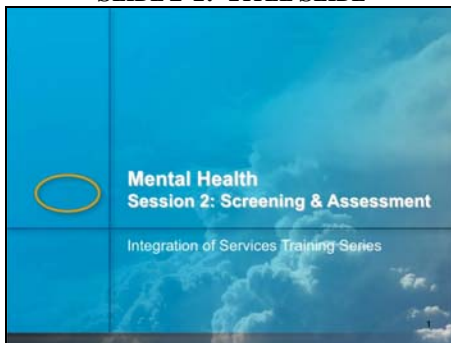


The Integration of Services Training Series

MODULE 2. MENTAL HEALTH

Session 2: Screening and Assessment

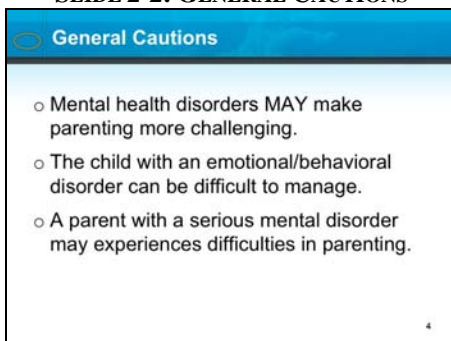
SLIDE 2-1: TITLE SLIDE



Say:

In this session, we'll discuss how the child welfare practitioner can screen a person's mental health functioning to determine whether to refer him/her for a mental health assessment.

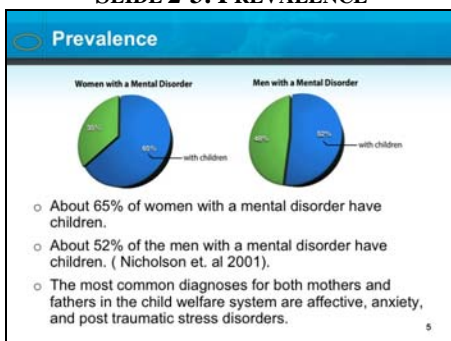
SLIDE 2-2: GENERAL CAUTIONS



Say:

- *As we discussed in Session 1, the presence of a mental disorder with the parent doesn't mean that the parent is unable to care for their children.*
- *Many parents with mental disorders never come to the attention of child welfare agencies and provide appropriate safety and care for their children.*
- *Also, the presence of an emotional/behavioral disorder with the child doesn't mean that the parent has not been appropriately parenting or that they can't parent the child.*
- *It is dangerous to make assumptions about the family dynamics based upon the fact that a family member may have a mental disorder.*

SLIDE 2-3: PREVALENCE



Summarize the slide:

- These percentages are reported on the Substance Abuse and Mental Health Service Administrations website and are based upon the National Comorbidity Survey.
- Parents identified themselves as having a mental disorder and considered the disorder an "illness" meaning that they recognized that the disorder had some type of impact on their functioning.
- The prevalence figures reported by the survey respondents are similar to what is reported in the literature.

SLIDE 2-4: TREATMENT UNIT: FAMILIES

Treatment Unit: Families

- Diagnosable mental disorders are common in the U.S.
- 31% of women and 17% of men have a mental disorder (not including substance abuse) within a 12 month period.

- SAMHSA

6

Say:

- *Given the high prevalence of mental disorders, it is very likely that the child protective investigator and the case manager will work with families with mental illness.*

SLIDE 2-5: TREATMENT UNIT: FAMILIES, CONT.

Treatment Unit: Families Cont'd

- Nearly half of the children of parents with a mental disorder also have disabilities themselves.
(NIDRR/RTC data)
- Families should be considered the treatment unit—not individuals.



7

Say:

The percentage of children with a disability (does not indicate just emotional/behavioral disorders) compels us to work with the family unit to not only address mental health treatment specifically for the mental disorder but to also address parenting skills and other supports to meet both the parents' and children's needs.

SLIDE 2-6: CHILD WELFARE PRACTITIONER ROLE

Child Welfare Practitioner Role

Know that:

- Parents with serious mental illness may be at risk for abusing or neglecting their children.
- It is difficult to tell when potentially dangerous parenting styles or situations are related to mental illness.
- The signs of a potential mental illness overlap with other signs of maladaptive parenting.
- The worker is not responsible for identifying a mental illness – only identifying the possibility and getting appropriate assessments.

