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Administration for Children and Families
Office of Family Assistance

National
Responsible
Fatherhood Clearinghouse



NRFC Webinar Series

Let's Talk About Mental Health

Transcript

February 18, 2015

Moderator:

- Nigel Vann, National Responsible Fatherhood Clearinghouse (NRFC)

Opening Remarks:

- Lisa Washington-Thomas, Chief, Self-Sufficiency Branch, Office of Family Assistance, Administration for Children and Families, U.S. Department of Health and Human Services

Presenters:

- Joe Joes, Founder and CEO, Center for Urban Families
- Dr. Tiffaney Parkman, Lecturer, School of Health and Human Services, University of Baltimore
- Dr. Frank Blaney, Project Coordinator, L.A. Fathers Program
- Dr. Sophie de Figueiredo, Coordinator of Mental Health Services, Project NATEEN
- Dr. Bridgid Conn, Postdoctoral Psychology Fellow, Project NATEEN

Operator: Good day, everyone, and welcome to the National Responsible Fatherhood Clearinghouse webinar entitled "Let's Talk About Mental Health." Today's call is being recorded. At this time I would like to turn the conference over to Nigel Vann. Please go ahead, sir.

Nigel Vann: Okay, thank you very much and good morning, good afternoon no matter where you may be. And I see in the chat box we've been talking about having a mind-calming moment, so I think that's a good way to get us started. Thanks for that, Adam. And this is certainly an important issue to talk about, so we're very pleased that we're able to do this today. It's something that we've heard fatherhood practitioners talking about a lot as an issue that really needs a lot more attention, so we're very pleased to start the conversation today and we're looking forward to ways to continue it moving forward. Before we dive into the subject, let me just point out a few things about the screen you're seeing and how today's webinar is going to work. Everybody is hearing the audio through the computer. If you have any problems with that, you can put a message in a chat box and someone can respond as much as we can. You also saw a sign a minute ago that today's webinar is being recorded and that recording along with a transcript and all the slides and presentation materials will be posted on the Fatherhood.gov website within a few weeks' time, so please check back to have a look at those.

As usual, we'll have a Q and A session at the end of the webinar, and you can see at the bottom of your screen there is a Q and A box. You can type any questions for the presenters in there. So just remember to use the Q and A box for questions for the presenters and you can use the chat box for talking amongst yourselves or any other issues with

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the audio. After you put a message in there you just click on the bubble to make it appear. And also let me say that with the Q and A session at the end, we'll answer as many questions as we can. If we can't answer all of them, we will post written responses to those questions later.

So today we've got two sets of presenters lined up for you. One is from an established fatherhood program in Baltimore, the Center for Urban Families that have been working with fathers since the late 1990s, and then we've got a newer program in California that's based in a hospital setting. And each of those are going to talk to you about their experiences and offer recommendations for ways we can have this conversation with fathers. And I'll introduce the presenters in a few minutes, but before I do that, I just wanted to turn to our federal lead and cheerleader, Ms. Lisa Washington Thomas with the federal Office of Family Assistance, who we just found out in our pre-conference call is going to have a birthday in two days. So let me take the opportunity to say "Happy birthday, Lisa," and please move us forward from our mind-calming moment here to the conversation.

Lisa Washington Thomas: Thank you. Thank you, Nigel. I just want to thank everyone for participating. I want to thank our presenters and I want to thank you all participants for dialing in and logging in to our webinar. This webinar, if you don't remember, is a response to your request in our last webinar regarding how fatherhood programs can help their children through bullying issues. We asked at the end of the webinar, what topic would you like to most talk about? And during our webinar, you overwhelmingly responded that you wanted more information about mental health. So I want to thank Nigel for asking the field about what they needed and then developing a great webinar to respond to that need.

We feel that talk about mental health is so important because it's almost a taboo in our society when it shouldn't be. I looked at some statistics from the National Institute of Mental Health, and it estimates that 43.7 million adults age 18 or older in the U.S. have any type [sic] of mental illness in the past year. Within the same year, there were 29.1 million Americans or 9.3 percent of the population who had diabetes, but we are so eager to talk about diabetes and how you can prevent it and how you can treat it, but we don't want to talk about mental health even though there are people who need more information. We have more people who have a disease just like diabetes, and that we should be offering to help them just like we want to help our family members who have diabetes. So I am so glad that we are beginning this conversation. By far it won't be the last with this dialogue, and we look forward to more information on how we can better serve you. But we don't have a poll at the end of this webinar. In your comments or questions, please leave us some information about further topics that you are interested in. Thank you so much, and I turn it back over to you, Nigel.

Nigel Vann: Okay. Thank you very much, Lisa. So can we go to the next slide? I get to choose the slides here. I'm very sorry. There we go, thank you.

So I just wanted to give you a brief overview again of the National Responsible Fatherhood Clearinghouse. If you've joined us for our webinars before, you've seen this, so I'm not going to dwell on this slide. But that's how you contact us. You can see the website. You can also see the website in the additional web resources box at the bottom of your screen. If you click on that it takes you to Fatherhood.gov. Let me also point out on the left that you can download the full bios for the presenters and you can download additional resources for the topic which I'm going to say a few words about in a few minutes.

The one thing I want to stress on this slide is that we do have the National Call Center at 1-877-4DA-D411, and we do encourage practitioners and fathers to dial that if there's any issue, and there's trained counselors at the end who can help talk about most issues that they're very good at doing, mediation between fathers and mothers, and they can identify local resources as well. So with that, let me move us to our next slide.

We just wanted to underline some of the comments that we just heard from Lisa about the importance of mental health, the fact that it really is our emotional, psychological and social well-being that affects how we think, feel and

act. And some days we feel okay, some days we don't; and as the slide points out, one in five of us this year is going to experience a mental health problem. But only about a third of us is likely to get any treatment for that. And we also know that if we're male, we're less likely to even talk about this. So in terms of the work that fatherhood programs get to do, we can really participate in that last bullet there, and all these notes come from the Federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Promotion and prevention requires people and communities to think and act differently by addressing mental health issues before they become mental illnesses. And we know that a lot of the men involved in these fatherhood programs are struggling with all sorts of issues. How do you get a job? How do you pay the bills? How are you going to see your kids if you're a non-residential dad? How are you going to deal with your various relationship problems? What about all the violence in the community? And so those are some of the kinds of things that we're going to talk about today in terms of, how do we help men talk about this more?

So we want to take a look at some of the issues that dads are experiencing, some of the kind of issues they're going to talk about in programs, some ideas of assessment tools that we might look at building in to help us recognize symptoms. I think the fatherhood programs have really, by and large, done a really good job of creating a safe and nurturing environment where men do feel comfortable talking about these issues. Men will open up and share things that they may never have talked about before, and we're going to hear quite a bit about that on the webinar.

I like to think about that as we create this space for men to take off that mask of masculinity and really start opening up and sharing amongst themselves what's bothering them, what are the issues from childhood that are still bothering them. And often, just being a good listener, facilitating support from other fathers can be enough to make a lot of guys feel better, but there are times when issues require more clinical counseling and support. And so a lot of what we want to focus on today is, what do we do to help the staff of our programs recognize when we can help a dad directly, and when we need to reach out for support from other colleagues or for clinical support in the community.

As I said at the beginning, it's an issue that we've been grappling with for a good while. We've grappled with a number of issues in the field. And in order to reach out and form partnerships in the community, particularly in the child support enforcement arena, the domestic violence arena, the child welfare arena, we've been able to reach out to employers in the business community to help participants in programs. So it's really time to find ways in which we can work more closely with the clinical community out there. So we're going to hear some thoughts about that today.

Finally, before I introduce our first set of presenters, I just want to point out again that there is the Helpful Resources document in the bottom left-hand corner of your screen that you can download. And the left-hand side of the slide that we're showing right now [shows] just a few of the websites that we have on that resource document.

