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Children's Services Practice Notes is a newsletter for North Carolina's child welfare workers produced four times a year by the North Carolina Division of Social Services and the N.C. Family and Children's Resource Program, part of the Jordan Institute for Families and the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing recent research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace regular supervision and peer consultation—only to enhance them.

Let us hear from you!

If you would like to comment about something that appears in this or any other issue of Children's Services Practice Notes, please do so! Address your comments to:

John McMahon

Jordan Institute for Families

UNC-CH School of Social Work

Chapel Hill, NC 27599-3550

State Courier Number: 17-61-04

E-mail: johnmcmahon@mindspring.com

Newsletter Staff

Joanne Caye, MSW, Advisor

Lane Cooke, MSW, Advisor

John McMahon, MA, Writer/Editor

Selena Berrier, Writer

Daniel Brezenoff, Writer

Michelle Wetherby, Writer

CHILD WELFARE AND MENTAL HEALTH ISSUES

A lot of mental health issues affect children's services. There are those that have to do with mental illness, developmental disabilities, and substance abuse in the families and children you see in your work. Then there's the challenge of maintaining your own mental health while you work with families in crisis.

And then there are the interagency, professional-to-professional issues of interacting with mental health workers and with North Carolina's large and sometimes confusing public mental health system. These are the issues

that lead to questions such as, "why won't they accept my referral?" or "why does it always come back to the issue of confidentiality?" or "what's going on over there—I can't keep up with all the changes!"

This edition of *Practice Notes* is primarily concerned with this last issue—the challenge of working effectively with our state's mental health system. We hope these pages will help you in your efforts to collaborate with the people in the mental health system, and to improve outcomes for the families and children you serve.

COLLABORATION WITH MENTAL HEALTH: INSIGHTS FROM AN "OUTSIDER"

Today it is widely accepted that families and children benefit when DSS and mental health systems collaborate. But what does that mean to you? What, specifically, can child welfare workers do to achieve and improve this collaboration?

To get the perspective of someone who really knows what it's like to work in both these systems—simultaneously—*Practice Notes* contacted Jay Taylor. A psychologist employed by Cleveland Center, Cleveland County's mental health center, Taylor has an office located in Cleveland County DSS. From this unusual vantage point, he sees the challenges faced by two systems charged with serving many of the same families.

PN: What do child welfare workers need to know about the mental health system in North Carolina?

MH is undergoing flux at the state level: developing, changing, and adapting programs in different areas.

There are 40 different area programs. Each does business in a somewhat different way. Because area programs tend to be different from one another, it's hard to make suggestions or give advice for working with MH that will be applicable statewide.

Still, it would be very useful if every worker knew when and how to make an appropriate referral to MH. They should understand



Jay Taylor

the criteria for treatment and recognize the guideposts that indicate treatment might work.

But since things are slightly different across the state, I'd recommend DSS invite MH folks into their agencies to do inservice training on this subject—to tell them about referrals,

and about what resources are available to them.

As a result of this, DSS workers should experience less frustration, and MH folks will get higher numbers of viable referrals.

For example, they'll get fewer requests to evaluate whether someone can be a successful parent. This seems simple, but it's not.

PN: What are some of the trends affecting MH that child welfare workers need to know about?

DSS social workers sometimes have difficulty recognizing or understanding that MH systems are trying to do more with less—the traditional ways of treatment are changing. Specifically, MH agencies are increasingly recognizing the value of group therapy formats to affect change for clients. This is especially true for the problems that confront families DSS sees. There are a lot more parenting, relationship, post-trauma, and skill-building groups.

Another one of MH's biggest challenges is finding ways of dealing with the pervasive deficit of social skills. To deal with this and other problems in the people we see, MH centers are trying to establish more efficient, non-clinic based ways of promoting MH—more in line with community centers, family resource centers, etc. MH is beginning to recognize these as informal treatment modalities.

PN: What effect does this have on child welfare social workers?

I think it affects case planning the most. It used to be that social workers could more or less count on the fact that there'd be openings for clients they referred for individual therapy. That's not so true anymore.

Another big movement in MH is toward more family-centeredness, more family autonomy and decision making. Actually, this is something DSS's and MH centers will find in common, especially with DSS initiatives like FFK and Challenge for Children and MH initiatives like CAP-MR and NC-FACES (which bring families in as partners in planning and decision making). The family-centered approach could be an important point of contact between the two systems.

