303:
Childhood Mental Health Issues:
Application to the Casework Process

Standard Curriculum

Developed by:
Gale L. Sherrid, LCSW

For
The Pennsylvania Child Welfare Training Program

University of Pittsburgh, School of Social Work
Pittsburgh, PA

May 2008

The Pennsylvania Child Welfare Training Program
University of Pittsburgh, School of Social Work
403 East Winding Hill Road
Mechanicsburg, PA 17055
Phone (717) 795-9048 Fax (717) 795-8013

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Acknowledgements

The Pennsylvania Child Welfare Training Program would like to thank the following people for their assistance in the development of the workshop Childhood Mental Health Issues: An Introduction for Child Welfare Professionals.

Kathleen A. Davis, Pennsylvania Child Welfare Training Program
Eugene Detter, Pennsylvania Child Welfare Training Program
Sheree Fletcher, Pennsylvania Child Welfare Training Program
Jana Hitchcock, Pennsylvania Child Welfare Training Program
Joan Landis, Private Consultant
Jody Price, Pennsylvania Child Welfare Training Program
Christine Reese, Pennsylvania Child Welfare Training Program
Kathy Jones Kelley, Pennsylvania Child Welfare Training Program
Judith Jhriad-Reich Ph.D., Private Consultant
Reed Reynolds, Pennsylvania Child Welfare Training Program
Jeanne Schott, Pennsylvania Child Welfare Training Program
Gale L. Sherrid, Pennsylvania Child Welfare Training Program
Tina Weber, Pennsylvania Child Welfare Training Program
Gordon R. Hodas, Ph.D., Pennsylvania Office of Mental Health & Substance Abuse

303: Childhood Mental Health Issues: Application to the Casework Process

Agenda for One-Day Workshop on Childhood Mental Health Issues: Application to the Casework Process

Estimated Time	Content	Page
30 minutes	Section I: Welcome and Introductions	3
1 hour,30 minutes	Section II: Integrating Critical Concepts	8
1 hour	Section III: Case Study Preparation	20
2 hours, 45 minutes	Section IV: Cross-Systems Panel Discussion	24
15 minutes	Section V: Closing and Evaluation	27

303: Childhood Mental Health Issues: Application to the Casework Process

Section I: Welcome & Introductions

Estimated Length of Time:
30 minutes

Key Concepts:
- Cultural context significantly affects provision of all child welfare and mental health services as well as the process of engagement for child welfare professionals with all children and their families.

Methods of Presentation:
Lecture, individual exercise, small group activity, large group activity

Materials Needed:
- ✓ Name tents
- ✓ Masking tape
- ✓ Idea catchers
- ✓ Post-It notes on each table
- ✓ Colored markers
- ✓ 2 Flip chart stands/pads
- ✓ Overhead projector/screen
- ✓ **Overhead #1 (Learning Objectives)**
- ✓ **Overhead #2 (Agenda)**
- ✓ **Handout #1 (Questions for the Panel)**
- ✓ **Handout #2 (Case Study Report)**
- ✓ **Poster #1 (Phases of Casework Practice: Navigational Guide)**

Outline of Presentation:
- ➢ Welcome participants
- ➢ Review the learning objectives and competency
- ➢ Share culturally-relevant information and resources from pre-work
- ➢ Introduce concept of cultural competency related to childhood mental health
- ➢ Establish ground rules
- ➢ Review Agenda and What's In It For Me (WIIFM)

Section I: Welcome & Introductions

Trainer Note: Please be sure to review the **Pre-Work Packet (Pre-Work #1: Instructions; Pre-Work #2: Case Study Report; Pre-Work #3: Questions for Panel; Pre-Work #4: Letter)** received by the participants prior to the training day. Prepare the training room in advance by placing name tents, markers, and handout packets on each table. Trainers are encouraged to label **flip chart** sheets with the following titles: **1) What's In It For Me? (WIIFM), 2) Parking Lot, 3) Cultural Insights, and 4) Culturally Competent Resources**. Post the first two flip chart sheets on the wall and leave the latter two on the flip chart pad initially. A pad of Post-It notes should be placed on each table. The questions from the Parking Lot should be posted for use during the panel discussion. The trainer is also encouraged to hang the following posters: **Poster #1(Phases of Casework Practice: Navigational Guide), Poster #2 (CFSR Performance Outcomes)** and **Poster #3 (Commonly Diagnosed Disorders in Children)**. **Handout #1 (Questions for the Panel)** and the Idea Catchers should be handed out at the beginning of the session or be available on the sign-in table. Spare copies of **Handout #2 (Case Study Report)** should be placed on the group tables for those who did not complete their **Pre-Work #2 (Case Study Report)**.

Step 1:
Welcome & Application Orientation

Trainer Note: Take breaks and lunch as best fits the group. Panelists are asked to arrive at 12:30 p.m. in order to provide time for the trainer to prepare them prior to beginning the panel. A maximum of five case studies are to be presented by the entire group. Case studies should be representative of various disorders, ages, and backgrounds. Panelists have been advised they will be finished at 3:30 p.m.

Welcome the participants to training as they enter the room and encourage each participant to take a Post-It note from their table and write down one item that they want to learn related to practice with children who have mental health issues. Instruct each participant to place his or her Post-It note on the **WIIFM** flip chart sheet.

Introduce yourself to the group, including background and experiences in the fields of mental health and child welfare. Review the learning objectives for the session using **Overhead #1 (Learning Objectives)**. Promote participants taking risks that will help them to learn and try out new skills in the safety of the classroom. Encourage trainees to jot down questions for the panel (on **Handout #1: Questions for the Panel**) and "aha's!" on the Idea Catcher throughout the day. Note that both these forms are available on their tables.