As Lisa mentioned, so that I was prepared for this course, I was talking to a few people in the field and just getting a sense about what some of the resources are that we should be sharing. And I just wanted to acknowledge the individuals on the right-hand side of the screen here. You gave me some useful tips.

So firstly, Denise Marzullo of the Mental Health American of Northeast Florida; she recommended a number of the websites that you see on that resource list. And she also recommended a couple of public service announcements that have been airing over the last few years on our TVs, and they feature Brandon Marshall of the Denver Broncos who talks in these short 30-second clips about his own experience with borderline personality disorder. He talks about how, you know, you go from anger through various mood swings. There's feelings of impulsivity and it leads to chaotic relationships. And so just by having a public figure talk about his own issues there--And then they provide links to websites and other places where you can seek help

I also talked to Howard Wells of the Jewish Family and Children Services in Sarasota, Florida, who shared work that they've been doing around grief and forgiveness in particular. He pointed out that they also create this safe environment where dads will talk about all sorts of issues that they may not have talked about before. And many of the guys and I think all of us, we have unresolved grief from things that have happened to us. It might be the loss of a loved one. It might be not being able to see our children, as I mentioned. It might be that you've just not been able to fulfill those childhood dreams. Whatever it is, we need to talk about that grief and find ways of moving on from it and forgiving people.

I also talked to Katrina Johnson from Horizon Outreach in Houston, Texas, and they work primarily with military veterans who have come home. And she helps them, first of all, acknowledge the PTSD issues that they're dealing with, and then helps them move beyond that, and helps them look at how that and other things are affecting their relationships.

And then finally, I just want to acknowledge Kenny Braswell, who's the Director of the Fatherhood Clearinghouse, who's done a good deal of work in this issue himself and was instrumental in starting to think about this webinar. He filmed a presentation by Dr. Sidney Hankerson of Columbia University a couple of years ago, and we've uploaded the video for that. It's available on YouTube, but there's a link on the Helpful Resources document where Dr. Hankerson was talking about issues to deal with mental health and black men in particular, and he talked about how it's hard for men to talk about this because of the stigma of mental health. We don't want to admit that we feel depressed or we might have other concerns, but he said it's important to think about how to have those conversations, because doing so can change lives. And the first part of those conversations is to start being honest, to move to healing places by honestly looking inside and talking about our issues, and then finding someone who we trust to get educated about the issues, to advocate for ways for approaching the issue differently, to network with others, and most of all, to find hope for the future.

So with those thoughts, I'm going to move to introduce our next set of speakers. As I said, we have speakers from an established program which is the Center for Urban Families in Baltimore. We'll be following that with a team of presenters from the Children's Hospital in Los Angeles. But first of all, to talk from the perspective of a long-established program, we have Joe Jones, who many of you are familiar with and have probably met, I'm sure. Joe has been doing this work since the early '90s. He founded the Center for Urban Families in 1999, having worked with the Men's Services Program for the Baltimore Healthy Start Initiative, and also bringing the National STRIVE Employment Program to Baltimore. And he's really been a leader in this field for a long while. He's established a program, he's got a large staff, a wonderful building there, but Joe, as he's going to talk about, is still struggling to see how we get to some of these clinical issues. Joe has received numerous awards and honors for his work. He currently serves on President Obama's Task Force on Fatherhood and Healthy Families, and he was also a Community Advisor on Fatherhood Issues to Vice President Al Gore.

Speaking with Joe today, we have Dr. Tiffany Parkman from the School of Health and Human Services at the University of Baltimore. Dr. Parkman has worked with the mentally ill for over a decade. She's worked in diverse settings, including community and private mental health care, group homes, penal institutions. Her research has included broad areas of qualitative and quantitative experiences in the areas of fathering, family life, prison re-entry and incarceration. She has hooked up with Joe to help the Center for Urban Families on a volunteer basis, I should say, to really take a look at how they're dealing with the whole issue of mental health.

Again, you can see the full bios for the presenters by downloading the bios in the left-hand box. With that said, let me hand the controls to Mr. Joseph Jones. Take us away, Joe.

Joe Jones: Thank you so much, Nigel, and good morning and good afternoon, everybody. First, let me start by thanking the Office of Family Assistance and the National Responsible Fatherhood Clearinghouse for uplifting an issue that I think all of us have grappled with. Whether or not we can articulate exactly what we were grappling with

remains to be determined, but when we think about the folks that we reach out to, sometimes [receiving] them from the most disadvantaged places in our country, it's not surprising that they would come to the table where there are several issues, some of which we've been very successful at addressing, and others like mental health we probably struggle with.

The Center for Urban Families, as Nigel mentioned, was founded in 1999, and last year we celebrated our 15-year anniversary. I think in his remarks, Nigel may have referred to us three or four times as [an] "established," quote-unquote, organization/fatherhood program. I'm almost embarrassed to say that accepting that moniker, we've not done as much as I would like us to have done to understand the issues of mental health and to come up with ways in which we have addressed them. Similar to, as Nigel mentioned, we bridge communities with the domestic violence communities to a greater degree and the child support community, two examples of communities where there was a lot of hesitancy to build bridges. But we've done so and done so relatively effectively, and there are many examples of organizations that have partnered together to address domestic violence and child support-related issues.

But we're in new terrain, new territory. And I'm not afraid, although somewhat ashamed, to say we are, along with maybe many of you on the phone, in this new territory, this new terrain where we're trying to work together to come up with a collective strategy and set of activities to help us address these issues.

The mission of the Center for Urban Families is to help fathers and families achieve stability and economic success. And for us, that means helping folks develop a set of soft and hard skills to get into the labor market and to advance; and on the stability side, to help them to think through how they build strong families, whether that's through our Baltimore Responsible Fatherhood Project or our Couples Advancing Together program, where we work with moms and dads, both programs in a cohort model. The Fatherhood Program obviously is all dads. The Couples Advancing Together model are couples who receive public benefits who indicate that they are quote-unquote in an "intact" relationship, and we're trying get the system to recognize the dad is an asset to his family at the same time the mom receives public benefits.

Associated with our direct services work is the work that we do around supportive services, whether it's literacy, legal, personal or professional development; to identify policy barriers that many of our folks may come up against that you cannot just simply program your way out of; and to think through, how do you develop a policy agenda that helps to alleviate those barriers and working with allied groups to achieve those goals? And then lastly, our Practitioners Leadership Institute, which is intended to provide training and technical assistance across the country. We have an academy where we select 10 practitioners from around the country to go through our PLI Academy, with the new Academy cohort coming online March just a few weeks from now.

So we're very happy with the history of the organization, but I said. I do not consider us to be an established program as it relates to this issue of mental health, and I hope that together, we will figure out ways in which all of us can become more established in this area together.

To give you some sense of how folks come to us: We have a really robust outreach apparatus. We have folks who hit the streets of Baltimore going to the most disadvantaged communities--we don't go to affluent communities--and we talk to people where they are about getting into a CFUF program. We also receive services from across the board, whether it's child support, to court, parole and probation, [to] a grandmother who simply says to a grandchild, "You screwed up and now it's time for you to get on the right path." And the grandmom may drag that person in by the ear, and that may begin the process for that individual. Once folks come in, there's an application process, an assessment process, and we administer a range of assessments. And I'm really happy that I can say that we have evolved with our assessments to now include a mental health screen that screens for depression, and then a PTSD assessment which had been informed by my partner on today's call, Dr. Tiffany Parkman. We'll talk more about her relationship with us and her knowledge of the field and how practitioners may want to think about addressing those issues.

After application and assessment, there's a referral to the right to a CFUF program, one of which I described earlier, or that person has some kind of pre-existing barrier that may require they receive an external service. That could be for mental health, substance abuse, homelessness, or extremely low literacy, as some examples. If they're able to have those effectively addressed they can come back to a CFUF program. So no one is ever completely cut out from a support service, but we want to make sure that we are providing support in a way in which we can be effective. In doing so, we do not put somebody into a program when they're not quite ready.