8

Summarize:

- In child abuse investigations and services, the parents are usually in a highly stressful situation.
- Both the circumstances that brought the child welfare services into the home and the fact that strangers are questioning their parenting is very difficult for the family members to handle.
- Therefore, it is not unusual to see signs of emotional distress and behavioral problems.
- Given the cautions about making premature judgments, the presence of mental illness symptoms may increase.
- The risk to the child and must be thoroughly reviewed. The child welfare practitioner's role is to identify the possibility of a mental disorder and get assistance to determine whether a family member has a mental disorder.
- Licensed mental health professionals are best equipped to complete formal screenings and evaluations.

SLIDE 2-7: HOW DO WE SCREEN?

How Do We Screen?

- Review information already available.
- Interview family.
- Use other screening tools.

Say:

- *Screening is a process; it is not a discrete activity. Child welfare workers use several different approaches to gain an understanding of the family's strengths and needs. In a way we are working with the family and others to put together the pieces of the puzzle.*
- *One good way to determine the family situation is to review the information already available. In many cases the family has had previous contact with the department and there is previous case information available.*
- *Also, during the interviews with the family members and other contacts, you can gather information about the family dynamics and family members.*
- *Carefully crafted questions can help you to find out information about previous mental disorders, symptoms or patterns of behavior that may help to identify the need to refer the family member for a mental health assessment.*

SLIDE 2-8: REVIEW EXISTING INFORMATION

Review Existing Information

- Past investigative summaries

Say:

- *Reviewing the record and other reports prepares the child welfare practitioner for their meeting with the family and helps them better understand the situation. (Record reviews, reading past evaluations available, police reports, talking to past service providers).*
- *When we know a family has a past record of involvement with the child welfare system, even if it is a report that did not have any findings, potentially there are important clues about the family in the records. Remember the last encounter may have left a strong impression with the family, good or bad.*

Review the items listed on the slide.

SLIDE 2-9: REVIEW EXISTING INFORMATION

Review Existing Information

- Past case records
 - Evaluations of child and parent
 - Services provided and provider reports
 - Provider case closure summaries
 - Patterns of child/parent challenges
 - Family dynamics and stressors
 - Family protective factors & support persons

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Ask:

What existing information have you found useful as you look for signs of an emotional disorder in a child or parent?

Possible Responses:

- Perhaps there are notes about former school placement indicating that the child was in special education, or a parent had a hospitalization.
- Look for issues regarding young children’s behavior.
- Was the parent unable to work because the child was expelled from pre-schools?

TRAINER NOTE

- *Lead participants through a discussion of their experiences when they review records for information. Has any of that information in the records given them a reason to look further into an issue with the family?*
- *Help participants balance the discussion of reviewing records including both indications of possible mental health issues and also coping skills and strengths. Too often records focus on the problems, not the strengths.*

SLIDE 2-10: LOOKING FOR BEHAVIORAL PATTERNS

Looking for Behavioral Patterns

- Documented risks in past situations.
- Previous services.
- Did the family member go to services?
- What was the result of services?
- If a mental disorder is documented, when was the onset?

12

Say:

- *So, in reviewing past records and in talking to past providers, we are looking for information as to whether there is an emerging pattern of specific behaviors that could indicate a mental disorder.*
- *It is useful to know what services have been tried in the past, and to what extent those services were effective.*
- *The record review can also be an opportunity to gather information about the family’s protective factors, including information about other family members who care about the children.*

SLIDE 2-11: LOOKING FOR BEHAVIORAL PATTERNS, CONT.

Looking for Behavioral Patterns Cont'd

- Were there apparent stressors?
- Create a picture of the multiple issues and timeline.



13

Say:

- *Knowing when the symptoms appeared to emerge and what events may have triggered the symptoms will help you understand the current situation.*
- *Also, the child welfare practitioner should look for any indications of recent or important “losses” such as a lost job, foreclosure on a home, family death, etc.*

SLIDE 2-12: SCREENING CONVERSATIONS

Screening Conversations: Essential Elements

- **Transparency:** be honest about why you are asking.
- **Trust:** Sharing what they are comfortable with.
- **Nonjudgmental** Approach.
- **Competence** – and knowing your role.

