

Youth - Write a note to your parent and express **appreciation**, love, etc. and leave it for **him/her** to find.

HOME **PROJECT/WEEK SIX**

Parent • Write a note to your child expressing appreciation, love, etc. and leave it for him/her to find, i.e., in **their** lunch.

HOME PROJECT/WEEK SEVEN

Youth • finish family scrapbook if not complete.

HOME PROJECT/WEEK SEVEN

Parent • help child complete family **scrapbook** if not yet finished.

HOME **PROJECT/WEEKS** ONE AND EIGHT

No homework assignments are given **during** the **first** and **last** week of the FAST session.

VII FAST Identification and Recruitment Strategies

A. Identification of FAST Families

There **are** many excellent programs offered to children and families. However these are often underutilized by the at-risk families. We have taken special measures to recruit voluntary participation of targeted families. This section identifies some of these approaches.

The school identifies the at-risk child. The school uses its own screening process to identify children who are at-risk. Because each school has the ability to do this in its own way, several different models can be used by participating schools. Each school may develop general guidelines for at-risk behaviors, and each school may depend on a pupil services team for implementing the chosen screening model. Teachers are known to be good predictors of the futures of children in their classrooms who are at-risk for problem behaviors in later years.

A longitudinal study by **Schedler** and Block (1990) described the childhood personalities of seven year olds who by eighteen had become frequent users of alcohol and other drugs. According to this study, the future frequent users were. at age seven: not getting along with **other** children: not showing concern for moral issues (e.g., reciprocity and fairness); having bodily symptoms from stress: tending to be indecisive and vacillating; not planful or likely to think ahead: not trustworthy or dependable; not able to admit negative feelings; not self-reliant or confident: preferring non-verbal methods of communication: not developing genuine and close relationships: not proud of their accomplishments: not vital, energetic, or lively; not curious and open to new experience; not able to recoup after stress: afraid of being deprived: appearing to feel unworthy and “bad”; not likely to identify with an admired adult; exhibiting inappropriate behavior: and easily victimized by **other** children.

After the at-risk child has been identified, the school makes the initial FAST contact **with the family**. In the past, schools have contacted families in several different ways: by mail, **through** telephone calls, when they come to the school (e.g., teacher conferences), and by **in-home visits**. The **initial FAST** contact with the parents by the schools has been made by various people: principals, teachers, school social workers, school counselors, and parent-community liaison staff. After several years of experience with different methods, we strongly recommend that, for hard-to-reach families, the school **staff** go to the family's home.

B. Recruitment of FAST Families

Successful recruitment of voluntary attendance is essential to a successful FAST program. Many of the targeted families of at-risk children are hard to reach. These may be the families for whom previous efforts have been insufficient, and there are complex reasons for **failures** to attract them to prevention, early intervention, and treatment programs.

One of the greatest needs of any such recruiting effort is a satisfactory answer to the question: "What's in it for me?" The gains must exceed the cost for each individual participant. Another obstacle to recruitment lies in the simple fact that participation in FAST is rarely the parent's own idea. The overwhelming majority of prospective of prospective FAST families are approached by the school because the school has identified a problem. Since the parent did not identify the problem, and since **he/she' may** feel little positive regard for the school, the parent may show little interest in helping the school solve "its" problem. Additional disincentives may be found in parents' alienation from schools, their lack of feelings of affiliation toward schools, and the perceived lack of shared values or beliefs between parents and schools. FAST addresses

all of these obstacles directly and usually overcomes them. FAST helps families feel **that they are gaining** more than they are losing by attending the meetings. FAST builds feelings of affiliation among parents toward the school, toward the community, and toward other FAST parents.

In the first two years of operation, eighty percent of the families that attended one FAST meeting continued on to graduate from the program. In other words, the program is powerful enough to keep the families coming once they have been recruited to the **first** meeting. All of these data are based on voluntary participation.

C. Incentives

FAST recruits potential participants in person, in their own homes, and engages parents who have graduated from the program to help in the recruiting effort with new families. A key element in the recruitment visit is the recruiter's effort to verbally match the concerns of the parent to what FAST can do for his/her family. While these methods are crucial to the program's recruiting success, and while the FAST session activities are a definite draw, FAST also offers several concrete incentives to achieve its eighty percent graduation rate: 1) FAST provides transportation to and from meetings for participating families, often in staff cars; 2) FAST provides a free meal for the whole family at each meeting; 3) FAST awards tickets to families for completing homework assignments. and these tickets can win each family thirty dollars worth of prizes in a drawing; 4) FAST provides childcare at meetings for infants and toddlers; 5) FAST offers family fun without using drugs; 6) FAST provides a graduation ceremony, and the school principal attends to award graduation certificates; other guests are welcome to attend; 7) FAST

offers monthly meetings for graduated families for the next two years. These meetings include a **meal**, a review of program principles and exercises, and an outing, and free babysitting is provided as an additional reward for families who attend. This incentive constitutes one of the FAST program mottos: **Once in FAST, always in FAST.**

These incentives help win the trust and cooperation of most families who agree to attend at least one FAST meeting, although getting a family to its **first** meeting remains difficult. To date, only forty percent of the parent who have been approached by the schools have been willing to meet with FAST staff. Even with an eighty percent program completion rate for families who attend a first meeting, simple multiplication tells us that the proportion of all identified at-risk children whose families complete the program is less than one in three (80% of **40%**, or 32%). We cannot overemphasize the importance of the recruiting effort; the impressive program completion rate can be realized only for families who are willing to give FAST a chance.

D. School Disclosure

The overall process of FAST recruitment is divided into three steps: the **first** two are performed by school personnel. and the third by mental health staff. Step one consists of identification of the child by the school (please reference the above section for **more** information). Step two consists of the school sharing its concerns about the child with his/her parent(s), **briefly** explaining the FAST program, and suggesting that the parent(s) meet with FAST staff in their home. Finally, step three consists of the **mental health** FAST staff making a home visit to explain the program in greater **detail**, answer questions. and attempt to recruit the family to a FAST group. Because step one has been gone into in greater detail in the above section, steps

two and three **will** be focused on in the following description.

Who should recruit? The first phase of the recruitment should be conducted by whoever at the school knows and has an existing relationship with the parents. This person may be a school social worker, a counselor, a teacher, or the principal. The matter of who should make the first contact may best be decided by a building consultation team. When no single staff member at school has had previous contact with a parent, it is important to select a staff member whom the parent is likely to trust enough to agree to discuss the matter. Voluntary attendance at FAST meetings will increase if the recruiters are people whom the parents already see as accessible, since many families who are recruited to FAST **are** not positively **affiliated** with the school.

How to disclose at risk status? It is the responsibility of the school staff to disclose its academic and/or behavioral concerns about the child that have caused the child to be identified as at-risk. We have found that this is essential to proposing participation in FAST. Explicit disclosure, however, is not an easy task. Usually it is much easier to be vague about the child's behavior, avoiding specific reasons why this particular family is being recruited to FAST. For example, a school recently recruited families for a FAST group by sending an invitational letter that was not specific to individual families and, moreover, did not inform the parents that their children had been **identified** as at-risk. **The** families then arrived at the FAST meeting feeling defensive, and demanding an explanation. The group became cohesive in its resistance. It was an experiment on our part that backfired and we learned from it. That experience and others have taught us that recruitment is **most** effective when the school tells the parent specifically what its concerns are about their individual child. When parents come into a FAST group, they

should know why they are there.

The disclosure of specific behavior of concern to school staff is similar to a doctor's delivering a bad diagnosis. The problem behavior might include apathy, a short attention span, a behavior disorder, hypersensitivity, etc. We offer the following tips and techniques to help in the delivery of an upsetting diagnosis:

1. Disagreement about diagnosis reduces compliance. If the **parent** cannot see, understand, or agree with what the school sees, there will be no FAST attendance.
2. The diagnosis must be formed in words that are familiar and easily comprehended by the parent(s). Academic jargon may ease the recruiter's discomfort, but most parents will be less likely to understand, and less likely to try to understand, a diagnosis that is delivered only in formal language. The explanation must be formed in "plain **English.**"
3. A diagnosis is often better understood when it is presented in several different ways. School staff should try to rephrase the diagnosis in their multiple references to it, and provide a written explanation in addition to their spoken words.
4. School staff should listen to the parents' description of the child's behavior at home, and then use phrases from the parents' vocabulary to restate the school's concerns. This approach highlights the similarities between the parents' and school's perception, and is therefore much more likely to win the parents' cooperation.
5. School staff should make a point of describing one or more positive things about the child's behavior or performance at school. Hard-to-reach parents are accustomed to hearing negative remarks from the school. A few specific positive observations from the teacher will help balance the presentation and increase positive feelings.
6. School staff should respect the parents' love for their children. The staff should approach the meeting with the **firm** belief that all parents love their children, care about their children's education, and want the best for their children. The school and the parent are both part-time caretakers and teachers for the child; they are teammates in a combined effort to do what is best for the child. As a matter of attitude, the school staff should always give parents the benefit of the doubt and treat them accordingly.

After the school has explained its specific concerns about the child, and made sure that the parent understands and agrees with its perception of the problem, the school then suggests the FAST program as a possible **instrument** to help the family address these concerns. School staff who participate in this initial recruitment for FAST must know enough about the program to be able to explain it to the parents. A parent needs to understand the connections between the

school's concerns for his/her child and the FAST program, which directly addresses those concerns. FAST school staff need to know enough about the program and its benefits to persuade a parent to take **the** next step, which is to agree to meet with school and mental health staff in a personalized FAST recruitment visit, again the family's own home, so that they can learn more about the program and decide whether it might help meet their needs. It is important to remember that it is the school's **role to** screen, identify, and refer families to the program. The school must, however, respect each family's right to confidentiality, and therefore should not refer a family to FAST's mental health staff without first obtaining the permission of the family. For the the school's protection, it must obtain a written consent from the parent for this referral.

A family's acceptance or rejection of FAST will depend largely on the school's investment in this recruitment effort. Mental health staff can encourage the recruiters by keeping in frequent contact, answering questions, and offering assistance. In particular, be sure to provide positive feedback: "You've got three out of six families agreeing to meet with a Family Service staffer. That's great!" School personnel usually are very busy at the beginning of a school year and at semester breaks, and often lack the time to recruit for the FAST program. There are some ways to help them with recruitment:

1. During school registration. be available to speak to staff, teachers, and other parents about the FAST program, and invited FAST volunteers, parent-liaisons, and Parent Advisory Council members to join you in these presentations.
2. Attend any school functions that parents attend and set up a FAST table to call attention to the program, distribute brochures and other promotional/informational materials, and answer questions.

E. Mental Health Recruitment

Once a family agrees to meet with mental health staff, it is essential that the mental health

staff visit the family as soon as **possible**.

Many parents are wondering about the program because it is the school that has identified and articulated the child's problem. If time is taken to listen to the parent's concerns, it will help staff to better describe the benefits of FAST in terms that are directly responsive to the parent's identified needs.

Often staff is from a different social class and educational level than the parent that is being recruited. Staff may have no experience as a parent or as minority, but staff must seek out common ground. The more similarities between staff and parents, the easier it is to establish trust. Since **staff** may have all the societally designated power, and the parent very little, it is staff's responsibility to reach over that invisible wall between the two people. It is important to be very aware and sensitive to power issues. In short, staff must be human beings **first** and professionals second. He/she must be able to see, listen, and empathize with the "human being" of the parent.

A common problem for human service providers over the years has been trying to obtain the cooperation of hard-to-reach families, who have not asked for what is offered, and who have not identified the problem that some else thinks should be solved. FAST has addressed this major and complex issue with both strategic and unorthodox approaches. At the outset, frankly, recruiting is not always easy. It is quite often difficult: the success rate will improve with practice. We have devoted much of our energies to trying out and evaluating different strategies. Some of the approaches that did and did not work are listed below, so that the benefit of our experience may be reaped by others:

1. Introduce yourself as part of the FAST program and name your agency.
2. Use the first fifteen minutes or so to break **the** ice - as "getting to know you" time. Do

- not talk about school. Do not talk about FAST. Do not talk about the at-risk child. **Only** after making a personal connection will you be able to proceed effectively with **the goal of** your visit: to recruit the family to voluntary participation in the FAST program.
3. **Relate** to the parent **as** one human being to another, and with the respect and consideration clue a person in his/her own home. Be honest. Be open. Listen and look around. Ask about his/her interests.
 4. **Try to discover** overlapping interests and experiences between the parent and you. Find a common ground, an area of agreement, or similar tastes in television shows, music, color, or anything.
 5. Avoid disagreements with the parent. Switch topics if any disagreement emerges.
 6. Ask FAST graduates to help recruit new FAST parents to the groups. The mere presence of a FAST graduate at an in-home visit lends considerable credibility to the program, and testimonials from past or present FAST parents are of immeasurable value in winning the confidence and cooperation of prospective participants. Moreover, the active participation of a FAST graduate delivers important “subtext” messages to the prospect: “You can trust this program and these people.” Doors will open for you.
 7. Determine in advance a specific date and time for the new group’s first meeting, so you can notify the parent at the recruitment visit.
 8. Contact parents face-to-face, not by telephone (40% have no telephone).
 9. Conduct recruitment visits in the families’ own homes.
 10. Show the consideration to set up in-home meetings at convenient times for the families.
 11. Listen to parents’ concerns about their children’s schooling, their children’s behavior at home, and even other family issues.
 12. Anticipate and “preempt” likely obstacles to participation, especially for families with small children. Explain that FAST provides free transportation and free **childcare** at the meeting site for infants and toddlers. Explain that FAST holds its meetings in the evenings to be more convenient for the families, and that the program provides a free hot meal at **5:30**.
 13. Mention the material incentives for participation in FAST, such as each family has a chance to win thirty dollars worth of useful prizes in a lottery, and other grab-bag prizes are offered to kids.
 14. Mention the rewards for completing the eight-week program, such as a family flag, a framed FAST graduation certificate. and a framed family photo.
 15. Mention the post-graduation FAST incentives, such as eligibility to attend monthly FASTWORKS meetings, for two years. that repeat and reinforce the weekly program, with meals and special events. and lasting friendships and informal “networking” benefits with other FAST parents.
 16. Provide written information. such as handouts that the parent may keep, about the FAST program and its benefits for the family and the child’s in-school behavior.
 17. Explain how FAST is different from other services and programs:
 - FAST treats parents **with** respect.
 - FAST empowers parents.

FAST is fun. It is a no-lose. all-win program.
FAST is voluntary.

- Each family unit is supported as a unit, and parents like it. What we do **is support** the parents while they support their children. FAST provides a relaxed and comfortable atmosphere where parents can do this.
18. If the parent agrees to attend a meeting, ask him/her to fill out a **form** and sign a piece of paper indicating that the family will come to at least one session.
 19. If the **parent remains suspicious** or reluctant, suggest that he/she “Come and try it, just once.” (We **are** confident that our program will win their acceptance if they will attend just one meeting).
 20. If the parent still does not want to participate, suggest that you visit again next semester. (Be sure to make a note, later, of a few specific topics that would be appropriate subjects for inquiry and/or ice-breaking with this family upon your **return** visit).

Some approaches that did not work are listed below:

1. Announcements in parent newsletters, mailed to all parents.
2. Fliers sent home in every child’s backpack describing the FAST program and announcing the new group’s meeting time and place. (Ten families came to the group, out of 485 who received invitation fliers. None of the families who attended had at-risk children; they were all middle-class families with involved parents who very much enjoyed the sessions. None were hard-to-reach families).
3. Telling people about the FAST program at school meetings with parents (for example, **PTO** meetings).

Self-referrals to FAST simply will not happen **until** after a school’s FAST program has become well enough established for the program to benefit from word-of-mouth “advertising” in the community. This makes active recruitment efforts especially critical in the beginning, for at least the first two or three eight-week sessions. Since FAST has focused on “hard-to-reach” families, which often are socially isolated, the growing reputation of FAST in a school over time may not be enough to reach most potential FAST families. Unfortunately, therefore, we **cannot** count on self-referrals, even after a program is moving successfully.

Some FAST participants, however, do have friends whose families could benefit from the program, and word-of-mouth promotion within the circle of friends or within a neighborhood **can** be helpful. Current FAST families can invite friends and neighbors to their graduation, and you can then encourage these people to consider joining the next FAST session. On such occasions,

you might describe FAST in **these** or similar words:

1. FAST is a family program for children who may be at-risk for having problems in school in the future, or who may be having behavioral or academic problems. We believe that working **with** the whole family helps children more **than** anything else.
2. Children's self-confidence grows when they can see and feel their parents' support, and when parents take an interest in what their children are doing. When your self-confidence gets an extra boost, you feel like you can do anything! Children feel that way, too.
3. FAST is a "fun while you learn" program. It is totally positive and provides eight nights out for the family, which include a family supper, games, socialization, childcare, and prizes.

This short "commercial", combined with the recommendations of peers, may prompt some families to refer themselves for future FAST groups.

VIII. FAST Evaluation

A. Limits of Data Collection

Evaluation has been referred to throughout this document. This federal grant enabled us to do several data analyses: 1) Thoreau Elementary School over three years with three levels of trained FAST facilitators (1989-1992); 2) FASTWORKS survey for Thoreau FAST graduates (1989-1992); 3) evaluation of statewide replications, using the same forms used in this grant and reported in Section V; and 4) a random assignment single school study using the same instruments, and reported in Section V.

With the major current OSAP grant, we anticipate with the help of an outside evaluator from the University of Wisconsin-Madison, to identify more extensively what the impact of this program may be.

The practical application of the evaluation design became victim to the unique problems of collaborative research with high-risk populations. Obstacles arose which required multi-party co-ordination of evaluation activities at all levels. Collaborative agreements made at the administrative level were subject to tensions arising at lower levels, where line workers and dis-affiliated parents worked to establish trusting relationships under their own agenda. The **time-consuming** working through of program challenges in the model development and research process paid off in a refined approach towards this type of programming. The solutions derived helped avoid pitfalls at new sites during program expansion and dissemination.- Nonetheless, research efforts in this project school were hampered and conclusions must be limited.

An agreement was negotiated with the Madison Metropolitan School District to form comparison groups matched with FAST children through demographic variables and similar at-

risk status. Unfortunately, data collection suffered from breakdowns in administrative collaboration. Program evaluation efforts from outside the school system ran into objections from staff and parents, who then declined consent to participate. No extra resources were committed to data collection, such as payment to families. Busy school **staff**, without extra release time, saw data collection as a low priority, particularly pre-and-post tests of control families not receiving FAST services. Union disputes had promulgated dissatisfaction among teachers with extra tasks such as completing rating scales and questionnaires.

The labeling of children as at-risk and the disclosure of this label to parents touched a sensitive nerve with parents. Reluctance to directly deal with this issue, and reactance by parents, made it difficult to engage many participating and especially control group parents in evaluation activities. Over time, techniques and an approach to the labeling issue developed which is reflected in current FAST training.

B. Procedures

After families had been identified and recruited as described above, FAST facilitators requested participation in evaluation procedures. If parents consented, they completed questionnaires prior to the first FAST meeting, and again after graduation. FAST staff members were available for assistance and answering questions about evaluation. Parents were assured of confidentiality of results. and that no evaluation results would end up in individual school behavioral files. Code numbers were utilized to increase feelings of confidentiality. Teachers completed measures on children in. their classrooms.

As negotiated with the school district. a small subset of children were assigned to a

matched comparison condition. However, it became impossible to collect parent-generated data due to constraints described above. Teachers making ratings were not blind to experimental condition, due to the nature of this family-school involvement program.