Remind participants that **Case Study Reports (Pre-Work #2)** will be used later in the day during the panel presentations. Encourage participants to complete a **Case Study Report (Handout #2)**, which is provided on their table, during break if they did not complete one in their Pre-Work. Advise them to refer to **Poster #1 (Phases of**

Casework Practice: Navigational Guide) and the Continuum of Care found in the **Childhood Mental Health Issues: Resource Book** (p. 70) as needed.

Guide participants through the completion of their name tents:

County	Unit/Department/Function
Length of time in position	1 barrier to accessing the mental health system **or** 1 piece of culturally-relevant information from article

Instruct participants to write the county in which they work in the top left corner of the name tent, write their position in the agency in the top right corner, write the amount of time they have been in their position in the bottom left corner, and write one barrier to accessing the mental health system or one piece of culturally relevant information from the Pre-work article in the bottom right corner.

Trainer Note: For example, barriers could be engaging families; coordination with service provider agencies and resource families; the courts; accessing culturally competent services and assuring the safety and well-being of children. Information from the pre-work article could include: a new mental health intervention/perspective, a statistic from the article, a comment/quote, a new idea sparked by reading the article or a new resource.

When the name and four corners are complete, ask participants to stand their name tent in front of them and to share introductory information from their name tents with the others seated at their table.

Once all tables have completed the above tasks, ask for a volunteer recorder. Ask how many participants read the Pre-work article. Discover how many brought their Pre-work list of culturally relevant resources. Have participants with culturally relevant information and those with culturally relevant resources share with the whole group. As participants share, have the recorder write information on the appropriate flip chart sheet (Cultural Insights or Culturally Competent Resources). When all respondents have answered, post the flip chart sheets on the wall.

Recognize that childhood mental health issues do not exist in a vacuum; many other issues and systems are involved. Advise participants that the Department of Public Welfare is moving toward a goal of basic-level co-occurring competency for all human service professionals. Instruct participants to share briefly their reactions to article information, ways to advocate for inclusion of new interventions with service providers and how a client might feel when they are working with community agencies that have different cultural backgrounds from their own.

Close with the following (Cross, et al., 1989):

> "Culturally competent service providers are aware and respectful of the values, beliefs, traditions, customs, and parenting styles of the people they serve. They

are also aware of the impact of their own culture on the therapeutic relationship and take all of these factors into account when planning and delivering services for children and adolescents with mental health problems and their families.

"For many programs, cultural competence represents a new way of thinking about the…delivery of mental health services. Becoming culturally competent…requires cultural knowledge at all service levels, including policymaking, administration, and practice. Even the concept of a mental disorder may reflect a western culture medical model." – rather than the strengths-based solution-focused model agencies are now embracing.

"Types of services should be culturally appropriate; for example, extended family members may be involved in service approaches, when appropriate." For example, Family Group Decision-Making includes extended family members and uses them as resources to help provide for the safety, well-being, and permanence of children. Collaboration with community resources, which specifically address cultural, religious, or ethnic needs, is also a way to incorporate child- and family-focused services into child welfare service planning and delivery."

Cultural competence should be woven throughout all interventions, contacts, and settings to help assure the safety and well-being of individuals, groups, and families. Knowing the beliefs and attitudes that guide the development or culture is the basis from which awareness comes. Consistently using that knowledge and applying the guidelines to practice over time brings cultural competence.

Step: 2:
Training Environment & Expectations

Trainer Note: Each training room should already have a poster with some of these guidelines. If it does not, prepare one in advance or use flip chart paper to write out guidelines while reviewing.

The classroom is a microcosm of a cultural environment. Each school has its own culture for learning. In the Child Welfare Training Program, the following guidelines help shape that culture for learning:

- ✓ Be on time: the "15-minute rule" means participants cannot miss more than 15 minutes of the entire workshop or they will not receive training credit for the training;
- ✓ Follow the training schedule: 9:00 AM to 4:00 PM with breaks and lunch;
- ✓ Document your presence on the sign-in sheet;
- ✓ Provide Constructive and Motivational Feedback;
- ✓ Respect yourself and others: treat one another with respect and professional courtesy (i.e., no interruptions, no monopolizing the conversation);
- ✓ Take risks to maximize your own and others' learning;

- ✓ Practice to make knowledge and skills permanent;
- ✓ Focus on learning: turn off cell phones (or place them on silent) & only contact office for emergencies to minimize disruptions;
- ✓ Use the "Parking Lot" for questions which require panel input; and
- ✓ Any other trainer/training-specific rules (e.g., let a certain individual know if the room is too hot/cold so it can be adjusted or hold questions until the end).

Step 3:
Review of Agenda

Take this opportunity to read aloud all of the items posted by the participants on the WIIFM flip chart and point out those items that will be covered in this training. Place the Post-it notes of those items that will not be covered in this training on the "Parking Lot" flip chart. At the end of the training, review the WIIFM flip chart and make sure that all of the concerns and questions have been addressed.

Provide an introduction of the training day by reviewing **Overhead #2 (Agenda)**. Describe how the learning objectives will be accomplished primarily through large and small group activities, as well as the case study presentations to the panel to help participants apply *Childhood Mental Health Issues* knowledge and skills in the context of casework practice.

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Section II: Integrating Critical Concepts

Estimated Length of Time:
1 hour, 30 minutes

Key Concepts:
- Many systems are involved in monitoring and ensuring effective treatment for children and adolescents with mental health issues.
- Incorporating knowledge and skills associated with mental health disorders into casework practice leads to better outcomes for children and adolescents with mental health issues.
- Engaging family members and caregivers in the treatment process supports outcomes of safety, permanency, and well-being for children.
- Resilience is a precursor to the eventual attainment of recovery.