Our core objectives in our Baltimore Responsible Fatherhood Project--and I'm isolating this program because we're talking about dads' need for services--our core objectives here are to increase child support awareness and management, to work very closely with our state child support office, and beyond that we have child support staff on site here at the center. We work to improve the acquisition demonstration of parenting skills for dads, helping relationships and effective communication among dads and their partners or the moms of the children that they have had. Increasing client job readiness and employability is also one of our core objectives related to BRFP.

The value of what we do relative to mental health I think is in our peer support group. I want to distinguish--and this is probably no surprise to anybody on this call--peer support groups are different than a curriculum group. Here we're talking about, and Nigel mentioned it before, having a safe place where guys can come together where they don't have distractions. They can do self-reflection, they can share everything, mutual support. And they can do so with us having a cohort model. Folks really began to bond with one another. They began to share stories. And inevitably, what comes out of that are the kind of issues, that can require us to have the professionals we have today, that sometimes we don't have the capacity to address. That includes father access--and you'll hear more about this in terms of this concept of arrested development that Dr. Parkman helped us to understand; domestic violence; substance abuse; community violence; stress, which includes economic stress--and so many of the people we work with are disadvantaged and sometimes completely poor, they don't have any kind of income; post-traumatic issues; and other unresolved trauma or grief.

We help men to understand the influences of the experiences in their world view; messages that they transmit to their children, which is critically important to all of us who work on strengthening fathers and families; and issues that may impact labor market performance and participation. [To] support and facilitate feedback from group members is helpful for some issues. We underline some issues because there are acute issues that may arise through the group, sort of a peer support group process, that we don't have the capacity to address, and we don't want to do more harm by trying to address issues that we don't have the capacity to address.

Challenges faced here at CFUF have to deal with more serious issues: major depression, chronic stress, post-traumatic stress issues, schizophrenia, and other issues that just can overwhelm a staff. And it hasn't been until the last year and a half that we've had someone like Dr. Parkman adopt us. And she'll probably strangle me after this call saying, "I did adopt you all?" Yes, you did adopt us, because we begged her to. But we also have new relationships with the University of Maryland School of Social Work and the Morgan State University School of Social Work, where we have interns here on staff now where we didn't have before.

Need for mental health screening tools: We have the original set of tools that Dr. Parkman helped us to refine and [that we] commented on. Lisa in her comments mentioned this cultural stigma associated with mental health, where people don't want to be quote-unquote perceived as "crazy." And just an observation--Nigel mentioned this as well--for some reason, women have capacity to be able to disclose the stuff that's going on with them around mental health; and guys have shown, at least in terms of my experience, we hold onto stuff to our detriment. There's a lack of leadership with professionals in the mental health community. We don't know how to connect to those communities. We don't know how to assess whether or not a mental health practitioner is a quality practitioner, so how do we know whether or not we would even want to refer someone there? And this is similar to how we talked about we need to develop these relationships as we did with child support and domestic violence.

And here I'm going to turn it over to our good friend and our adopted mother, Dr. Tiffaney Parkman.

Dr. Tiffaney Parkman: Thanks, Joe. And so what I'm going to talk about really is how I came to work with the Center for Urban Families based on my experiences and lessons learned working with fathers in a correctional setting and also in the mental health field.

One of the big issues that I've seen in terms of working with men in a correctional setting is that for many prisons, the people who have a diagnosed mental illness, they are separated from the rest of the population. I worked in a prison in Georgia and that's what we did. So there were levels and everyone was assigned a level. So even in the prison system it was highly stigmatized or you were considered "mental health" if you had a diagnosis or if you lived in certain dormitories.

So we have a large percentage of men who were coming from the corrections facility, one, with a mental health disorder--and I'll address this in terms of arrested development--but we had men who were coming with a mental health disorder; and then another population of guys who were coming who maybe have a mental health diagnosis or disorder, but went untreated and would not like help because of the stigma attached with it based on their experience in a correctional facility. So it's getting to the stigma, particularly for men of color, [that] has been great if they have [had] interface with the criminal justice system. 'Just in how mental health is handled in that system.

And so one of the things that I've come to understand and try to work with when I'm working with men, or working with patients, or even in doing training sessions, is this notion of arrested development, arrested emotional development. And a lot of the men that we're working with have had some type of trauma early in their life or adolescence that really has stunted their emotional growth or their ability to take in experiences and fully learn from them.

And so this type of trauma for men can happen [for] many different reasons. Perhaps economic deprivation in childhood. Maybe there's some child abandonment issues. Many of the fathers that we see in these fatherhood programs have father problems and maybe they don't know their father, or the father was never around so they have abandonment issues with that.

Poor neighborhood conditions. Growing up in poor neighborhood conditions can be a source of trauma for individuals in terms of witnessing violence, drug use or just seeing negative depictions of romantic relationships or even negative parental relationships.

Trauma can also come in unsupportive school environments. So we know that in a lot of communities where we have economic deprivation, we see school systems that are not engaging children, particularly boys, in terms of school success or in terms of learning. So we see men falling behind or children falling behind.

And then finally, interactions with the criminal justice system can be a form of trauma. Being incarcerated, going through that whole process; being incarcerated, arrested, patted down, pulled over, sat on the sidewalk and handcuffed, can all be a form of trauma. When this happens early on, it does something to the mental state of the father, of the man, of the person. So taking in new experiences, learning from those experiences, can really stunt one's growth in terms of how they see the world and how they interact. [sic]

So what we know in terms of mental health and thinking about who has a mental health issue or who has a mental health diagnosis, is that we think of schizophrenia or bipolar disorder [sic]. And depression is huge among this population, among black men, in terms of, if we think about arrested emotional development as a cause for what's happening or what's going on. Depression is one of the most undiagnosed illnesses for the population. So when we think about depression, we can think about irritability. We can think about sleep problems. We can think about restlessness and feelings of guilt. And a lot of what we see, particularly in my research and work coming out of

working with young men who were leaving the prison system, young black men who were leaving the prison system, was that there was this disconnect in terms of where they were emotionally, where they were financially, where they were in everything in life, and where society said they should be, or where their family said they ought to be. And so when you have this disconnect about where you should be and where you actually are that tends to lead towards feelings of depression or emotional instability, because you don't have the coping skills to handle these things and move forward. And that's a direct impact of the arrested development and being in areas where you don't have access to therapeutic interventions.

And so for our fathers, we see a lot of cumulative disadvantage. Socioeconomic factors. Criminal justice systems. We see untreated mental health issues. Arrest development issues. And all of that taken together really impacts how they see themselves as fathers and as men, which can really be two separate issues of concern, and can really raise the issues of mental health for these guys as they deal with what it means to be a man, and also what it means to be a father in the context of having children and doing what's necessary for themselves and their families.

So when I think about helping and training practitioners or clinicians or in patients myself, I think about how the men define manhood and how they define fatherhood based on their experiences, based on what happened in their past. Because all of this really informs how they see their mental health and how they act out and behave in those ways.

One of the major things, when I moved to Baltimore and I got connected with the Center for Urban Families, was really looking at their staff training and professional development and how they are helping their clients move through the system. And so what I've been really impressed [with] is the staff being able to understand their own experiences, and their abilities to help the clients. And so I've been able to offer a lot of suggestive activities in terms of staff training and how to engage with the clients. One thing that I tell my students all the time is that everyone has different experiences, and so your outlook is not always going to be the outlook of the clients that you serve. Even if you're from the same neighborhood, you could still look at things very differently. And so you have to guide the conversation very delicately in individual and group settings, just as you think about arrested development, just as you'd think about unchecked mental health issues.