C. Measures

As a collaborative family support and empowerment program, the selection of measures for use was guided not only by the research literature, but also as a collaborative efforts with parents and educators as part of the multi-disciplinary team. As such, the evaluation of FAST has been proposed in accordance with the stated values of FAST, respect for the school ecologies involved, and the political mission of FAST as a family support program (Fraser & Leavitt, 1990). So, for example, measures which risked pathologizing FAST families or parents (for example, the Beck Depression Inventory, or the Sense of Parental Competence **subscale** of the Parental Stress Inventory) were seen as dis-empowering by the Parent Coordinator Council which reviewed all measures, and were excluded from the evaluation design.

Basic demographic information concerning child age, sex, race, parent educational attainment, family structure, transportation and telephone accessibility, meeting attendance and completion (“graduation”) were collected for participants.

Quay-Peterson Revised Behavior Problem Checklist (RBPC): a well-standardized, empirically derived behavior rating scale with excellent psychometric qualities of reliability and validity (Quay and Peterson, 1987). Scoring on six subscales including Conduct Disorder, Socialized Aggression, Attention Problems. Anxiety-Withdrawal, Psychotic Behavior, Motor Tension-Excess. In six standardization samples, alpha reliability coefficients for the subscales

ranged from .70 to .95. **Interparent** reliability for the subscales (all significant at $p < .05$) were **CD=.70, SA=.93, AP=.73, AW=.55, PB=.67, and ME=.77**. The RBPC has been used in many settings with parent and teacher ratings (Forehand & Long, 1988; **Frick, Lahey, Hartdagen, & Hynd, 1989; Hagborg, 1990; Lahey, Russo, Walker, & Piacentini, 1989; Mattison, Bagnato, & Strickler, 1987**).

The standardization samples for the RBPC are described in the **test manual**, and are **normed** for child sex, age, and rater (teachers v. parents) The standardization samples are comparable to the expected race and class composition of the FAST participants. An attempt to establish local (Wisconsin) norms on an older sample of middle school age children arrived at a distribution of scores very nearly equivalent to those described in the Quay Peterson manual (Arthur, 1991).

Family Adaptability and Cohesion Evaluation Scale (FACES-III) (Olson, 1982, 1986). This popular self-report questionnaire provides scores on the dimensions of Family Adaptability and Family Cohesion. The scale has demonstrated reliability and validity, with standardized norms. FACES-III is completed by parents. FACES-III is one of the few standardized measures of family variables, and has the advantage of validation and easy administration and scoring. The standardization sample is generally equivalent in demographic make-up to the participants in the current evaluation.

Social Insularity **Subscale** of the Parenting Stress Inventory (PSI) (Abidin, 1986). The PSI is a standardized measure with established reliability, validity, and standardized norms. The Social Insularity **subscale** consists of 7 questions which taps perceptions of social support. This measure is only used with FAST programs staffed with Family Service, Inc., of Madison

personnel as members of the collaborative team.

Parent-School Involvement Survey (Epstein, 1989). Selected questions concerning attitudes towards the school, perceptions of opportunities for parent involvement, and self-report of parent involvement. Questions were selected under the guidance of the FAST team. This questionnaire was developed for use in a Chapter One school of an inner city neighborhood, and is one of the few surveys of family and school relationships. The survey is completed by parents. A brief, **3-item** questionnaire was developed for teachers to report on family involvement and affiliation.

D. Results

The demographic make-up and attendance rates of targeted children and families are described in Table I.

Comparisons of outcomes on standardized instruments from pre-intervention to post-intervention are described in Table II. Only two of the seventeen T-Tests show statistically significant change for FAST graduates: Parent ratings of Anxiety-Withdrawal problems show statistically significant improvement over the course of FAST: and the increase in family cohesion during FAST is highly statistically significant. Other pre-to-post score changes are in the predicted direction. but do not achieve statistical significance.

Solomon (1975), empowerment is a:

“process whereby the social worker engages in a set of activities with the client or client system that aims to reduce the powerlessness that has been created by negative valuations based on membership in a stigmatized group... A process of development of an effective **support system** for those who have been blocked from achieving individual or collective goals.” (p. 19)

Four strategies for empowering families were identified by Solomon (1985):

1. ENABLING the family to draw more on its own resources;
2. LINKING with others who can provide new perceptions and/or opportunities;
3. CATALYZING additional resources that may be needed before the family’s resources can be fully utilized; and
4. PRIMING systems to respond more positively.

Gutierrez (1990) describes five aspects of empowerment with families:

1. The families should recognize that they might not be entirely or even primarily responsible for their problems. but they will have to take responsibility for their solution.
2. The helping professionals have expertise that can be made available to the family for the problem-solving process.
3. **The** resolution of the problem will require a collaboration of the family and the “helpers” as peers. The family brings unique knowledge on its problems, and the helper brings specialized knowledge, usually gained from training and experience with many families with similar problems.
4. The family’s relationships with many external social institutions may influence the etiology and maintenance of their problems (e.g., their relationships with the police department, public housing, hospital or neighborhood health clinic, probation department, or schools.
5. The “System” is not monolithic, but rather is made up of many sub-systems as indicated above. Effective ways of relating to these external systems can be learned, just as building relationships with other people can be learned.

To be empowered must be based on an actual experience of exercising power; it is not a lesson which can be taught with words. There needs to be instances of self-initiated behaviors

which are rewarded by having a positive and desired impact. There needs to be an enactment of the newly negotiated relationship for power to be brokered. The power invested in the social worker must be decreased; social distance reduced; and the clients' identity, autonomy, and reciprocity in the relationship promoted. The job of social workers then is to create circumstances in which the client can be powerful; to provide supports so that clients may directly access the benefits and prerequisites accorded to the mainstream of society. Social workers must leave with the capacity to solve problems in the hands of the client (Parsons et al, 1988).

C. The Families and Schools Together (FAST) Program

FAST is a voluntary eight-week program for whole families, up to twelve at a time, in which positive connections are built between people. The program emphasizes and supports positive relationships between: 1) a mother or father and one child; 2) a mother and all of the rest of her family unit; 3) a mother and another adult; 4) mothers with other mothers in a group; 5) mothers with school personnel; 6) mothers with community-based professionals; and 7) mothers in the community. These relationships **are** built by orchestrating and directing the process of structured encounters between people. Each of the experiences builds up the mother/father role in relation to other (see table on FAST Curriculum).

Based on structural family therapy principles (Minuchin, 1978, 1985), the program begins by each family sitting at a family table. The family unit is protected from intrusions, and its boundary is promoted by separate tables for each family. They eat a meal together at this table, and the children are helped to go to the counter and fill a plate take to their mother, who

deserves a rest, Immediately, the parent experiences something different: the FAST staff is **respecting her** hard work as a **parent**, giving her a break from serving her kids, and supporting her by helping the kids to serve her needs. None of this is articulated, it is only experienced_

After singing together, each family makes a family flag; materials are available to choose, and parents are asked to make sure that each person in their family puts at least one thing on that flag. It is assumed that the parent can do this, and directions are given to the parent, rather than to everyone, underlining the authority of the parent in their family unit. A picture is taken of each family with their flag, and then each week the flag and the picture are placed on the table ahead of time to identify their space.

Each week there are two additional family-based activities called Scribbles and Feeling Charades. The parent is given instructions, which include “be sure that each person in your family gets a turn, and be sure that no criticisms **are** made.” These exercises are based on delinquency prevention research (Alexander and Parsons) and on substance abuse prevention research (**Schedler** and Block, 1991). but they are also fun and everyone laughs as they participate together as a family. Everyone in the family begins to experience a sense of order, pleasure, and fairness, and the parent has created that feeling for her family at their table.

The generations are then split off, the children go off to play, and the adults break into twosomes for fifteen minutes (e.g.. they can go out for a smoke). It is suggested that they review their day with each other, without giving advice or judgment (effective listening). This hassle review talk is stress reducing. Breaking into dyads also builds a buddy system, which can function to reduce the likelihood of **low-income**, depressed mothers taking it out on their children (Belle, 1983).

After Buddy Time, the whole group of adults convene to hang out together. The clinical **social** worker **leads** the group with the parent/consumer, and begins by saying “I am Lynn; I have two **children**, a girl named Ruth who is **fifteen** and a boy named Ben who is eleven. Today, my stress level is about eight.” She turns to the **parent** co-facilitator who takes a turn. Both have modeled limited self-disclosure as peers. They also make immediately clear that there is no particular agenda. Because **all** of the parents have a child the same approximate age attending the same school, living in the same community, over eight weeks, this group of parents can become extremely close. However, **this** will depend on the co-facilitators emphasizing interdependence and promoting the self-help process, rather than being the experts with the answers. Potential parent leaders are identified and supported to take over the process for the follow-up program.

After experiencing the mutuality and the support of the adult group time, the parent spends fifteen minutes of quality time with her at-risk child (who returns from Children’s Time). There are no interruptions, the time and space are protected. and play materials are available for selection. Parents are coached to Not Boss. Not Teach. and Not Judge during this one-to-one time. They are instructed to follow the child’s lead. let the child be in charge, and to describe what the child is doing or mimic it. This is a child psychiatry technique developed by Dr. Kate **Kogan** (1975. 1978). and. if done everyday at home for fifteen minutes, can have a major impact on **the** mental health of the child. The **mother** can frequently **see** the change in her child immediately. and she knows that **she is** responsible for bringing on that positive change in her child. She learns the techniques experientially of doing a modified form of play therapy.

Finally, **the** entire group returns to their family tables, and a lottery is held. The parents

(not the children) are told the secret that the lottery is **fixed**, and each family will win once. Thirty dollars worth of nice items are won with high drama. Whoever has the winning ticket wins for their whole family. The winning family is cheered on by the group. The winning family is also give thirty dollars cash to buy and prepare the meal for the next FAST session. **They** trade the experience of receiving from FAST with the experience of giving to FAST. The built-in reciprocity of exchange indicates a trust in and respect for the parent to come through **with** responsibility after having won the prizes. No parent has ever let down the program. The whole group forms a large circle, and requests are made for any announcements to be made (**like** “My mama got a job” or “Joey got a badge at school for good attendance today”) or birthdays to be sung for? The meeting closes with a non-verbal circle ritual called RAIN, which people of all ages can join in on, and it ends with arms up in the air to be the SUN.

After eight weeks, a big graduation event is held. During the privacy of the adult group time, the co-facilitators read out individual **affirmations** to each parent with specific positive behavioral observations about their parenting which were compiled by the FAST staff. These are then given to them to take home. Everyone invites guests to graduation and the principal comes to hand out certificates. Often teachers come, as well as relatives and friends. Each family marches up together as a unit, with graduation hats on (one school got the high school band to come and play “Pomp and Circumstance”). and shakes hands with the principal. A picture is taken for the FAST scrapbook. The volunteers are acknowledged for their work.

These multi-family group sessions are facilitated by a collaborative team made up by a minimum of four members. These are all paid positions: a parent/consumer; a school professional (e.g., school social worker); a clinical social worker from a community-based, **not-**

for-profit agency; and a alcohol and other drug abuse counselor from a community-based, **not-for-profit** agency.

Without each of these four members represented, FAST training does not take place. The collaborative team is trained together, plans together, facilitates the group together, and processes the group together. The parents staff is a central partner to each aspect of the planning and the direct service provision of the program. The initial training of the FAST facilitator's team includes a discussion of shared responsibility for assuring that the parent voice will be sought after and listened to in the small group process.

After the eight-week FAST program is completed: 1) everyone is evaluated to determine the impact of the program; 2) linkages are made to community services where appropriate; this is done by the appropriate FAST team member who knows the **parent** and is trusted by the parent; and 3) the follow-up two year program is begun. FASTWORKS is a monthly follow-up meeting to which all families who have graduated from FAST are invited for two years. The basic curriculum listed above is repeated, along with a special event or outing for the family. These activities are planned by the Parent Advisory Council (**PAC**), made up of leaders from past FAST programs. They have elected officers and receive a budget to allocate and staff support to help them with arrangements. The PAC is also asked to send a representative to two meetings a year with all of the administrators to review how the FAST local programs are proceeding. A FAST Leadership Camp is held each summer for whole families to do leadership training for selected parents, and the FAST curriculum is also repeated daily at the Camp.

D. FAST Program into Policy: Empowerment Stories

The FAST program was **initially** developed in 1988 by the senior author at Family Service in Madison, Wisconsin, with funding from United Way and a state grant from Health and Social Services out of the Alcohol and Drug Prevention Unit (McDonald, et al, 1991). The initial collaborative partners were PICADA and Lowell Elementary School, Madison Metropolitan School District. In 1990, Sue **Rohan**, a Democratic Assembly person, introduced FAST into Assembly Bill 122 as a part of a continuum of drug prevention and treatment services. The Bill eventually passed through the Democratic dominated legislature and was supported by the Republican Governor, to allocate one million dollars per year (now in its third year) to replicating FAST across the state of Wisconsin.

At one point in the process, FAST parents, rather than professionals, were asked to testify about FAST to a sub-committee, with an audience of **400** and television cameras. I turned to three mothers and said, "It's up to you"; I thought, "they won't let me talk." I gave an encouraging smile and patted the back of Margaret as she moved up to the microphone. She wore a long-sleeved, high collar, black knit dress with white pearls around her neck and her blonde hair was pinned up. She looked very bright and seemed amazingly calm. In a clear tone, she started to speak to the multitude. I remembered our first meeting almost eighteen months before, when I drove to her house to take her and her three children to their FAST group meeting. Even though I had come to see her many strong traits, watching her now at the hearing made me see her in a new way.

Margaret testified: "When I was invited to attend FAST, because of a complicated family situation, I was stressed and not being sufficiently attentive to my daughter. She was having all

kinds of problems at school. I am glad I participated in FAST; it is a great program. I started paying good one-to-one attention to my **daughter**. Now, she's been tested by the schools as talented and gifted. Now, I have two jobs, and one is with FAST. Both of us have better **self-esteem**. I can go to school and speak up for my kids now. I feel better about myself and my kids, thanks to FAST. FAST helped me to be able to talk to people at [my daughter's] school and relate to them as human beings."

"Wow", I thought, "you have come a long way, Margaret. All we did was believe in you. This program gave you support as a parent. It empowered you so that you could take care of your kids in the loving way you wanted to." In 1992, Margaret completed one and a half years on the job as a FAST facilitator, the first FAST parent to be hired in the position by Family Service.

Mildred was also dressed perfectly in red, white, and black with **tri-color** shoes to match. She was a handsome black woman and her two children came up to the microphone with her. "They had already passed a test showing off their mother's parenting skills", I thought; they waited two and a half hours in a crowded room to speak.

Mildred testified: "FAST treated me with respect when I was down and out. FAST helped me and my children. They want to tell you themselves." ("Oh no, what will happen now", I thought anxiously). Both of the small children stood up together, with their feet on the chair, so that they could get near the microphone. Then there was a long pause. The little girl just giggle, but **the** older piped up loud and clear. "we like Special Play." (I wished Kate Kogan could have heard that).

In 1992, Mildred is the first FAST parent to be on the Board of Family Service, Madison,

Wisconsin. She also was recently employed three-quarter time at the community center in neighborhood as the Assistant Director.

The third mother, Melissa, came up to the microphone. She was wearing tight jeans and a large dark sweater, with boots. She is a short, sturdy white woman with dark sparkling eyes and brown hair. She was very nervous. I wondered how much she was going to reveal. She had been going to AA groups for several months.

“I want you to know that I am a recovering alcoholic and drug abuser.” Her voice and shoulders were shaking. Pause. My colleague, **Stella Payton**, had gone up with her and was sitting next to her; she rubbed her leg under the table. The television lights focused on her. “I drank and used for years and years. Both of my parents were alcoholics. I have been in and out of drug rehabilitation programs and always went back to serious drug abuse. Then, I went to FAST...”

I remembered the night that it happened. In the fourth week of the FAST program, the AODA counselor always shows a film or does a puppet show on the topic of the child’s perspective on living with an alcoholic parent. It is both educational and emotionally charged. I was sitting next to Melissa and her son, Johnny, while they watched the film. I noticed Johnny got very agitated and began running around the room. Melissa got very strict with him and become angry, telling him to “SIT DOWN:” After the film, each family discussed some aspect of the film at their family table. Melissa and Johnny were both very much on edge and left as soon as possible. We processed after the group and expected them to not ever return to FAST. Instead. Melissa called on the FAST facilitators during the week and asked to see a counselor at Family Service.

She continued: "One night, I came home with Johnny after seeing a film about a kid with an alcoholic father. Johnny said to me, 'Mom, I don't have to be like that kid in the movie, do I?' I said, 'No, Johnny, you don't.' I have been sober for over a year because of FAST. This has changed Johnny's life so much. My older daughter has even moved back home to get some mothering from me that she missed out on when I was using. This program works."

She wept. I wept. Others wept. She was so courageous. Someone from the audience came up and spoke quietly to her and smiled and patted her back. I was moved to hear these heartfelt words. I could not remember ever hearing public testimonials about the impact of any family therapy efforts. I knew that these families needed some support, and that if we **could** put our arms around the family unit, they could hold onto each other better. But, who gets the feedback look in social work? Melissa sat up straight. We had thought she was finished.

She continued: "I have one more thing to say. I am the Chairperson of the FAST Parent Advisory Council and we just raised \$340 by running a Halloween Dance, so that FAST kids could have a good Christmas. I hope you vote for FAST, so that many families all over the state can have a good Christmas, too."

In 1992, Melissa flew with me to Washington, DC to testify at SOAR hearings being held in the Senate Building on Addictive Health Coverage issues. She moved everyone in the audience again with her story. She also became the FAST Statewide Parent Representative to the State Advisory Board. She continues to work full-time as a state employee. She had a relapse and used FASTWORKS to pull herself out of it.

E. FAST Participant Profiles

FAST targets elementary school children whom teachers have identified as at-risk for later problems. Typically, they are eight year old boys behind in school, unpredictable, apathetic, hypersensitive, depressed, have conduct problems in class, and short attention spans.

FAST invites whole families of these at-risk children to participate in the program. Typically, they have been single mother families, with marginal income, on welfare. Sixty percent have no car and forty percent have no telephone. They are depressed, stressed, isolated, and depleted. Most have a family member who has been involved in substance abuse. On family cohesiveness measures, they show normal levels of connectedness rather than dysfunction, i.e., they care about their children.

FAST has been conducted in rural, suburban, small town, small city, and urban ghetto schools. It has supported families whose origins were European American, African American, Native American, Spanish-speaking American, and Asian American. It has supported single parent mothers, single parent fathers, married parents, divorced parents, and three generational families. FAST programs have been conducted in Wisconsin, Illinois, Iowa, Michigan, Kansas, and Delaware.

FAST evaluation has been conducted with an experimental design at one setting, as **well** as with **pre/post** questionnaires filled out by parents and teachers at over thirty sites. The data repeatedly show at **least** a twenty-five percent improvement in the child's mental health indicators after eight weeks. Longitudinal data **are** not yet available.

IV. FAST as a Multi-Family Prevention Strategy*

A. Introduction

Family therapy techniques have in **recent** years **been** used to address issues of poverty and related dysfunction in conjunction with juvenile court systems and county social work systems, in what **are** commonly called family preservation programs. Although impressive in their impact, the techniques **are** made accessible so late in the continuum of services, that only a few families benefit. In this paper, a prevention/early intervention family therapy program is described, in which schools do case finding and refer elementary school children and their families to collaboratively run, eight-week multi-family groups. This approach has been identified nationally as a model substance abuse prevention program, a model delinquency prevention program, and a model early intervention for high-risk youth program. It has been funded by various public and private sources, and has been replicated in almost seventy school-community collaborations in six states. This paper was funded by **OHD/ACF** federal grant **#90-PD-165**.