Methods of Presentation:
Small group activity, large group activity

Materials Needed:
- ✓ Masking tape
- ✓ Colored markers
- ✓ 2 Flip chart stands/pads
- ✓ Squishy popcorn ball (1)
- ✓ Overhead projector/screen
- ✓ **Overhead #3 (Childhood Mental Health Review Topics)**
- ✓ **Poster #2 (CFSR Performance Outcomes)**
- ✓ **Trainer Resource #1 (PA Standard on Monitoring)**
- ✓ **Trainer Resource #2 (2002 Child and Family Services Review (CFSR) Data)**
- ✓ **Trainer Resource #3 (Tips for Effective Collaboration)**
- ✓ PA Standards (table copies)
- ✓ *Childhood Mental Health Issues: Resource Book* (table copies)

Outline of Presentation:
- ➢ Review of *Childhood Mental Health: An Introduction for Child Welfare Professionals* training
- ➢ The Importance of Monitoring
- ➢ Tips for Collaboration and Summary

Section II: Integrating Critical Concepts

Step 1:
Summation of Childhood Mental Health Issues: An Introduction for Child Welfare Professionals

Popcorn Perceptions

Instruct each participant briefly write down the most beneficial thing they learned from the *Childhood Mental Health Issues: An Introduction for Child Welfare Professionals* and how they put it into practice*.* For those who did not attend the *Introduction,* ask them to draw from their experience in working with children with mental health issues and write information they have found useful in their practice.

Trainer Note: When using the squishy popcorn ball for this activity, please advise the participants ahead of time that you will be tossing a ball around the room similar to a "Hot Potato" game. Make sure to get the ball back at the end of the exercise.

Give them 1-2 minutes to jot their answers down. When the trainer points to them (or throws them a popcorn ball), have each participant stand, share their information with the group, toss the ball to another participant and then sit back down.

State that the purpose of this exercise is to help them review knowledge and understanding gained from the *Introduction* or related to their experience quickly and thoroughly as well as to assist them in preparing for this training. Introduce the concept that hope and the need to restore hope is paramount to promoting healing and positive outcomes of safety, permanence and well-being for children and wholeness for their families. Encourage participants to embrace the knowledge previously learned in the *Introduction* or through other experience/education. Participants should be able to identify many of the following content areas. When the whole group has shared, summarize the information given, and provide a brief review of any areas that were not mentioned using **Overhead #3 (Childhood Mental Health Review Topics)**.

Behavioral Indicators:

Trainer Note: Review of the topics listed below should take no longer than 10 minutes to complete. Information does not need to be covered in the detail listed but all **bolded** topic areas should be. Use the information below as a reference guide for the overview. The disorders listed below are organized by type and then name of the disorder. Participants may be referred to the commonly diagnosed childhood disorders listed in the **Childhood Mental Health Issues: Resource Book** (p. 15) for a more detailed study of behavioral indicators.

- Mood Disorders
  - Major Depressive Disorder – more frequent in children/adolescents under stress/who experienced loss. who have attention, learning, conduct or anxiety disorders or who have a family history of depression
    - Frequent sadness, tearfulness, crying
    - Decreased interest in activities; or inability to enjoy previously favorite activities
    - Persistent boredom; low energy
    - Increased irritability, anger, or hostility
    - Frequent complaints of physical illnesses such as headaches and stomachaches
    - Frequent absences from school or poor performance in school
    - Poor concentration
    - A major change in eating and/or sleeping patterns
    - Talk of or efforts to run away from home
    - Thoughts or expressions of suicide or self destructive behavior
    - Use of alcohol or drugs, or increase in such use
  - Bi-Polar Disorder – may occur in children and teens, especially those who have parent/s with Bi-Polar Disorder
    - ongoing combination of extremely high (manic) and low (depressed) moods
    - highs may alternate with lows or the person may feel both extremes at the same time
    - sexualized behavior
    - "rapid cycling" characterized by extreme mood lability with rapid mood shifts many times during the course of a day or even more frequently than this.
- Anxiety Disorders
  - Post-Traumatic Stress Disorder – three core symptoms are: re-experiencing, avoidance & number, and hyper-arousal (see pages 70-71 of the Resource Book for more information.)
    - To severe, one-time/infrequent trauma:
      - frequent memories of the event
      - upsetting and frightening dreams
      - worry about dying at an early age
      - losing interest in activities
      - physical symptoms such as headaches and stomachaches
      - increase of sudden and extreme emotional reactions
      - problems falling or staying asleep
      - irritability or angry outbursts
      - problems concentrating
      - acting younger than their age (for example, clingy or whiny behavior, thumb sucking)
      - showing increased alertness to the environment
      - repeating behavior that reminds them of the trauma
    - With chronic trauma, may also appear to be:
      - "manipulative"
      - disinterested in relationships with helping adults

Trainer Note: This presentation may "turn off" a child welfare professional and create a desire to engage in an unnecessary power struggle with the child or adolescent. The child welfare professional should also be aware that symptoms of chronic trauma can present as similar to other psychiatric disorders, such as depression, bipolar disorder, ADHD, and anxiety disorders; therefore, there is a need for a careful history of the child and family. At times, referral for psychiatric evaluation will be indicated.