When you're talking with the men, when you're talking with the clients, you have to sort of look for the markers that they're not going to tell you. You have to listen for what they are not trying to tell you, but [what] you know that could possibly be problematic in their mental health improving or in the status of the father improving. One of the key things is being able to stay in your lane and know your limitations as being a helpful provider, knowing when you need to redirect someone to greater levels of care or service and then seeking help from or support from a colleague. So I've been able to field questions about someone being in a work program, in the STRIVE program, who maybe shouldn't be because they aren't ready and they have unchecked mental health issues or they have other issues that are going on that are really impeding their success being in that program.

And then finally, learning from other clinicians. One awesome thing that the Center for Urban Families has done is [they've] really latched onto other training programs who are coming in and bringing cutting edge designs and therapeutic techniques to help the clients to get from point A to point B. Also, Joe talked about the incorporation of assessments in programming, and that's really key here--really knowing the types of individuals that are coming into your centers and knowing what's happening. Base-level depression screenings. Substance abuse screenings. Knowing whether or not your clients have been abused in the past or if they have done the abusing in the past, and really knowing where they stand. It really helps to help the person figure out what program they're in and where they need to navigate in terms of mental health and in terms of doing the best that they can in their programming.

So my role for Center for Urban Families has really been the mental health person, really the person who can help bridge the mental health gap between fathers and service providers. As a therapist, I think everyone needs some of type of therapy, and at some point in time we could all be diagnosed with a mental illness because we handle things differently. At the beginning of the semester my students are bright-eyed and bushy-tailed, and by midterms, they're

staring at me like a deer in the headlights. Being a life-long student, I know that look, and so I'm able to adjust what needs to be done so that I can make sure that they get what they need, but also so that they're well at the end of the semester.

And so we have to figure out a way that we can bridge this gap and make mental health services and treatment not so stigmatizing and evasive. The peer support groups are great in that you train peers in terms of how to help and talk about these issues, and how to really get people talking about their past, talking about what's going on with them where it becomes second nature. Sometimes when I'm talking with clients or patients and they're just telling me everything, then I stop them and I [say], "You just had a therapy session." And it really erases some of the stigma and some of the thoughts that they have about what it means to actually talk to someone about your problems. The peer support groups are really a great way to sort of tiptoe into the mental health field, and it's really a less clinical intervention for newcomers to mental health services.

Gatekeeper assistance--and this is huge. The Center for Urban Families, they have a wonderful, wonderful person there who knows everyone. She knows everyone's story. She knows who needs what, what's happening and what's going where. And so the gatekeeper person is really the one who says "You need to get this help," or "You need this type of treatment," or "This is what I see going on with you." People trust that gatekeeper person. When I arrive to the center, they don't know me. They don't really trust me, and they're not really going to talk to me. But the gatekeeper knows me, so she tells the client that this is someone you can trust and you can talk to, then they come to me and that relationship is established. That has been very key and helpful in establishing other groups that I've done for the Center in terms of sexual abuse with the women at this particular center. We have had some men who have asked for groups based on the relationship they've had with the gatekeeper, and we're working now to try to make that happen. So in your organizations, if you have a gatekeeper, someone who is close to the participants who has their trust and that they trust, that can be a key way to help bridge the gap between mental health services.

Creating community partners who can vet resources before you send clients. This is huge. What we know in mental health is that you might have three or four therapists before you find the right one, similar to a hairdresser or a barber; so this population can be turned away if they have one bad experience with a therapist or any type of mental provider. So creating allies or creating community partners with people who understand your population and people who are willing to come in and do the work with them--understanding the background, understanding the stigma, understanding the arrested development--can be crucial in terms of bridging that gap. So vetting resources before you send clients can really save future setbacks from your clients, because that relationship can really further enhance the mental health services that you can provide your clients.

And then finally, finding an ally. I consider myself an ally to the Center for Urban Families. We found each other through someone who I actually spoke with and realized my common interests and my research objectives and the population that I was interested in working for, that CFUF, that that's where they were [sic]. They connected us and ever since then, I've been very interested in trying to bridge the gap of mental health services with their clients and help the organization in total, just to overcome this gap. I volunteered my time to help them in any way that I can. Finding an ally really has its challenges, particularly if you don't, say, live near a teaching institution or where there aren't people who readily want to volunteer their time on any issues like that. So I would say networking. I would also say when you look at your community partners, if there are people there who are really interested in the work you're doing, they will come and perhaps look over your assessment tools, and maybe look at some of the programs that you're doing and give their feedback in terms of what's happening; and you can really use that type of help to bridge the mental health gap between fathers and service providers, and make it so that there's optimal learnings in other programs that you have with the fathers. And for the most part, that has been my experience and the ways that I've contributed to the fatherhood program, the burgeoning fatherhood program at the Center for Urban Families.

Nigel Vann: Well thank you very much, Tiffany. Joe, do you want to add anything else before we move on?

Joe Jones: Just one thing in terms of finding an ally. Dr. Parkman obviously has a credential--I won't say obviously because folks on the webinar today, you haven't met Dr. Parkman, so you're trusting that she has a credential because she says she has one and I'm saying she has one, right? So trust is paramount in this relationship. But Dr. Parkman does have a credential and she does have a competency as a clinician and as an educator to be able to help the Center. But equally as important, she fits well within the CFUF culture. So she doesn't come in as quote-unquote Dr. Parkman, "I'm coming here to serve and to identify your mental health needs and make you un-crazy." That's not the approach she takes. She fits in well, and I think if she had the competency but she didn't fit well within the culture, it would be a challenge for the folks that we work with to make that connection and to have Dr. Parkman help us in the way that she has helped us. She is also very flexible, and she is a coach, and she is a teacher. And as she mentioned, she volunteers her time. She does it with a lot of energy and enthusiasm, and we're so very, very thankful. And I do want to correct one thing I said up front: I said that she's like our adopted mother. She's really our adopted big sister.

Dr. Tiffaney Parkman: [laughing] I'll take that. I'll take that.

Joe Jones: [laughs]

Nigel Vann: Well thank you very much, guys. Okay. And we'll come back to you with more questions and discussion after we hear the next presentation. So now we're going to move from Baltimore to Los Angeles. I think there's probably slightly better weather in Los Angeles today. We're going to hear from three people at the Children's Hospital in Los Angeles.

First of all we have Frank Blaney, who is the Project Coordinator for the L.A. Fathers Program. Frank has got a Master's Degree in Negotiation, Conflict Resolution and Peace Building with an emphasis on violence prevention among urban youth, and he's worked in the field of violence prevention and leadership development for the last 12 years.

And he's going to be accompanied here, as you see on the screen, by two more doctors, Dr. Sophie de Figueiredo and Dr. Bridgid Conn. Bridgid's areas of clinic expertise include increasing motivation and engagement in mental health services among underserved at-risk communities and providing culturally sensitive and developmentally-informed adaptations of evidence-based treatments. Her research focuses on mental health stigma and service utilization among ethnic and racial minority adolescents and young adults. Sophie is a licensed clinical psychologist. She's the coordinator of mental health services for Project NATEEN, which you're going to hear more about. Her areas of clinical expertise include providing trauma-informed and culturally sensitive mental health services to underserved and at-risk adolescents, young adults, and their families, and her research focuses on the impact on health providers of working with traumatized populations.

So they've got a lot of very useful information to share with us here. You'll see in the Web Resources box at the bottom in the center of your screen, there's three assessments there that they are going to refer to briefly that you can download if you're interested, and we're also going to add those to our resources list when we post that to the website after the webinar. So let me hand it over to Frank to get the L.A. presentation going. Frank.