Over the last twelve years, the federal government has systematically withdrawn programmatic support for poor children and families; poverty has increased dramatically, without providing a safety net for children. Not surprisingly, the impact on **caretaking** systems has been overwhelming in the health care system, the housing system, the foster care system, the child welfare system, the juvenile **court** system, and in the schools. None of these systems have adequate staff in numbers *or* in training to cope with **the** flood of increasing numbers of symptomatic children coming from impoverished, multi-problem circumstances. **The** usual way of doing things must be reconsidered, because it is not working now.

***This** chapter is a draft of a paper which will be submitted to American Family Therapy Journal authored by Lynn McDonald.

Depending on one's political orientation, the families are blamed for having created **their own** circumstances or the government is blamed for having redistributed the wealth unevenly. Neither of these positions leads directly to a clinical course of constructive action in relation to our nation's children. Family therapists in practice seem to withdraw from the advocacy/political action arena and suggest that there is not anything that they, as individuals, can do. We suggest in this paper that there is something family therapists can do, using only five hours per week for eight weeks to help about twelve families at a time. We appeal to the readers to honor your social responsibility involved in knowing a family therapy technology which can be helpful to children in disadvantaged circumstances. We appeal to you to work with schools.

B. Collaboration with Schools

In order to be effective in collaborating with schools, some background information may be useful. Techniques for joining with schools, and the systems analysis of family/school tensions will be presented, and recommended steps to be taken are given.

Background:

Until the late 1980's, schools had effectively functioned in a relatively isolationist manner, in relation to other public and private sector human services agencies. However, this has changed dramatically on a national, state, and local level in the last several years. A desperate confusion and helplessness arising from the multiple unmet needs of the children, whom schools want to reach, has led to the opening up of the schools to collaborative efforts. The growing recognition of the inadequacy of **current** strategies has fueled a search for new approaches. In recent years, innovative coalitions of agencies, schools, and families have often succeeded where

traditional approaches have failed. These success stories have so dramatically demonstrated the effectiveness and efficiency of collaboration that the concept has rapidly won enthusiastic acceptance from many diverse sources.

At the same time that schools are beginning to welcome cooperation with other professionals and organizations, there are recession related cutbacks which restrict school monies available for new programs. In some states, schools are **restricted** from sub-contracting with private sector agencies for services. Unions often have protections for their members against after-school hours work; in some places, schools are closed after school is over. These **realistic** issues have inhibited collaborative school-based efforts in the past. But the change is now in the willingness of the school administrators to problem-solve together on how to overcome the obstacles, so that disadvantaged children can learn at school. For example, ongoing categorical funding which targets parent involvement (Chapter I), children at-risk, drug-free schools, truancy, learning disabled/emotionally disturbed, etc., have been earmarked for Families and Schools Together programs.

The Council of Chief State School Officers, an organization of the heads of public education agencies from every state, articulated this shift in perspective in the Forward to a Guide for State Action, entitled “Family Support. Education. and Involvement” (1989):

“The realities facing today’s families mean that they often do not have the time, resources, or skills for that kind of **support** or assistance. Schools must do more to position families to help their children in school. Expanding school action in family support, education, and involvement presents new sets of expectations and many feel this adds to an already overburdened set of responsibilities for schools; the situation is such that the potential for the school to address basic family needs must be used. Much of the effort must be carried by **schools** in alliance with other service agencies. Much of the effort will require use of existing programs of community and adult education and will require reshaping traditional school/parent organizations and partnerships.”

Joining with the School:

Acknowledge the rigid hierarchy: when we began to collaborate with schools, we first met with a colleague in the school district administration, and asked him to recommend an **open-** minded principal to us who might be willing to consider a collaborative, multi-family group approach. The school administrator set up and attended the meeting with the principal and us, from Family Service, a not-for-profit mental health agency. The school district system is rigidly hierarchical, and at the same time, each principal is in charge of his/her own school, Entry into the school system for a collaborative effort without the active support and ownership of the principal is ineffective.

Speak a common language: the FAST program is written as a curriculum, as a package; it is straight forward and teachable. There are clear directions. There is also a research background for the program and careful evaluation. It takes six and a half days of training over a four month period; results will be noticeable in that short of a time. The manuals and the approach is compatible with schools. FAST is being used in almost seventy schools in six states.

Find a shared goal: There needs to be a clear benefit to the school for proceeding with this collaboration. The two commitments which we can make which appeal to the schools are improvement in classroom behavior of difficult to manage children, and increased parent involvement in the school by the parents of those children. The second issue seems to us to be related to the first. Often we are informed that the parents have repeatedly been invited to school functions. but never show up; the implication is made that they must not care for their children. the school personnel will have tried **all** of the approaches with which they are familiar, and, if these fail, they often scapegoat the parent (Our recommendation is to try another way; i.e., "let's

work together to get the parents involved”).

C. Analyzing the Family-School System

Let us analyze the structural components of the family-school system with structural family therapy language:

1. The parent and the teacher are both in the executive sub-system; they both care about the child and his future;
2. If the parent and the teacher cooperate in helping the child, then the child thrives;

BUT

3. If there is no distance and distrust between the teacher and the parent because of non-child related social discrepancies, such as experience, education, income, or lifestyle, or if there **are** race, gender, social class, and age differences which create distance, the child suffers from their disconnected relationship; or
4. If there is distance and distrust because every school initiated contact that the parent has with the teacher is negative and feels critical about the child or parent, the child suffers: or
5. If the teacher thinks the parent does not care about the child or if the parent thinks the teacher does not care about the child; or
6. If they are irresolvably conflicted. the child suffers; and/or
7. If there is an attempted coalition between the teacher and the child against the parent. the child is tom apart with loyalty issues.

These factors alone **could** contribute to conduct disorders in the classroom, unpredictable academic behavior, poor attendance. etc.: all issues which concern the teacher. As family therapists, it is clear how to proceed:

1. Join with each party. the restructure;
2. Get the child out of the middle;

3. Help the teacher and the parent to see each other as human beings, rather than stereotyped, one-dimensional figures, and help them to really listen to each other's perspectives; and
4. Work with the parent and the teacher to problem-solve together as partners on how to help that child succeed.

The process which needs to be initiated for this to happen probably should be organized by someone from outside the conflicted executive sub-system, i.e., not a parent and not a school person. Depending on the level of the distance, distrust, conflict, **coalition**, scapegoating, stereotyping, not listening, not caring, etc., an outsider will be more or less necessary to proceed.

Preferably, this outside will be aware of power as it affects relationships, and will provide the necessary support for the least powerful member of the conflicted dyad, before beginning the mediation of negotiating process. However, it must be a person who is not willing to ally with one or the other member of the conflicted dyad, and who can stay focused on the goal of helping the two to help the child to succeed in the future. It should be a non-judgmental, process oriented person, who can take charge of the interactions so that productive change can be experienced, rather than repeated conflict and failure.

If there are many children and families with possible distance/distrust/conflict issues with the school, a structure serving many families to facilitate the resolution of the problems set out in the analysis above could be helpful for the school. FAST provides the structure for all of this to happen: outsiders with family therapy training are brought into a collaborative process with the schools and the families; the parents are empowered throughout the program (McDonald, et al, submitted): the collaborative team representing the parent, the school, and two **community-**based agencies obstructs alliances; and the structured FAST curriculum promotes positive encounters.

The eight-week multi-family group meetings are positive experiences which can reduce parental skepticism that they never get anything from the school. School personnel attend all of the sessions, and their presence is seen as supportive and human, having no particular agenda. By the end, the stereotyping from both sides is reduced, and the parents and the teachers have had opportunities to engage in non-certified interactions for **the** sake of the child. FAST is a bridge towards more cohesive family and school relationships. Expectations for the school involvement in the FAST program are laid out in very specific ways, specifically by a role, in the FAST Orientation and Training Manual (McDonald, et al, 1992):

Teacher:	Identifies high-risk children Evaluates target children pre and post Attends FAST graduation night
Pupil Services/Building Team: School Social Workers School Psychologists Guidance Counselors School/Community Workers Principal	Identify high-risk children Obtains release of information from parent to refer to FAST
One School/FAST Liaison:	Makes home visits to recruit whole families Attends multi-family evening groups Transports families to meetings Attends weekly FAST planning meetings
Principal:	Supports the FAST program Organizes an in-service for teachers Provides comp. time for staff involvement Attends administrative collaborative meetings twice year Attends graduation to award FAST diplomas

D. Multi-Family Eight-Week **Group** Curriculum

Almost nothing is taught in this curriculum: there are no teachers. Instead of teachers,

there are at least four co-facilitators for each multi-family FAST group. These four are a school professional, a family therapist, an alcohol and other drug abuse counselor, and a consumer/parent. The two non-school professionals should be from community-based, **not-for-profit** agencies.

Instead of lectures or presentations, the family members learn experientially by going through the same routines each session for eight weeks. ‘They actively participate in exercises with brief interactional instructions. These exercises structure familial interactional sequences based on structural family therapy principles (Minuchin, 1976, 1978). There are ten routine structured activities; each one has a different set of member participants and distinct process goals. The groupings are listed below:

Meal	Family unit	Thirty minutes
Flags* (*first session only)	Family unit	Forty-five minutes
Music	Family unit	Ten minutes
Scribbles	Family unit	Fifteen minutes
Feelings Charades	Family unit	Fifteen minutes
Kids’ Play	Children separate	Sixty minutes
Buddy Time	Adult dyads One to one	Fifteen minutes
Parents’ Talk	Adult group	Forty-five minutes
Special Play	Parent/one child One-to-one time	Fifteen minutes
Lottery	Family unit	Ten minutes
Announcements/Rain	Whole group circle	Ten minutes

TABLE I
FAST PARTICIPANTS **SAMPLE DEMOGRAPHIC** CHARACTERISTICS

Variable	Value	Frequencies	N reporting
Child Gender	Male	75 %	52
	Female	25 %	
Child Age	5 years old	15.4 %	39
	6 thru 9 years old	84.6 %	
Child Ethnicity	Caucasian-American	50.9 %	53
	African-American	47.2 %	
	Hispanic-American	1.9 %	
Maternal Education	Less than 12 years	26.5 %	34
	High School Graduate	73.5 %	
Paternal Education	Less than 12 years	25.0 %	8
	High School Graduate	75.0 %	
Parental Structure	Two-Parent Family	25.0 %	42
	Single Mother Family	75.0 %	
Number of Children in Family	Single child	3.8 %	26
	Two children	30.8 %	
	Three children	34.6 %	
	Four children	23.1 %	
	Five or more	7.6 %	
Transportation	Family Car	60.5 %	38
	No Family Car	39.5 %	
Telephone	Telephone in home	34.2 %	38
	No telepbone in borne	65.8 %	
FAST Sessions Attended	0 sessions	5.9 %	51
	1-4 sessions	13.7 %	
	5-8 sessions	81.4 %	
FAST Program Completion	Graduated FAST	85.2 %	54
	Did not graduate	14.8 %	

TABLE II
MEANS AND STANDARD DEVIATIONS FOR MEASURES
IN FAST GRADUATE SAMPLE

Measures	N	Pre-tests		Post-tests	
		M	SD	M	SD
Teachers' RBPC Ratings:	25*				
Conduct Disorder		10.24	9.9	9.16	10.0
Socialized Aggression		1.96	2.3	1.56	2.3
Attention Problems		10.00	7.2	9.76	7.8
Anxiety-Withdrawal		4.24	3.5	3.72	4.0
Psychotic Behaviors		1.04	1.9	1.04	2.2
Motor Excess		2.60	2.4	2.24	2.5
Total RBPC Score		30.08	18.7	27.48	21.8
Parents' RBPC Ratings:	35				
Conduct Disorder		16.26	8.7	15.71	8.6
Socialized Aggression		4.31	4.4	4.06	5.4
Attention Problems		10.26	7.1	9.71	7.2
Anxiety-Withdrawal		7.43	4.7	6.29	4.7*
Psychotic Behavior		2.51	2.4	2.57	2.5
Motor Excess		3.43	2.3	3.37	2.1
Total RBPC Score		38.43	18.1	33.93	25.9
FACES-III	25				
Family Cohesion		38.12	5.0	40.92	5.0*
Family Adaptability		24.80	5.2	26.40	7.4
PSI: Social Isolation	20	19.95	5.3	20.05	4.7

One-Tailed Paired Pre-to-Post T-Tests

- P < .05
- * P < .01

*In our experience with FAST, the larger samples show statistically significant changes in each domain. Here, the significant improvements are in anxiety-withdrawal (items relate to self-esteem) and to increased family cohesiveness.

TABLE III
MATCHED COMPARISON CONTROL GROUP OUTCOMES

Measure	<u>FAST Program</u>		<u>Control</u>	
	M	SD	M	SD
Teacher RBPC	(N=44)		(N=19)	
Pre-Test	32.80	18.7	41.73	16.8 *
Post-minus-Pre	(N=26)		(N=10)	
Difference	-2.69	15.8	-6.10	17.7
Child Age	6.79	1.3	7.25	1.1

One-Tailed T-Test Comparisons between group means
* P < .05

There is no difference in change scores between groups on the RBPC, with **both** groups showing positive changes in teacher ratings of behavior problems. There are several explanations for **this**. A statistically significant difference exists in pre-test scores between the groups. Higher ratings on the RBPC are more unstable, so these scores may have shown more regression to the mean. At post-test, children who have completed the FAST program still have lower RBPC scores than the comparison group.

TABLE IV
PARENT AND TEACHER AGREEMENT ON
RBPC RATINGS
(N= 43)

	CD	SA	AP	AW	PB	ME
Correlation:	.3896	.2385	.5874	.3437	.1329	.4610
Probability:	P=.005	P=.062	P=.000	P=.012	P=.198	P=.001

One-tailed tests of statistical significance

Correlational analysis yields **statistically** significant agreement between independent ratings by parents and by teachers on the salient **subscales** of the Revised Behavior Problem Checklist (RBPC; Quay & Peterson, 1987).

TABLE V
EVALUATION OF
EMPOWERMENT OF PARENTS
INTO FAST FACILITATORS

FAST Facilitator Level of Training	Dates of FAST Program	No. of FAST Graduates	Pre - Post FACES III Parent Scores	Pre - Post RBPC Parent Scores
MSW	Fall 1989	2	P=<.09	N.S.
	Spring 1990	7	NA	P=<.065
BSW	Fall 1990	7	P=<.14	N.S.
	Spring 1991	7	P=<.06	P=<.004
GED/FAST	Fall 1991	10	N.S.	N.S.
GRADUATE/ PAC LEADER	Spring 1992	5	P=<.09	P=<.056
TOTAL	6 FAST Programs	38		

One tailed t-test

When we reanalyzed the **data** from this school by semester, and identified the level of education of the FAST facilitator, it was clear that in alternating semesters there were significant **improvements** of the children's functioning at a statistically significant level.

TABLE VI
Correlation between Maternal **Social** Support Measures
 And Total Parent **Child** School Behavior Problems

	Parents' Total <u>RBPC</u>	Teachers' Total <u>RBPC</u>
<u>Milardo Support Scale</u>		
Positive Support	.2848 P=.185 N= 12	.3620 P=.152 N= 10
• Negative Support	.3858 P=.108 N= 12	.3652 P=.150 N= 10
Parent Stress Inventory social Isolation	-.2598 P=.076 N= 32	.1235 P=.262 N= 29

A trend towards significance is found between Parents' Social Isolation Score and parent ratings of child behavior problems. While statistical tests are below significance levels for other comparisons, the correlations themselves are fairly high. The small number of subjects involved reduces the statistical power of the **test.** **This** underlines the link between parental **stress** and isolation with child behavior problems at school.

TABLE VII
 Correlations Between Differences in Parent RBPC Subscales and
 FACES-III Cohesion Difference Scores, Pm-to-Post
 (N=35)
 RBPC Subscales

	CD	SA	AP	AW	ME
FACES-III Cohesion	.1826 P=.191	-.3842 P=.029	-.1728 P=.204	-.0580 P=.392	-.2727 P=.094

The statistically significant relationship shows that increases in Family Cohesion during the FAST **program are** associated with decreases in child behavior problems in the **area** of **Socialized** Aggression. There is a trend towards significance in the correlation between increased Family Cohesion and decreased Motor Excess problems.

IX. FAST Replication Evaluation - Thirty Wisconsin Sites

A. Introduction

This program evaluation analysis of the FAST program represents a collaborative effort by FAST families, staff, and teachers at over thirty elementary schools across the state of Wisconsin. Each collaborative FAST team includes professionals from the elementary school and a local mental health agency, an alcohol and other drug specialist, and a parent-liaison. Questionnaires were collected at the local level over the 1990-1991 school year, and aggregated in coded form for analysis at the FAST Databank, at Family Service in Madison, Wisconsin. (A portion of this data was previously reported in the FAST Statewide Evaluation Report of April, 1991).

B. Wisconsin Statewide FAST Program Evaluation Results

The average age of the FAST children (**N=596** reporting) is 7.8 years old, and 93% of the at-risk children participating were between the ages of five and ten years old. 66% of the at-risk children are male. Ethnically, 83% of the children are white, 7% **are** African American, and 10% are Asian, Native, or Hispanic American. 85% of the family had at least one other child in the family in addition to the identified child at-risk (for 467 families, the average number of children at home was 2.6).

50% of the FAST households have no adult male “father figure” involved with the family. 13% of the families in FAST (**n=581**) have no telephone by which they could be reached by schools. 20% of the families had no transportation to come to schools for meetings. Of those reporting. 16% of the mothers (**n=423**) and 24% of the fathers (**N=300**) had not graduated from

high school. (These rates are likely to be underestimates, because of the sensitivity of identifying oneself as a school drop-out. Also, Graduate Equivalency Degrees (**GED's**) and parents who reported "twelve years of school" **were** counted as High School Graduates).

Of families that agreed during recruitment to attend at least one meeting, 85% graduated from their FAST program with consistent attendance and participation (**N=212**).

The behavior problems of at-risk FAST children dramatically improve in several domains, according to standardized, quantitative measures completed by both parents and teachers before and after the eight-week FAST curriculum. Participating parents and teachers completed the Revised Behavior Problem Checklist (RBPC) for FAST children prior to and after graduation from the eight-week FAST curriculum. The RBPC is a well-standardized, empirically derived eighty-nine item behavior rating scale with acceptable psychometric qualities of reliability and validity, and standardized norms (Quay & Peterson, 1987). The subscales cover child behaviors in the domains of conduct disorder, socialized aggression, anxiety-withdrawal, attention problems, psychotic behavior, and motor excess.

Average RBPC ratings of FAST children document that at-risk children are already high in behavior problems. Both parents at home and teachers at school report similarly high levels of problem behaviors. At referral, FAST children are one to two standard deviations above the established means for problem behaviors, placing them at approximately the eighty-fifth percentile for problem behaviors, relative to the standardized norms in the RBPC Manual.

FAST child graduates show **significant** reductions in behavior problems after completing the FAST eight-week curriculum with their families, as shown in the accompanying tables. Parents record highly statistically significant decreases of 20 to 25% in specific domains of

problem behaviors.

Parents complete the Family Adaptability and Cohesion Evaluation Scale (FACES **III**; Olson, 1986) before and after FAST. This twenty item questionnaire has scales for family cohesion (the emotional bonding between family members) and adaptability (family flexibility under stress). FACES-III has well established reliability, validity, and standardized norms. High family cohesion has been shown to buffer the deleterious effects of stressful life events and circumstances on children, and is related to lower levels of AOD problems and delinquency in children. In the statewide sample of 332 families, families reported significantly improved levels of family cohesiveness after participating in FAST.

The Social Isolation **Subscale** of the Parent Stress Inventory (PSI; Abidin, 1986) includes six questions which tap parents' (mothers') perceptions of social support. Higher scores indicate isolation from sources of emotional support. Social isolation of parents has been linked to breakdowns in parenting and negative child behaviors. Over the course of FAST,, mothers report statistically significant improvements in social support, as measured by the PSI Social Isolation Subscale.