- Separation Anxiety Disorder -- At least one symptom from the list below accompanies the anxiety and worry.
  - With younger children:
    - Clingy
    - Follow parents
    - General fear or apprehension
    - Nightmares
    - Somatic symptoms (dizziness, headaches, stomachaches)
  - With older children:
    - Think about illness or tragedy happening to them/their caregivers
    - Apathetic or depressed
    - Reluctant to leave home
    - Reluctant to participate in activities with their peers
- Generalized Anxiety Disorder – seen in children and adolescents
  - excessive anxiety and worry about personal performance and approval of others, (apprehensive expectation)
  - occurs more days than not for a period of at least 6 months
  - significant distress or functional impairment
  - physical symptoms, such as muscle tension, nausea or frequently having to go to the bathroom
  - unable to relax
  - startle easily
  - difficulty concentrating
  - trouble falling asleep or staying asleep
- Obsessive Compulsive Disorder – a brain disorder often diagnosed in adolescence or early childhood
  - Intense, recurrent obsessions and/or compulsions
  - unwanted recurrent and persistent thoughts, impulses, or images that cause marked anxiety or distress
  - repetitive behaviors or rituals (like hand washing, hoarding, keeping things in order, checking something repeatedly) or mental acts (like counting, repeating words silently, and avoiding)
  - symptoms that interfere with a child's normal routine, academic functioning, social activities, and/or relationships

- Disruptive and Attention Disorders
  - ADHD
    - trouble paying attention

        - inattention to details and makes careless mistakes
        - easily distracted
        - loses school supplies, forgets to turn in homework
        - trouble finishing class work and homework
        - trouble listening
        - trouble following multiple adult commands
        - blurts out answers
        - impatience
        - fidgets or squirms
        - leaves seat and runs about or climbs excessively
        - seems "on the go"
        - talks too much and has difficulty playing quietly
        - interrupts or intrudes on others
    - Oppositional Defiant Disorder
        - a pattern of uncooperative, defiant, and hostile behavior toward authority figures:
            - Frequent temper tantrums
            - Excessive arguing with adults
            - Active defiance and refusal to comply with adult requests and rules
            - Deliberate attempts to annoy or upset people
            - Blaming others for his or her mistakes or misbehavior
            - Often being touchy or easily annoyed by others
            - Frequent anger and resentment
            - Mean and hateful talking when upset; and,
            - Often spiteful and vindictive
    - Conduct Disorder
        - Aggression to people and animals
        - Destruction of property
        - Deceitfulness, lying, or stealing
        - Serious violation of rules
- Neurodevelopmental Disorders
    - Autism-Spectrum Disorders (PDD, Asperger's and Autism)
        - Impaired social interaction:
            - Failure to develop age-appropriate peer relationships
            - Lack of spontaneous sharing of enjoyment or interests
            - Lack of social or emotional reciprocity
        - Impairment in communication:
            - Delay or lack of spoken language
            - Impairment in initiating or sustaining conversation
            - Repetitive or idiosyncratic conversation
            - Lack of age-appropriate, spontaneous make-believe or imitative play
        - Restrictive, repetitive behavior, interests, or activities:
            - Preoccupation with stereotyped restrictive interests
            - Inflexible adherence to nonfunctional routines or rituals
            - Stereotyped repetitive motor mannerisms

        - Persistent preoccupation with parts of objects
- Attachment Disorders – frequently diagnosed by age 5
    - Reactive Attachment Disorder
        - Persistent failure to initiate or respond to social relationships in a developmentally appropriate way in most contexts:
            - Excessively-inhibited, hypervigilant or highly-ambivalent and contradictory responses; or,
            - Diffuse attachments with marked inability to exhibit appropriate selective attachments; and,
        - The disturbance is not due to developmental delays
        - Disrupted caregiving characterized by at least one of the following:
            - Persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection;
            - Persistent disregard of the child's basic physical needs
            - Repeated changes of primary caregiver that hinders the child from forming stable relationships

Trainer Note: Children diagnosed with attachment disorders, especially young children, can do well once placed in stable, nurturing, permanent homes. Emphasize instilling hope in children, families (including resource families), and other professionals regarding positive outcomes for children with attachment disorders.

- Eating Disorders –typically teenage females
    - Anorexia Nervosa
        - typically perfectionists and high achievers in school
        - low self-esteem
        - believe they are fat regardless of how thin they are
        - needing a feeling of mastery over their life
    - Bulimia
        - binges on huge quantities of high-caloric food and/or
        - purges body of dreaded calories by self-induced vomiting and often by using laxatives
        - may alternate with severe diets, resulting in dramatic weight fluctuations
        - hide the signs of throwing up by running water while spending long periods in the bathroom
- Other disorders
    - Schizophrenia – symptoms generally include a combination of delusions, hallucinations, or language distortions AND decreased emotional expressions such as flat affect, the production, or development of speech, and goal-directed behavior, both affecting the social or occupational functioning of the child/adolescent. Delusions can be themed, persecutory (someone is out to get them), grandiose, or religious in nature.

Trainer Note: Childhood schizophrenia is much less common than adult onset type of schizophrenia, which does occur in adolescence.

- Early Warning Signs of Adult-Onset Schizophrenia:
  - Seen to have uneven motor development, such as unusual crawling, in childhood
  - Difficulty knowing dreams from reality
  - Sees and hears sounds or voices that do not exist
  - Has vivid and bizarre thoughts and ideas
  - Shows extreme moodiness
  - Reveals peculiar behavior
  - Says people are "out to get them"
  - Shows severe anxiety and fearfulness
  - Confuses television or movies with reality
  - Has severe problems in making and keeping friends
  - Withdrawals frequently and reveals a lack of active relating
  - Reveals a lack of emotional expressiveness
  - Appears grossly disorganized in areas such as appearance, hygiene, general presentation
  - Makes incoherent responses unrelated to the topic or to the speaker's own statements, known as "loose associations")
- Substance abuse or dependence

Trainer Note: Substance use and abuse can mimic psychiatric disorders in children and adolescents, especially relating to the effect, intoxication with, or withdrawal from a substance. It is, therefore, important for child welfare professionals to inquire about possible use of substances, the possible role of drugs and alcohol, and the need to be alert to their possible role in the presentation of a child and (especially) an adolescent.