14

Say:

- *In building trust with families, the elements listed on the slide are vital if we want to learn more about the family’s situation and identify safety risks, strengths and needed services.*
- *It is important to let families know upfront that you have read past records.*
- *Parents should not be pressured to share information about possible mental health issues. Urge them to share what they are comfortable with. Many people are very fearful of revealing that they have a mental disorder.*
- *The same strategy is important when asking them about their children.*
- *Remember that the children may be aware of their parent’s mental disorder and be very protective of the parent or embarrassed. Children may not know the word “stigma” but they likely know through experience what it means.*
- *Be aware of your body language and feelings to ensure that they convey acceptance, not judgment.*

TRAINER NOTE

During the discussion:

- *Highlight areas that show good engagement and an understanding of working with people with mental disorders.*
- *Highlight comments that show empathy and an understanding for the parent’s situation.*

Ask:


- *How many of you have had experience interviewing people with mental illness?*

- *Did you feel comfortable?*
- *If you felt uncomfortable, why was that?*

Ask for examples of a situation when the worker felt that the conversation went well. What was that like? How did it happen?

SLIDE 2-13: ASKING THE PARENT ABOUT THE CHILD

Asking the Parent about the Child



- As a parent, you are in the best position to tell me about your child. What are some qualities that really describe him/her? What are some qualities that you noticed since s/he was a baby?
- Have you had any concerns or worries in the past year or six months about how your child is doing at school? With other kids? At home?

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Discuss these questions with the group.

- As a parent, you are in the best position to tell me about your child. What are some qualities that really describe him/her? What are some qualities that you noticed since s/he was a baby?
- Have you had any concerns or worries in the past year or six months about how your child is doing at school? With other kids? At home?

SLIDE 2-14: ASKING THE PARENT ABOUT THE CHILD

Asking the Parent About the Child

- Can you tell me about a time when you think [Johnny] was the most care-free he has ever been, no stress? What was happening at that time? What, if anything, is different now?
- When I talk to [Johnny], I want to help him feel comfortable. What do you suggest that I say or do?

20

Discuss these questions with the group.

- Can you tell me about a time when you think [Johnny] was the most care-free he has ever been, no stress? What was happening at that time? What, if anything, is different now?
- When I talk to [Johnny], I want to help him feel comfortable. What do you suggest that I say or do?

SLIDE 2-15: TALKING WITH A CHILD

Talking with a Child

- What, if any, worries or fears do you have right now?
- How would your parents/teachers/friends describe you?
- Would they say that you have changed lately? How?

16

Say:

- *Children know when they are different than others and it can be a very painful subject.*
- *Even small children age three and four chose not to play with children with emotional/behavioral problems.*
- *This pattern can continue into middle childhood and adolescence.*
- *The child may not want to divulge some of this information at first. The questions on the slide should be worked into the overall conversation with the child as you help them tell their story.*

SLIDE 2-16: WHEN A PERSON HAS A MENTAL DISORDER

When a Person Has a Mental Disorder

- What is your understanding of this diagnosis and how it affects you?
- What helps you manage those "symptoms"?
- When you are feeling your best, what is different?
- Does the medication have any side effects that are bother to you?

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SLIDE 2-17: WHEN A PERSON HAS A MENTAL DISORDER, CONT.

When a Person Has a Mental Disorder, Cont.

- How do your children understand this illness?
- How does your family understand this illness and how it affects you?
- If you could get more help in managing this condition, what would it be?
- How can I help?

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SLIDE 2-18: INTERVIEWING OTHER SOURCES

Interviewing Other Sources



- School personnel
- Treatment providers
- Extended family

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Say:

- *When you know a person has a mental disorder, prompt them to share information with questions like these on the slide.*
- *Try to approach this subject with empathy.*
- *Mental disorders are not something that people like to talk about to strangers. They are very personal. Confiding that you have a mental disorder can be risky.*
- *In some states a parental mental disorder is justification for removal. Parents are terrified that they will lose custody of their children.*
- *Other results of stigma could mean loss of friends or a job.*
- *You must convince the parent that the information will be kept very confidential.*

Say:

- *The record review and interviews with family members may make you begin to wonder about whether a family member has a mental disorder. The parent may have mentioned that they went to a certain program or that the child is in special education.*
- *When interviewing the school personnel, ask several questions about the child's behavioral patterns and emotional responses to situations.*
- *If the child is in special education it is important to know what classification he/she is under. Remember that young children are often not "labeled" as emotionally disturbed or seriously emotionally disturbed and may be classified as having a speech/language delay.*
- *For these children, you will have to interview the child's teacher about the child's classroom behavior. Observing the child's interaction with the teacher and other children is helpful.*

