PROMOTING RESILIENCY IN CHILDREN, FAMILIES AND COMMUNITIES:
Connecting Schools, Public Health and Mental Health

Missouri Bright Futures
Spring Workshop 2006

Developed by Georgetown University National Technical Assistance Center for Children's Mental Health and Bright Futures at Georgetown University.
Facilitated by Cathy Ciano, Neal Horen, Ph.D., Ellen B. Kagen, MSW, and Rochelle Mayer, Ed.D.

AGENDA

8:00–8:30 Registration

8:30–8:45 Welcome and Introductions

8:45–9:15 Looking Back and Looking Forward

An interactive session to highlight the importance of the public health approach to mental health and linking our professional skills in a collaborative environment. The Comprehensive System Management Team (CSMT), which guides state and local leadership, policies and practice in promoting the public health approach to mental health, will be shared. This session will also give communities the opportunity to design a vision for the future service delivery system.

9:15–10:15 BARRIER BUSTERS: Family Engagement and Involvement

Through a variety to activities, participants will be exposed to the inner journey of families experiencing multiple stresses and learn valuable lessons about how to engage and build strong relationships through understanding mental models, shifting paradigms from deficit to strength based models and understanding the role of culture in building trust.

10:15–10:45 BARRIER BUSTERS: Informed Consent and Issues of Confidentiality

The State of Missouri will introduce an interagency confidentiality form that can be used when working as a team with families. In addition, through a series of role plays, participants will examine the issues of trust and family involvement as they relate to informed consent.

10:45–11:00 Break

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11:00–11:25 BARRIER BUSTERS: Facilitated Referrals and Individualized Care Planning

Community teams will be challenged to implement needed referrals within a variety of constraints. Participants will be exposed to the Individualized Care Planning approach and examine the application of Individualized Care Planning principles to supporting families and promoting the social and emotional well being of children.

11:25–12:15 Bright Futures and Systems of Care

The application of Bright Futures to "Barrier Busters" will be reviewed and new Bright Futures tools to promote social and emotional development will be introduced. In addition, tools for creating a referral network and resources for locating community-based services will be presented to help communities design a facilitated referral system that is based on knowing when to seek help, where to seek help and how to seek help. Resources available through the MCH Library (mchlibrary.info) will be featured.

12:15–1:00 Lunch

1:00–3:00 Using Bright Futures Tools In Practice

Part One: Through scenarios on maternal depression and child maltreatment, participants will use the Bright Futures Tools and other resources to address family engagement, confidentiality, facilitated referrals and individualized care planning

Part Two: Through scenarios on trauma from natural disasters and obesity, participants will address child, family and community challenges using the public health approach to mental health.

3:00–3:30 Planning for the Future: Structure, Process and Leadership

Community teams will consider next steps in implementing structures, processes and leadership to serve the social and emotional needs of all children.

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Workshop Presenters

Cathy Ciano
Executive Director
Parent Support Network of Rhode Island

Cathy Ciano is currently the Executive Director of the Parent Support Network of Rhode Island, a statewide family organization, which advocates for the needs of families who have children, youth, or young adults with mental health and related challenges. As a family leader, Ms. Ciano has partnered in shaping state policies and practices as they relate to children's mental health; provided ongoing training in developing family driven and culturally responsive approaches; and empowered a strong cadre of family advocates. Ms. Ciano has shared her experiences through many formal presentations, consultations, and training both statewide and nationally. Ms. Ciano is also a faculty member of Georgetown University's National Leadership Academy.

Ms. Ciano is the parent of five children ranging in ages from 18-27. Two of her oldest children who are now young adults have struggled with bi-polar disorder and substance abuse issues for the last ten years. Ms. Ciano's experiences with navigating service systems for her family, has provided her with the insight and knowledge to become a strong family advocate working within the systems of care. She has had to learn first hand the challenges of working with the Juvenile Justice, Child Welfare, Special Education and Behavioral Health systems. Ms. Ciano continues to advocate for an integrated systems approach recognizing that the needs of children and families cut across systems.