Dr. Frank Blaney: Good afternoon, everyone. Thank you for allowing us to speak on this subject. It's really critical for fatherhood movements. I just wanted to mention on this first slide that we're going to cover a little bit [of] what differentiates us from Center for Urban Families. We are in the broader context of Children's Hospital Los Angeles, and within that, we operate within the Division of Adolescent and Young Adult Medicine, which is its own separate entity away from the main hospital. And the L.A. Fathers Program operates within a broader program which is called Project NATEEN. That's a social service program specifically focused on helping teen parents. Most of the clients that

are served there are young women, and L.A. Fathers came about as a result of the need to be able to help the young men that become young parents.

And you can see the little circles around the picture of the family that we've got there. I won't hit on all of them, but I just want to point out a few. One, it's important to remember that although our program is based in Children's Hospital Los Angeles, it is a community-based project. We have three key partners that help us out with some of the components of the program. One is MCS/Worksource Hollywood, and what they basically do is help us with the assessments regarding vocation, with the resume building and with the job placement component. When we do our workshops, we bring in another community partner, Echo Parenting, which has a specific focus on non-violent empathetic-based parenting. They've been working in the community for over 10 years, and they basically reoriented their curriculum to focus on our younger population of males. We also work with a community partner, a domestic violence, and sexual assault agency called Peace Over Violence. They were very instrumental in helping us plan out our policies around domestic violence incidents and how to handle those, [and] they come in and do trainings with our groups.

One of the advantages of being housed in Children's Hospital is that just a couple of floors down from where our groups meet, we have a specialty health care clinic. We've got all sorts of services that are provided, and most of them are free of charge. So that's a big advantage for our population since they are low income and often have a lot of high health care needs.

And just a little bit more in detail about our program. Our program focuses on young fathers. Since our beginning of program operations in July 2012, we've been able to serve 713 fathers. And just to help set the context, "Why is a social service program set within Children's Hospital?" is one of the questions that comes about sometimes. And the theory behind that is that if we're helping 713 fathers, we're helping at least that many families and that many more children. It's a prevention mindset versus an intervention mindset. So we're really trying to provide these services at this critical juncture in these young people's lives to be able to provide and encourage them to have more stability in their family.

The specific target area that we have focused on since the inception of the program is what's called SPA 4, Service Provider Area Four, in L.A. County. It has the second-highest poverty level in all of L.A. County and also happens to be the first in recent immigrants that come, many of them from Central America. And it's important to remember that so many of the young men that we're serving are low income, have a lot of challenges around providing for their family.

So along with some of the higher needs that we're attempting to meet and some of the social skills that we're trying to develop, we also really try and focus on meeting some of their concrete needs. We provide the workshops around healthy relationships and nonviolent parenting. That term "workshop"--if you tell a young man who's maybe had some problems in classroom experiences, "Well we've got a domestic violence class. We've got a healthy relationship class," that kind of brings up negative connotations in their mind, whereas "workshop" is something that tends to appeal to young men a little bit more.

We also have recently developed an advanced group which, when folks have gone through our 10-week core curriculum on the healthy relationships and nonviolent parenting, they're eligible to get into an advanced group, which is really nice where we try to take some of those pro-social skills that we were developing, specifically towards the children and towards romantic partners, and seeing how those apply in the workplace, as well as address some of the deeper psychological needs.

We do provide incentives for participation. Transportation is a real big issue in Los Angeles, and definitely with the youth we serve, so we try and provide transportation tokens for them. Obviously, things like diapers are a big expense, so one of the ways that we try to draw young people into the program is letting them know that if they

come to the workshops on a weekly basis, they'll be eligible for getting a package of diapers for their kids. They'll be eligible for the transportation tokens. We also have an on-site community food bank, which if you put yourself in the shoes of let's say, a 16, 17-year-old kid that happens to have a kid, they may be in school full-time. They may not be able to work. But if they're able to show up to the mother's house and come with some groceries, with some diapers, that makes a big imprint on her and on that family, just indicating that this young man is trying to do their best. And really the key thing that our program is centered around is really intensive case management. The case management is a real critical element. So immediately after we do our intakes, when people come in the program, we already start working with them about what are their short, mid-term and long-term goals. And of course, the vocational element is a critical thing. I don't know if this is the situation with Joe, but that's a real key carrot that kind of gets guys into the program, because they have so much social pressure to "Get a job, get a job." Many of them even drop out of school to work just to make ends meet. And so we need to be very realistic about what we're able to accomplish for them, and empower them to move towards getting greater economic stability in their lives.

Just a broad overview of some of the challenges that these young men face--There's obviously some pretty deep social, economic and historical challenges that they have. There's been, obviously, a history of systemic racism and oftentimes discrimination against the communities that these young men come from, and that is a challenge for them when they start to approach social institutions. Oftentimes even though social service folks like us--we think we're nice people, we're trying to help--oftentimes in their minds, we're viewed as part of the establishment or part of the system. So that's another trust barrier that we need to get through. Many of the people in our community have issues with their immigration status. Again, we have many recent immigrants in our program and we also have of course language barriers. We made a very strong effort to make sure that we have a good number of bilingual Spanish and English-speaking personnel that are involved in the project [and that] our outreach materials are in Spanish and English.

One of the realities of life in Los Angeles is dealing with the issue of gangs. And we don't have time to really get into the whole historical context of that, but oftentimes you'll have young men in our program who have had grandfathers and great grandfathers that were gang-involved. It's just considered by them to be a form of self-protection or a way to almost have a surrogate family when maybe things in their biological family may not be as stable as they would have wanted.

Unfortunately, again this is pretty common I'm imagining with other urban communities, low-income communities across the country. Our school system, L.A. Unified School System, has a pretty high dropout rate. Most of those dropouts are young men, so a lot of times they'll be behind the eight ball when it comes to completing their education which can open up greater doors for employment. The unemployment rate for young people, especially young men of color, is pretty significant in Los Angeles. So another barrier that we're trying to push through is just the broader economic situation.

And again, the doctors will talk about this in more detail in a moment, but the young men that come into our program have been exposed to a lot. And a lot of them have been exposed to community violence. A lot of them have been exposed to domestic violence. Domestic violence is one of the key indicators of future involvement with gang life and being involved with gangs. So when they come to our doors, there's a lot that they're carrying and we need to be mindful as service providers.

Another thing that they're dealing with is just the stigma of being young parents. Oftentimes they'll end up losing their support system of friends, their families. The mothers' families will become very angry with them, very judgmental towards them. It's a very difficult and lonely situation that they face. And I think that's one of the things that really makes them gravitate towards the groups, because the groups are that area where they're able to get peer support and understand "You know, I'm not the only one that's struggling and trying to go through this." And next slide, please

Dr. Bridgid Conn: So continue [with] what Frank was saying, there does continue to be stigma regarding mental health with concerns. We hear [concerns] in the groups of being seen as “crazy,” and that seeking services is viewed as a weakness within the culture. We’ve at times had our guys talk about fear that receiving mental health services will in some way preclude them from being able to access certain jobs or being able to get into the military, for instance. So this idea of stigma is a concept that we really try to unpack and address within this program using a multi-tier approach. So what you’re seeing here is a visual model of how the L.A. Fathers Program inherently addresses the stigma towards mental health services really programmatically. It’s woven throughout.

At the base level you see the interdisciplinary teamwork which really supports the integration of mental health services throughout our program infrastructure. This collaborative aspect is facilitated by frequent team meetings and open door policies that promote frequent communication between staff members. There’s always consultation going on to ensure that if one of our clients is at risk, that we’re responding in a timely manner and in ways that are sensitive and appropriate. All of the staff are trained in motivational interviewing techniques, which really helps to build up these young persons’ focuses on their life goals and their values, which then enhances their motivation to engage in our program and in future mental health services. Our integration allows for additional opportunities for screening, identification, and conversations with these fathers about mental health and treatment. By being woven in and really being able to partner up with the case managers, we’re able to address some ambivalence that they may have about engagement and service utilization. As will be talked about in greater detail later on, the staff are also constantly supported with maintaining a trauma-informed approach.

