**Case Example**

***CASE EXAMPLE:*** Okazawa-Rey (1998) provides an example of a community response to the needs of African American grandparents who have become primary caretakers of their grandchildren. The initiating problem is one well established in the community and national scenes. Many people have become addicted to crack-cocaine and are relinquishing their responsibilities as parents and productive citizens to pursue drug use. An example of a program responding to this problem is the Grandparents Who Care Support Network of San Francisco. Most members are “poor and working class, middle-aged and elderly African-American women” (Cox, 2002; Okazawa-Rey, 1998, p. 54). They have gained custody of their grandchildren because of their own children’s neglect. This is due to drug abuse, incarceration because of drug convictions, and the unwillingness to submit their grandchildren to strangers in the public foster care system.

 These grandparents have found themselves in the strange and unusual circumstance of having sudden responsibility for small children at a stage in life when they feel they were done with all that. This problem is compounded with the health problems many children suffer due to poor prenatal care, drug use during pregnancy, and child neglect. These grandparents “desperately need day care, special education services, transportation, respite care, and money” (Okazawa-Rey, 1998, p. 54). To get services, they find themselves trying to negotiate the confusing maze of bureaucracies governing service provision.

 Two health care workers, Doriane Miller and Sue Trupin, identified the problems and needs, and established Grandparents Who Care (Okazawa-Rey, 1998). The program is based on four philosophical principles. First, individual health problems transcend the fault of the individual. They are related to mezzo and macro conditions. Second, cultural, legal, and organizational barriers often hinder access to needed services. Third, even if people can get needed services, they may be inadequate and unable to meet needs. Fourth, empowerment at the micro, mezzo, and macro levels is necessary for maintaining optimal health and well-being (Breidenstein, 2003).

 Grandparents Who Care established a series of support groups to provide information, emotional support, and practical advice. Groups consist of two to twenty-five grandparents, are co-led by professional health care personnel including nurses or social workers, and meet weekly for 90 minutes. Grandparents Who Care has a board of directors made up of grandparents, citizens, and concerned health care professionals who advise the organization.

 Group members provide each other with support and help addressing a range of issues. For example, “When one woman faces a particular problem with her grandchild in the school system, another one will describe her dealings with this system and offer suggestions concerning the most effective ways to intercede” (Okazawa-Rey, 1998, p. 58). Members can thus share their experiences with each other and help work through issues. The professional co-leaders can assist the group by providing technical information about service availability, eligibility, and accessibility.

 Grandparents Who Care expanded its work in several macro dimensions to further empower its members. First, grandparents were trained as group leaders who go out and form new groups. In this way, the program’s supportive help spread to help grandparents elsewhere in the community.

 Second, Grandparents Who Care undertook political advocacy and lobbying on its members’ behalf. One problem advocates addressed involved the legal difficulties grandparents experienced in receiving foster care payments. As relatives, they did not technically qualify as foster parents. Other financial support available to them was not nearly as good as that provided to unrelated foster parents. Grandparents Who Care advocates lobbied with a state legislator to pass a bill allowing grandparents to receive greater benefits.

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