PN: What do you think the future of the MH/DSS relationship looks like, especially for line social workers in DSS's?

When working with MH, DSS workers will continue to face difficulty regarding legal and confidentiality issues. It is important for them to un-

derstand that MH isn't trying to be difficult, they're trying to comply with increasingly complex guidelines. When social workers see them as making the rules up rather than just complying with them, the friction increases.

I also think that as time goes on, DSS workers will be expected to really understand how other systems work. The more you know about the MH systems in your area, the more you'll be able to help the families you serve.

PN: Do you have any parting words of advice?

I'd recommend line workers get to know somebody at your local MH center you can call regarding particular cases, referrals, resources, etc., someone you can call and just pick his or her brain. It would be ideal if every child welfare worker had one MH worker they could call if they had a question.

Also, it may help to remember that both systems are trying to do more with less. One solution is to share resources.

SUGGESTIONS FOR WORKING WITH MENTAL HEALTH

- Individual line workers can make a difference by
 - getting to know a MH worker in your area and
 - finding out about the criteria for referrals and area resources
- Supervisors and managers can make a difference by sitting down with MH representatives to
 - resolve the system conflicts that can hold up cases
 - get a sense of what their counterparts are doing
 - open lines of communication. If each knows what the other is doing on an ongoing basis, we'll be less likely to replicate or impede each other's efforts to help clients, and we'll be able to avoid embarrassing and troublesome situations (e.g., when a family has two home visits from two different agencies on the same day).
- Remember that both systems are facing the issue of how to do more with less. One solution is to share resources.
- Understand that each area program does things differently and try to find out how things work in your community.
- If difficulty arises regarding legal and confidentiality issues, remember that MH isn't trying to be difficult, they're trying to comply with increasingly complex guidelines.

"The family-centered approach could be an important point of contact between the two systems."

WORK FIRST, QSAPS, AND COLLABORATION

Because they seek to improve outcomes for families, North Carolina's departments of social services and mental health centers are working together as never before.

Work First, with its requirement that those involved in the program be screened for substance use problems, is a major contributor to these new interactions. To meet this substance-abuse screening criteria of Work First, mental health centers have been hiring new QSAPs, or Qualified Substance Abuse Professionals, often locating them on-site at DSS.

In an effort to shed some light on this new arrangement, *Practice Notes* interviewed several agencies in the Northeastern part of the state. What follows is a look at how the relationship between DSS and mental health changed as a result of this collaboration around Work First.

A MULTI-COUNTY EFFORT

The Work First Program in the North Hampton, Bertie, Hertford, and Gates county DSS programs began in April 1998. At this time the mental health agency in the area, Ronoake/Chowan Human Services Center, and the DSS's met to work out a plan. A meeting was scheduled in which the staff from the various agencies were introduced and the referral process was explained.

In addition, the mental health agency conducted some training for DSS staff that included role playing, information about substance abuse and dependence, and an introduction to the AUDIT and the DAST, two tools used for substance abuse screening. Several months later these groups met again to discuss confidentiality, the referral process, and to explain the various roles people would have with Work First.

These meetings helped both agencies understand their respective legal constraints, including state and federal regulations. This meeting also helped the agencies connect on a more personal level as they spent time together, where previously they had not known each other.

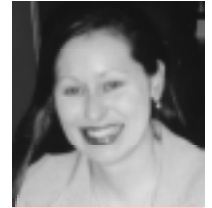
At first DSS staff were somewhat ambivalent about the mental health aspects of the Work First Program. Behind this lay the fact that they did not feel qualified to use the AUDIT or the DAST, and because they had lots of other paperwork.

THE QSAP

This ambivalence was eased by Heather Stoume, who was hired by the mental health agency as the QSAP for Work First. Early on Stoume sat in on some interviews to facilitate the screening process, made sure people knew her, explained what her role would be, and provided additional training to DSS staff members who missed the initial training session.

Heather puts herself "out there." She is direct about her

dedication to the clients and her desire that the program work. She stays visible, makes herself available, and attends meetings. She communicates with DSS regularly regarding clients' progress, letting DSS know whether clients are in treatment and whether they are following the treatment plan. She's treated as a part of the DSS team.



Heather Stoume

LOGISTICS

Heather has set up days she will be in various clinics: she spends one day in each county and Fridays at the mental health center. She is shuffled around and sits where office space is available. Her phone number is posted all over the clinics and most people know her schedule.