- *One or more of the family members may have been seen by a mental health treatment provider. However, that knowledge does not tell you about whether the person has a mental disorder, or if so, how severe. Be careful about making assumptions. Maybe they attended a parent program there or went for counseling during a stressful time in their life.*
- *Consent for release of information will be necessary for you to interview the treatment provider.*
- *Also, assumptions can't be made about the presence of a mental disorder if the person is going to a substance abuse program. That program may be co-occurring capable (serves both mental health and substance abuse). Don't assume that because a person is not going to a mental health center they don't have a mental disorder or are not receiving mental health services.*
- *Using carefully developed interview questions with extended family members can also help you identify any past mental health involvement and determine what coping skills were successful in the past. Be careful about confidentiality.*
- *Remember that you are looking for strengths upon which to develop strategies to keep the children safe.*

SLIDE 2-19: OBSERVING PARENTAL BEHAVIORS

Observing Parental Behaviors

- The most common diagnoses for parents in child welfare are;
 - Affective Disorders --- major depression and bipolar
 - Anxiety Disorders
 - Post Traumatic Stress Disorder
- Specific behaviors may raise suspicions of mental health.
- Mental disorders have many symptoms in common.
- Signs of certain mental disorders have been identified.

Summarize the slide:

- Women with a mental disorder have a higher chance of recurring symptoms for several months after the birth of the baby. Mothers also may develop their first symptoms at this time.
- As you visit with parents in the first months after giving birth, look for signs of depression as described on the slide.
- We need to be sure that we can recognize that the parent is experiencing something that is not typical and may require mental health assessment and intervention.

SLIDE 2-20: SIGNS OF POST PARTUM DEPRESSION

Signs of Post Partum Depression

- The baby blues don't go away after 2 weeks.
- Symptoms of depression get more and more intense.
- Symptoms of depression begin any time after delivery, even many months later.
- Mom has thoughts of harming herself or baby.



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Say:

- *About 70-80% of women have 'baby blues' after childbirth: beginning 2-3 days after birth and then receding in a few hours or a week later without treatment.*
- *About 10% of women develop postpartum depression. Onset is most commonly 1-3 weeks after delivery and does require treatment, which could include medication and/or counseling. It does not seem to relate to mother's age or number of children.*
- *Risk is very high to infants; however the risk over time can be significantly diminished if the condition is treated.*

SLIDE 2-21: INFANT/TODDLER BEHAVIORS

Infant/Toddler Behaviors

- Displays very little emotion.
- Does not show interest in sights sounds or touch.
- Rejects or avoids being touched or held or playing with others.
- Unusually difficult to soothe or console.
- Unable to comfort or calm self.
- Extremely fearful or on-guard.
- Does not turn to familiar adults for comfort or help.
- Exhibits sudden behavior changes.

FSU- Center for Prevention and Early Intervention Policy

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Say:

- *Sometimes infants and toddlers show symptoms of emotional/behavioral distress.*
- *Review behaviors listed on the slides.*

Ask:

- *How often do they see these behaviors . . . particularly a cluster of them with one child?*
- *Would anyone like to share with the group a situation when you were aware that an infant was having emotional problems?*
- *When you observe these behaviors what resources do you have to work with the parents and the infant?*
- *What types of parental issues often co-exist with the infant's symptoms?*

SLIDE 2-22: PRESCHOOLER BEHAVIORS

Preschooler Behaviors

- Cannot play with others or objects.
- Absence of language or communication.
- Frequently fights with others.
- Very sad.
- Unusually fearful.
- Inappropriate responses to situations. (e.g., laughs instead of cries)

Center for Prevention and Early Intervention Policy

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Say:

- *These are behaviors in a preschooler that may raise your concerns about an emotional/behavioral disorder.*
- *When you talk with the parent or teacher about the child's behavior, it is important to consider the severity of the behavior.*

SLIDE 2-23: PRESCHOOLER BEHAVIORS, CONT.

Preschooler Behaviors Cont'd

- Extremely active.
- Loss of earlier skills. (e.g., toileting, language, motor)
- Sudden behavior changes.
- Very accident prone.
- Destructive to self and/or others.