Child development

- Ways child welfare professionals can assist parents include:
  - Share information regarding developmental expectations in a culturally-sensitive manner
  - Encourage connections with family members and friends that have experience with child rearing
  - Identify a mentor who can provide individualized education
  - Refer for parenting classes or parent support groups
  - Provide resource materials
  - Model appropriate interactions and reasonable expectations

Barriers that influence treatment services for children and adolescents:

- Fragmented delivery system
  - Gaps in public and private insurance coverage
  - Using services as punishment instead of treatment
  - Insufficient knowledge
  - Extensive waiting lists for treatment services
  - Long geographical distances (especially in rural areas)

Perceptions and stigmas associated with child/adolescent mental health issues

- Societal perceptions may include:
  - Mental health disorders are not true medical illnesses
  - If the parent is mentally ill, the child will have mental health issues, too.
  - Children and adolescents are not affected by depression and anxiety.
  - Children should not be prescribed medication for hyperactivity or inattentiveness.
  - People with mental illness are dangerous.
- Culture influences how people view mental health issues, how they express their symptoms, and how they interact with the service delivery system.
- Stigmas associated with receipt of mental health treatment are one of the many barriers that discourage people from seeking treatment.
  - The majority of children fail to receive any mental health services, which can greatly impact the safety and well-being of children.
  - Approximately half of families who begin treatment terminate it prematurely, usually after 1-2 visits.

Promoting Resiliency and Recovery includes:

- Forming a trusting relationship with the child
- Using a treatment approach/technique best suited to the child's needs
- Engaging the child's family
- Focusing on child's own personality and strengths
- Identifying family strengths and protective factors
- Connecting with natural supports

Impact of child abuse and neglect:

Trainer Note: Child welfare professionals should know that there is an increased risk of a child/adolescent being abused or neglected as a result of the behaviors that he or she might exhibit due to mental health issues. Furthermore, a child/adolescent may also develop mental health issues because of abuse or neglect that they experience. Encourage participants to list other areas of concern for children and adolescents as well as constructive interventions used to ensure their safety, well-being and permanence.

- Examples of areas of concern:
  - Poor mental and emotional health
  - Cognitive difficulties
  - Social difficulties
  - Difficulties during adolescence
  - Juvenile delinquency and adult criminality
  - Alcohol and other drug abuse
  - Abusive behavior

Trainer Note: Again, trainer may refer participants to the **Childhood Mental Health Issues: Resource Book** (p. 71).

System of Care "players" (professionals) involved in the child and adolescent mental health system include both the child-serving systems:

- Managed Care Organizations
- Children and families as partners
- Mental Retardation services
- CASSP

and the array of available mental health services:

- Office or outpatient services
- Targeted Case Management (TCM)
- Home-Based Treatment Services
- Family Support Services
- Day Treatment programs
- After-School Partial Hospitalization programs
- Emergency/Crisis services
- Respite Services
- Therapeutic Group Home
- Community Residential Rehabilitation (CRR) Host Home
- Residential Treatment Facility (RTF)
- Inpatient psychiatric hospitalization

Remind participants that further information regarding topics covered in the *Introduction* is available through the **Childhood Mental Health Issues: Resource Book** and encourage participants to continue using this resource book as a reference guide to inform their work.

Step 2:
Monitoring

Having concentrated on recognizing the need for mental health intervention and accessing treatment during the *Childhood Mental Health: An Introduction*, this workshop will concentrate on application of the knowledge and skills related to child and adolescent mental health issues to casework practice. Ask participants what next steps they might take, after referring a child with mental health issues for treatment.

Trainer Note: Answer should include material related to monitoring the progress and effectiveness of service plan goals/treatment plan in order to ensure the safety, permanency, and well-being of the child.

Reinforce and summarize participants' responses. Inform them that, while there are many "next steps," this workshop will narrow the focus to how monitoring affects child well-being, safety, and permanency.

Solicit definitions of "monitoring" from the group and record their answers on the flip chart. Advise participants that the definitions for monitoring to be used in this workshop is "regulating performance" or "checking progress." Instruct participants to look at **PA Standard IV-A.1.c (Monitor Service Delivery: Knowledge and Value Base)** in the table copies and relate their answers to how "checking progress" relates to the Family Service Plan and timeliness.

Trainer Note: Please refer to **Trainer Resource #1 (PA Standard on Monitoring [IV-A])**. The desired answer is "comparing on a monthly basis how the service plan requirements meet services being delivered and outcomes."

Ask participants what that might look like at their own agencies. Ensure they cover regular contacts, checking progress, engaging the child and family in service planning and delivery throughout the process, collaborating with cross-systems partners, meeting regularly with supervisor and internal stakeholders, and revising the plan as needed.

Advise participants that one way of evaluating our ability to meet the standard is through the federal Child and Family Services Review (CFSR) process. This process is an evaluation by the Administration for Children's Services (ACS) of Children and Youth agencies' compliance with providing quality services related to safety, permanency, and well-being of children. Refer participants to **Poster #2 (CFSR Performance Outcomes)**.

Note that Pennsylvania has already been through one Child and Family Services Review in 2002 and is currently preparing for another in 2008. Ask participants to turn to the 2002 CFSR Data in the **Childhood Mental Health Issues: Resource Book** (p. 112, Appendix D). Have the participants refer to the **Poster #2 (CFSR Performance Outcomes)** explanation of Well-Being #3 and then read the opening sections of the **Trainer Resource #2 (2002 CFSR Data)**.