C. FAST Experimental Comparison Study

Efforts at establishing comparison groups in school settings to date have been very difficult. School staff and parents alike have not been receptive to additional evaluation beyond the children and families involved in the program, and resources for funding comparison group data collection have been limited.

Although support and consultation for a comparison evaluation design were offered to all

n

FAST schools implementing the program in collaboration or training with Family Service, it was in Spring, 1991 that the first school district negotiated an experimental design with random assignment to condition. The pool of at-risk children eligible for FAST was generated, using school district criteria (guided by an at-risk checklist developed by a leading school district), and then the at-risk children were randomly assigned to FAST recruitment or to the control condition.

Parents in the waiting list comparison group were contacted by mail and offered \$25.00 for the completion of evaluation questionnaires before and after the eight-week treatment period, an amount roughly equal to the tangible incentives (guaranteed doorprize) received by parents participating in the FAST program. (Funding for this was sponsored by the American Institute for Research, which had recognized FAST as a model program for AODA prevention). Approximately 50% of the pool in the control condition agreed to participate in the evaluation.

⤿

In this random assignment comparison study (**N=22**), all children were in grades kindergarten through third. 85% of the children were Caucasian, 60% **were** male, and 40% **were** from single-parent families. The school serves a predominantly white, middle-class neighborhood.

This study documents that the FAST program improves child self-concept., a central protective factor against the development of school failure, AODA, and delinquency. Children in FAST (**N=8**) showed statistically significant pre to post improvements on the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (**Harter & Pike, 1984**). while non-participating control students (**n=14**) did not. FAST involved children showed significant improvements on paired t-tests for the scales measuring their sense of maternal acceptance, cognitive self-competence, and peer acceptance. For FAST children, improvements

n

on subscales were: MA average scores of 16.5 pre-intervention to 18.9 post, significant at **.01** level; CC average scores 19.5 pre-FAST to 21.5 post, significant at **.02** level; PA average pre-FAST scores of 18.9 improved to post scores average 20.3, statistically significant at **.04** (one-tailed test). In comparison, children assigned to the control condition did not demonstrate significant improvements over the same time period: MA average pre-scores 15.5, post 16.6, not statistically significant; CC average pre-scores 18.9, post 20.0, N.S.; PA average pre-scores 16.3, post 16.3, N.S. (Neither condition showed significant improvement on the remaining subscale, Physical Competence).

Child behavior problems are predictive of future school problems, AOD problems, and delinquency. In this study, FAST was shown to reduce child behavior problems as rated by parents, beyond the effects of natural maturation or other influences. FAST parents (**N=7**) reported significant decreases in aggregate child problem behaviors (total RBPC scores), compared to non-FAST parents (**N=10**). FAST children significantly reduced behavior problems over the initial phase of FAST, compared to other at-risk children from the same school, but who were not in the FAST program. Total RBPC scores for FAST graduates decreased from 43.4 pre-FAST to 26.7 after FAST graduation, while Control children's scores went from 33.0 pre-test to 28.0 post-test. Using a repeated measures ANOVA design, this condition by time interaction effect is significant at **.068**. This level of significance is acceptable because it is remarkable to demonstrate any effects in such a small sample, due to the limited statistical power in such tests. Reductions of **subscale** scores for the FAST group were statistically significant in paired t-tests, reflecting the general pattern described with other samples.

TABLE I
FAST EVALUATION
WISCONSIN STATE PRE TO POST AVERAGES
1990-1991 SCHOOL YEAR

<u>Measures</u>	<u>Pre-FAST</u> <u>Means</u>	<u>(sd)</u>	<u>Post-FAST</u> <u>Means</u>	<u>(sd)</u>
Parents' Ratings: (N=358)				
RBPC Conduct Disorder	17.01	(9.7)	1337 • **	(9.1)
RBPC Socialized Aggression	2.85	(3.4)	2.11 • **	(2.9)
RBPC Attention Problems	11.22	(6.9)	9.05 • **	(6.3)
RBPC Anxiety-Withdrawal	7.65	(4.6)	6.11 ***	(3.8)
RBPC Psychotic Behaviors	1.89	(2.1)	1.60 ***	(1.9)
RBPC Motor Excess	345	(3.3)	2.77 ***	(2.4)
FACES-III Family Cohesion (N=332)	36.91	(6.8)	38.13 ***	(7.1)
FACES-III Family Adaptability	24.09	(5.6)	2438	(5.8)
PSI: Social Isolation (N=68)	22.07	(4.1)	22.79 *	(4.0)
<hr/>				
Teachers' Ratings: (N=408)				
RBPC Conduct Disorder	11.73	(11.0)	10.45 • **	(10.6)
RBPC Socialized Aggression	1.84	(3.8)	1.71	(2.8)
RBPC Attention Problems	11.93	(8.3)	10.08 ***	(7.4)
RBPC Anxiety-Withdrawal	5.94	(4.8)	5.02 ***	(4.5)
RBPC Psychotic Behavior	133	(2.2)	1.25	(2.1)
RBPC Motor Excess	3.10	(2.9)	2.65 ***	(2.6)

TABLE II
 PARENT-SCHOOL INVOLVEMENT MEASURES
 DANE COUNTY, 1990-1991 SCHOOL YEAR

Parents' (N=68) reported involvement with schools, pre and post FAST (eight-week curriculum). Items were selected from the Parent-School Involvement Survey of the John Hopkins Center for Effective Elementary Education (Epstein, 1989). Parents reported level of involvement with the school over the previous two months, with the following four-point scale:

1 = Never do 2 = Not yet
 3 = One to two times 4 = Many times

<u>Item</u>	<u>Pre-FAST</u>	<u>Post-FAST</u>
"Talk with the teacher at school"	3.07	3.37 *
"Go to special events at school"	2.70	3.01 *
"Go to PTA/PTO meetings"	1.50	1.56

*Significant at the .05 level.

X. FASTWORKS Evaluation

A. Introduction of Survey Instrument

To ascertain the impact of the follow-up program, which involves monthly meetings open to **all** FAST graduates at a school for two years, we conducted survey questionnaires in December, 1992 of all FAST graduates from seven groups (six from Thoreau and one from Head Start in the same neighborhood). These surveys (see attached questionnaires) were dropped off or mailed to each home. Those not returned by mail received a telephone call or visit two weeks later. Many were home visited to help them complete the survey by **the** FAST facilitator (a FAST graduate) or a graduate social work student. Of the fifty-nine possible graduates, **thirty-seven** surveys (**62%**) were completed.

TABLE I
THOREAU FASTWORKS QUESTIONNAIRES

	Graduated	Responded
Fall 1989	8	4
Spring 1990	11	5
Fall 1990	8	5
Spring 1991	6	6
Fall 1991	10	6
Spring 1992	8	6
Spring 1992 (Head Start)	8	5
TOTAL	59	(62%) 37

No Response:

3% Not willing to respond 2
32% Moved and no response 20
(Three moved and responded)
23 of 59 moved in three years: 40%

Of those who did not respond, twenty had moved and could not be found. Only two

refused to complete the survey. Of the fifty-nine graduates from 1989 to 1992, 40% had moved.

The results have been tabulated and are encouraging. The numerical responses are reported **first**, followed by the written remarks for anecdotal evidence of the FASTWORKS impact on the family. 62% of the parents reported attending monthly sessions: 28% sometimes (i.e. once a year or more); 10% never. Our records on attendance supported these numbers.

70% of the parents reported doing Special Play with the target child at least once a week. This is central to the maintenance of change for the child.

70% reported keeping in touch with an average of 2.2 friends from FAST outside of the monthly meetings. They reported giving each other support of various kinds including sharing advice, babysitting, giving emotional support, doing services, etc. in that order of frequency.

There was a significant impact reported related to increased involvement in the community since FAST. The community activities (see Table III) were of varying types. **Self-**improvement activities showed 40% pursuing further training and education; 16% obtaining **full-**time jobs. Seeking relevant help for problems showed 27% seeking counseling for self or child, and 16% going to alcohol and other drug treatment. Community participation showed in community center activities (35%), church activities (32%), and as a volunteer in community organizations (14%). Leadership in FAST Parent Advisory Council showed 11%.

Involvement in school **activities** showed 32% becoming involved in Parent Teacher Organization (PTO) and 65% **reporting** much more involvement or somewhat more involvement in their child's schooling.

Finally, on reports of change **of** attitude or knowledge (see Table IV), parents saw the most change in feeling much more powerful in helping their own child to succeed (**70%**), in

much better knowledge of the negative effects of alcohol and other drugs (70%), (64%) in child feeling much more positively about school, and (64%) in feeling their own self-esteem was much higher.

B. Parents' Remarks

Please read the following quotes of the parents about what they liked best about FASTWORKS:

What have you enjoyed most about FASTWORKS?

- “Everyone getting together.”
- “I take a break from the kids [for] a few hours. I enjoy meeting people.”
- “[The] parent group; it gets pretty interesting. All the other things are enjoyable, too.”
- “The get-togethers, parent-teacher **gathering[s]**, and special events.”
- “Getting out, being with the kids, and meeting the other parents.”
- “Special Play, parent group, and Feelings Charades.”
- “The **talk[ing]**; the way my child’s face lights up.”
- “Meeting other families.”
- “Everything. I like working with my **child(ren)**. I like the parent group a lot, also.”
- “Support from other people concerning children and the events.”
- “[I have] learned to spend more quality time with my family.”
- “Spending time with my kids and learning to enjoy [them] more.”
- “We like it when the kids are playing and we have **group sessions by** ourselves.”
- “Meeting with other parents and [their] children (who are friends of my child). Getting to know how my child feels.”
- “Talking to other FASTWORKS staff.”
- “The FAST songs; the children enjoy it.”
- “I liked it for our family; it [is] something to do together.”
- “Doing something different other than sitting at home.”
- “Parents problem-solving issues with the FAST staff.”
- “Rollerskating, FAST Summer Camp, and other special events.”

What part of FASTWORKS do you find most helpful for your child and family?

- “Eating with other families. and socializing together.”
- “[FAST **staff**] helping me understand my daughter.”
- “Special Play.”
- “The chance to talk to someone when I have with [my child] at school.”

“Being able to get out and play with other kids.”

“**Play time** with others.”

“Parent group.”

“Child’s play - Scribbles and feeling as a part of the family.”

“It is something [my son] can relate to; he really needs the one-to-one attention from me.

“The parent group, Special Play, Feeling Charades, and the meal are all helpful and important because one event supports the other.”

“Feelings can sometimes bring out how we might be feeling at that time. Scribbles can help us discover what we **are** capable of if we try hard enough or put forth a little effort.”

“[The] closeness, [the] bond with each [person].”

“When the children like helping and doing things with us, like **fishing**, bowling, and hunting. ”

“Everything.”

“They give help with places you can call.”

“Being around the other kids and having a chance to express themselves.”

“When we sit down to eat as a family, and do Scribbles.”

“Time to spend with one child without getting interrupted.”

“Meeting other kids/families in the neighborhood. [**There** is] a real effort to find a way for one-to-one time. [It is] good to have open, non-threatening staff who are helpful and thoughtful regarding family needs, resources, problems, or offering ideas to improve family needs.”

How would you improve FASTWORKS? What would make it better for you and your children?

“[Have FASTWORKS] more often, with more involvement from the families.”

“It should be longer.”

“**Smaller** groups.”

“Transportation is sometimes hard, especially when it’s cold.”

“**[We]** like it the way it is.”

“[Mom] organized.”

“It is perfect as is, except for one thing: bring in speakers to educate on us on **different** problems we encounter.”

“[Have] it on a Friday evening or weekend so the children don’t have to be up late when they have school the next day.”

“It is a good program already.”

“Meeting bi-monthly.”

“We would like to have more events like bowling, rollerskating, swimming parties, **etc.;** a mix of things instead of the **same** events all the time.”

“Have parents to help in organizing activities.”

“More FASTWORKS **outings**, if possible.”

“Just going through the program helped my children as well as myself. I would just leave everything as is. You’re doing great.”

“Parents spend more time together; [have] the children play the entire time.”

“A longer time for us together. For example, have discussions that include the **children**.”
“It’s nice the way it is.”
“Having time to do Special Play with both of [the children], instead of just one.”
“During the meeting, have more time **to** do Special Play.”
“Have more control over the children.”
“An opportunity for alternating one-to-one time with kids, which I **usually** don’t do at home; encouraging other activities outside home, school, or just for families.”

What suggestions do you have to improve attendance at FASTWORKS meetings?

“Give actual **training** classes during FASTWORKS.”
“I would like to have it on a different day; for example, Friday.”
“Let people know earlier about events.”
“None.”
“Speakers to educate us and to better our family communication.”
“Parents develop telephone tree; **call** other parents with invitations to attend and give updates of events.”
“Not convenient with split custody; I would not be able to attend events without my children.”
“We should have public transportation or have our own bus to pick up people who don’t drive, own a car, or are too poor to pay for public transportation.”
“[Have] parents organize group meetings in or around their homes.”
“Keep sending our fliers.”
“Free food, more guest speakers on housing, and more parent talk.”
“Provide transportation.”
“Call parents ahead of time and make sure they have transportation.”
“More telephone calls before meetings: stress the importance of attending.”
“Put up fliers of FASTWORKS meetings.”

C. Impact

These remarks tell us with more power than numbers can do that something positive seems to be occurring in the lives of these disenfranchised and impoverished primarily single mothers of at-risk children.

Thank you for funding this grant.

TABLE II
COMMUNITY INVOLVEMENT

Since FAST, what are the activities in which you have been involved in the community?

(N=37)

16%	Full-time job
40%	Further education
35%	Community center
32%	Church involvement
32%	PTO
27%	Counseling for self or children
16%	AODA treatment
11%	FAST PAC
14%	Volunteer organizations

Since FAST, how involved are you in your child's schooling?

35%	Much more
30%	Somewhat more
35%	No change

TABLE III
FASTWORKS

Frequency **in** attendance:

62%	23	More than once a month
		Once a month
10%	4	Every other month
9%	3	Once every six months
9%	3	Once a year
10%	4	Never
<hr/>		
100%	37	

Special Play with target **child**:

	6	Daily
49%	18	Two to three times per week
	2	Once per week
<hr/>		
70%	26	
9%	3	One to two times per month
21%	8	Almost never anymore

Keep in touch **with** outside FASTWORKS:

35%	13	Frequently
35%	13	Once in awhile
<hr/>		
70%	26	
17%	6	Rarely
13%	5	Never
<hr/>		
Average 2.2 friends		
	26	Share advice with others
	23	Raising children
	20	School
	13	Babysitting
	13	Give emotional support
	11	Do tasks, errands, or services

BIBLIOGRAPHY

Abidin, RR (1990). Introduction to the Special Issue: The Stresses of Parenting. Journal of Clinical Child Psychology. **19(4):298-301**

Abidin, RR (1986). Parenting Stress Index Manual. Pediatric Psychology Press, Charlottesville, VA.

Alexander, JF and Parsons, EV (1973). Short-Term Behavioral Intervention with Delinquent Families: Impact on Family Process and Recidivism. Journal of Abnormal Psychology. 81: 219-225.

Alexander, JF and Parsons, BV (1982). Functional Family Therapy. Brooks/Cole, Monterey, CA.

Attneave, Carolyn L, Ph.D. (1976). **Social** Networks as the Unit of Intervention. Family Therapy, Theory & Practice 220-231.

Attneave, C and Verhulst, J (1986). Teaching Mental Health Professionals to See **Family** Strengths. Family Resources. Ed. by MA **Karpel**, Guilford Press, New York, NY: 259-271.

Belle, D (1980) Low Income Depressed Mothers: Parent Intervention. Harvard University Press, Cambridge MA.

Beyond Rhetoric: A New American Agenda for Children and Families, National Commission on Children, U. S. Government Printing Office, Washington, D.C.

Birch, HG and Gussow, JD (1970). Disadvantaged Children: Health, Nutrition, and School Failure. Grune and Stratton, Inc., New York, NY.

Blechman, E A & McEnroe, MJ (1985). Effective Family Problem Solving. Child Development 56: 429-437.

Bloom, M (1985). Life Span Development: Basis for Preventive and Interventive Helping. MacMillan Publishing Company, New York, NY.

Brenner, Gail F. et al (1989). Supportive and Problematic Social Interactions: A Social Network Analysis. American Journal of Community Psychology Vol. 17, No. 6: 831-836.

Clark, R (1983). Family Life and School Achievement: Why Poor Black Children Succeed or Fail. University of Chicago Press, Chicago, IL.

Cochran, CT and Meyers, DV (1982). Children in Crisis: A Time for Caring, A Time for Change. Sage Publications, Beverly Hills, CA.

Coleman, J and Hoffer, T (1987). Public and Private High Schools: The Impact of Communities. Basic Books, New York, NY.

Coleman, W S (1990). Attention Deficit Disorders, Hyperactivity and Associated Disorders. Calliope, Madison, WI.

Collins, A and Pancoast, D (1976). Natural Helping Networks: A Strategy for Prevention NASW, Washington, D.C.

Cowen, EL and Hightower, AD (1986). Stressful Life Events and Young Children's School Adjustment. In: M Auerback and AL Stolberg (Eds.) Crisis Intervention with Children and Families (85101). Hemisphere Publications, Inc., New York, NY.

Cowen, EL, Hightower, AD, Pedro-Carroll, J, & Work, **WC** (1990). School-Based Models for Primary Prevention Programming with Children. Prevention in Human Services 7: 133-159.

Cowen, EL and Work, **WC** (1988). Resilient Children, Psychological Wellness, and Primary Prevention. American Journal of Community Psychology 16:591-607.

Cmic, K, Greenberg, MT, Robinson, NM, and Ragozin, AS (1984). Maternal Stress and Social Support: Effects on the Mother-Infant Relationship from Birth to Eighteen Months. American Journal of Orthopsychiatry 54:224-255.

Dunst, CJ, **Trivette, CM**, and Deal, AG (1988). Enabling and Empowering Families: Principles and Guidelines for Practice. Brookline Books, Cambridge, MA.

Edelmen, NW (1992), The Measure of Our Success, Beacon Press, Boston, MA.

Egeland, B, **Breitenbucher, M**, & Rosenberg, D (1980). Prospective Study of the Significance of Life Stress in the Etiology of Child Abuse. Journal of Consulting and Clinical Psychology 48(2): 195-205.

Elkin, M (1984). Families Under the Influence: Changing Alcoholic Patterns. W.W. Norton & Co., New York, NY.

Elizur, J and Minunchin, **S** (1989). Institutionalizing Madness: Families, Therapy, and Society. Basic Books, Inc., New York, NY.

Ell, K (1984). Social Networks. Social Support. and Health Status: A Review. Social Service Review March, 1984: 133- 149.

Epstein, JL (1989). School and Family Connections: Theory, Research, and Implications for Integrating Sociologies of Education and Family. In: D Unger and M Sussman (Eds.) Marriage and Family Review: Families in Community Settings.

Epstein, **JL** and Scott-Jones, D (in press). School-Family-Community Connections for Accelerating Student Progress in the elementary and Middle Grades. To appear in H Levin (Ed.) Accelerating the Education of At-Risk Students.

Finn, C (1987). The High School Dropout **Puzzle**. Public Interest (Spring).

Fleischer, G (1975). Producing Effective Change in Impoverished, Disorganized Families: Is Family Therapy Enough? Family Therapy Vol. 2, No. 3:513-526.

Fraiberg, S (1977). **Every Child's Birthright: In Defense of Mothering**. Basic Books, New York, NY.

Fraser, MW, Hawkins, JD, & Howard, MO (1986). Parent Training for Delinquency Prevention: A Review. Child and Youth Services.

Fraser, MW, Pecora, PJ, and Haapala, DA (1991). Families in Crisis: The Impact of Intensive Family Preservation Services. **Aldine** de Gruyter, New York, NY.