Center for Prevention and Early Intervention Policy 27

- *Here are some questions to consider:*
 - *Does the behavior fall within the typical range of behaviors for the developmental stage?*
 - *When did the behaviors first start?*
 - *Are they more common at school or at home?*
 - *What events make the behavior better? Worse?*
 - *What actions taken by the parent or teacher have helped the child?*
 - *What does the teacher think or recommend?*

Review each of the slide points with the participants.

Ask:

- *What type of information do you usually get from child care and pre-k teachers?*
- *Are the early childhood education settings helpful to the parents?*
- *Do they provide any parenting support?*

SLIDE 2-24: CHILD/ADOLESCENT BEHAVIORS

Child/Adolescent Behaviors

- Troubled by feelings.
- Experiences big changes in behaviors such as changing friends, declining school work.
- Begins to show very unusual behaviors.



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Discuss with the participants examples of these behaviors that they see, and that some of these are behaviors that you see in many adolescents. Given the family situations that you work with, if these signs are evident, a mental health evaluation should be sought.

SLIDE 2-25: CHILD/ADOLESCENT BEHAVIORS, CONT.

Child/Adolescent Behaviors Cont'd

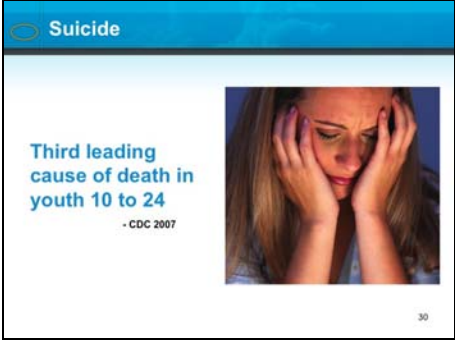
- Starts using drugs.
- Develops different eating patterns.
- Starts to get into serious problems with the law, being very aggressive, setting fires, killing animals, or threatening to hurt himself or others.

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**Participant Guide
Module 2, p. 16**

Refer the participants to more information in their Participant Guides, page 16: Signs of Mental Health Disorders in Children/Youth that can Signal a Need for Help.

SLIDE 2-26: SUICIDE



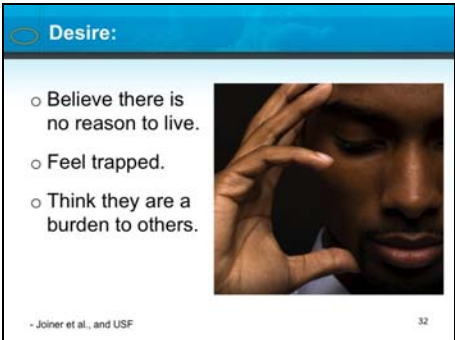
Say:

- *Unfortunately suicide is too common in youth. Suicide is the third leading cause of death in youth in the US between the ages of 10 and 24 (2007).*
- *It is probable that child welfare practitioners will encounter children, youth and adults who have or are contemplating suicide.*

SLIDE 2-27: MULTIDIMENSIONAL ASPECTS OF SUICIDE



SLIDE 2-28: DESIRE



Say:


- *Thinking about and committing suicide is multidimensional and includes the following:*
 - o *Desire*
 - o *Capability*
 - o *Intent*
 - o *Protective Factors*

National Suicide Prevention Lifeline (Joiner et al., 2007, and University of Florida 2008)

SLIDE 2-29: CAPABILITY

Capability

- Pain exposure has been for a long time.
- The desire for self-preservation is reduced.
- History of Violence.
- Impulsive or reckless behavior in the past.
- Thinking about death.



- Joiner et al., and USF 33

Say:

- *The desire to commit suicide, also called suicide ideation, occurs when people have overwhelming emotions such as:*
 - *Believe there is no reason to live*
 - *Feel trapped*
 - *Think they are a burden to others*

Joiner et al. and USF

Say:

- *The ability to carry out the suicide thoughts is based upon several issues. It is very dangerous to assume that the child is too young to try to commit suicide. Below are some of the factors that increase the capability to commit suicide.*
 - *Pain exposure has been for a long time*
 - *The desire for self-preservation is reduced*
 - *History of violence*
 - *Impulsive or reckless behavior in the past*
 - *Thinking about death*

Joiner et al., and USF

SLIDE 2-30: PLANNING TO COMMIT SUICIDE

Planning to Commit Suicide

- Have a suicide plan.
- Begin to prepare for the suicide.
- Tell people that they are intending to kill themselves.
- The intent may be the strongest indication.