Pennsylvania did not meet substantial conformity for Well-Being Outcome #3 (adequate services to meet children's physical and mental health needs) in the following areas of concern:

- Adequate intensity and duration of mental health services to meet children's needs
- Adequate monitoring to assure recommended children's mental health services were actually received
- Sufficient services to meet the prevalence of child/adolescent mental health needs and the needs of their families.

Ask participants how the CFSR shows the impact of the monitoring process on Pennsylvania children with mental health issues (see above). Compare answers to the flip chart answers regarding what monitoring is to consider if completion of the monitoring tasks listed would address the above concerns. Then ask participants to read the next two sections of the 2002 CFSR Data.

Additional Barriers (Barriers to treatment):

- extensive waiting lists for treatment services
- long geographical distances (especially in rural areas), which make it difficult to access services
- family-focused treatment is also difficult to access within the mental health system

How Barriers Impact Outcomes:

- delay or lack of positive outcomes for improving child/adolescent mental health issues
- lack of timeliness in which a child or his/her family might have in completing goals and objectives
- family systemic issues are often not addressed in conjunction with the child's areas of need

Review the information and then ask how the following Actions might change the outcomes:

- ✓ Be diligent in accessing services
- ✓ Engage families in the process of establishing reasonable goals and objectives when service planning
- ✓ Seek out and advocate for family-focused treatment
- ✓ Follow-through with obtaining progress reports and documenting treatment services

Step 3:
Monitoring Related to Job Function

Advise participants that, in order to change the outcomes through monitoring, they will need to be able to apply the general components of monitoring (covered above) to their specific work environment. Instruct participants to group themselves according to work unit/job function (*e.g.,* screening, intake, in-home services, placement, Independent Living, and/or adoption). Instruct each small group to take 2-3 minutes to identify several job-specific tasks involved in monitoring, which they will then share with the larger group.

Some themes brought out regarding the discussions on monitoring should include:

- Engaging and including the child and family in meetings, assists in developing and maintaining permanency of the child in the most family-like setting possible.
- Allowing enough time to accomplish the work and being realistic about time expectations encourages family involvement and completion of needed documentation.
- Use of supervision ensures monitoring occurs in a timely fashion.
- Evaluating and changing the plan as needed promotes well-being through inclusion of alternate planning in a supportive way.

- Connecting children and families with culturally competent providers helps ensure they are receiving appropriate services.
- Maintaining regular contacts/holding regular meetings with other agencies/workers helps assure child safety through interagency and/or intra-agency collaboration.

Step 4:
Conclusion

Advise participants that they have outlined what child welfare professionals can do to help successfully engage children and families in order to access and maintain meaningful mental health treatment through the use of monitoring tasks. Encourage participants to think back to the squishy ball activity in *Childhood Mental Health Issues: An Introduction for Child Welfare Professionals*, during which volunteers juggled the balls, representing the family having to deal with safety threats and risk factors, with the addition of protective capacity of the family. The exercise illustrated the positive impact of cooperative communication, the need for families and others to collaborate, and the importance of a comprehensive assessment by the child welfare professional to assist in managing the family's struggles.

Note that, as with the family members, the caseworker and providers are also attempting to juggle many different priorities and tasks. Reinforce that planful collaboration and monitoring is essential to positive outcomes for children and families.

Refer participants to the Tips for Collaboration in the **Childhood Mental Health Issues: Resource Book** (pp. 74-76) and briefly review the information regarding the principles of collaboration, using **Trainer Resource #3 (Tips for Effective Collaboration)**, noting how they tie in to the above themes of monitoring.

Advise participants that collaboration is necessary in order to affect positive outcomes for children and families in the child welfare system. State that this exercise has emphasized the importance of keeping the primary goals in mind at all times, in order to:

- create a context for restoring hope to the child and family and
- promote constructive, collaborative treatment planning to benefit the child and family

By including the child and family in all aspects of the planning and evaluation, child welfare professionals can instill hope in children and their families and promote positive outcomes for current and future generations.

303: Childhood Mental Health Issues: Application to the Casework Process

Section III: Case Study Preparation

Estimated Length of Time:
1 hour

Key Concepts:
- Use of case studies from participants' own caseloads helps promote long-term impact on best case practice.

Methods of Presentation:
Large and small group activities

Materials Needed:
- ✓ Colored markers
- ✓ Masking tape
- ✓ 2 Flip chart stands/pads
- ✓ Overhead projector/screen
- ✓ 25 multi-colored index cards – 5 for each table
- ✓ **Handout #1 (Questions for the Panel) (revisited)** (5 additional copies)
- ✓ **Handout #2 (Case Study Report)** (5 additional copies)
- ✓ **Handout #4 (Criteria for Selection of Case Studies)**
- ✓ **Pre-Work #2 (Case Study Report)**
- ✓ **Pre-Work #3 (Questions for the Panel)**
- ✓ **Poster #3 (Commonly Diagnosed Disorders in Children)**

Outline of Presentation:
- ➢ Review case studies brought
- ➢ Select case studies for panel presentation
- ➢ Post prepared questions for panel
- ➢ Complete case study preparation

Section III: Case Study Preparation

Step 1:
Selection of Case Studies

Trainer Note: Case studies must include sanitized/cleansed/redacted information (*e.g*., first name, last initial only; no addresses, birthdates, or social security numbers) obtained during risk, family, and safety assessments, as well as sanitized/cleansed/redacted psychological/psychiatric evaluations completed on the child(ren) and/or caregiver. **Emphasize** that real names should not be used.