Fulmer, Richard H, Ph.D. (1987). Special Problems of Mourning in Low-Income Single-Parent Families: Clinical Issues in Single-Parent Households. M Lindblad-Goldberg (Ed.). The Family Therapy Collections 19-29. Aspen Co., Rockville, MD.

Garbarino, J and Abramowitz, R (1982). Children and Families in the Social Work Environment. **Aldine** Publishing Co., New York, NY.

Garbarino, J, Guttman, E, and Seely, **JW** (1987). The Psychologically Battered Child. **Jossey-Bass**, San Francisco, CA.

Geismar, LL & Wood KM (1986). Family and Delinquency: Resocializing the Young Offender. Human Sciences Press, Inc., New York, NY.

Gibbons, J (1990). Family Support and Prevention: Studies in Local Areas National Institute for Social Work, London, England.

Gilligan, C (1982). In a Different Voice: Psychological Theory and Women's Development. Harvard University Press, Cambridge, MA.

Goetz, K (Ed.) (1992). Programs to Strengthen Families. Family Resource Coalition, Chicago, IL.

Golan, N (1981). Passing Through Transitions: A Guide for Practitioners. The Free Press, New York, NY.

Gottlieb, BH (1983). *Social Support Strategies: Guidelines for Mental Health Practice*. Sage Press, Beverly Hills, CA.

Greif, GL and DeMaris, A (1990). Single Fathers With Custody. Families in Society: The Journal of Contemporary Human Services 259-266.

Guemey, BG (1977). Relationship Enhancement. Jossey-Bass, San Francisco, CA.

Guemey, BG and Guemey, L (1989). Child Relationship Enhancement: Family Therapy and Parent Education. Person-Centered Review 8/4(3):344-357.

Guemey, BG and Guemey, L (1987). Integrating Child and Family Therapy. Psychotherapy Fall 24(35):609-614.

Gutierrez, LM (1990). Working with Women of Color: An Empowerment Perspective. *Social Work* 35(2):149-153.

Haley, J (1976). Problem Solving Therapy: New Strategies for Effective Family Therapy. Harper & Row, New York, NY.

Haley, J (1980). Leaving Home: The Therapy of Disturbed Young People. McGraw-Hill, New York, NY.

Harter, S and Pike, R (1984). The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children. Child Development 55: 1969-982.

Hawkins, J David, Lishner, Denise M. and **Catalano, Richard F (1985). Children Predictors and the Prevention of Adolescent Substance Abuse. In: CJ Jones and RJ Battjes (Eds.): Etiology of Drug Abuse: Implications for Prevention. National Institute on Drug Abuse, ADM85-1385.**

Heifetz, LJ and Baker, D (1977). Behavioral Training for Parents of Retarded Children: Alternative Formats Based on Instructional Manuals. American Journal of Mental Deficiency 82: 194-203.

Hops, H. Tildesley, E, Lichenstein, E, Ary, D. & Sherman, L (1990). Parent Adolescent **Problem-Solving Interactions and Drug Use. American Journal of Alcohol Abuse 16(3&4):239-258.**

Imber-Black, E, Roberts, J. and Whiting, RA (Eds.) (1988). Rituals in Families and Family Therapy. W.W. Norton & Co., New York, NY.

Joanning, H, Quinn, W, Thomas, F; and **Muller, R (1992). Treating Adolescent Drug Abuse: A Comparison of Family Systems and Therapy. Group Therapy, and Family Drug Education. Journal of Marital and Family Therapy Vol. 18. No. 4:345-356.**

- Kagan, R and Schlosberg, S** (1989). Families in Perpetual Crisis W.W. Norton & Co., New York, NY.
- Kagan, S, Powell, D, Weissboard, B, and Zigler, E (Eds.) (1987). America's Family Support Programs. Yale University Press, New Haven, CT.
- Kazdin, AE** (1987). Conduct Disorders in Childhood and Adolescence. Sage, Newbury Park, CA.
- Keniston, **K and** Camegie Institute on Children (1977). All Our Children: American Family Under Pressure. **Harcourt** Brace Jovanovich, New York, NY.
- Kogan, KL (1978). Help-Seeking Mothers and Their Children. Child Psychiatry and Human Development. **8(4):204-218**.
- Kogan, KL, Gordon, BN, & Wimberger, HC (1972). Teaching Mothers to Alter Interactions with Their Children: Implications for Those Who Work with Children and Parents. Childhood Education 49: 107-110.
- Kumpfer, KL & Turner, CW (1990-91). The Social Ecology Model of Adolescent Substance Abuse: Implications for Prevention. International Journal of the Addictions **25(4A):435-463**.
- Lindblad-Goldberg, M (1987). The Assessment of Social Networks in Black Low-Income Single Parent Families: Clinical Issues in Single Parent Households. In: M Lindblad-Goldberg (Ed.) Family Therapy Collections, 39-46. Aspen Co., Rockville, MD.
- Loeber, R (1990). Development and Risk Factors of Juvenile Antisocial Behavior and Delinquency. Clinical Psychology Review Vol. 10: 1-41.
- McCubbin, H, Sussman, M. and Patterson, J (1983)**. Social Stress and the Family: Advances and Development Family Stress Theory and Research. Hawthorne Press, New York, NY.
- McDonald (**Wikler**), L (1980). Folie a **Famille**: A Family Therapist's Perspective. Family Process 257-268.
- McDonald, L (1990). FAST: Families and Schools Together. Capitol Comments, Wisconsin Council on Human Concerns, January 1990: 5-6.
- McDonald, **L**, et al. Families and Schools Together: An Innovative Substance Abuse Prevention Program. Social Work in Education: A Journal for Social Workers in School Vol. **13**, No. 2, January 1991:118-128.
- McGoldnick, M, Anderson, CM, and Walsh, F (Eds.)**. Women in Families: A Framework for Family Therapy W.W. Norton & Co., New York, NY.

Masten, AS, & Garmezy, N (1985). Risk, Vulnerability, and Protective Factors in Developmental Psychopathology. In: BB Lahey and AE **Kazdin** (Eds.), Advances in Clinical Child Psychology Vol. 8, New York, Plenum.

Manser, E (1973). Family Advocacy: A Manual For Action. Family Service America, Milwaukee, WI.

Miller, A (1984). For Your Own Good: Hidden Cruelty in Child Rearing and the Roots of Violence. Farrar, Straus, Giroux, New York, NY.

Minuchin, **S** (1986). Family Kaleidoscope. Harvard University Press, Cambridge, MA.

Minuchin, S (1979). Families and Family Therapy. Harvard University Press, Cambridge, MA.

Minuchin, **S**, Montalvo, B, Guemey, BG, Rosman, BL and **Schumer, E** (1967). Families of the Blaine. Books, New York, NY.

Nichols-Casebolt, AM (1988). Black Families Headed by Single Mothers: Growing Numbers and Increasing Poverty. Social Work 306-313.

Olson, DH, Sprenkle, DH, and Russell, CS (1979). Circumplex Model of Marital and Family Systems I: Cohesion and Adaptability Dimensions, Family Types, and Clinical Applications. Family Process 18:3-28.

Olson, DH, Russell, CS, and Sprenkle. DH (1983). Circumplex Model of Marital and Family Systems VI: Theoretical Update. Family Process 22:69-83.

Olson, DH (1986). Circumplex Model VII: Validation Studies and FACES III. Family Process 25:337-351.

Olson, DH. Portner, J, and Lavee, Y (1987). Family Adaptability and Cohesion Evaluation Scales III. In N **Fredman** and R **Sherman** (Eds.) Handbook of Measurements for Marriage and Family Therapy 180-184. **Brunner/Mazel** Publishers, New York, NY.

Olson. DH (1991). Commentary: Three-Dimensional (3-D) Circumplex Model and Revised Scoring of FACES III. Family Process 30:74-79.

OSAP Prevention Monograph-5: Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk (1990). U.S. Dept. of Health and Human Services. U.S. Govt. Printing Office.

OSAP Prevention Monograph-C: Youth and Drugs: Society's Mixed Messages (1990). U.S. Dept. of Health and Human Services. U.S. Govt. Printing Office.

OSAP Prevention Monograph-7: Ecology of Alcohol and Other Drug Use: Helping Black High-Risk Youth (1990). U.S. Dept. of Health and Human Services. U.S. Govt. Printing Office.

Oyemade, UJ & Washington, V (1989). Drug Abuse Prevention Begins in Early Childhood. Young Children **44:6-12**.

Patterson, G (1975). Families. Research Press, Champaign, IL.

Patterson, G (1975). Families: Applications of Social Learning to Family Life (Rev. Ed.). Research Press, Champaign, IL.

Paulu, N (1989). Improving Schools and Empowering Parents: Choice In American Education. Washington, U.S. Dept. of Education, Office of Educational Research and Improvement.

Pianta, RC, Egeland, B, and Stroufe, LA (in press). Maternal Stress and Children's Development: Prediction of School Outcomes and Identification of Protective Factors. In: J Rolf, A Masten, D Cicchetti, K Nuechterlein, and S Weintraub (Eds.): Risk and Protective Factors in the Development of Psychopathology. Harvard University Press, Cambridge, MA.

Pogrebin, LC (1983). Family Politics: Love and Power - An Intimate Frontier.

Pollner, M and McDonald-Wikler, L (1985). The Social Construction of Unreality: A Case Study of a Family's Attribution of Competence to a Severely Retarded Child. Family Process **24:241-257**.

Porter, J, DR (1971). Black Child, White Child: The Development of Racial Attitudes. Harvard University Press, Cambridge, MA.

Powell, GJ (Ed.)(1983). The Psychoeducational Development of Minority Group Children. Brunner Mazel, Inc., New York. NY.

Quay, HC and Peterson, DR (1987). Manual for Revised Behavior Problem Checklist. University of Miami, Coral Gables. FL.

Rapkin, BD, and Stein, CH (1989). Defining Personal Networks: The Effect of Delineation Instructions on Network Structure and Stability. American Journal of Community Psychology Vol. 17, No. **2:259-267**.

Richters, J and Pellegrini, D (1989). **Depressed Mothers' Judgments About Their Children: An Examination of the Depression-Distortion Hypothesis**. Child Development **60:1068-1075**.

Rutter, M (1983). Stress, Coping and Development: Some Issues and Some Questions. In: N Garnezy and M Rutter (Eds.): Stress, Coping and Development in Children (1-41). McGraw-Hill, New York, NY.

Rutter, M (1990). Psychosocial Resilience and Protective Mechanisms. American Orthopsychiatric Association 3 16-33 1.

Satir, V (1972). **Peoplemaking**. Science and Behavior Books, Inc., Palo Alto, CA.

Schorr, LB (1988). Within Our Reach: Breaking the Cycle of Disadvantage. Doubleday, New York, NY.

Schedler, J and Block, J (1990). Adolescent Drug Use and Psychological Health: A Longitudinal Inquiry. American Psychologist 45: 6 12-630.

Shelton, TL, Jeppson, ES, and Johnson, BH (1987). Family-Centered Care for Children with Special Health Care Needs. Association for the Care of Children's Health, Washington, D.C.

Snyder, J & Patterson, G (1987). Family Interaction and Delinquent Behavior. In: HC Quay (Ed.) Handbook of Juvenile Delinquency 216-243. John Wiley & Sons, New York, NY.

Solomon, BB (1985) How Do We Really Empower Families? New Strategies for Social Work Practitioners. Family Resource Coalition Report 4:3.

Statham, Daphne (1978). Radicals in Social Work. Routledge and Kegan Paul, London, England.

Strayhorn, JM and Weidman, CS (1989). Reduction of Attention Deficit and Internalizing Symptoms in Preschoolers through Parent-Child Interaction Training. Journal of the American Academy of Child and Adolescent Psychiatry 28(6):888-896.

The Wisconsin Study: Alcohol & Other Drug Use (1989). Wisconsin Department of Public Instruction.

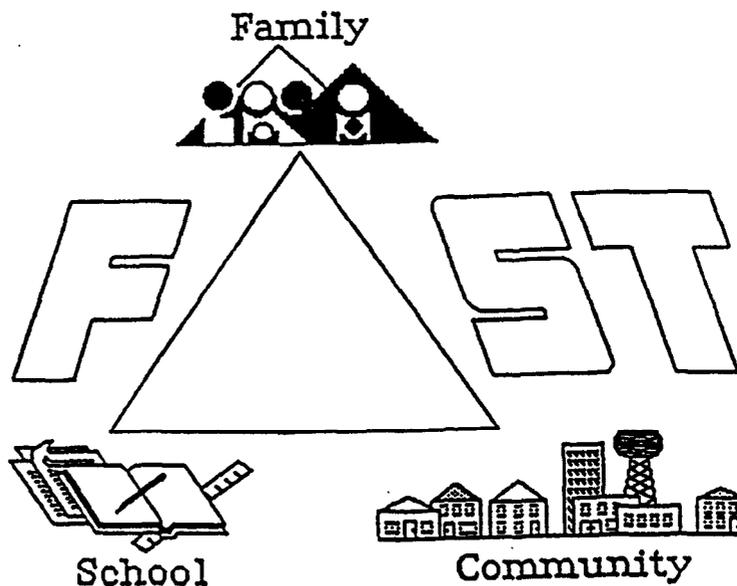
Tracy, M (1990). Identifying Social Support Resources of At-Risk Families. Social Work 252-258.

Turner-Hogan, P, and Siu, Sau-Fong (1988). Minority Children and the Child Welfare System: An Historical Perspective. Social Work 493-498.

Van Den Huevel, D, Contrucci, V, Erpenbach, W, and Kunelius, L (1986). Children At-Risk: A Resource and Planning Guide. Department of Public Instruction, Madison, WI.

Velez, CN, Johnson, J, and Cohen, P (1989). A Longitudinal Analysis of Selected Risk Factors for Childhood Psychopathology. Journal of the American Academy of Child and Adolescent Psychiatry 28(6):861-864.

- n Wahler, RG (1983). Predictors of Treatment Outcome in Parent Training: Mother Insularity and Socioeconomic Disadvantage. Behavioral Assessment 5: 301-333.
- Webster-Stratton, C (1989). The Long-Term Effectiveness and Clinical Significance of Three Cost-Effective Training Programs for Families with Conduct-Problem Children. Journal of Consulting and Clinical Psychology 57(4):550-553.
- Webster-Stratton, C (1990). Stress: A Potential Disruptor of Parent Perceptions and Family Interactions. Journal of Clinical Child Psychology 19(4):302-312.
- Webster-Stratton, C (1991). Coping with Conduct-Problem Children: Parents Gaining Knowledge and Control. Journal of Clinical Child Psychology 20(4):413-427.
- Wehlage, GG (1990). Dropping Out: Can Schools Be Expected to Prevent It? In: L **Weis**, E Farrar, and H **Petrie (Eds.): Dropouts from Schools: Issues, Dilemmas and Solutions**. SUNY Press, New York, NY.
- Werner, E and Smith, R (1982). Vulnerable But Invincible: A Study of Resilient Children. McGraw Hill, New York, NY.
- Wikler, L (1981). Chronic Stress of Families of Mentally Retarded Children. Family Relations 04/81:181-188,
- Wilcler, L, Savino, A, and Kyle, J (1974). Behavioral Modification Parent Groups: A Manual for Professionals. Charles B. Slack, Inc., Inglewood, NJ.
- Wikler, L and Slater, M (1986). Normalized Family Resources for Families with a Developmentally Disabled Child. Social Work Sept.-Oct.:385-390.
- Wikler, L, Wasow, M, and Hatfield, E (1983). Looking for Strengths in Families of Developmentally Disabled Children. Social Work July-Aug.:313-315.
- Wilson, JQ (1987). Strategic Opportunities for Delinquency Prevention. In: JQ Wilson and GC Lounsbury (Eds.): From Children to Citizens (Vol. 3): Families, Schools, and Delinquency Prevention. Springer-Verlag. New York, NY.
- Wolfe, DA, et al (1981). A Competency-Based Parent Training Program for Child Abusers. Journal of Consulting and Clinical Psychology 49:633-640.
- Wolin, SJ, Bennett, LA, & Noonan, DL** (1979). Family Rituals and the Recurrence of Alcoholism over Generations. American Journal of Psychiatry 136:589-593.



GENERAL INFORMATION

ABOUT

**FAMILIESANDSCHOOLSTOGETHER
F.A.S.T.**

AND

F.A.S.T. TRAINING

Estimate of Staff Hours Per FAST Group (Breakdown)

Staff Member	Before 8 Weeks	8 Weeks	After 8 Weeks	Total
Mental Health	40-45*	120	30-35	190-200
School Staff Member	20-25*	65	10	95-100
Parent Aide	20-25	65	15-20	100-110
Chldrn's Recreation Coord.	10-15	65	10	85-90
AOD Staff Member	-0-	65	-0-	65

- **After the first** group, which **will** involve two to four times as many staff hours.

Estimate of Staff Hours Per Monthly Meeting (Breakdown)

Staff Member	FAST- WORKS	PAC	Family Contacts	Newsletter
Professional	8	5	5	2
Parent Liaison	8	5	5	2

20 hrs/monthly meeting (8 + 5 + 5 + 2) x 12 mos/yr = **240 hrs/yr.**

Expenses for **the** year (i.e., food, **travel**, newsleaser publication, mailings, tickets, **prizes**, etc.) average **about** 5300 per **month**, or \$3,600 each **year**.

Actual additional costs of **both** phases of a *FAST* program (i.e., initial eight-week program followed by **monthly** meetings for graduate families) can vary widely. Considerations include in-kind contributions from agencies, volunteer time, and donations from **the** community. **We** suggest that *any additional costs* be estimated and established jointly by **the administrative** representatives **each** collaborative **partner**.

Costs **that** must **be** budgeted as direct expenses:

Food	\$200
Plates, Napkins, Silverware	50
Lottery Prizes	250
Film and Frames	30
Diplomas & Frames	75
Flag Materials	20
Special Play Toys	100
Parent Liaison	660
Child Care*	400
Total, with Paid Child Care:	\$1,785
Total, with Volunteer Child Care:	\$1,385

- You may be able to obtain in-kind **child care** from volunteers (e.g., **high-school** students).

The charts below show the distribution of responsibilities of collaborative partners:

SCHOOL

Teachers	◊	Identify high-risk children.
Building Team	◊	Identify high-risk children.
School	○	Home visits to recruit families.
Lion Staff	◊	Attend multiple-family groups.
	○	Transport families to and from group meetings.
	○	Attend weekly FAST staff meetings .
Principals	◊	Meet quarterly with collaborative teams to supervise program.
	○	Attend graduation to award diplomas.

ALCOHOL-AND-OTHER-DRUG AGENCY

Counselors	◊	Co-lead multiple-family group meetings.
	○	Show AODA film and lead discussion at fifth family meeting.
	○	Provide AODA assessment, if needed .
	○	Transport families to and from group meetings and other services.
	○	Attend weekly FAST staff meetings .
Administrators	◊	Meet quarterly with collaborative teams to supervise program .

MENTAL HEALTH AGENCY

Staff	○	Meet with school-building teams for identification of at-risk children.
	○	Visit prospective FAST families in their homes to recruit to the program .
	○	Transport families to/from group and other services.
	○	Co-lead multiple-family groups.
	○	Facilitate/maintain good communication among collaborative partners (many phone calls).
	○	Meet with community agencies to facilitate referral processes .
	○	Visit families in their homes to link families to other resources .
	○	Facilitate weekly FAST staff meetings.
	○	Meet quarterly with collaborative teams to supervise program.
	○	Assist project director with assigned duties.
	○	Provide orientation, training and supervision to parent paraprofessionals , volunteers and graduate social work students.
	○	Attend monthly PAC planning sessions and monthly FASTWORKS , and send invitations, call and transport to FASTWORKS events.
Project Director	◊	Supervise staff weekly.
	○	collect data and evaluate .
	○	Write quarterly reports , grant renewals.
	○	Organize, facilitate quarterly meetings .
Administrator	◊	Supervise project director .
	○	Attend quarterly policy meetings .
	○	Administer budget .