- Joiner et al., and USF 34

Say:

- *A person who is intending to commit suicide may engage in planning. They sometimes:*
 - *Have a suicide plan*
 - *Begin to prepare for the suicide*
 - *Tell people that they are intending to kill themselves.*
 - *Intent is a very important indicator of potential suicide. Those who intend to commit an act often will.*

Joiner et al., and USF

SLIDE 2-31: PROTECTIVE FACTORS

Protective Factors:

- Help the person to see that they have a reason to live.
- Help to establish meaningful relationships and a sense of belonging.
- Help them to understand how to value life.
- Help them to see that they are “wanted”.


More info at: www.bakeractraining.org and www.helpromotehope.com 35

Say:

- *There are several things that people can do to establish protective factors. Some of these are:*
 - *Help the person see that they have a reason to live.*
 - *Help establish meaningful relationships and a sense of belonging*
 - *Help them to understand how to value life.*
 - *Help them to see that they are “wanted”.*

SLIDE 2-32: MUST ASK QUESTIONS

Must Ask Questions



I want you to know that I care about you and your family, even when things are tough between us or we don't agree. For that reason, I will always ask:

- *Have you thought or felt that you might hurt yourself or others?*
- *Do you have any reason to feel unsafe now or in the past?*

24

Say:

- *When closing an interview with parents or children, there are two safety-related questions that are important to ask.*
- *Whenever we are talking with people about their emotional status, we have a primary obligation to safeguard their lives and health as well as that of others.*
- *Starting with these questions may lead to withholding, but weaving them into the screening or other conversation could save a life.*
- *Try to always ask. It can be helpful to make this part of your working agreement with everyone.*
- ***What to do when answer is yes . . .***
 - ***Call the local mental health emergency services provider to discuss the situation and develop a plan of action when you feel there is a suicide risk.***
- *Under statute, you are a mandated reporter. Try to determine if the threat or fear is real (not colloquial, i.e., ‘I could have killed him when he spilled that milk!’) but err on the side of caution.*
- *If the concern is real, you will want to get advice and guidance from your supervisor and make the appropriate referral.*
- *If you do make a referral, and you have a positive alliance with the person, it is important that they know that you will support them through the process.*

TRANSITION

- *Suicide is of course the most serious outcome of emotional distress, and is a tragic event. Child welfare workers should team with mental health professionals to ensure that they are continually watching for possible indications of suicide thoughts and intentions.*
- *As we discussed this morning, it is not uncommon for more than one member of the family to have a mental disorder. Unfortunately, because of genetic transmission and environmental factors, children of parents with mental disorders may have similar issues.*
- *The family dynamics can become very difficult if the family members have a serious disorder. However, as we have talked about before, the presence of a mental disorder does not necessarily mean that the parent can't keep the children safe.*
- *Safety for the children, and long term well-being, is dependent upon the parent's capacity to parent, just as it is with other parents. It is recognized that parents with a mental disorder that is either not treated or with escalating symptoms may pose a risk to the child.*

SLIDE 2-33: PARENT FACTORS THAT REDUCE RISK

Parent Factors That Reduce Risk

- Does not have a history of abuse or neglect.
- Has children that are older than five.
- Has another care giver in the home without a mental disorder.
- Has a history of managing her illness
- Has a support system that will assist with the children.

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SLIDE 2-34: PARENT FACTORS THAT REDUCE RISK, CONT.

Parent Factors That Reduce Risk

- Has a safety plan (advance directive) to keep the children safe.
- Does not use substances.
- Has never had psychotic symptoms. (delusions/hallucinations)
(Gopfert, Webster, and Seeman 2004)
- Has a positive view of the child.

37

Say:

- *The safety of the child(ren) is related to the degree to which the parent is able to manage the mental disorder and properly function in the parenting role.*
- *As we talked about this morning when discussing the contextual framework, many variables impact whether the parent can parent properly.*

Review the factors listed on the slide.

Ask:

How are you able to determine whether these factors are in place?

Are you able to help families put safety plans in place?

SLIDE 2-35: REQUESTING AN ASSESSMENT

Requesting an Assessment

- There are several different types of mental health assessments.
- Be clear why you are making the referral and what you want to learn.
- If possible, specify the type of assessment that you would like.
- Providers may specialize in certain areas and assessments.