Ellen Kagen, M.S.W.
Director of Communities Can
Georgetown University Center for Child and Human Development
National Technical Assistance Center for Children's Mental Health

Ellen B. Kagen, MSW, Director of Communities Can at the National Technical Assistance Center for Children's Mental Health, has over 20 years experience working in the field of children's services and collaboration. Her areas of expertise include leadership, strategic planning, service system infrastructure, negotiation and conflict management, and interagency collaboration at the state and local levels. Ms. Kagen is on the faculty of Georgetown University at the Center for Child and Human Development where she also directs their Leadership Academy, a national leadership learning and consultation effort for families and professionals in the field of health and human services. She also is the editor of their

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leadership training curriculum which focuses on the leadership role in systems change and transformation. Prior to her work at Georgetown University, Ms. Kagen served as the Deputy Director of the Robert Wood Johnson Foundation's, Mental Health Services Program for Youth (MHSPY) and the Deputy Director of the National Resource Network (NRN) for Child and Family Mental Health Services at the Washington Business Group on Health. She has a wide range of experience training and facilitating at the national, state and community levels and regularly trains and consults with such entities as the: Texas Health and Humans Services Commission, New Jersey Division of Health and Mental Health, St. Louis System of Care, Missouri Department of Mental Health and the Oregon Children's Commission. She holds an MSW in social strategy from the University of Maryland and a Certificate in Leadership from Harvard University's Kennedy School of Government.

Neal M. Horen, Ph.D.
Co-Director Training and Technical Assistance/Clinical Psychologist
Georgetown University Center for Child and Human Development
National Technical Assistance Center for Children's Mental Health

Dr. Horen is a clinical psychologist who has focused on community-based work for the last ten years. He has developed and coordinated a violence prevention effort focused on capacity building, as well as served as Associate Director of the Early Childhood team of the National Technical Assistance Center. In that capacity, Dr. Horen has worked closely with numerous states and communities in development of systems of care for young children and their families. Currently, he is working closely with a native health corporation serving 58 Yupik Eskimo villages in Southwest Alaska on how to develop a system of care for children birth to five. In addition, Dr. Horen continues to spend time working in direct clinical care including development of social skills interventions for young children, reflective supervision of early childhood mental health clinicians, He also serves on several national committees including the Early Childhood curriculum committee of the National Traumatic Stress Network grant program. He is director of the HOYA clinic that offers therapeutic and assessment services for children and families.

He also is Director of the State Infrastructure Grants Technical Assistance Center which assists states to: 1) learn skills and strategies for comprehensive cross agency planning to improve service delivery systems for youth with co-occurring disorders and their families; 2) develop effective partnerships with SAMHSA funded community grant sites; and 3) sustain and grow community-based systems of care as part of an overall state plan. Dr. Horen's primary interest is in early childhood mental health and he has lectured extensively on infant mental health, as well as the impact of trauma on child development. Dr. Horen is married and is the father of three children, ages, 6, 5, and 5.

Rochelle Mayer, Ed.D.
Research Professor and Director
National Center for Education in Maternal and Child Health
Bright Futures at Georgetown University

Rochelle Mayer is Research Professor and Director of the National Center for Education in Maternal and Child Health (NCEMCH) at Georgetown University. Since 1985 she has provided leadership for the National Center's mission and activities, serving as Principal Investigator of the Maternal and Child Health (MCH) Library and over $50 million in research grants to improve health services for children and families. Current projects include the MCH Library, the Project on Pediatric Care Linkages for Developmental Services, and the Bright Futures Tools for Social and Emotional Development. Dr. Mayer is also Editor of *Educating Children for Democracy*, the professional journal of the International Step by Step Foundation. Prior to coming to Georgetown University, Dr. Mayer served as Education Director of the Infant Health and Development Program at Harvard University and as Research Psychologist at Bank Street College of Education.

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Looking Back Exercise

TABLE ACTIVITY

- Please make notes on this form about how you have used Bright Futures and new ways in which you have interacted with others in your community.
- Assign a recorder and facilitator.
- Have a brief conversation at your table. Each person will share one way they have used Bright Futures and one new interaction with community partners that has occurred as a result of the Georgetown Missouri Bright Futures Fall training (about 30 seconds per person).

What have you done differently since the Georgetown Missouri Bright Futures Fall Training (5 months ago)?

Use of Bright Futures Mental Health Guide and Tool Kit:

New linkages with Community Partners:

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Creating a Shared Vision of the Future

Using the materials on your table and the flip chart paper, create an artistic representation of what you would like your community system to look. **Create a system that would serve the needs of all children and their families.**

Be as creative as you can and feel free to use metaphor.