Clients sign a release of information form so Heather can obtain information from DSS about the substance use screening results. Once a client is referred to her, she conducts the SUDS-4 (Substance Use Disorders Diagnostic Schedule - 4) which takes about an hour and a half to complete. If a client scores in the substance abuse or dependence range, an appointment is set up with a substance abuse counselor, and, if necessary, transportation is arranged.

Once a client has been referred to treatment, Heather follows up to make sure the client is attending his or her appointments and reports back to DSS. This is important because TANF benefits can be reduced if a client fails to participate in prescribed substance abuse treatment.

RESULTS

The Work First collaboration has helped the Ronoake/Chowan Human Services Center and the social service agencies involved develop a better understanding of each other's strengths and limitations. For example, DSS now knows more about the services offered by the mental health center, and the mental health center appreciates the amount of paperwork involved in a client case, as well as the strain associated with the large case loads in Work First.

And, by giving them the QSAP, Work First has expanded DSS's capacity by providing them with a professional to call on when they have questions related to mental health or substance use.

Sources

- Wanda Piland, R.N., B.S.N., C., Adult Program Manager, Roanoke, Chowan and Human Services Center
- Renee Shaw, B.S. Work First Employment Services Social Worker, North Hampton County Department of Social Services
- Anna Sheyett, MSW, CCSW, Behavioral Healthcare Resource Program, Jordan Institute for Families, UNC - Chapel Hill School of Social Work
- Heather Stoume, B.A., Substance Abuse Counselor, Roanoke/Chowan Human Services Center

UNDERSTANDING NORTH CAROLINA'S MENTAL HEALTH SYSTEM

Social services and mental health are two of the biggest care systems in our state. Understanding the pressures that the mental health system faces will help you promote a better working relationship between the two systems and, ultimately, provide better service to the families and children who use them.

OVERVIEW OF MENTAL HEALTH

The public system of mental health treatment and services in North Carolina is provided by 40 area programs. Each area program must provide services for people with mental illness, developmental disabilities, and substance abuse problems. However, services are strictly voluntary and provided on the basis of "medical necessity" and clinical judgement.

All area programs have one or more mental health centers where these services are provided, and/or they may contract with other entities to provide some services. In general, area programs provide a range of services that may include:

- Assessment, diagnosis, and a treatment plan
- Individual or group therapy
- Case management, which may include helping individuals locate housing, apply for SSDI (Social

Security Disability Income) or SSI (Social Security Income), manage their personal finances, or periodic follow-up on an individual's condition (NAMI of NC, 1998). It is important to note that not all clients receive case management to this extent.

- Psychosocial day programs (clubhouses)
- Medication management
- Crisis services
- Partial hospitalization/day treatment programs
- Other in-home services, such as high risk interventions for children

In addition, four state psychiatric mental hospitals also provide treatment for people with mental illness. Admission to a state hospital (whether it is for long- or short-term treatment) usually requires an evaluation at one of the area programs.

MISSION STATEMENTS

The mission of the N.C. Division of Mental Health, Disabilities, and Substance Abuse Services is to "enable North Carolina's most vulnerable and disabled persons with mental, developmental and substance abuse problems to exercise their rights and responsibilities as citizens" (NC Div. of MH, 1998). The N.C. Division of Social Services mis-

supporting and self reliant" (NC Div. of SS, 1998).

Despite the difference in focus found in these mission statements, the approaches of these two agencies are not completely different. The differences that do exist, however, sometimes cause tension or misunderstanding that obscures the fact that mental health and DSS often work with and care about the same families. Closer collaboration between child welfare and mental health workers is one way to get beyond misunderstanding and improve outcomes for families and children.

Understanding the pressures on the mental health system should make this collaboration easier.

PRESSURE ON THE SYSTEM

Following a budget crisis in 1991, state mental health officials were desperate for other sources of money and encouraged area program directors to go after federal funds, particularly Medicaid money. Although the federal money funded an expansion of services, it required a state "match." In a match arrangement the state and county pay approximately 30 percent of all claims and the federal government pays the remaining 70 percent.

A federal investigation regarding Medicaid billing by the mental health centers between 1995 and 1997 revealed that North Carolina owes the federal government \$17.5 million for improper billing. The "improper billing" reflects the extra charges area programs attached to some services in order to cover expenses for services to clients (including children) without insurance of any type. "Center directors and their advocates say they plowed the money they saved into

THREE THINGS TO KEEP IN MIND ABOUT NC'S MENTAL HEALTH SYSTEM

- Mental health treatment is not a mandated service—it requires the client's consent.
- Treatment cannot occur without a formal clinical diagnosis of the client.
- Services are provided on the basis of "medical necessity" and clinical judgement.

services for people without Medicaid or any other health insurance, many of them substance abusers" (Heath & Clabby, 1998). The result of the \$17.5 million payback will be a reduction in the Medicaid flow to the centers by up to \$40 million a year.