PARENTS

	○	Attend weekly meetings.
	○	Complete pre/post assessments.
	◊	Support children in educational process .
	○	Determine when and if their families are in need of additional assistance (e.g., community services).
	○	Attend monthly FASTWORKS events following graduation.
	○	Participate in Parent Advisory Council, overseeing monthly activities.

F.A.S.T. COSTS PER CHILD*

	<u>YEAR ONE</u>	<u>YEAR TWO</u>	<u>COSTS PER CHILD</u>	<u>YEAR THREE</u>	<u>YEAR FOUR</u>	<u>COSTS PER CHILD</u>
FAST PROGRAM:						
Eight Weeks FAST Graduated families:	10 10	10 10		10 10	10 10	
Monthly FASTWORKS:	10	10 10 10 10 10		10 10 10 10 10 10	10 10 10 10 10 10	
TOTAL :						
Families served:	30	70		80	80	
At-Risk Children Served:	30	70	\$800	80	80	\$500
At-Risk Children and their Siblings Served:	75	175	\$530	200	200	\$200

***ASSUMPTIONS:**

1. Graduating ten families per eight-week FAST group.
2. Eight-week FAST groups being run two times a year.
3. A monthly FASTWORKS for two years of follow-up.
4. At one school, one collaborative team run by a half-time staff in community-based agency.
5. Budget of \$40,000/year which covers rent, xeroxing, materials, administrative overhead, clerical, and professional salaries.
6. Average family size 2.5 children.

VARIABLES TO REDUCE COSTS:

1. Graduate 12 to 15 families per group.
2. Run 3-4 8-week FAST groups per year/school.
3. Hire full time staff to run two schools.
4. Schools and agencies contribute in-kind for administrative overhead salaries or materials.

Twenty-six FAST sites participated in several levels of FAST program evaluation. The preliminary results of FAST evaluation show that the FAST program can be replicated successfully at new sites, with encouraging results in the identification of at-risk children and recruitment of their families for FAST. Local FAST collaborative **teams** have given uniformly positive ratings of FAST program components at new sites, consistent with past positive feedback from participating parents.

The evaluation documented that participating FAST children have high initial levels of problem behaviors which place them at risk for the development of later serious academic, AODA, and delinquency problems. Quantitative measures from parents and teachers, taken pre- and **post-** the eight week FAST program, show highly statistically significant reductions in attention problems and hyperactive behaviors, which are critically correlated with academic success. Parents report highly significant reductions in the conduct disorders and aggressiveness of their children, and also improvements in the self-esteem related **subscale** of **anxiety-withdrawal**. FAST families are already **cohesive**, but grow even more connected during FAST.

These evaluation data also highlight the FAST program replicability. With the FAST training, including on-site visits by FAST trainers, and the FAST Training Manual, communities were able to initiate and carry out successful collaborative prevention programs. FAST was effective when it crossed geographical lines, in both urban and rural settings, for groups including middle-class intact families, for larger groups (graduating 12 families in two districts) for special-needs children, and for Spanish-speaking, Hmong, Native American and black families. The participation of these families and schools in this evaluation was critical in being able to show the utility of FAST in replication.

FAST TRAINING MANUAL

The results reported have been achieved in programs **which** received the certified training.

The U.S. Department of Education published a report "Planning for Dissemination" (Susan **Loucks**, 1983) which outlines the best procedures for ensuring exemplary dissemination of model programs. The *FAST* training model fulfills each identified step of this report. The *FAST* training represents a substantial commitment of time, **energy**, and money by your community. However, the *FAST* training results to-date appear worthy of these investments.

Recently an external review by site visitors from Washington, D.C. strongly recommended that we NOT dilute this *FAST* training program. They (CSR, report on March 20, 1991) said that in their experience across the country, a major risk of new successful programs is to **expand** too fast, rather than to monitor the quality of the program. We have decided, as a result of these warnings, to limit access to our *FAST* training program as follows:

1. Only certified *FAST* sites can do training.
2. Only certified *FAST** trainers can do: (a) collaborative team building, (b) collaborative team planning, and (c) on-site supervision.
3. The Orientation and Training Manual and Program Workbook are given out to people as a part of the training; the Manual cannot stand alone.
4. Communities can only be trained to do *FAST* if they bring collaborative teams with a minimum of four participants who are housed in at least two settings (i.e., school and community agency):
 - a school professional (social worker or counselor)
 - a mental health professional
 - a substance abuse professional
 - a parent
5. Written reports must be completed to indicate core elements have been replicated to gain *FAST* program certification.

*A certified *FAST* trainer is a senior-level professional who has completed a **minimum of** an eight-week *FAST* program and has trained a community team. Trainers are certified through the national training center in Madison, Wisconsin.

PROGRAM TRAINING

Replication of the FAST model in another community is an involved process because of the program's necessarily collaborative nature and its foundation in family therapy principles. The Families and Schools Together training model is a clinical one, involving on-site visits over the course of your first FAST group. Although FAST is not counseling or treatment per se, the curriculum is based upon family therapy principles. As such, the on-site visits may be viewed as analogous to clinical supervision.

The FAST training program is organized into three phases, as follows:

Phase I: Two days of community-based team training in Madison.

- A. Building a team out of a group (up to eight people).
- B. Training tailored to your role (i.e., school staff, alcohol and drug counselor, mental health social worker, and parent liaison).
- C. Observation of a FAST group meeting.
- D. Distribution of the FAST Training Manual (one copy for each team member).
- E. Introduction and consultation with your on-site FAST trainer, and planning for your first FAST group.

Phase II: On-site consultation visits.

- A. On-site visits during your first FAST group.
 - 1. One and a half days around the day of the session **#1**:
 - a. Four hours on the morning of the day of session **#1**, to review meeting site, materials, Special Play toys, preparation checklist, etc.
 - b. Four hours observing session **#1**.
 - c. Four hours the morning after session **#1**, to process the previous evening, plan for the upcoming session, and discuss concerns.
 - 2. Two one-day visits, around the days of session **#5** (AOD) and session **#8** (graduation), respectively:
 - a. Four hours observing the FAST session.
 - b. Four hours the morning after the session, to process the previous evening, plan for upcoming sessions, and discuss concerns.
- B. Telephone consultations:
 - 1. Scheduled telephone consultations following each of the five FAST **sessions** not attended by the trainer; one hour per session, to process the session and answer questions.
 - 2. Additional telephone consultations, as needed.

Phase III: One day of community-based team training in Madison.

- A. Process your completed FAST group...
 - 1. As a team.
 - 2. According to your role (i.e., direct service staff, administrator, -parent **liaison, etc.**).
- B. Plan for monthly follow-up meetings with your FAST graduates (the FASTWORKS program).
- C. Award FAST certification to community-based teams.

Each school site is considered to be a **community-based** team. A complete community-based team includes **representatives** from these four groups; school; mental health agency (nonprofit, public or private); alcohol and other drug (AOD) agency; and parent liaison. We recommend contacting Head Start as one source of parent leaders.

BUDGET FOR FAST TRAINING

To train a Single collaborative team/site in Madison. Wisconsin beginning with Phase I.

Full-Phase Training

Phase I, II and III provided by FAST staff (\$4,200 per team/site, to train 4 collaborative team members plus up to 6 additional people)	\$4200
Annual evaluation and technical assistance fee* (\$200 per year)	200
Training of Trainers* * (\$500 per team/site)	500
TOTAL FULL-PHASE FEE FOR A SINGLE TEAM/SITE	<u>\$900</u>

Part-Phase Training

Phase I and III provided by FAST staff (trainer for Phase II provided by site)	\$2,400
Annual evaluation and technical assistance fee*	200
TOTAL PART-PHASE FEE PER SINGLE TEAM/SITE	<u>\$ 2600</u>

* The revenue generated from the annual evaluation and technical assistance fee will pay for the costs associated with gathering and collating statistical and demographic data regarding the program, preparing reports on evaluation results, providing telephone technical assistance, and correspondence with each team regarding statistics and performance by region, etc.

** After team members have completed one 8-week FAST session, up to three members may receive training to become trainers in Madison, Wisconsin. Upon completion of the training, trainees may then do Phase II for one new site each. These sites would qualify for Part-Phase Training.

Note: These prices do not include travel or per diem costs for the National FAST trainer to come to the site for Phase II, which costs are to be assumed by the site.



Wisconsin Clearinghouse

Prevention Resource Center
Alcohol and Other Drugs
315 North Henry Street
Madison, WI 53703-2018
(800) 248-9244 (608) 263-2797

This publication is not covered by
copyright law and may be copied freely.

Communities Creating Change

Exemplary
Alcohol and Other Drug
Prevention Programs
1990

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, or
Mental Health Administration
Office for Substance Abuse Prevention
in cooperation with the
National Association of State Alcohol or
Drug Abuse Directors and the
National Prevention Network

RP0768

Introduction

There can be no “one-size fits all” prevention program or strategy. Prevention activities must **be consistent with** the priorities, values, world view, and ways of communicating that exist in each community.

—Citizen's Alcohol and Other Drug Prevention Directory

The origins of alcohol and other drug abuse **are** complex and deeply embedded in our culture, our **social structure**, and our economic systems. Cultural norms and *values*. **national** policies. State and **local laws**, law enforcement practices, school policies, the behavior of parents, and the beliefs and **attitudes of** individuals may all contribute to alcohol and other **drug** problems. Effective prevention approaches address these complex factors.

Research **confirms** that alcohol and other drug abuse prevention strategies help individuals to develop **and** maintain healthy lifestyles, behaviors, and **attitudes**. **These** same strategies can help individuals improve their self-perceptions by teaching them that they **are competent**, that they are an important part of something larger than themselves, **and** that their actions affect **the** direction and events of their lives. Prevention strategies can assist individuals in living **personally** satisfying and enriching lives as they constructively confront complex, stressful life situations.

Because the creation and maintenance of a drug-free society **are** crucial to the **health** and **well-being** of all Americans, the Office for Substance Abuse Prevention (OSAP), **the** National Association of State Alcohol and Drug Abuse Directors (**NASADAD**), and its **affiliate—the** National Prevention Network (**NPN**)—**present the** 1990 Exemplary **Programs**. They **are** showcased **here** to provide **the** public with models that can **be** replicated or adapted in communities across **America**.

The goals of the Exemplary **Program** Study **are** twofold. **First, the study** provides models of **state-of-the-art** alcohol and other drug abuse prevention programs that may **be** replicated or adapted by others. Second, national attention is focused on exemplary **alcohol** and other drug abuse prevention efforts. All **alcohol** and other **drug** abuse **prevention programs are** nominated for recognition by the State alcohol and **drug** agency or through **selected** national organizations.

The 1990 Exemplary Programs **illustrate** a wide variety of approaches that **are** effective in diverse **communities** because no single approach will be effective in **every area**. They demonstrate that prevention can be **best** achieved **through** multiple strategies that address **the** unique **characteristics**, **cultural** diversity, and **structure** of **each community** in **the** Nation. **These programs offer strategies** designed for **prevention** practitioners, individuals interested in becoming involved in the field, and public **policymakers** at **the** community, State, and national levels.

Communities **have the unique opportunity** to involve individuals as **agents** of social change, thus forming a **strong base** of support for new standards that not only prevent alcohol and other **drug** abuse, but also build a climate of health and positive growth **Through** broad participation and motivation, communities have the power to **collectively create a drug-free** society. The 1990 Exemplary **Programs reflect** practical plans of action that **are** yielding encouraging results in the ongoing effort to eradicate the abuse of alcohol and other **drugs**.

Recognizing excellence in **prevention** programming is traced back to annual meetings of State prevention coordinators during the late seventies and **early** eighties. Throughout the period of 1983-85, a committee of the NPN drafted a procedure for identifying and selecting outstanding

programs. In 1986, the process was further refined by the addition of criteria by which to rate the programs. The procedure included a call for nominations that went out to local programs through the States and through the national organizations that were represented on the Committee. In 1987, the first Exemplary Programs were recognized at a special ceremony in Washington, DC. The second set of Exemplary Programs was acknowledged in 1989 at the Second Annual Prevention Research Conference.

During the winter of 1989-90, the national nomination process was used to identify effective alcohol and other drug abuse prevention programs. The program nominations were reviewed and rated by 33 professionals who were selected for their expertise in the field of prevention and other related areas of activity. Reviewers included representatives of alcohol and other drug abuse agencies, national organizations, NPN associate members, and previous Exemplary Program winners.

Reviewers rated the applications by identifying major strengths and weaknesses, giving an overall summary of each program's characteristics, and rating the applications on a 10-point scale in the following categories: philosophy, background and need (program planning), goals and objectives, evaluation, marketing and promotion, target population(s), activities and strategies, community coordination, replicability, and program management. State agency personnel and national organizations submitting nominations reviewed the information contained in each application and certified its accuracy. The review committee then met in Washington, DC, to identify the 1990 Exemplary Programs and those that merited honorable mention.

The Exemplary Programs are arranged in alphabetical order by State and are followed by the honorable mention category.

Families And Schools Together

This unique program in Madison, WI, includes **schools, mental health agencies, alcohol and other drug agencies, and hard-to-reach families as collaborative partners in an effort to empower families to become the primary prevention agents for their own children.**

Lead Agency

Family Service
128 E. Olin Avenue
Madison., WI 53713

Contact Names

Lynn McDonald, Ph.D., ACSW
Program Director

Nic Dibble
Project Manager

Telephone

(608) 251-7611

State Director

Larry W. Monsoa ACSW
Wisconsin Office of Alcohol and Other Drug Abuse
1 West Wilson St.
P.O. Box 785 1
Madison, WI 53707
(608) 266-3442

State Prevention Coordinator

Louis Oppor
(608) 266-9485

Clientele

Children who are at **high risk** for alcohol and other drug **problems** and who **are** members of **hard-to-reach** families, half of whom **are** from minority groups. A **profile of a typical participant** includes **the following characteristics:** male, average age of **8 years and 3 months**, **1 or more years behind in school, behavioral problems in the classroom, limited attention span, inconsistent work performance, apathy, hypersensitivity, depression, high stress, and family trauma.**

Children and their families participate in an 8-week program of **weekly** multifamily meetings followed by a **2-year phase** of monthly meetings for **graduate** families. **Once a program** is fully operational in an **elementary school**, approximately **40 families can be served in the preliminary 8-week phase.**

Major Services

The Families and Schools Together (F.A.S.T.) program's mission is to educate children about their rights **to have an alcohol- and other drug-free life. It simultaneously provides** parents the **opportunities** to deal **with** their own **dependence and codependence issues**, so that they may

ultimately become the primary prevention agents for their children. The activities are based on family systems **theory, stress and social support research**, and child **psychiatry** techniques.

- A comprehensive F.A.S.T. program curriculum was developed with the **goal** of reducing the likelihood that participating children will become alcohol and other drug abusers in **adolescence**. The **curriculum** incorporates the following elements:
 - At the first meeting, families construct a flag as a unique symbol of family unity.
 - Each session begins with a meal that is eaten as a family unit, with **families** at separate tables.
 - A structured family communication exercise contributes to a **strong** self-image as members take turns listening to each other.
 - Families participate in a “feelings identification” **exercise**, which helps them learn about each other’s feelings, as well as their own.
 - Parents participate in a parent support meeting that teaches **them** to modify their children’s behavior **through** behavior contracting.
 - Parents **and children** spend one-to-one quality time, which **builds self-esteem** for both participants.
 - A **lottery** is held with one family winning as a family **unit**.
 - A closing activity, designed to provide positive and fun **alternatives** to using alcohol and other **drugs, reinforce** family ties.
- The **F.A.S.T. Training Manual** was developed to **address all areas necessary** for **replication of the program** when used in conjunction with **the training model**. It contains **strategies for** dealing with each component of the **curriculum**, as well as an **appendix** that includes all **record-keeping instruments**.
- **Community** coordination is essential to the **success of the F.A.S.T.** program. The following elements illustrate its **collaborative nature**:
 - Schools **identify** the high-risk students **and** make **initial contact with parents**.
 - **Mental health agency staff provide overall coordination and handle linkages to community resources**.
 - **An alcohol and other drug specialist conducts related program activities and provides assessments of parents who may be abusing alcohol or other drugs**.
 - **Parent staff recruit families and encourage them to remain in the program**.
- **A newsletter, which is written and prepared primarily by parent graduates, is circulated locally to families and community agencies**.

The F.A.S.T. program is currently listed in Wisconsin Act 122, the State’s **Antidrug Bill; \$1 million** is appropriated for its replication in communities **throughout the State**.



FAST Program Links Families and Schools Together

A model for a community-wide program of prevention and early intervention is Families and Schools Together (**FAST**). **FAST** is a collaborative program for children at risk that aims to prevent future school failure, juvenile delinquency, and alcohol and other **drug** abuse in adolescence. **The FAST** program has realized considerable success using a family-based approach that strengthens parent-child relationships, enhances overall family functioning, reduces family stresses, encourages family networking, and helps families feel **more** comfortable in their dealings with schools and other community resources. **FAST** begins in the school and creates bridges **between** the child's family and the community.

The **FAST** program was **conceived** and developed by Lynn McDonald of **Family Service**, a private nonprofit mental health agency in Madison, Wisconsin, where **FAST** was first implemented in 1988. **FAST** is a collaboration involving the schools, nonprofit mental health social services, education and assessment agencies for alcohol and other drug abuse, and the families of **the** children.

What Does FAST Do?

1. **FAST** helps at-risk children to **feel** better about themselves and do better in school. The **FAST** program encourages **parents** to spend quality time with their children every day. Parents are coached in an effective play-therapy technique, and the children show significant improvement in **self-esteem**, attention span, and classroom behavior in a short time.

2. **FAST** targets the whole family, **not** just the at-risk child. **FAST** brings the whole family together. Families are recruited in their own homes and are invited to participate voluntarily **in** eight weeks of multiple-family group meetings. The structured **FAST curriculum** is designed **so** that everyone, regardless of age, can have fun while systematically

altering parent-child interactions, empowering parents, and building Parent support groups.

3. **FAST** is collaborative. **FAST** is interdisciplinary, inter-agency, and inter-bureaucratic. All **fac-**ek of the program are *reviewed* regularly by **all** collaborators. The challenge of positive **interven-**tion for **children** at risk demands collaboration **across sectors of the delivery** system.

4. **FAST** targets elementary **school children** through universal screening by teachers identifying at-risk children. Virtually everyone agrees on the importance of early intervention to the critical issues of alcohol and other **drug abuse**, high **school truancy**, and delinquency. **FAST** makes use of elementary **teachers'** observations to lead to **school** referrals to **FAST**, with parent **agreement**.

5. **FAST** empowers parents to become partners in the challenge of helping children at risk. **FAST** employs a cooperative model of partnership with the families of at-risk children. **Parents** are *often* hard to reach and are **mistakenly characterized** as being unconcerned about their children. But **FAST** regards parents as experts on the subject of their children. **FAST** uses a stress model to support **parents** while engaging their active, voluntary participation in all levels **of the** program: **policy development**, curriculum development, recruitment of new families, hosting meetings, and fundraising. A Parent Advisory Council, **com-**posed of **FAST** parent graduates of the eight-week program, participates in all of these **activities**.