At the second level you’ll see outreach. Within outreach, the case managers normalize mental health services in all of their interactions, reinforcing the integration of mental health within our program. Something that the case managers I think really do well is establishing these trusting relationships, which then fosters trust towards mental health. Oftentimes this is the first encounter that our young fathers are having with mental health, so we want to make it one that is inviting, open, and has a trusting feel to it, so that they feel more comfortable approaching us should they have issues in the future that they want to discuss. Having visible, in-house psychologists really helps to demystify mental health, that we’re not some people that exist somewhere out there where they’re never going to be able to access them, but that we’re always around and that they can access us when they need us. It makes it possible for us as psychologists to meet with clients informally and with the case managers present to help establish a link and provide a warm handoff. Similarly, our outreach occurs through co-facilitation of the support group which Frank mentioned before. This Advanced/Alumni Support Group is co-facilitated by a psychologist and a case manager together.

And then finally, you’ll see at the top level our group curricula. This is again the workshops and group discussions that Frank had mentioned that allows for experimentation of self-disclosure within a safe space, and includes education regarding the benefits of mental health services and self-care. And in these groups, psychologists can also be present to debunk myths that they may have. If they have any questions that come up in the moment, we can help address those and kind of demystify mental health further. Self-disclosure in groups then helps to prime them for their openness within mental health, and helps to kind of model for them what it may be like to engage in therapeutic services. The curricula is really couched in ongoing support and workforce development with our Advanced/Alumni group. So overall, we utilize a graded, flexible approach to introducing and integrating mental health services throughout our program.

Dr. Sophie de Figueiredo: Thank you, Dr. Conn, and thank you, Frank, for the introduction of the program. This is Dr. de Figueiredo speaking. So Dr. Conn just really discussed how the L.A. Fathers Program structure inherently functions to decrease stigma toward mental health services, and I’m going to talk now more specifically about what services we actually provide. Before I do that, I have to acknowledge the fact that we’re very fortunate to have funding to be able to provide these services, and that we can only provide these services because people at the administrative level wrote into their budget opportunities for funding for mental health services, and none of this would be possible

without that. So I acknowledge that we're very fortunate to have that. I also want to acknowledge that we have buy-in from the administrators and from the program as a whole toward mental health services, and it really reflects that they have a positive engagement with services so that they can model that for the youth.

So we really created this mental health program within Project NATEEN. And I'm partially funded to participate in the L.A. Fathers Program and in NATEEN as a whole, so I see young mothers as well, and so does Dr. Conn. I'm going to go through the different areas that we provide support.

Supporting staff is a huge part of what we do, and I'd say it's almost half of what we do, so we provide clinical services and a lot of staff support. And that's actually shown to be really important, just like Dr. Parkman mentioned in her talk. We provide internal and external training. Internally to the staff, we've trained, we've provided trainings on identifying mental health issues, what the red flags are, kind of understanding their scope of practice. We've provided training about trauma and trauma-informed care, domestic violence in teens, early childhood development, motivational interviewing like Dr. Conn had mentioned, substance use and other relevant topics to support their work with the young fathers. This kind of didactic support strengthens the staff's ability to identify and manage mental health issues if they arise during one of their interactions, and it helps them to better understand and empathize with their clients. We've provided training within the larger division of Adolescent Medicine and also externally to other community agencies in L.A., and that helps build healthy, trusting relationships with other organizations that we can partner with, so that if we do need to make referrals out, we have relationships and networking that's been done through training. We make ourselves available to staff for ongoing consultation whenever it's needed, and we're also available for on-call crisis support in the event of a clinical emergency. I ran a group for the case managers called Care for the Caregiver. It meets twice a month. I'm going to talk about that a little more in detail, but I just wanted to touch on it here.

So moving on to assessment. Staff training and support facilitates better and better assessment of our clients' needs. Every participant that joins the L.A. Fathers Program gets a comprehensive psychosocial assessment with one of the case managers, and that occurs within the first 30 to 60 days of program enrollment. The psychosocial is loosely based on what's called the HEADSS Assessment, and there are links to that in the web resources box on the bottom and also on the resources page that you'll be able to download after the webinar. This HEADSS Assessment was actually developed here at CHLA in the '80s and continues to be widely used as a general screener for risk factors and protective factors that may impact mental health. Really quickly, HEADSS stands for Home environment, Education and Employment, Drugs, Sexuality, Suicidality [sic] and depression. So through that we're screening for those issues and more. It could be through their psychosocial intake that the case manager may identify some things and refer them to mental health at that point in time. Although that may be the first formal assessment that a case manager will do, part of the training that we've been able to provide is to help them constantly assess for any new triggers or new reactions to life stressors, because we know our population has chronic life stressors.

And if something comes up, like I mentioned earlier, we're available for crisis support. I wanted to provide a quick example that I will weave in and out of what I'm going to continue to say. A few months ago, we had a young father who was new to the program, and he reported hearing voices telling him to kill himself during the psychosocial intake. This was with the case manager. So case manager appropriately contacted a supervisor and they came and found a psychologist, myself, for crisis support. I completed a risk assessment and determined that he actually wasn't suicidal or psychotic, but rather, he was experiencing acute resurgence of PTSD symptoms resulting from witnessing community violence, and those symptoms were manifesting in hopeless thinking, basically so powerful that to him it felt like a voice, but he wasn't actually intending to do anything like kill himself. So through mental health support, we were able to establish that—ensure his safety because he had already such a trusting relationship with this case manager. Even from that first interaction, he was open to receiving mental health support and was referred for further intervention with me later on.

For those clients that are referred for mental health services, they undergo a more comprehensive assessment, so we take our own psychosocial history and that gets woven into their treatment plan. If needed, we have the capacity

to provide in-house psychological testing, looking at cognitive functioning, socio-emotional functioning, personality development to better inform treatment or clarify mental health presentations. And we've been able to train our case managers to use the Ages and Stages Questionnaire, which is a screening tool used to identify at-risk infants, because we know that in young parents, the rates of developmental disabilities and delays are greater than in the general population, so we can screen for these and make appropriate referrals.

In terms of the direct clinical services that we provide, we have the capacity to provide a range of services. So Dr. Conn and I provide individual, couple, parent-child, group and family therapies depending on the needs of the client. Our clinicians are well trained in trauma-informed practice, and we're trained in various types of evidence-based treatments that we can then modify to fit the client that we're working with. We have the capacity to provide joint treatment of substance use and trauma together, as we often see this as a presentation of our youth. And if the substance use becomes something that is out of the scope of our practice, then we actually have a substance use and prevention treatment program, that happens to be housed on the same floor as the L.A. Fathers Program, that we can refer to.

We hold a weekly drop-in clinic, and that is for consultation both for case managers and for clients alike. Case managers often bring clients during that hour just to meet us, to ask any questions that they may have about mental health services, and they might come on their own to ask questions about whether a referral is appropriate, and we can triage to different clinics. In terms of the client that I mentioned earlier, we were able to provide individual services and actually couple services so we could tag team for clinical reasons in that way.

And then [I will] skip to research because I think I'm running out of time. So we know that there's a paucity of research for young fathers, and having mental health support within the clinic has allowed us to continue data collection. And we intend on writing up some of the data that we've collected so that we can disseminate that knowledge, and include that into further program evaluations and grants.

So like Dr. Parkman talked about, there's a lot of mental health needs within this community, and trauma being something that's very overrepresented in young fathers. So for this reason, the trauma-informed model and trauma-informed principles sits perfectly as a larger framework for fatherhood programs. Taking a trauma-informed approach assumes that all clients have experienced an adverse event over the course of their lives, and shifts the health care approach from "What's wrong with you?" to "What's happened to you?" so much less pathologizing and stigmatizing. This is actually a framework that everybody in our division is trained in, so in my opinion it helps to just generally de-stigmatize mental health services and pathologize less as an organization.