38

Say:

- *If you suspect that one or more of the family members have a mental illness, it is necessary to make a referral to a mental health provider for an assessment.*
- *If the person is already in treatment, contact with the provider should give you information on the current status.*
- *If the mental illness is considered severe, a request for a parenting capacity assessment should be made.*
- *Now, let's talk about mental health assessments for parents, children, and parenting capacity.*

Materials:

Participant Guide Worksheets

**Participant Guide
Module 2, p. 18**

**Participant Guide
Module 2, p. 26**

**Participant Guide
Module 2, p. 27**

ACTIVITY 2-1: Which Assessment?

PURPOSE: For the participants to review the list of types of assessments and consider the different information that they provide.

TIME: 15 MINUTES

DIRECTIONS:

1. Ask the participants to turn to page 18 in the Participant Guide. There is a list of assessment types and a general statement of their purpose.
2. On page 26, there is a brief description of the parent, Latasha, which includes information about their strengths and some concerns that have been identified.
3. Please read both documents and answer the questions on page 27.
4. Please check your answers with others at your table.

Process:

- Ask a few tables to share how they did. Discuss briefly as a whole group.

Points to make:


- Be sure you look at all issues.
- Many participants may only think about substance abuse and domestic violence.
- What about Traumatic Brain Injury and Post Traumatic Stress Disorder?

- What about cognitive functioning?
- Did she fall because of a seizure?
- In this case the mother had TBI and the fall resulted in some additional injury which she recovered from. She had depression as well. She had many strengths including being a loving mother but needed some rehabilitative memory tools to help her meet the children's needs as well as some supportive counseling. She also needed vocational rehabilitation.

SLIDE 2-36: WORKING WITH MH PROFESSIONALS

Working with MH Professionals

- Provide as much information as possible.
- Be clear about the needed information.
- Ask how the results of the assessment will be conveyed.
- Ask about timelines.
- Ask for the results to be shared with you.
- Arrange for the results to be shared with appropriate family members.
- Ask about next steps.



Summarize the slide:

- Parents who are already in treatment with a mental health professional should not be referred for a new assessment until that treatment professional is consulted.
- A parent's perspective as to whether they are satisfied with their current treatment provider should be considered.
- The more information about the family you can share with the mental health professional, the better the results will be. Collaboration starts at the time of the referral. If possible, talk to the mental health professional about the key issues and have a clear understanding of what to expect from the assessment. Remember, releases of information are necessary.
- It is important to clearly understand how and when the results will be shared with the family members. If possible, you or an informal support should be with the family when the family members are informed of the results. The results may be very troubling to the parent or child and they may need support to understand the implications and next steps.

SLIDE 2-37: ASSESSING PARENTAL CAPACITY

Assessing Parental Capacity

Parenting Assessment:

- Parenting abilities
- Psychiatric factors
- Environmental stressors
- Available supports
- Child(ren) requirements

- Ostler, 2008
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Summarize the slide:

- Completing assessments of parenting capacity for people with mental disorders is a specialty field.
- Try to ensure that the assessor has the appropriate credentials to do this work. The parent should be fully informed about the purpose of the assessment and the possible consequences.
- Some programs integrate treatment with ongoing assessments of parenting capacity, such as child-parent psychotherapy.
- If assessments for parenting capacity are not available the child welfare practitioner may have to obtain information from several sources.
- The use of a team of individuals may be necessary to adequately assess parenting.

SLIDE 2-38: COLLABORATION

Collaboration

- Collaboration starts at the time of referral.
- Make teaming expectations clear.
- Ensure parents have appropriate supports.
- Work with the mental health professional to support the family members.
- Create a sense of "working together" not taking "sides".

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Summarize the slide:

- The referral is the time to start your collaboration with the family's individual team. It is important to try and start a good professional working relationship.
- Be sure that the mental health professional understands that you expect them to function as part of a team to work together to better understand the family's needs and provide them with the necessary supports.
- Be sensitive to the parent's or child's reaction to the assessment results.
- No parent or child wants to hear that a family member has a mental disorder. It can be very frightening. They may need help in coming to terms with this and understanding what it means.
- Remember that we hear mental health diagnostic labels being discussed on a regular basis but the children and families do not. The first time someone hears a diagnosis applied to their child or to themselves can be devastating.
- Partner with the mental health professional to support the family through this process.
- Help the families get in touch with local groups such as National Alliance on Mental Illness or Federation of Families may be helpful.