The pressure to pay back funds while providing quality services has put a strain on the mental health system throughout the state. Child welfare workers need to recognize that as mental health resources become more scarce, local collaboration between mental health and child welfare is critical.

In the years to come, strong, collaborative relationships will be essential if families and children in need of care are to have continued to access the services they need.

WHAT YOU CAN DO

- If child welfare and mental health workers in your area aren't meeting already, organize or suggest a meeting. Use the meeting to discuss the changes occurring and ways you might work together to best serve clients.
- Use staff meeting and supervisory time to raise the issue of collaboration between the two systems.
- Keep up with the changes. Pay attention to news stories about the mental health system so you know what is happening.
- Use every opportunity you have to make connections with workers in the mental health system.

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N.C. DIVISION OF MENTAL HEALTH PROGRAMS AND SERVICES

Carolina Alternatives: Provides mental health, developmental disabilities and substance abuse services to citizens in all 100 counties through 40 area authorities for MH/DD/SA services (Area Programs).

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD): A Medicaid program serving individuals with the MR/DD (ICF/MR) in the community instead of in an institution or group home setting.

Developmental Disabilities Section (DD): Provides services for North Carolinians with developmental disability, developmental delay, atypical development, and those at risk for these conditions.

Mental Health Services (MH): Promotes improved quality of life for adults with severe and persistent mental illness and for other persons (and their families) affected by significant mental health problems.

Substance Abuse Services Section (SAS): Branches include Adult; Child, Adolescent, and Women's; DWI/Criminal Justice; Prevention; Employee Assistance; and Drug Regulatory. Specialty functions include Administration; Institutional Services; Research and Planning; Policy; and Educational Services.

Child and Family Services: Facilitates and monitors non-residential and residential child mental health services in each of the 40 Area Programs, as well as in the children's units in the four psychiatric hospitals, and in the two residential re-education centers for children. These services are for children ages birth to 18 (and their families) who have or are at-risk for emotional disturbance.

Thomas S. Services: In order to become members of the Thomas S class, individuals must have resided in one of NC's psychiatric hospitals on or after March 22, 1984, as an adult, and must have a diagnosis of mental retardation or have been treated as such. The treatment of these individuals, based on the District Court's Order, is to be provided in a manner that promotes their independence, enhances their dignity, and is as consistent as possible with societal norms, in view of each person's individual and special needs.

Crisis Services: Works with citizens with psychiatric and/or alcohol and other drug disorders and/or developmental disabilities by initiating and supporting the development and ongoing improvement of crisis response and crisis stabilization services, and crisis prevention services for individuals who are high users of emergency and inpatient services, especially those individuals with multiple, co-occurring disorders.

Willie M. Services: Services for children under age 18 who are seriously mentally, emotionally, and/or neurologically handicapped with accompanying violent or assaultive behavior; who are likely to be involuntarily institutionalized or placed in a residential program; and who are not receiving appropriate treatment, educational, or rehabilitative services. Each child is provided medical treatment, education, training, and care; the least restrictive living conditions appropriate for his/her needs; and placements and services that are actually needed, rather than those that are currently available.

Source: N.C. Department of Health and Human Services, Mental Health Division. (1998, August 4). [Online]. <<http://www.dhr.state.nc.us/DHR/DMH/>>

WORKING WITH ADULTS WITH MENTAL ILLNESS

While most parents with mental illness do not abuse their children, and while the parents of most abused children are not mentally ill (National Clearinghouse, 1994) child welfare workers often encounter adults with mental illness. Making the appropriate referrals is extremely important in such cases.

However, once you have assisted an adult with mental illness in reaching people who can address his or her needs, you will probably still be interacting with this person, perhaps very closely. You may be required to share some decision-making regarding his or her children.

The children who are your clients are part of a larger system that includes their close family members (Anderson & Carter, 1990). The mental illness of an adult in the household can have a powerful effect on children (Schlosberg & Kagan, 1977). You and your clients may face difficult situations that require you to interpret, understand, and react to an adult's actions when those actions may be confusing, or even frightening, due to the adult's illness.