Think about…. if we were able to serve all children and their families regardless of where they are in terms of their needs, what would it look like for all the partners to work together?

When you are finished, please put the name of your community on the finished piece of art and be prepared to discuss what it represents.

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Left Hand/Right Hand

Your Case: Background, situation, content

Thoughts and Feelings Not Said	What Was Said, like a Movie Script

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NAME: Billy Smith, 16 years of age

BACKGROUND INFORMATION:

- Oldest of four children born prematurely to a 16 year-old mother.
- Three younger sisters who have different biological fathers.
- No relationship with his biological father. Father left prior to Billy turning 4 years of age.
- Mother denies any difficulties during pregnancy; denies substance use during pregnancy.
- No reported problems during toddlerhood.
- Physical developmental milestones appeared to have been achieved within normal limits.

- Sexual abuse alleged at age 6, but not substantiated.

- At age 10, Billy was placed in foster care in the custody of the Children's Division, allegedly due to being sexually molested by his mother's boyfriend at the time. Mother denies molestation, but admits daughter was molested and Billy forced to lay on top of his sister. Billy stated to this examiner that his Uncle Nick had rubbed him when he was younger.

- Billy remained in CD custody for approximately 3 years. During this time Billy was reportedly in two foster homes and had inpatient and residential admissions due to his behavior.

- When questioned about his friends in the community, Billy reported he did not have friends anymore, but did spend time with his cousins. His one cousin also has a history of involvement with the juvenile office so Billy feels they now try to keep each other out of trouble. He reported they spend time riding their bikes or "seeing girls." Billy reported that he has had a job in the past doing farm work, and is very interested in getting another job.

EDUCATIONAL HISTORY

Attended Head Start. Problems denied by mother, but staff reported aggression and oppositional behavior. The staff indicated that there was concern about his learning skills, as he had not passed two different developmental screenings.

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Elementary School. He is noted to need "a lot of individualized attention to complete assignments." He reportedly does not follow directions and has recently "shown some very aggressive behavior toward other students and also adults." It was also noted that he has a short attention span, seems distracted at times and sometimes has difficulty following multi-step directions.

At age 10 Billy began having fights at school. At that time, screening indicated no health concerns, no vision or hearing concerns, but some concern with speech and language. Borderline Intellectual skills and he qualified for special education services. Billy was labeled Emotionally Disturbed. A behavioral observation completed at the same time indicated that Billy "frequently displays inappropriate behavior. He has difficulty accepting authority figures and easily erupts when confronted about his inappropriate behavior choices. Billy has difficulty interacting with peers. According to staff, he frequently tells lies about someone or a situation. He has stolen items many times during the past year… Billy has difficulty staying on task and needs one-to-one instruction." This was based on Billy continuing to have "difficulty building or maintaining satisfactory interpersonal relationships with peers, parents and teachers…exhibits behavior indicative of a general pervasive mood of unhappiness or depression; and has a tendency to develop physical symptoms, pains, or fears associated with personal or social problems."

In Middle School, multiple suspensions begin. He is noted to be in the classroom for students with Mental Retardation.

10th grade. Billy is truant from school frequently this past year because he was fearful of another student to whom he owed money. His mother would allow him to stay home from school and then let him go out in the community once school was out. He is repeating 10th grade.

Age 16. Billy is suspended weekly or biweekly from October through February, as well as receiving multiple corporal punishments and detentions. Infractions included disparaging language, disobedience, verbal altercations and being late. He was suspended f or 10 days in the winter due to being in police custody for a burglary in his home neighborhood. A Manifestation Determination conference was held the next week in respect to this last incident. It was determined that the behavior of stealing was not a manifestation of his disability.

MEDICAL HISTORY/FAMILY HISTORY

Billy and his mother denied any history of, or current significant health concerns. Review of educational and treatment records have noted a history of asthma and juvenile onset diabetes. Billy's mother reports that she is concerned with Billy's ability to avoid sweets and that he drinks too much pop. In addition, she struggles to get him to comply with his insulin regimen. Ms. Smith is noted to have medical issues of her own, including diabetes, high blood pressure and migraine headaches. The family history is positive for substance abuse on the father's side. Billy has not keep his annual physical appointment this last 5 years.