Explain to participants that, having covered important concepts related to monitoring children with mental health issues, they will now be using the knowledge and skills gained to practice the art of collaboration in preparing and presenting case studies to a cross-systems (and consumer – if children/youth and families involved) panel.

Trainer Note: Be sure to inform the participants what agencies/consumers will attend for the panel session.

Have the participants review the list of disorders on **Poster #3 (Commonly Diagnosed Disorders in Children)** and determine if their case study falls into one of the listed categories. By a show of hands, ask participants to identify which diagnosis their case study falls and write on a post-it note the number of hands and place it on the *Poster* next to each category and totaling the amount per category (*e.g*., Mood Disorders cases 3). Inform the participants that each group will be choosing a case study to present and encourage participants to communicate with one another so a variety of diagnoses are selected.

By a show of hands, determine the number of participants who have brought information listed in their Pre-Work instructions on of the following two topics: either a Psychological/Psychiatric Evaluation or an ISPT/CASSP Meeting they attended. Ask them to share with other participants a synopsis of their case study. For example, "I have an intake case involving a 12-year-old Latino boy with conduct disorder who is living with his mom and 3 younger siblings in the city; he has had some behavioral issues and learning difficulties at school. He and his family are receiving no services. The mother is primarily Spanish-speaking but does not want services from the local Hispanic-American Center because she thinks the workers there will gossip about her family to other families in the community."

Distribute **Handout #4 (Criteria for Selection of Case Studies)** and instruct other participants to take 10 minutes to share their case study synopses at their table. Ask participants to use the poster to select one of the case studies from among their group members once everyone has shared. If a particular group has no case studies, ask at least one participant to switch tables with someone from a table who has none. Encourage participants to choose multi-faceted cases.

Circulate among groups, ensuring each group selects a case study which represents a wide array of disorders, ages, cultural backgrounds, living arrangements, level of services being received, cases at different points on the casework continuum, and other factors, such as parent mental health involvement, legal status or a child with school problems related to mental health issues.

Trainer Note: There should be at least one younger child and one adolescent case study chosen. In addition, there should be cases representing difficulties being encountered at different stages: making the referral, obtaining authorization for services, having services delivered once authorized, transfer of case to a different mental health worker or agency, obtaining meaningful progress reports, and so forth, in order for a representative cross-section of cases to be presented.

If there is not at least 1 – 2 completed **Pre-Work #2 (Case Study Report)** in each group, provide the group with a blank copy of **Handout #2 (Case Study Report)** and have them complete it prior to continuing with the rest of the activity.

Trainer Note: Refer participants to Continuum of Care found in the **Childhood Mental Health Issues: Resource Book** (p. 70) and the **Poster #2 (Phases of the Casework Process: Navigational Guide)** if they need help in completing the **Handout #2 (Case Study Report)**.

Step 2:
Questions for the Panel Not Related to Selected Case Study

Provide each group with a blank copy of **Handout # 1 (Questions for the Panel)**. Have each table select a group recorder. Excluding the questions related to the selected case studies; have the groups review and discuss any questions or concerns from **Pre-Work #3 (Questions for the Panel)** or **Handout #1 (Questions for the Panel)** identified earlier in the day or during pre-work. Have the group recorder write down questions the group wishes to pose to the panel based on that information on the blank form provided. Collect the compilation forms and advise participants they will be provided to the panel prior to their presentation.

Step 3:
Preparation of the Case Study

Instruct each group to discuss the selected case study, including any information from a psychological/psychiatric report or an ISPT/CASSP meeting. Encourage participants to use all the resources available from the pre-work and to share information with those in other groups during their case study preparation. Have participants look at cultural resources/information posted around the room. Encourage them to see which resources or information might be useful and to incorporate the consideration of these resources in formation of questions for the panel related to the appropriateness of treatment.

Trainer Note: Distribute five index cards to each table while they are discussing the case study. Be available to each group as they work to answer any questions that might arise and to ensure that each group is prepared.

Advise groups they have 35–40 minutes to:

- Choose to use the same recorder or select a new one to write final questions on index cards.
- Identify a reporter who will present the group's case study to the panel.
- Review and discuss selected **Pre-Work #2/Handout #2 (Case Study Report)** and supporting documentation in detail.
- Examine **Pre-Work #3/Handout #1 (Questions for the Panel)** and add additional questions
- Identify top 3-5 questions for panel and have recorder write them on the index cards provided.
- Have reporter rehearse presentation of case study for small group.

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Section IV: Cross-Systems Panel Discussion

Estimated Length of Time:
2 hours, 45 minutes

Key Concepts:
- Interaction with cross-systems partners strengthens collaborative ties with formal and informal resources.

Methods of Presentation:
Panel presentations, case study presentations, large group discussion

Materials Needed:
- ✓ 5 Sharpened Pencils
- ✓ **Handout #1 (Questions for the Panel) (revisited)**
- ✓ **Pre-Work #2/Handout #2 (Case Study Report) (revisited)**
- ✓ **Panelist Letter #1 (Panel Invitation Letter)** -- 6 extra copies

Outline of Presentation:
- ➢ Introduction of Panel Members
- ➢ Panel Discussion and Case Presentations
- ➢ Questions and Answers

Section IV: Cross-Systems Panel Discussion

Trainer Note: Prior to the start of this section, provide each panel member with a sharpened pencil with which to take notes as well as a copy of the **Panel Letter #1 (Panel Invitation Letter)**. Review the related questions and panel expectations with the panel members. Panel members should be asked to review **Handout #1 (Questions for the Panel)** that were collected from each table during Section III as well as questions from the Parking Lot flip chart. Advise agency panel members to address questions #1, #2, #10 and #13 from **Panel Letter #1(Panel Invitation Letter for Cross-Systems Partners)** in their introductory statements. Have youth/family members address questions #1, #2, and #3 from **Panel Letter #1 (Panel Invitation for Youth/Family)** during their introductory statements. Ask panelists to answer as many of the other questions as possible during their responses to participants' questions. Remind them that trainees come from various counties and ask that they answer questions accordingly. Keep a copy of the invitation letter to assist with facilitation. Remind panelists that confidentiality is paramount.