It is therefore important to have some basic knowledge and skills regarding adult mental disorders. Mental illness is distinct from developmental disabilities, such as autism or mental retardation (DSM-IV, 1994). While these ailments are also risk factors for abuse (Cantwell, 1980; Frude, 1989), and may introduce new difficulties into your work, we will limit our discussion here to working with adults with mental illness.

Mental illnesses are extremely varied. Some can be quite serious and debilitating; others may be so mild as to go unnoticed, even by mental health professionals. Since your client is the child, you aren't there to treat the adult's illness. Attempting to do so would be inappropriate (Reamer, 1995; Hepworth & Larsen,



Being mentally ill does not automatically prevent someone from being a good parent.

1997). However, increasing your knowledge can prepare you to work more effectively with adults who are mentally ill.

Learn About Mental Illness. Consider reading further about mental illness, especially any particular illness that affects the adults with whom you work. You can discuss these issues with mental health professionals, remembering to respect the confidentiality of the adult in question. Learning about mental illness can help you work with a mentally ill adult and avoid stigmatizing mental illness.

Avoid Stigmatizing Mental Illness. Adults with mental illness have long been the victims of severe social stigmas, based on the assumption was that they had a moral deficiency (Lin, 1995). Today, professionals recognize that most individuals with mental illness suffer from a biological imbalance of the chemicals in the brain; this is why many medications are effective in treating mental illness (Kramer, 1993). Other contributing factors to mental illness include medical conditions, stress, trauma, severe childhood abuse, prolonged substance abuse, exposure to toxins, and genetically inherited traits (DSM-IV, 1994; Rauch, Sarno, & Simpson, 1991).

Balance Flexibility with Firmness. You can expect that parents with mental illness will be difficult to work with sometimes. Depending on their particular condition, they may be unwilling to accept

responsibility, unable to remember agreements, untrustworthy, difficult to understand, inconsistent with discipline, poor at keeping appointments, and unpredictable emotionally (Schlosberg & Kagan, 1977). They may generally demonstrate confusing behavior.

On the other hand, adults with mental illness, like everyone else, are responsible for their actions. Missed appointments, lying, and dangerous behavior cannot be accepted. Communication with your supervisor—or with the appropriate mental health professionals on your agency's staff—is the surest way to avoid problems (Shulman, 1995).

Good Supervision is Critical. In dealing with adults with mental illness it is crucial that you receive consistent supervision from someone with the professional training and experience to assist you. This person will be able to help you make the distinction between appropriate flexibility with a mentally ill adult and inappropriate collusion with that adult. In other words, a certain amount of tolerance may be necessary to get your job done.

Confidentiality. Confidentiality may also become an issue with adults with mental illness. Keep in mind that only information essential to the treatment of your client and the safety of staff, clients, and other individuals need be shared with other professionals, and only people legally allowed to have such information should get it (Reamer, 1995; Hepworth & Larsen, 1997). Working with adults with mental illness may provide some interesting stories, but these individuals are entitled to privacy, and breaking confidentiality is a serious offense. Speak with your supervisor about any questions you may have about this.

Monitor Your Level of Involvement. It may be appropriate to offer some lim-

ited assistance to adults with mental illness in the family of your juvenile client. Letting the adult know about services in the community or handing the adult a bus schedule can be a very useful way of relieving family stress without taking on the role of “rescuer” (Schlosberg & Kagan, 1977). But the safety of the child(ren) is your primary concern, and becoming over-involved with the parents can be detrimental.

There is also the risk of forming an adversarial or confrontational relationship, and this, too, can be harmful to your work. *Countertransference* (emotional reactions on your part that affect your work) is a serious risk. It is easy to become frustrated or angry with an adult’s inappropriate behavior. It is also understandable that you feel sympathy for people with mental illness and that you may want to help them (Lin, 1995). But allowing these reactions to interfere with your primary role would be unprofessional and detrimental to your work (Schlosberg & Kagan, 1977; Hepworth & Larsen, 1997).

Focus on Strengths. It would be quite easy to regard people with mental illnesses as crises waiting to happen and, focusing on their problems, to view their situations as hopeless. But rather than focusing on the problems, you will meet with more success and reduce stress and stigmatization if you seek to find the particular strengths of each individual, family, and system.

So, while a parent may have a severe mental illness, such as depression, that person may also be extremely intelligent. Or, while a parent may be suffering from substance abuse disorder, he or she may express great love for his or her children, and be willing to receive assistance with parenting skills.