PSYCHIATRIC HISTORY

At age 10 Billy began treatment at Community Mental Health Center to target development of socially appropriate behavior when he is angry or upset.

First psychiatric admission at age 10. Threatened a teacher with a pair of scissors. Billy reported at the time of admission he had trouble concentrating, increased appetite, resented the foster home he was in (Billy indicated that there was physical and emotional abuse occurring) and showed little remorse for his behavior.
Evaluation. Full Scale IQ score of 59, a Verbal IQ score of 55 and a Performance IQ score of 70 on the WISC-III.

- Projective measures suggested significant regression, low self-esteem and feeling helpless.
- Provisional diagnoses of Major Depressive Disorder, Moderate, without Psychotic Features; Oppositional Defiant Disorder; Posttraumatic Stress Disorder, Childhood Onset; Enuresis; Physical and Sexual Abuse of a child; learning disabilities in writing and reading; and Moderate Mental Retardation.

- Age 15. Billy is admitted to Children's Psychiatric Hospital from detention (had been banging his head and engaging in self-mutilating behaviors); self-inflicted cut on penis, tried to choke himself with broken spoon.
- Upon admission Billy reported feeling depressed, suicidal, sleep disturbances, vague auditory hallucinations. It was noted that he had a past history of suicide attempts, placing scissors to his stomach on one occasion. It was also noted that he had a history of lying, stealing, running away from home, setting fires and cruelty to animals.

- Upon admission he was taking Geodon 20 mg bid, Lamictal 50 mg, Wellbutrin SR 150 mg and imipramine 25 mg bid, previous history of monthly Haldol-b shots.

- Billy was readmitted to Children's Psychiatric Hospital later that year by a civil commitment order. He had reportedly threatened others with a board and a bb gun and had also reportedly threatened to kill himself. He was discharged after a two-week stay and a medication adjustment.

- Billy was admitted to the Health Center two months later for not getting along with his family and the family's fears that he may harm himself. Other documentation indicated that he had been at ABC Residential Center and had been smearing feces and swinging a baseball bat at staff. A psychological evaluation was completed during this admission by John Doe, Ph.D. The report describes Billy as a "concrete-thinking, impulse-ridden, inadequate-feeling, adolescent male, who is having difficulty coping with what he perceives as a very stressful and threatening world."

LEGAL HISTORY

At age 11 Billy was detained in the Another Co. Detention Center due to two counts of a Class C misdemeanor of assault in the third degree, a class A misdemeanor of assault in the third degree,

a class C felony of tampering in the first degree, and a class D felony of property damage in the first degree, all related to assaulting a teacher and aide at school.

In detention Billy put his hand in the toilet, flushing repeatedly until it flooded; hit his head and hand against the wall and floors; threatened to kill staff and peers; and undressed and made inappropriate sexual comments. Billy was maced at least twice while in detention to "bring his behavior under control."

At age 13 Billy was referred to the juvenile office related to allegation that he was flourishing a gun. Upon police investigation it was found to be a toy gun which was confiscated. The original referral was rejected.

At age 14 (Fall) Billy was referred to the juvenile office after shooting another juvenile in the back of the head with a BB gun. Records indicate that Billy was detained at that time.

At age 14 (Winter) Billy was referred to the juvenile office for shoplifting cigars.

At age 15 (Spring) Billy was referred to the juvenile office for shoplifting a pair of shoes from WalMart.

At age 15 (Summer) Billy's mother filed a report with the juvenile office due to an altercation in the home in which Billy threatened his mother's boyfriend with a knife, resulting in a cut to the boyfriend's hand.

At age 15 (Fall) Billy was referred to the juvenile office for allegedly stealing a BB gun from WalMart.

At age 15 (Winter) Billy is in detention for what appears to be the above-cited allegation of stealing. It was noted in an order that the detention center and local hospital will "no longer be able to care for the juvenile due to his continuing threats of suicide, self-mutilation, intentional defecating, and spreading feces on himself and his surroundings, and his refusal to respond to commands."

At age 16 Billy is referred to the juvenile office for unlawful use of a weapon in that he allegedly displayed a BB gun to a younger peer. Approximately ten days later Billy was referred for sexual misconduct in that he allegedly touched the vagina of a 14 year-old female asking "if he could hit it." This was handled through an informal adjustment and Billy was placed on house arrest.