6. **FAST** increases **feelings** of affiliation between the families of at-risk **children** and the school. **FAST** acknowledges **and addresses the many attitudinal barriers** to effective intervention. School staff and other human **services** professionals sometimes carry stereotypical perceptions of the families of at-risk children, while many families' interactions with school personnel have **been limited in the past to problems and** complaints= **FAST** meetings encourage new **perspectives**; they **provide opportunities for the at-risk child to observe the cooperation between his/her parents and teacher**. **Research suggests that familial feelings of affiliation toward the school contribute greatly to a child's likelihood of completing high school.**

Families and Schools Together: An Innovative Substance Abuse Prevention Program

LYNN MCDONALD, DEBRA COE BRADISH,
STEPHEN BILLINGHAM, NIC DIDDLE, and CELESTERICE

Families and Schools Together (FAST) is a substance-abuse prevention program that focuses on elementary school children identified as at risk by classroom teachers. FAST uses a whole-family approach, serving as many as 10 families at a time, and actively recruits families that were previously not coming to the school. The program is a collaborative effort that involves community agencies and parents as partners. FAST addresses the factors that correlate with adolescent substance abuse; the authors describe these factors and the results of the program to date.

■ Substance abuse is universally regarded as an urgent priority in this country's social agenda. Although state policymakers, law enforcement and health and social service agency personnel, school system officials, and families seem to agree on the magnitude of the problem, there is as yet no consensus on an appropriate response. Many people see promising solutions in some combination of more prison beds, increased police staff, and stiffer legal penalties for offenders. Others regard substance abuse as a symptom of deeper sociological ills and insist that any long-term solution must address the poverty and racism that underlie the dramatic explosion of drug-related crimes.

Despite the diversity of opinions across this etiological continuum, all involved hope for swift action to alleviate the pain that substance abuse inflicts on so many human beings. This article describes a prevention and early intervention program for which the early returns are

promising. The program targets elementary school children who are not yet involved in substance abuse but who exhibit at-risk behaviors that make them statistically more likely to become users of alcohol and other types of drugs later in their lives. Another 10 years of follow-up data will be required for a full program evaluation, although short-term measures are encouraging. The program, called Families and Schools Together (FAST), seems to be effective—perhaps even dramatically so.

FAST originated in Madison, Wisconsin, at Family Service, Inc., with the cooperation of the Prevention and Intervention Center for Alcohol and Other Drug Abuse (PICADA) and Lowell, Marquette, and 11 other public elementary schools. FAST initially was funded as an alcohol and other drug model prevention program by grants from United Way and Dane County (Wisconsin) and the State of Wisconsin Department of Health and Human Services. The program is a carefully blended approach drawn from a diverse assortment of accepted methods and techniques. The FAST approach incorporates research on multiple factors that correlate with adolescent substance abuse (Bloom, 1985; Elkin, 1984; Hawkins, Lishner, & Catalano, 1985; Schiedler & Block, 1990) as well as empirical studies on the value of social support in reducing the intrafamilial impact of chronic poverty (Heile, 1980; Egeland, Brienbacher, & Rosenberg, 1980; McCubbin, Sussman, & Patterson, 1983; Wahkr, 1983; Werner & Smith, 1982; Wikler, 1981; Wikler & Slater, 1986).

FAST uses published child psychiatry techniques that build resilience in children (Alexander & Parsons, 1973; Barkley, 1987; Cochrane & Meyers, 1982; Cowen & Work, 1988; Egeland et al., 1980; Heile & Baker, 1977; Kogan, 1978; Patterson, 1975; Rutter, 1983; Wikler, Savino, & Kyk, 1974) and strategies to empower clients from culturally diverse backgrounds (Solomon, 1985). FAST also seeks to help family feelings and relationships, with schools, which have been shown to help prevent school failure (Coleman & Hoffer, 1987; Cowen & Lightower, 1986; Epstein, 1983; Finn, 1987; Pianta, Egeland, & Sroufe, in press; Wehlage, Rutter, Smith, Lesko, & Fernandez, 1990). Perhaps most important, FAST uses family therapy techniques to strengthen overall family functioning (Minuchin, 1986; Minuchin, Montalvo, Guernsey, Rosman, & Schumer, 1967). The FAST program is built on social work values and skills including school social work, group work, family therapy work, community organization, advocacy, and linkages to appropriate services.

FAST Program Elements

Four core program components characterize the FAST prevention program: (1) a targeting of at-risk elementary school children, (2) use of a whole-family approach, (3) active recruitment, and (4) collaboration with community agencies and parents as partners.

Targeting At-Risk Children

FAST targets at-risk children at the elementary school level. In Wisconsin, where FAST originated, the state Department of Public Instruction mandates the identification of children at risk for school failure. The teachers draw from their own experience with many children for this process. The program relies on teacher referral for identification of potential candidates for the FAST program. Sixty percent of the children referred from spring 1988 through fall 1989 were boys of an average age of eight years and three months. A referred child is typically one or more years behind in school; shows conduct problems in the classroom; has a limited attention span; shows inconsistent work performance; and is likely to be apathetic, hypersensitive, depressed, and highly stressed, with known family trauma.

Teachers cooperated in filling out the Quay-Peterson Revised Behavior Problems Checklist (RBPC) (Quay & Peterson, 1987), a standardized and normed evaluation tool (Quay, 1983, 1986). On this measure, 85 percent of the FAST children had scores that placed them in the most dysfunctional 10 percent of all children in the areas of conduct disorder and attention span.

A recent longitudinal study on frequent users of alcohol and other drugs identified several consistent characteristics of seven-year-olds who later became abusers (Shedler & Block, 1990). Future frequent users at age seven got along poorly with other children, showed no concern for moral issues, had bodily symptoms from stress, tended to be indecisive and vacillating, were unlikely to think ahead, were untrustworthy or undependable, were unable to admit to negative feelings, lacked self-reliance or confidence, preferred nonverbal methods of communication, failed to develop genuine and close relationships, lacked pride in their accomplishments, lacked energy or liveliness, were not curious or open to new experience, were unable to recoup after stress, were afraid of being deprived, appeared to feel unworthy and "bad," were unlikely to identify with an admired adult, exhibited inappropriate emotive behavior, and were easily victimized by other children.

The parents of the referred child are informed of the at-risk identification by the school staff person who is most familiar with the family. The staff person explains the classroom behaviors that generated the concern. The staff person suggests a referral to FAST.

Whole-Family Approach

Rather than view the risk-related classroom behaviors as a child's individual problem, FAST sees the child as a part of his or her family and regards the parent as the primary prevention agent for that child. To reduce the child's at-risk status, the whole family is engaged through a home visit, and the whole family participates in the two-phase prevention program. As many as 10 families participate in phase 1 for eight consecutive weekly meetings. Following "graduation" at the final multifamily meeting, phase 2 begins. At monthly meetings, the phase 2 curriculum is reviewed in conjunction with special social events. The meetings are planned and executed by the graduated parents with staff support.

The curriculum of the multifamily meetings is derived from family therapy principles, techniques from child psychiatry, and group work theory. Families sit at tables where they enjoy meals as family units. At the first session, each family creates a flag with idiosyncratic family symbols and displays it prominently at its table each week. One-third of the session is spent on family-strengthening activities that focus the family's attention on itself through fun and laughter-producing interactive assignments. Communications are structured to encourage listening and turn-taking within families whose members otherwise may not take the time to listen carefully to each other. One game encourages family members to identify one another's feelings by prompting "feeling talk." The final activity is a rigged "lottery" that provides families an opportunity to win prizes as a unit, thereby promoting family cohesiveness and helping family members feel like winners.

For the second third of the session, the parents meet as a support group while the children play separately. During this meeting, the facilitator promotes interdependence among the parents and activates group sharing but specifically avoids the role of "teacher" to the parents. Parents seem to look forward to the respite from their children and the time of nurturance.

A critical part of the curriculum is a "special play" period in which each parent spends 15 minutes with his or her at-risk child alone at their family table. Other siblings in the family remain outside during this time.

The FAST staff coaches parents in a modified play therapy technique, and each daily repetition of this quality one-to-one time is assigned as "homework" each week. Following each break and the support group meeting, the parents quickly master this new technique, with the staff's sympathetic prompting.

The FAST program enables adults to succeed at parenting. The philosophy underlying the program is that all parents love their children but that the loving parenting process can be interrupted by circumstances, such as stresses and social isolation, beyond parental control. Support, food, fun, and respite are offered to the adult nurturer to better equip him or her for the parenting work that only he or she can do. FAST uses a positive, not a punitive, approach. The program achieves its goals by respecting and supporting parents, rather than by criticizing and undercutting their power. The program seeks to support and empower parents to become the primary intervention agents for their own children.

Active Recruitment

The school, not the family, identifies the problem. And the school, not the parent, initially recognizes the child's need. Vigorous recruitment and extensive outreach, therefore, are essential for voluntary participation of families.

To date, the typical FAST family has been headed by a single parent (usually the mother) whose own income is supplemented or entirely provided by public assistance. The typical family is depleted—often depressed, stressed, isolated, and chaotic and has a history of substance abuse by at least one member. The parent is caring but lacks the material and emotional resources to support and sustain an effective parenting effort. Sixty percent of program families have no car, and 40 percent have no telephone.

FAST's recruitment effort relies heavily on personal in-home visits by staff who are conscious of the likely barriers to trust and communication and who work to circumvent or overcome these barriers. The recruiting staff anticipate that many parents perceive them as bureaucratic authority figures representing institutions with which families have had unpleasant relations in the past. FAST staff demonstrate their humanity by seeking out common interests and attitudes with parents that can serve as a foundation for friendly and mutually respectful relations. Program recruitment also benefits from the staff's ability to offer each family specific incentives, including free transportation to and from meetings,

a free hot meal at each meeting, on-site infant and toddler care, cash prizes, and the ongoing support of a nonhierarchical, nonjudgmental staff.

The combination of tangible incentives and in-home visits appears successful in recruiting hard-to-reach families. Of the families recruited for the 17 sessions to date, 80 percent consented to attend a first meeting. Of those families who attended a first meeting, 80 percent were persuaded by the strength of the FAST curriculum to continue on to graduation.

Collaborative Structure

FAST requires the active participation of four collaborative entities: public school staff, two community agencies (a mental health agency and a substance abuse agency), and representatives of the parents. This partnership involves collaborative agreements involving agencies and schools, salaried and volunteer FAST positions, planning meetings, joint recruitment of families, cocounseling of meetings for families, and program evaluation. Working together is time-consuming, awkward, and challenging because these four partners historically have little or no experience working together as a team. Language differences, scheduling challenges, conflicting priorities, alternative values, funding complexities, and confidentiality issues are several areas that may require patience and painstaking discussion and negotiation to ensure effective collaboration.

Parents are empowered in the collaborative partnership in several ways. They are hired as staff to help recruit parents and facilitate groups. They elect graduated parents to a parent advisory council (PAC) that becomes the organizing force for phase 2 of FAST. PAC members contribute to policy decisions and attend staff meetings. Parent leaders from Head Start make excellent FAST staff and can help create a transition for Head Start families into the public schools.

FAST facilitates community linkages by establishing a bridge of trust (a concept developed by Jack Schroeder, Director of Pupil Services, Madison Public Schools). As the hard-to-reach parent works alongside the FAST collaborative staff, the partnership breaks down stereotypes and myths about parents who do not care and school staff who are judgmental and dismissive. Human beings emerge. The family fun, the children's laughter, the smiling and proud parents, the principal handing out graduation certificates and inviting parents to coffee in his or her office, the formally attired school social worker singing and eating with the family, the reading of affirmations of parental competence at graduation—all of these factors contribute to the successful joining of forces to help at-risk children.

FAST Addresses Risk of Substance Abuse

The FAST program addresses four factors that have been correlated with adolescent substance abuse: (1) parental substance abuse; (2) low self-esteem; (3) inability to discuss feelings; and (4) a lack of routines, rituals, structure, and communication. Moreover, FAST program activities demonstrate how to have fun without drug.

Parental Substance Abuse

Parental substance abuse is addressed indirectly and directly through the FAST program. The FAST staff assess alcohol use indirectly by educating children about their right to have nonusing parents. The whole family views and discusses a film about a substance-using father. Staff present children with information about substance abuse and about how to protect themselves in unsafe situations that involve alcohol and other drugs in the presence of the parents, thereby educating everyone about alcoholism and chemical dependency. Printed materials also are distributed.

Alcohol counselors are present at the weekly multifamily sessions but merely participate in the positive family activities, unless they sense overtures for further involvement. Alcohol counselors are available to make home visits to further discuss alcohol and other drug use and to link family members to treatment programs or to Alcoholics Anonymous meetings. Many families that have been hard to reach through conventional outreach efforts for substance abuse counseling become accessible through the FAST program, even though they were recruited for other reasons. About 10 percent of FAST parents fully completed treatment programs, a rate FAST collaborators considered satisfactory.

Low Self-esteem

Low self-esteem in the at-risk child is directly addressed by FAST through the parent, who is considered the most powerful influence on the elementary school-age child's self-concept. Support and promotion of parents empower them to engage actively in the modified play therapy techniques. Each parent uses this technique once a week at the meeting and then attempts it every day at home. This one-to-one quality time appears to affect positively children's functioning in many areas, including self-esteem. Parents report significant changes in their children's

self-esteem over the eight-week period; FAST staff encourage parents to take full responsibility for these changes.

Inability to Discuss Feelings

The inability of an at-risk child to discuss personal feelings increases his or her risk for alcohol and other drug involvement. The FAST curriculum includes a family game in which the at-risk child identifies his or her feelings and the parent identifies the feelings of the parent. Each week the child and the parent act out and guess feelings in a game of charades. They then tell each other when they last felt sad, happy, glad, mad, hopeful, curious, scared, or surprised. The young person learns that feelings can be named and talked about within the family.

Lack of Routine and Structure

Families need to communicate rules and routines to prevent alcohol and other drug abuse in their adolescents. Through the FAST program, parents learn the benefits of structured family interactions as an alternative to a chaotic home life with no or inconsistent rules. Parents and children experience the routine of the consistent weekly FAST curriculum. The FAST agenda and activities serve as a model of the appropriate responsibilities of parents by foreshadowing events, establishing rules, and setting consequences for different behaviors. The parents practice these techniques in the eight-week curriculum and are supported as they explain rules to their children.

Inasmuch as alcohol and other drug abuse in adolescence is an oft-pursued avenue to having fun, FAST offers an alternative experience as parents and children learn there are ways to have a good time that do not involve substance use. During phase 2 of the program, families go on outings together over a two-year period to bowling lanes, roller skating rinks, baseball games, restaurants, and parks, and they repeat portions of the original FAST curriculum.

FAST Evaluation

Various indexes have been used to monitor the impact of the FAST program to date, although the long-term effect is not yet known. Because FAST is built on empirical studies, both the program and its impact should have some replicability.

Parents' ratings of their children on the Quay-Peterson RIII-C anxiety-withdrawal subscale, which has been correlated with childhood depression and lack of self-esteem, showed significant decreases between pre-FAST and post-FAST administration. Teachers' pre-FAST and post-FAST ratings of children showed declines on the attention-problem and conduct disorder subscales of the Quay-Peterson RIII-C (Quay & Peterson, 1987).

As for ratings of parents, parents reported an increase in social support on seven of 17 questions on Milardo's (1988) perceived social support measure. Over the course of the FAST program, mothers reported improved scores on the family cohesion dimension of the Family Adaptability and Cohesion Evaluation Scale (FACES-III) (Olson, Portner, & Lavee, 1985).

School social workers have given positive appraisals of the program in their schools and have encouraged colleagues in other schools to adopt FAST. They have seen the program as an efficient use of their over-committed time. The hours involved can be as few as 20 per semester for initial recruitment and as many as six to 10 per week when cofacilitating meetings and individual collaboration planning meetings.

Other authorities have been similarly impressed by the achievements of the FAST program. The State of Wisconsin allocated \$1 million toward replication of the program in other schools throughout the state, and the Federal Office of Substance Abuse Prevention in 1990 honored FAST with an award as an Exemplary Model Program, one of only 10 in the nation.

The success of Families and Schools Together depends on the level of commitment of the respective coparticipants, which testifies to its collaborative nature across service sectors. This commitment is possible, however, only because each partner sees its involvement as a vehicle for achieving its respective professional or personal goals. The school connects with parents who are not involved in their children's education and intervenes with at-risk students before they fail in school. The mental health agency serves hard-to-reach families it otherwise would not see. The alcohol or drug agency is able to provide assessment and treatment services, as appropriate, to parents in need. Finally, parents are able to enjoy their families more as they become the primary agents of substance abuse prevention for their own children.

ABOUT THE AUTHORS

Lynn McDonald, PhD, ACSW, is Program Director of FAST Family Service, Inc., 128 East Olin Avenue, Suite 100, Madison, WI 53713. Debra Coe Bradish, ACSW, MSSW, is Program Director, Prevention

and Intervention Center for Alcohol and Other Drug Abuse (PICADA), Madison, WI. Stephen Billingham, MA, is Program Evaluator of FAST Family Service, Inc., and Nic Dibble, MSSW, is Program Manager of FAST Family Service, Inc., Madison, WI. Celeste Rice, MSSW, is School Social Worker at Lowell Elementary School, Madison, WI.

REFERENCES

- Alexander, J. F., & Parsons, E. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*, 219-225.
- Barkley, R. A. (1987). *Defiant children: A handbook for parent training*. New York: Guilford Press.
- Belle, D. (1980). Mothers and their children: A study of low income families. In C. L. Hekerman (Ed.), *The evolving female: Women in psychosocial context* (pp. 1-16). New York: Human Sciences Press.
- Bloom, M. (1985). *Life span development: Bases for preventive and interventive helping*. New York: Macmillan.
- Caheane, C. T., & Meyers, D. V. (1982). *Children in crisis: A time for caring, a time for change*. Beverly Hills, CA: Sage Publications.
- Coleman, J., & Hoffer, T. (1987). *Public and private high schools: The impact of communities*. New York: Basic Books.
- Cowan, E. L., & Hightower, A. D. (1986). Stressful life events and young children's school adjustment. In S. M. Auerback & A. L. Stolberg (Eds.), *Crisis intervention with children and families* (pp. 85-101). New York: Hemisphere Publications.
- Cowan, E. L., & Work, W. C. (1988). Resilient children, psychological well-being, and primary prevention. *American Journal of Community Psychology, 16*, 591-607.
- Egeland, D., Briesenbacher, M., & Rosenberg, D. (1980). Prospective study of the significance of life stress in the etiology of child abuse. *Journal of Consulting and Clinical Psychology, 48*(2), 195-205.
- Elkin, M. (1984). *Families under the influence: Changing alcoholic patterns*. New York: W. W. Norton.
- Epstein, J. L. (1983). Longitudinal effects of person-family-school interactions on student outcomes. In A. Kerckhoff (Ed.), *Research in sociology of education and socialization* (Vol. 4). Greenwich, CT: JAI.
- Finn, C. (1987). The high school dropout puzzle. *Public Interest* (Spring), 64-74.
- Hawkins, J. D., Ushner, D. M., & Catalano, R. F. (1985). Childhood predictors and the prevention of adolescent substance abuse. In C. L. Jones & R. J. Battjes (Eds.), *Etiology of drug abuse: Implications for prevention*. Washington, DC: U.S. Government Printing Office.
- Heiletz, L. J., & Baker, D. (1977). Behavioral training for parents of retarded children: Alternative formats based on instructional manuals. *American Journal of Mental Deficiency, 82*, 194-203.
- Kogan, K. L. (1978). Help seeking mothers and their children. *Child Psychiatry and Human Development, 10*(4), 204-210.