Step 1:
Cross-Systems Panel Introduction

Advise participants that the panel members have been chosen to represent different mental health service provider agencies and, if available, from client families. Identify that the representatives will discuss the services their agencies provide or the services received, coordination with the support service agencies and how the individual or agency interacts with Children and Youth. Introduce the panel members and give each one up to 5 minutes to explain their role related to mental health services for children for the above areas.

Step 2:
Case Study Presentations

Advise participants that, during the case study presentations, they will have an opportunity to discuss practice barriers they encountered. Beginning with Group 1, give each group 5-10 minutes to present their **Pre-Work #2/Handout #2 (Case Study Report)**, note what factors and behaviors contribute to the child/family's protective capacities and ask the group's top 3-5 questions (one at a time) from the **Pre-Work #3/Handout #1 (Questions for the Panel)** associated with their **Pre-Work #2/Handout #2 (Case Study Report)**. Note that time will be given at the end of all the presentations for additional questions/information.

Panel members will have 15-20 minutes per group to:

- respond to the group's top 3-5 questions
- highlight red flags (risk/safety factors; child or parent behaviors) that would signal an immediate need for mental health intervention
- identify signs of the need for ongoing mental health intervention

- note what other factors or behaviors contribute to the protective capacity of family
- answer remaining questions from the **Panel Letters #1** as related to the case presented:
  - **Panel Invitation Letter for Cross-Systems Partners**: questions #3 through #8, #11, #12
  - **Panel Invitation Letter for Youth/Family**: questions #4 through #11

Trainer Note: Monitor each group's presentation time and each panel member's response time in order to accommodate all participants and panelists. The suggested times for presentations and responses are to help guide you in timekeeping but actual participation should be tailored to each group. Request that specific panel members respond to questions that most closely relate to their area(s) of expertise. Incorporate questions from the compilation questions sheets as appropriate.

Allow 15-20 minutes for any final questions from **Pre-Work #3** or **Handout #1 (Questions for the Panel)** or the compilation questions. Advise participants they may address any other questions to the panelists after the training. Have panelists who are willing to do so/for whom it would be appropriate provide contact information to participants.

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Section V: Closing and Evaluation

Estimated Length of Time:
15 minutes

Key Concepts:
- Adult learners retain a greater percentage of information presented when it is applied immediately.
- Advocating for mental health services for children and their families supports the child welfare mission of safety, permanence, and well-being for each child.

Methods of Presentation:
Lecture, individual activities

Materials Needed:
- ✓ Overhead projector/screen
- ✓ **Overhead #4 (Key Concepts)**
- ✓ **Handout #5 (Action Plan)**
- ✓ **Handout #6 (Bibliography)**
- ✓ Evaluation Form

Outline Presentation:
- ➢ Summary of Key Concepts
- ➢ Completion of Action Plan
- ➢ Trainer Evaluation

Section V: Closing and Evaluation

Step 1:
Summary

Review any key points brought out by panelists regarding overcoming barriers, referral processes, and coordinating collaborative outcomes. Look at Post-It notes on the WIIFM and Parking Lot flip chart sheets and review how issues were answered/try to answer any questions still remaining. Reiterate the key principles of monitoring and challenge participants to be part of meeting the CFSR goals.

Remind the participants of these key points by displaying **Overhead #4 (Key Concepts)**:

- Cultural context issues significantly affect provision of appropriate mental health services to children and their families.
- Many systems are involved in assuring effective treatment for children and adolescents with mental health issues.
- Incorporating knowledge and skills associated with mental health disorders into casework practice leads to better outcomes for children and adolescents with mental health issues.
- Engaging family members and caregivers in the treatment process supports outcomes of safety, permanency, and well-being for children.
- Interaction with cross-systems partners strengthens collaborative ties with formal and informal resources.
- Advocating for mental health services for children and their families supports the child welfare mission of safety, permanence, and well-being for each child.

Encourage participants to remember that advocacy for the most appropriate, accessible services helps assure that the individual and family needs are met. Collaborating with case management through the mental health system and/or managed care organizations can assist in this process and may address any concerns about the quality of services provided. Encourage children/adolescents and their families to use advocacy organizations, such as child advocate groups and parent organizations, for ongoing support.

Emphasize the need for incorporating knowledge gained from the workshops into everyday practice and encourage participants to continue using the **Childhood Mental Health Issues: Resource Book** as a reference guide. Ask participants to share at work the community resources and insights gained with others who did not attend the training.

Step 2:
Identify Next Steps

Distribute **Handout #5 (Action Plan)** and reiterate that, for effective casework practice, child welfare professionals need to transfer the skills learned to working with children

and families. Ask each participant to use **Handout #5 (Action Plan)** to develop an action plan that they will use to further enhance these skills. Distribute **Handout #6 (Bibliography)** to participants if not distributed at the beginning of the training day and encourage participants to do research on their own.

Step 3:
Training Evaluation

Once participants have completed the **Handout #5 (Action Plan)**, distribute the Evaluation Forms for completion and thank them for coming.

Trainer Note: Please write a note for Training and Delivery regarding which panel members actually participated in the panel and include it with the materials being submitted back to the Training Program.

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