No matter how severe the mental illness, there are always strengths to be

built upon. Take the time to learn about your clients’ families and their strengths; they will appreciate it, and everyone will benefit (Hepworth & Larsen, 1997).

Treat Everyone As A Person First. It is best to approach adults with mental illness in the same way you would relate to anyone—with respect, with appropriate boundaries, and with an understanding of that person’s role in the life and care of your client. Therefore, discussing parenting strategies with a parent with mental illness, just as you would with another parent, is appropriate.

Granted, this may be more difficult due to the parent’s illness. While many with mental illness are extremely intelligent and motivated, a severe mental illness can present communication barriers, and may hinder the parent’s ability to implement parenting strategies. Yet each parent will have strengths that can serve as a starting point. The ability to read, or a sincere motivation to learn, can be the perfect starting point for a struggling parent.

Certain mental illnesses may make it difficult or impossible for a parent to care for children effectively and consistently (DSM-IV, 1994). A mental health professional, such as a psychiatrist, psychologist, or clinical social worker, may recognize these situations; he or she may also be able to treat parents with therapy or drugs so that they are again able to function as a parent.

The training given to a child welfare worker may enable you to judge that a particular parent is being neglectful due to mental illness.

However, when judging whether the parent with mental illness is capable of proper care, the same criteria should be used as with any other parent—that is, your careful, informed observation. Simply being mentally ill does not disqualify someone from being a parent. In fact, many adults with mental illness benefit from the structured approach to parenting offered by child welfare workers. In the end, people with mental illness are just human—no more, no less.

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PRACTICE TIPS

1. Afford the same respect to people with mental illness as you would to anyone else.
2. Take a strength-based perspective.
3. Watch for signs of abuse or neglect, just as you do with other parents.
4. Be flexible, but expect adults to take responsibility for their actions.
5. Do not try to rescue or cure the person with mental illness; instead, make referrals.
6. Communicate with your supervisor frequently.
7. Honor confidentiality.
8. Don’t take things personally. Don’t get frustrated. Be patient.
9. Take some extra time to learn about the person’s illness by reading or talking with professionals.

MH REFERRALS

What constitutes a “viable” referral to a mental health agency? Because things work in slightly different ways in North Carolina’s 40 area mental health programs, there is no one answer to this question—depending on the MH center, you’ll get a different response about what DSS workers need to know. The best solution to this might be, as Jay Taylor suggests, to invite representatives of your local MH agency to conduct an inservice training on this subject at DSS.

While a tailor-made workshop is the ideal, there are certain things you can do to increase the chances that the referrals you make will work for you, your counterparts at mental health, and the families you serve. The following suggestions emerged from interviews *Practice Notes* conducted with several practitioners from area mental health programs.

IMPROVING REFERRALS TO MENTAL HEALTH

- 1. Inform mental health about the reason for the referral.** Without this, mental health workers must ask parents and children why they have come to the clinic. If the person doesn’t know (or claims not to know) beyond “I’m here because DSS sent me,” MH will be hampered during the intake screening. For example, if the referral is for sexual abuse but the client denies sexual abuse, MH often will move on in the evaluation rather than “fishing” for an answer. A phone call or a letter could provide this information.
- 2. Consider using a client-information release form.** If there were a form clients could sign allowing DSS to release information to other agencies, DSS would be free to list the presenting problem as part of the referral, including a court order, if applicable. For example, the referral could state that the client needs to be evaluated for substance abuse, providing detailed information. Ample detail in the referral gives MH a better idea where to begin in treatment.
- 3. Include appropriate client contact information.** If a work number is obtained, note what times are suitable to call the workplace. If a client does not have a phone, list an alternate phone number of a friend, etc.
- 4. List other agencies and professionals involved in the case.**
- 5. Clearly state your agency’s expectations for the referral outcome,** as well as what your continuing role would be in the case.

Sources

Ursula Nerdrum, MSW, Adult Therapist, Franklin County Mental Health Center; Joyce Smith, B.S. Clinical Case Manager, Child and Family Services, Warren County Mental Health Center; Anita Toney, RNC, LPC, Director, Warren County Mental Health Center

IN THIS ISSUE: WORKING WITH MENTAL HEALTH

Family & Children’s Resource Program
Jordan Institute for Families
UNC–School of Social Work
Campus Box 3550
Chapel Hill, NC 27599-3550
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