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Reframing Exercise: Rethinking the Language We Use

Current Vocabulary	*Reframed*
Dysfunctional →	Example: Families experiencing multiple stresses
Case →	Example: Family
Client →	
Case Manager →	
Resistant →	

Current Perspective	*Reframed*
This mother will not conform →	Example: This mother values individuality
This family resists assistance →	Example: They are a proud family who want to be able to make it on their own
My treatment plan →	Example: The family's treatment plan
The family life is chaotic →	
This parent is overly aggressive →	
This parent exhibits attention seeking behaviors →	

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Sample Questions for Assessing Family Strengths

What do you like to watch on television?

What are your favorite movies, books?

Which celebrities do you like and why?

What are the best things about each of your children?

What are the best things about your parents?

What do you do for fun?

Who are your close friends? Why are they special to you?

What kind of future do you hope to see for your children?

What kind of future do you hope to see for yourself?

What makes you mad?

What do you do to "blow off steam"?

How did you meet your spouse/significant other?

What is your neighborhood like? How long have you lived there?

What were you like as a kid?

What are your kids going to be like as adults?

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Family Engagement & Trust Building Skills Checklist

- o **I have clearly communicated my concerns with the family using a strength-based approach.**
- o **I am aware of my own mental models.**
- o **I am learning what questions to ask, and not assuming anything.**
- o **I am aware of not using jargon, and speaking a language the family understands.**
- o **I am taking the time to really get to know the family.**
- o **I am viewing the family as a whole, not as a case.**
- o **I am identifying and reinforcing the child & family's strengths.**
- o **I am keeping the family informed by providing helpful information.**
- o **I am learning about and honoring the culture of the family.**
- o **I am supporting the family to feel empowered in driving their own care.**
- o **I am encouraging the family to be involved in every level of planning.**
- o **I am helping to preserve the family's privacy and dignity.**

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- **I am respecting the family.**
- **I am respecting the family's schedule.**
- **I am being patient and supportive.**
- **I am making myself accessible.**
- **I am interacting with the family as a partner.**
- **I am being clear with the family about my role and limits.**
- **I am being a good listener.**
- **I am not judging or blaming the family for their problems.**
- **I am acknowledging the family's expertise.**
- **I am learning about the family's values.**
- **I am addressing basic needs, and facilitating connections to appropriate resources.**
- **I am supporting the family by being positive and hopeful.**
- **I am following through on my promises.**
- **I am respecting the method the family is using to cope.**
- **I am encouraging and helping to facilitate family–to–family support and networking.**
- **I am building a trusting relationship with the family and supporting them to reach their goals.**

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Exploring Family Culture

Pick a partner. Select three questions. Have a dialogue. What did you learn?

SAMPLE QUESTIONS:

- **What do you like most about your child/ren?**
- **What would your life look like if things were better?**
- **What makes you happy?**
- **What are your favorite memories?**
- **Who are your close friends and why?**
- **What do you do for fun?**
- **What is your connection to the faith community?**
- **What do you see as your best qualities as a parent?**
- **How are decisions made in your family?**
- **What are mealtimes like?**
- **Who has been the biggest influence on your life?**

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Red Light, Green Light: Role Play

As you observe the interaction, think about what you feel is going well and what is not going well. Under the red light side, write down those things that you would like to see happen differently. Under the green light column, note those things that went well.

RED LIGHT	GREEN LIGHT

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RED LIGHT	GREEN LIGHT

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Facilitated Referral Checklist

This checklist can be used once the professional and the family have agreed that a referral is appropriate and that the family would like assistance from the professional in facilitating the referral.

Before I make a referral, I have:

☐ Discussed with the family to what agency I am referring.
- Where they are located.
- What services they offer.
- My experience working with this agency.

☐ Discussed access to transportation with the family.
- Access to a car that is in working order.
- Access to public transportation and is the agency on the route?
- Is the schedule for public transportation convenient for them (i.e. will appointments occur during regularly scheduled times)?

☐ Discussed with the family cultural and familial issues.
- How will family and friends react to this referral?
- Does this agency have similar values to the family and to other systems partners?

☐ Discussed with the family their concerns about the referral.
- How this referral will impact our work and relationship.
- How I will communicate with the referral.
- How the referral will communicate with me.
- How we will all communicate with the family and others involved in the work.