- McCubbin, H., Sussman, M., & Patterson, J. (1983). *Social stress and the family: Advances and developments in family stress theory and research*. New York: Hawthorne Press.
- Millardo, R. (1988). *A social support measure*. Unpublished manuscript, University of Maine.
- Minuchin, S. (1986). *Family kaleidoscope*. Cambridge, MA: Harvard University Press.
- Minuchin, S., Montalvo, B., Guernsey, D. G., Rosman, H. L., & Schumer, E. (1967). *Families of the slums*. New York: Basic Books.
- Olson, D. H., Portner, J., & Lam, Y. (1985). *FA(15-III)*. SC. Paul: University of Minnesota Press.
- Patterson, G. (1975). *Families*. Champaign, IL: Research Press.
- Pianta, R. C., Egeland, B., & Sroufe, L. A. (in press). Maternal stress and children's development: Prediction of school outcomes and identification of protective factors. In J. Roll, A. Masten, D. Cicchetti, K. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology*. Cambridge, MA: Harvard University Press.
- Quay, H. C. (1983). A dimensional approach to children's behavior disorder: The revised behavior problem checklist. *School Psychology Review*, 12, 244-249.
- Quay, H. C. (1986). Classification. In H. C. Quay & J. S. Werry (Eds.), *Psychopathological disorders of childhood* (3rd ed.). New York: John Wiley & Sons.
- Quay, H. C., & Peterson, D. T. (1987). *Manual for the Revised Behavior Problem Checklist*. Coral Gables, FL: University of Miami Department of Psychology.
- Rutter, M. (1983). Stress, coping and development: Some issues and some questions. In N. Garmezy & M. Rutter (Eds.), *Stress, coping and development in children* (pp. 1-41). New York: McGraw-Hill.
- Shedler, J., & Block, J. (1990). Adolescent drug use and mental psychological health: A longitudinal inquiry. *American Psychologist*, 45, 612-630.
- Solomon, O. B. (1985). How do we really empower families? New strategies for social work practitioners. *Family Resource Coalition Report*, 4(3).
- Wehrlage, G. G., Rutter, R. A., Smith, G. A., Lesko, N., & Fernandez, R. R. (1990). *Reducing the risk: Schools as communities of support*. New York: Falmer Press.
- Wikler, L. (1981). Chronic stresses of families of mentally retarded children. *Family Relations*, 30(2), 281-288.
- Wikler, L., Savino, A., & Kyle, J. (1974). *Behavioral modification parent groups: A manual for professionals*. Inglewood, NJ: Charles B. Slack.
- Wikler, L., & Slater, M. (1986). Normalized family resources for families with a developmentally disabled child. *Social Work*, 31(5), 385-390.

Accepted September 25, 1990

After divorce, help kids put the pieces together with..

CHILDREN & DIVORCE

New from AGS

Introducing Children of Divorce, a group discussion and skill building program for children, grades 3-6. With peer support, children learn how to cope with their feelings and concerns following a divorce. Complete with the leader's guide, a Kidsbook with a variety of activities, and a Parentsbook that helps parents support and reinforce learned skills.

For more information, simply complete and mail this coupon to:

AGS®
4201 Woodland Road, RL171
Circle Pines, MN 55014-1796



Please Send Me:

1 Children of Divorce brochure (#8558) | 1 Free AGS catalog (#9991)

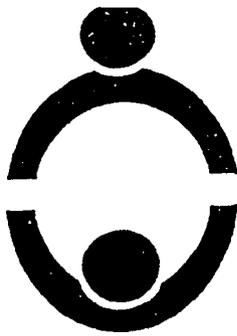
Name: _____

School/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Best time to call: _____



THE PREVENTION REPORT

The National Resource Center on Family Based Services

(Fall 1991)

THE PREVENTION REPORT is a publication of the National Resource Center on Family Based Services, The University of Iowa School of Social Work, 112 North Hall, Iowa City, IA 52242 319/335.2200. Funding provided by the Children's Bureau, Office of Human Development Services (Grant a 90CJ0955101)

We welcome articles related to family-based services from practitioners, administrators and other interested readers. Legislation, research, practice methods, new materials in the field, upcoming prevention conferences, as well as responses to articles appearing in this publication, are all welcome. Address inquiries or submissions to Anne Zalenski, The Prevention Report, National Resource Center on Family Based Services.

NATIONAL RESOURCE CENTER STAFF

Marcia Allen,
Executive Director
Wendy Deutelbaum,
Family Development Director
Kristine Nelson,
Research Director
Miriam Landsman,
Senior Research Associate
Margaret Tyler,
Research Associate
Anne Whitehead Zalenski,
Program Assistant
John Zalenski,
Information Specialist
Debbie Black,
Executive Secretary
Curie Atwood,
Publications Secretary
Sarah Nuh,
Training Coordinator
Donna Nielsen-Espey,
Administrative Assistant

F.A.S.T.

A Prevention Program That Works

by Lynn McDonald

In 1986 Family Service, a not-for-profit mental health agency in Madison, Wisconsin initiated an intensive in-home family preservation program called F.I.T. (Families In Transition). All of the clients were court-ordered adolescents about to be placed in residential treatment center for long-term care. Rather than focusing only on the troubled adolescent, the entire family unit was ordered to participate involuntarily in family therapy to deter placement. After 3 months of family focused intervention, 74 % of F.I.T. families were reported still together one year later, and indicators showed increases in family harmony.

As a social worker/family therapist in the mental health system, I wondered whether early intervention using a family-based approach might not have a powerful impact on these at-risk families. In addition to preventing costly placements for adolescents, could we not work to prevent initial involvement in the court or child welfare system? The first challenge was to establish a procedure for early identification. If the child is not "in the system," and if the parent has not initiated the therapeutic intervention, who would be most able to identify the at-risk child? Family Service turned to the school and found in one a responsive, welcoming elementary school principal. Together we agreed to address the challenge of prevention for children at risk for truancy, school dropout, substance abuse, and delinquency.

Schools can do thorough screening of all children in kindergarten through third grade (ages 5 to 9) with efficiency. Research on teachers' track records indicates that their astute and practiced observational skills can be relied upon to identify high-risk youngsters. However, until the late 1980's, schools maintained a discreet distance from the mental health, social services, and medical systems. Recently this has changed. The crushing effects on children of poverty, joblessness and transiency have crossed over into the classroom. Schools are now searching for help in addressing these problems outside. (See "What it Takes: Structuring Interagency Partnerships to Connect Children and Families to Comprehensive Services," January, 1991, a joint publication of the Education and Human Services Consortium, 1001 Connecticut Avenue, NW, Suite 310, Washington, DC 20036 [202-822-8405].)

IN THIS ISSUE . . .

- F.A.S.T. (Families and Schools Together) - A Prevention Program that Works
- The Family Unity Model - Looking for and Building on Family Strengths
- SPECIAL INSERT - RESEARCH EXCHANGE NEWSLETTER
- PLUS
 - *Conference News
 - *Training Opportunities
 - *Provision Resources
 - *Materials Available

In January, 1988, a model prevention program called F.A.S.T. (Families and Schools Together) was first led by United Way of Dan) County and by the Wisconsin State Department of Health and Human Services. F.A.S.T. is a collaborative program whose partners are teachers, mental health workers, substance abuse counselors and parents working with 5 to 9 year old children who have been identified within the school system as being at risk. It is based on family therapy principles and targets the whole family unit.

F.A.S.T. is now being used in over 40 schools throughout Wisconsin with 35 other potential sites around the country. The F.A.S.T. program received national honors and recognition in 1990-1991 through three separate independent reviews of prevention programs. The U.S. Office of Substance Abuse Prevention made it one of 10 exemplary programs in 1990 and recently awarded a \$1.4 million 5-year grant to further adopt and evaluate the F.A.S.T. program. The national reviews underscored four distinguishing features of the F.A.S.T. program:

"F.A.S.T. is now being used in over 40 schools in Wisconsin."

- 1) collaboration,
- 2) early intervention,
- 3) Careful evaluation and replication and
- 4) a family systems approach.

The program is simple: the family receives 8 weeks of multi-family weekly sessions followed by 2 years of monthly multi-family sessions. The meetings take place at schools in the evening and the multi-disciplinary collaborative team staffs the program. The number of families served at a time can be between 8 and 45, and F.A.S.T. aims at graduating 12 per group. The format is structured and developmentally appropriate to 5 to 9 year olds, while flexible enough to include other siblings and intergenerational groups. Building stronger families, building better links between families, schools and community agencies, and increasing each child's functioning level are the three central goals of F.A.S.T.

The method is process oriented rather than didactic. It involves parent support, rather than parent training. Every structured activity focuses on building and sustaining relationships: 1) within each family unit; 2) between parents and the at-risk child; 3) between adult dyads; 4) among all the parents; 5) between parents and various professionals; and 6) among the families and professionals in each of the F.A.S.T. classes.

The F.A.S.T. program has been very successful at recruiting families of at-risk children who participate voluntarily... These families generally have been isolated, uninvolved, and "hard-to-reach" families. Ninety percent are single parent families, 80% are families on welfare, and most are stressed, chaotic and depressed, with substance abuse in the family history. Even including those families who have attended just one F.A.S.T. session, 80% have graduated from the initial eight week program. This success is due largely to a

"Central to the success of F.A.S.T. are support and empathy -- rather than judgement and blame --"

heavy emphasis on recruitment strategies, use of multiple incentives, and on value clarification among the professional team members during training.

The F.A.S.T. program assumes that every parent loves and wants the best for his or her child and should be given the support needed to be his or her own child's prevention agent. Central to the success of F.A.S.T. are support and empathy -- rather than judgement and blame -- along with a non-hierarchical professional team which includes parents as team members.

Standardized evaluation is achieved through parent and teacher assessments of the at-risk child's behavior before and after the 8-week sessions. Average overall increases in the child's functioning consistently range between 20% and 40%. These data come from multiple sites over several years and include an experimental design with a control group. Specific areas most statistically significantly affected have been attention span improvement, motor activity reduction, improved conduct, and increased self-esteem. Family cohesiveness has also improved significantly. Long-term follow-up on truancy, school drop-out, delinquency, and Substance abuse is planned. What seems clear, even at this point, is that this carefully developed prevention program -- crafted by combining and applying social science/social work research in family therapy, family stress theory, child psychiatry, stress and social support findings, group work and community organization -- can work to help at-risk children from stressed families improve their functioning at home and at school. Although collaborative team programming is hard work, starting it early with the whole family is well worth doing.

Further information regarding training for F.A.S.T. programs, as well as more information in handout or videotape form can be requested through Nancy O, F.A.S.T. Family Service, 128 Olin Avenue, Madison, Wisconsin 53713 (608) 251-7611.

*Programs to
Strengthen Families*
A Resource Guide
Third Edition
1992

Kathryn Goetz, **Editor**

Family Resource Coalition
Bernice Weissbourd,
President

Judy Lang-ford Carter,
Executive Director

Lynn Pooley,
Director, National Resource Center for Family Support Programs



II. TARGETING SCHOOLS

The programs **in** this chapter are physically or **philosophically** linked to school. Many of these programs are primarily geared to **encouraging** school success and preventing academic failure. Some of the programs such as **Avance** Educational Programs for Parents and **Children** and Providing a Sure Start are independent and located **in** community-based organizations. Others, like PACE, Project FIESTA, and the **Family** Center in Clayton Missouri are based on a collaboration **with** the local school **district**. Programs that use schools as **logical** dissemination points for another agenda-Families and Schools Together, a substance abuse prevention program, and EPIC, a **crime** prevention effort-are also included in this chapter.

Families and Schools Together

Family Service, Inc.

128 East Olin Avenue, Suite 100, Madison, WI 53713
608/251-7611

Lynn McDonald, Ph.D., A.C.S. W., Program Director
David Hansey, Program Director

Overview

Families and Schools Together (FAST) is a unique substance-abuse prevention program designed to be **easily** replicated. In every location, FAST is a collaborative venture between an elementary school, a mental health agency, a substance-abuse prevention agency, and families. It targets high-risk elementary school children **using** a family-based approach.

FAST's four **main** goals are: (1) to enhance family functioning by strengthening the parent and child relationship and by empowering parents as primary prevention agents for their own children; (2) to prevent the target child from **experiencing** school failure by improving the child's behavior and performance in school, making parents partners in the educational process, and increasing the Family's feeling of affiliation with the school; (3) to prevent substance abuse by the child and the Family by increasing knowledge and awareness of alcohol and other drugs and their impact on child development, and by linking families to assessment and treatment services; and (4) to reduce stress experienced by both parents and children in daily situations by developing a support group for parents of at-risk children, linking families to community resources and **services**, and building the self-esteem of each family member.

History

Lynn McDonald, of Family Services, Inc., Madison, Wisconsin, conceived the idea for FAST in 1987, and enlisted the help of Lowell Elementary School in Madison's Metropolitan School District and the Prevention and Intervention Center for Alcohol and Other Drug Abuse (PICADA) to design the program model. Two grants were awarded to implement FAST in January 1988; one from the United Way of

Dane County and one from the Wisconsin Department of Health and Human Services, Alcohol and Drug Division. FAST has since expanded from two schools in Madison to almost seventy schools **across** the state of Wisconsin. The Governor's **Commission** on Education in the 21st Century formally recommended that by 1996 every elementary school in Wisconsin that wants a FAST program have one. Current adaptation of the FAST program for preschoolers and for middle-schoolers **is** underway **with** a five-year grant from the U.S. **Office** of Substance Abuse Prevention (OSAP).

Community

The original community served was Madison, Wisconsin, a mid-western, middle-sized city with a population of 190,000. The 70 schools now being served include a wide range of from very rural, **farming** communities, to very densely populated impoverished ghettos in the Milwaukee **metropoli**tan area, and to Indian reservations and suburban towns. The program has been used **in** affluent and economically depressed areas, multicultural and homogeneous areas. It has been used with African Americans, Native Americans, Hispanic Americans, Asians and Asian Americans, and white Americans. Since FAST is school-based, the neighborhood of **th**e school **determines** its community and the school selects its target populations.

Program Components/Services

- In each community, **FAST** conducts an **aggressive** outreach campaign which includes home visits, and incentives such as meals and prizes in order to recruit families for participation **in** the FAST program.

- The program meets for 8 weeks with 8 to 12 entire families in a large room. Activities include:

- (1) Participating in a structured program based on family therapy and child psychiatry research (e.g. making a family flag, a drawing and talking game, and charades about feelings)
- (2) Viewing and discussing a film or play about a child or an alcoholic in order to address the issue of parental substance-abuse
- (3) Engaging in developmentally appropriate family-based activities which help to change family interaction styles
- (4) Building a parent support group through nondidactic time with no agenda but networking
- (5) Spending one-on-one quality time together

Professionals from many different disciplines attend FAST sessions to become resources for parents.

- Monthly meetings for FAST graduates organized by parents with staff and budget support
- Information about and referral to alcohol and drug resources, including treatment and substance-abuse prevention programs

Participants

FAST's general target population is at-risk children aged five through nine and their families. Family is defined by living together, being connected, and including all adults having a caretaker role toward the child. The definition is meant to be inclusive.

School staff target specific families. Schools have targeted either all children in a certain classroom or only at-risk children or special needs children. Because of limited funding, most schools have selected children who showed behaviors which were perceived by their teachers as putting them at risk in later years for multiple problems.

FAST originally focused on at-risk children. Their

families were considered hard to reach: 60% had no car; 40%, no phone; 90% were single mothers.

Staff

Schools generally employ one half-time staff person to serve as a FAST facilitator. Responsibilities for this position include assembling and coordinating a team of school personnel and parents, substance-abuse prevention staff, and a youth worker; training teachers; recruiting and training volunteers; recruiting families by visiting homes; facilitating the eight-week night sessions; and participating in a planning meeting for monthly follow-up. The ideal FAST facilitator has a master's degree in social work, a knowledge of family therapy, and experience in community organization and working with children and families. Former participants who have continued to serve as parent liaisons or volunteer leaders have recently been hired as FAST facilitators. They have the specific FAST experience and knowledge necessary to be effective and they bring a consumer perspective to the facilitator role.

Outreach

Participation in FAST is voluntary. School staff invite families to join the program; and after a release of information is signed, FAST staff make home visits to actively recruit participants. Eighty percent of families visited attend one FAST session. Of these, eighty percent graduate from the eight-week program. In FAST's early days, over half of those identified by the school refused to let FAST staff visit their home; they were alienated from the school. FAST then began training school personnel and using parent graduates to recruit new participants. The program has become very popular and parents increasingly refer themselves because of word-of-mouth.

Evaluation

Evaluation is a central part of the rapid expansion of FAST. Family Service made a commitment to collect quantitative results with standardized instruments to demonstrate the impact of this school, community, and family-based prevention program. Parents and teachers fill out forms pre- and post-program. These forms are the Quay Peterson Behavior Problem Checklist and the FACES III (on family dynam-

ics by Olson). Both of these have shown statistically significant improvements in the child and family after only eight weeks of meetings. Improvements are in self-esteem, attention span, and family closeness. In addition, a small study with assignment to a **control** versus experimental FAST group supported these results.

Consumer satisfaction feedback from parents and children has been **extremely positive**. Professionals involved also rate the program positively on simple **Likert** scales.

Long-term **follow-up** data are now being collected.

Replication

FAST has been successfully replicated in approximately 70 schools across the state of Wisconsin. In addition, FAST has received **over** 180 inquiries from across the U.S. in the last six months of 1991.

The success of **FAST's** replication is believed to result from the replication process and materials which include (1) a **300-page** FAST training manual which outlines each step of the program (McDonald, et al. 1990; 1991 revision); (2) a formal, six and one-half day training program spread over four months and including three site visits for coaching and problem-solving; (3) training of local collaborative teams which consist of at minimum one mental health person, one substance-abuse person, one educator, and one consumer parent; (4) consulting and technical assistance for grant-writing to start FAST; (5) a site report and formal evaluation of each replication site.

Funding

The Madison-based FAST program has an approximate annual budget of 5436,550: **63%**, from the federal government (Office of Human Development, Office of Substance Abuse Prevention); 11.696, state government (Wisconsin Department of Health and Social Services, Office of Alcohol and Other Drug Abuse Prevention); **15%**, local government (Madison Public School District and Madison City Budget); **11.4%**, private **funds**, including monies from the United Way and the Madison Community Foundation.

FAST is very **fundable** in the 1990s. It can be funded by federal alcohol prevention dollars allocated

through every public school or by local branches of the United Way (United Way's national office identified FAST as one of 100 model programs for children and families in the U.S.). Funding can also come from demonstration grants or prevention **monies** from the Family Support Act. Chapter **I** money, which every public school receives, has a parent involvement requirement which could fund FAST. Clifton T. Perkins' adult education money for parenting classes has been allocated to FAST. Delinquency prevention dollars could also be directed to FAST.

Highlights

FAST has been honored with several national awards including (1) U.S. Office of Substance Abuse Prevention (OSAP) Exemplary Program Award, one of ten in the United States (June 1990); (2) American Institute of Research honor for inner-city substance abuse prevention-500 programs were reviewed, 6 received recognition as successful models (March 1991); (3) CSR, subcontracted by the U.S. Office of Human Development, reviewed 65 currently **federally** funded prevention programs and identified FAST as one of six model prevention programs for high-risk youth (March 1991).

These awards all identified FAST's collaborative teams and the family systems approach as unique, and praised the careful self-evaluation process.

suggestions

Prevention is a multifaceted, long-term **challenge**. FAST reports dramatic attitudinal and behavior changes; however, maintenance of these changes over time needs to be effectively addressed.

Publications

Brochures; training manuals; and videotapes. In addition, FAST has been described and published in various journals and newsletters: **National Association of Social Work** Newsletter (Washington, D.C., 1989); **American Association of Marriage and Family Therapists Newsletter** (Washington D.C. 1990); **The Prevention Report** (The National Resource Center on Family Based Services, Iowa City, Iowa, 1991); **National Organization of Student Assistance Programs and Professionals** (Boulder, Colorado, 1991); **Social Work and Education** (1991); and **Social Work in Japan** (1991).