Trauma-informed care can be thought of as a catalyst for engagement in mental health services for the following reasons: It encourages taking a strength-based approach to client presentations. Views problem behaviors as coping skills that were once effective in managing their trauma [sic]. [The care] and allows for positive, proactive experiences with their different case managers and other staff that they might interact with.

So I mentioned earlier the Care for the Caregiver group that I run. I want to acknowledge that trauma can impact an entire system or organization. And in fact, trauma-informed care is one of, like I mentioned, the guiding principles in our division. We run this group twice a month, and the purpose of this group is to help case managers when they're experiencing burnout, compassion fatigue, or vicarious trauma, which are the negative effects of working with traumatized populations. We know that the more empathic and caring our providers are, the more likely they are to experience these negative effects, and so we address these in our group. We also in our group provide a safe space for the case managers to talk about their own biases and reactions. We encourage self-care and self-compassion, and discuss other issues related to professional development. Compassion satisfaction is the good news, which is that through working with traumatized populations, providers can grow and increase their inspiration and positive feelings. So having support for your providers built in within the program can increase compassion satisfaction, and that's just generally for well-being of staff support. Go to the next slide.

Dr. Frank Blaney: So this is Frank again. I just wanted to mention, programmatically, what are some of the things that different organizations can do to integrate mental health services into their program? One of the things, obviously, when we're filling out applications for a potential stream of funding, is to include a line item in the budget for mental health services to support staff-time around that issue. We want to institute the policies and procedures for supporting mental health needs. And again, just to kind of echo what Sophie was saying, it's important to realize that we as caregivers are really modeling these approaches for our clients, and if we ourselves aren't taking care of ourselves, that's problematic.

We also want to assess--When we're hiring people to get into a fathers program, we want to ask them questions that would let us know what their own particular viewpoint around mental health services are: if it's a stigma to them, or if it's something that they feel is helpful. And when you get down to it, it's really important to really understand what's the overall program culture that you have around mental health. Because I sensed at times last year, our group was really struggling with a little bit of this stigma towards mental health, I asked Dr. Conn to come and just do a 15, 20-minute breakdown on what's it like to see a therapist, just answer some questions. Myself and the other facilitators are specific to mention in normal life that this is a good coping mechanism that they can engage in.

And really another key thing that we do is just mentioning about self-care. We've got a whole unit focused on self-care for the young fathers that we run them through, so that they can start to, on that level, integrate within their own lives healthy coping mechanisms versus some of the things they may have been exposed to in their family or in the communities.

Dr. Sophie de Figueiredo: And just to kind of summarize these best practices and recommendations from a clinical perspective, we throughout have highlighted that it really does assume that we have funding built in. As Frank was mentioning, that it is really important that at the management level, administrative level, and within the program, that there's acknowledgment of the importance of mental health and then there's funding provided.

So here you see that we really suggest making trauma-informed principles a priority, so really understanding the impact of trauma with our clients, but also at a systemic level for us, building warm and trusting, non-judgmental client relationships, being really developmentally-sensitive. I think we serve a wide range of youth here, so always being flexible and creative in our approach with these youth and being able to kind of roll with the punches and meet them where they're at. And then remaining self-aware, always checking in with ourselves and being aware of the population that we're working with. And I think that's something that continuously comes up in the conversation regarding that gap between provider and client, so bridging that gap and making a warm, trusting relationship with them. And then we really suggest that all of the staff seek out ongoing training, supervision and support to further develop our skills and to always remain aware of best practices and aware of the best ways that we can support our young fathers.

Just to end, in case we haven't said the word "trauma" enough in our presentation, our main take-home point is that best practices--in our opinion and in terms of de-stigmatizing mental health services-- best practices are inherently trauma-informed. This image kind of illustrates that it benefits us as organizations and clients to put some money in up-front to prevent the impact of trauma and chronic exposure to adverse events, and try to be as preventative as we can be, rather than paying for treatment later on, although both are needed. Our services will only be as good and as healthy as our staff, and that's also important in terms of the financial investment to consider in terms of trauma-informed best practices. That's all we have. Nigel, back to you.

Nigel Vann: Okay, thanks. Did you want to go to your last slide to show the resources? There you go. Resources are also going to be on the resource list that people can download. Is there anything there that you particularly wanted to highlight?

Dr. Sophie de Figueiredo: All of these are really great resources that I utilize frequently. One from SAMHSA, Trauma-Informed Care and Behavioral Health Services, has just about everything you possibly would want to know about trauma-informed care, from hiring practices to treatment principles to compassion fatigue to how it impacts clients, so that's a very comprehensive guide to it. And the Trauma and Resilience Adolescent Provider Toolkit is a great one to look at and use [for] different kinds of handouts for groups and clinical services as well. I just--

Nigel Vann: Okay—

Dr. Sophie de Figueiredo: --but you can use this.

Nigel Vann: Well great. Well thank you very much and very good presentation. You certainly, I think you answered some of the questions that were coming in. One of the key takeaways I'm picking up here is the importance of funding, obviously, the importance of making sure that we understand trauma-informed practices, and the importance of reaching out to the mental health community and finding ways to build them in for staff training and support as well as working with the dads. So let me just [ask] one general question, and perhaps I'll start with Joe and Tiffaney here, because we've only got a few minutes to respond to this, but I think the sort of overall questions we're getting here is, how do we engage with mental health, mental wellness groups in the community? It seems to me that unpacking that, what we're talking about is, we're talking about inviting people in from the mental health community to initially just talk with our staff, perhaps find some training, be available to talk with dads at some point, be available for referrals possibly down the road. But Joe and Tiffaney, can you just sort of unpack how that might look? And Joe, I'm thinking about the way in which you reached out to the child support community and the domestic violence community; how do you think that could play out with the mental health community?

Joe Jones: Well I think one, for organizations, you have to look at your internal community, look at your internal setup, and what does it mean for you to take on this issue? Is the leadership of the organization at a place where it is ready to embrace this issue? Or is there some pre-work that needs to happen internally to get to this place? And it's much different--I'm Founder and CEO of my organization, so if I bring something to the table, usually it's going to devolve down throughout the organization [sic]. But what happens if a case worker who's doing intensive case management is being exposed to these issues, doesn't feel like he or she has the capacity to address them, and tries to present it up as issues that need to be addressed, but the leadership does not embrace it? So I don't think you want to just go off without some forethought in terms of how our existing organizations are set up in the decision-making process. But then, assume we're all on the same page and move it forward--I'm of the opinion that it's really, it's a reciprocal relationship between the practitioner community meaning us in terms of fatherhood practitioners, and the mental health community. It's not that we simply want to ask the mental health community to do X, Y and Z for us, but how can we be a reciprocal resource or partner. It's no different than what we did with the domestic violence community.

I'll just give one quick example on how we bridge that gap. We both cared about individuals and families, but we both came at it from a different approach. The DV folks came at it from protecting the health and well-being of women and children, and we came at it from the protection of fathers who happened to be an important part of the family unit. We all cared about the same group of people, but we approached it differently and we had territorial preferences in terms of how we did it. Eventually we got together and we created a case study--and this would be leadership of my organization or leadership of the domestic violence community--and we did a case study with a family that had DV issues, and we said okay, fatherhood group, how would you all address this issue? And then DV folks, how would you all address this issue? In some cases, we had a common-ground understanding, and in some cases, we completely had differing approaches. But we agreed to accept things that we agreed to as common-ground, and then we parking-lotted a lot of the issues that we had struggles with. Eventually over time, we pulled one of those parking lot issues, we grappled and wrestled through coming up with a common set of understanding in terms of how we would approach the issue. And today we have a very mature partnership where we co-apply for

grants together. We do national presentations together. So I think that's a model, not "the" model, but a model for how we can think about bridging communities between the fatherhood community and the mental health community.