- The mental health professional, the family members, and you should work together to form a team with a common purpose: safety, permanence and well-being for the child and family.

Materials:

Blank Trainer Handout 1-2A: Family Assessment Form

Blank Trainer Handout 1-2B: Key Information for a Family Assessment

Flipchart paper

Participant Guide Worksheet

ACTIVITY 2-2: Family Assessment

OPTIONAL ACTIVITY DESIGNED FOR CASE MANAGERS.

PURPOSE: To better understand how to use the solution focused questions, screening process and the results of the assessments to complete the Family Assessment.

TIME: 20 Minutes

DIRECTIONS:

1. Hand out a blank version of the Family Assessment from the Florida Safe Families Network (FSFN) and the Key Information for the Family Assessment worksheet.
2. Ask the participants to refer to the scenario on page 26 of the Participant Guide. This is the same one that they used for the earlier assessment activity.
3. Working together at their tables, ask the participants to talk about how they would gather the information for the following sections of the family assessment:
4. What questions would they ask the parent?
5. How would they find out the necessary information about the impact of a parent's mental disorder on the family's ability to keep the children safe and address their emotional/developmental well-being?
6. What resources are available in the community to help them address these issues? What resources do they need in the community?
7. On the flipchart paper, ask the participants to record what they think are the key pieces of information that they would need to gather in order to address the child's safety and well-being.

**Participant Guide
Module 2, p. 26**

8. Ask the participants to place the chart paper on the wall. One person from the group will remain at the display to explain to others the group's information.
9. The other members of the group will walk around the room and talk with each other about what they thought and what would be some of the likely resources to obtain this information.

Process the Activity:

When group members return to their seats ask them a series of questions regarding the activity. Example questions include:

- ***What key questions would you want to ask the family members?***
- ***What issues might come up when you ask these questions? How could you address those issues?***
- ***How can you reduce the parent's fear about discussing these issues with you?***
- ***What type of formal assessments would you want to obtain? How do you think that family member will react when you ask them obtain the assessment? Why?***
- ***Are the mental health providers in your Circuit prepared to provide you with the necessary information for a good assessment of the impact of the mental disorder on parenting? Is the parenting capacity viewed within the contextual framework?***
- ***Do these assessments including parent-child observations and measurement of progress in parental relationships?***
- ***How do you assess the child's situation and the impact of the mental disorder on the child? Do different children react differently to the mental disorder with one of their parents? What patterns have you seen?***

Say:

Remember that in attachment and connectedness, the quality of the relationship is key to child development and usually to child safety.

SESSION SUMMARY

Summarize:

- In this session, we've focused on mental health screenings for infants/toddlers, preschoolers, children and adolescents, and adults.
- We've stressed that many maladaptive behaviors do not necessarily imply a mental disorder, nor does the presence of a mental disorder necessarily imply that a parent doesn't have the capacity to parent a child well.
- We've discussed common mental disorders and how to observe for them – and how to use previous records and interviewing questions to screen for them.
- Your job is to suspect and check for mental health disorders, and, if you feel they are possible or likely, to refer the family member for a mental health assessment.
- We concluded the session by discussing various assessments, how to discuss the results with the family members, and how to establish a team to promote child safety, permanence, and well-being.

Say:

I would like to end this section by sharing two stories with you about how mental disorders impact children. The trainer should share a story either from the research or their personal experience about how a child looks back and views their childhood experience living with a mother with a serious mental disorder.

Then end with the following information and quote.

At the closing of “Assessment of Parenting Competency in Mothers with Mental Illness”, by Teresa Ostler, 2008 the author invited a young woman who grew up with a mother with a mental illness to describe her experience.

The young woman ended her comments with the following statement, “The problems that families who encounter mental illness may face are vast. The surface picture does not always present a clear picture of what the experience is like for every member of the family. Look deep. Look hard. Pay attention to the small details.

Please do not assume the just because a parent is mentally ill, it means that he or she cannot care for or love his or her children. Please do not assume that just because a parent is mentally ill, it means that his or her children are too. I know that my mom was far from perfect, but I am still glad that she was part of my life. As strange as that sounds, I am. There is love behind the mask of mental illness. There is also hope.”