Nigel Vann: Okay. Okay. So let me ask either Dr. Parkman, Dr. Conn or Dr. de Figueiredo: As representatives of the mental health community, what do you think would be good advice to a fatherhood program in terms of trying to start this conversation that Joe is talking about?

Dr. Tiffaney Parkman: This is Dr. Parkman. I think that the example that Joe actually just gave is a great way to think about partnering. You can always invite mental health practitioners in to give presentations to your employees or to the people who will be working with the clients before a partnership begins. You can really get a sense of that mental health organization's, sort of their theoretical model, and if they are going to fit with your organization and what you want to do, if they are going to be able to be sensitive to the needs of your client. That can be a good way to start, just asking them [about] their thoughts and their models and their therapeutic practices and where they sort of stand, and you can get a feel for what types of services or what type of care your clients might experience under their direction. So I think that's a great way to sort of bridge the gap and start making these networking opportunities available.

Nigel Vann: Okay. Dr. Conn or Dr. de Figueiredo, anything to add to that?

Dr. Bridgid Conn: This is Dr. Conn. Just to kind of add to that, I think something that we've noticed here is that we do a lot of networking in the community to help develop internships for our fathers to really help develop relationships with community partners. And one thing that I keep hearing over and over from case managers is how much these allies respect the program and the curriculum that we've developed. We tell them about the program. We tell them about our goals and our aims and the things that we're trying to help these young fathers overcome. And I think because we have established this really clear set of objectives and goals and ways that we are trying to help these young fathers to move forward and to have productive, successful lives, that they're very open to really partner with us. And in terms of mental health communities, I think when we talk to them about de-stigmatizing mental health and the ways in which we're trying to prevent negative outcomes later on in life, that they're very much more open to kind of come to the table and work with us. And I think the work that we do in terms of community outreach, like providing training at other mental health facilities who don't have necessarily expertise with young parents, also sets up for this future alliance, should they ever need consultation or should we need to make a referral.

Nigel Vann: Okay.

Dr. Sophie de Figueiredo: This is Dr. de Figueiredo, and just to add to what's been said, because I agree with what everyone's saying, just on a practical level, our case managers are able to go out into the community with our clients and help, maybe broker some of the initial contacts or relationships with different kinds of organizations and agencies. That also helps kind of get a feel, because there are so many in L.A. County, so sometimes we're making blind referrals because it's close to where they live, for example. So our case managers can actually go out and help in that sense and get information and build relationships, so that's been helpful as well.

Nigel Vann: Absolutely, yes. Yes. So I do need to move to, just to do our poll questions real quickly, I realize there's a number of questions we haven't been able to respond to, but as I said, we will respond to those and post them online, and I'm going to come back after these poll questions just quickly to each of the presenters for a final thought. And Frank, one of the questions was, how do you get folk into your programs? So perhaps you could respond to that real quickly.

So you can see the first question on your screen. If you could just tell us whether you strongly agree, agree, or disagree with the question, and that's "I have a better understanding of the types of mental health issues--" Are we seeing that full screen, Stephanie? So the question is, "I have a better understanding of the type of mental health issues that fathers face." [pause] I'll give you just another few seconds on that. [pause]

Okay, thank you very much. Let's move to the second question which is, "I received good ideas and practical strategies that I can use to talk with fathers about mental health issues." Again, you can strongly agree, agree, be unsure, disagree, strongly disagree. "I received good ideas and practical strategies that I can use to talk with fathers about mental health issues." [pause]

And then the final question is, "In general, I received good information and resources that I can use in my work with fathers and families." [pause]

And while that's completing, Frank, would you just like to start and just tell us real quickly how you get guys into your program? I know you've got a few interesting ways of doing that.

Dr. Frank Blaney: Yeah. We place a big emphasis on direct outreach. Our community is so large, we just go to where the young fathers are at. That can be approaching a group of young men in a park and saying, "Hey, what's going on? You guys need jobs?" We go in pairs of twos. We're also building relationships with some of the gatekeepers in the community. We've been doing that for a while. We get a good number of referrals from probation, from other community organizations, it's kind of a everything-and-all. But when it comes right down to it, we're real big on direct outreach. That's what we found to be most effective.

Nigel Vann: Okay, great. Well, thank you. And I realize we are overtime, so I just give everybody a chance just to say one quick sentence as a final thought and then we'll bid you all farewell. Any final thoughts?

Joe Jones: This is Joe Jones with the Center for Urban Families. I'd say to everyone who is participating on today's call, regardless of where you currently are with respect to how you address mental health issues for the participants we care most about, don't feel inadequate if you're not quite where our colleagues in L.A. are with a really robust model in a hospital-based system. CFUF, as I mentioned when we first got started, we are kind of not quite where we would like to be and so we kind of acknowledge it, and I think the key is to acknowledge where you are, and to think about how you can build on that capacity to move forward in the future without feeling as though you're inadequate and therefore maybe I shouldn't tread any further.

Nigel Vann: Right, yeah. Yeah. We should close there, Joe, give everybody else a chance to talk as well [laughs]. Comments from any of our three doctors?

[voices talking over each other]

Dr. Tiffany Parkman: Go ahead, go ahead.

Dr. Bridgid Conn: Well, I just think it's important to say that it really is a growing process. It's continually changing and it's flexible. I do think we are fortunate to have some of the resources that we do have, and yet kind of balancing that out with understanding the challenges of addressing something like mental health stigma is a universal experience for us, and one that we're continually trying to address like with the Advanced/Alumni group [sic]. This is sort of a new partnership where case managers and psychologists are partnering to run the group together and model that we're on the same page, we're on the same team, and that a psychologist is not just there with the couch in the office, but actually in there with them, talking about the stresses that they have at work and how to manage that, and the stresses related to fatherhood and child development and things like that. So I think

really putting faces to mental health, and really showing how we can be flexible and supportive, is the number one take-home that I would highlight.

Nigel Vann: Okay. Flexibility.

[voices talking over each other]

Dr. Tiffaney Parkman: I agree with being flexible and even with what Joe said. This is a multi-faceted, ever-changing issue and problem. And I see one of the comments talked about men of color identifying mental health issues as spiritual health, and that's a whole, another tree of issues that you have to consider in working with men of color, because spirituality and the church is a huge part of one of the stigma and obstacles to getting mental health [sic]. So a big part of my work has been talking with church leaders and people who represent religious institutions, to say that we need to do a better job of identifying true mental health issues and using spirituality to help practitioners in terms of helping this population, because in the past it has really hindered progress in terms of mental health. But just keep working, and as researchers, we're trying to find new things and get information out for clinicians so that we can really help this population.

Nigel Vann: Okay, thanks Tiffaney. And Sophie, I'll give you the final word.

Dr. Sophie de Figueiredo: [laughing] That's a lot of pressure. Just to reiterate what everybody has said, I think we're all talking about the same idea of the importance of interdisciplinary collaboration, and I'd add to that, to be really creative about what that can look like so mental health, like Bridgid said, isn't just necessarily an office with a couch. We can really be proactive and just active in different kinds of communities and working with different providers in a lot of different ways. So I encourage all of us to keep working outside the box to make different kinds of interdisciplinary collaborations successful in reducing stigma in mental health for young dads and adult dads and all fathers.

Nigel Vann: Okay. Well thank you. And let me thank again all the presenters. I know they've put a lot of work into thinking about how to present this in a short period of time. And I thank the participants for hanging on with us here. Even though we've gone overtime, I see most people are still on the line by the looks of it, and you've got all the contact info there if you want to follow up with any of the presenters. Always feel free to e-mail us at info@fatherhood.gov. As Lisa said at the beginning, we're very open to suggestions for future topics for webinars and certainly do want to continue this conversation. We will post answers to questions we have not gotten to on the website in the next few weeks when we post the other materials. So with that, I wish you all a very good day. Thank you very much

Operator: And this does conclude today's presentation. Thank you for everyone's participation.