When I refer, I have:

☐ Discussed with the family what information I will share and how I will present it.
- Is there information not to be discussed?
- Are we in agreement as to the reason for the referral?
- My experience working with this family.

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☐ Called the referral prior to the family arriving.
- Explained the reason for referral in more detail.
- Given some history so the same information does not need to be collected.
- Shared information about the strengths and culture of the family.
- Shared information about current pressing issues in the family (transportation, crisis, other children, parental challenges).
- If they do not have access to car, how the referral will handle appointments.
- The family's current treatment plan.

☐ Sent more detailed information prior to the appointment.
- Sent testing, treatment plans, and other pertinent information in a packet.
- Called prior to the appointment to make sure the information was received.
- Described the values and principles that have been driving the work.

When I receive a referral I have:

☐ Discussed with the family what information I will share and how I will present it back to referral source.
- Discussed confidentiality, presented informed consent form, and have received permission to share information.
- Discussed the reason for the referral and checked in with the family as to their perception of the reason for the referral.
- Shared my experience of working with the referring agency and other partners working with the family.
- Discussed what information will be shared with the referral source, including initial impressions, treatment plan, and diagnostic information.

☐ Called the referral source after the family and I have agreed that the following items would be discussed:
- Initial concerns.
- Items covered, initial impressions, and diagnostic impressions.
- Family's treatment plan.
- How the treatment plan will intersect with the family's other treatment plans.
- Strengths and culture of the family.
- The need to develop an overall care plan.

☐ Discussed how we will communicate information to one another to ensure that the family's identified priority needs are being shared appropriately.
- If there are ongoing meetings how will my information be shared?
- If I make recommendations to the family or other agencies how will I make sure they are consistent?
- How will we all communicate together?

PROMOTING RESILIENCY IN CHILDREN, FAMILIES AND COMMUNITIES:
Connecting Schools, Public Health and Mental Health

Missouri Bright Futures

Spring Workshop 2006

Developed by Georgetown University National Technical Assistance Center for Children's Mental Health and Bright Futures at Georgetown University.
Facilitated by Cathy Ciano, Neal Horen, Ph.D., Ellen B. Kagen, MSW, and Rochelle Mayer, Ed.D.

Scenario 1: Maternal Depression (for odd-number tables)

A 16 year old you are working with gave birth to a son 3 months ago. In the last few weeks you have noticed that the young mother does not seem to be taking care of herself. She has not done her hair, put on any makeup or seemingly looked up from the ground in two weeks. This is quite different from previous behavior. She has been missing classes, not doing assignments, and has gotten into a number of verbal altercations with peers and staff recently.

	Selected content from Bright Futures and MCH Library Resources
Bright Futures in Practice: Mental Health Guide	***Developmental Chapters: Infancy*** • Postpartum Period, p. 34 • Early Identification of Families at Risk, p. 35 ***Bridge Chapters*** • Postpartum Mood Disorders, pp. 308-316
Bright Futures in Practice: Mental Health Tool Kit	***Tools for Professionals*** • Edinburgh Postnatal Depression Scale (EPDS), 59-60
Bright Futures Tools for Social and Emotional Development	***Infancy Tool*** • Building Family Relationships: When To Seek Help, p. 5
MCH Library Resources	• Postpartum Depression: Knowledge Path

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- **Heartland Public Health Education and Training Center and Heartland Center for Public Health Preparedness at St. Louis University School of Public Health, and**
- **Missouri Department of Mental Health**

Scenario 2: Child Maltreatment (for even-number tables)

A three year old you are working with has had changes in his behavior recently. He is more aggressive with staff and peers and refuses to take a nap, a stark change in his behavior in the last two months. He is clingy when dropped off in the morning by his mother and has refused to go home with her boyfriend when picked up in the afternoon. His play seems less organized and he has been having toileting accidents more frequently in the last month.

	Selected content from Bright Futures and MCH Library Resources
Bright Futures in Practice: Mental Health Guide	***Developmental Chapters: Early Childhood*** • Area of Concern: Critical or Detached Parents, p. 61 ***Bridge Chapters*** • Child Maltreatment, pp. 213-225
Bright Futures in Practice: Mental Health Tool Kit	***Tools for Professionals*** • How to Help Families Stop Spanking, 32 ***Tools for Families*** • Preventing Child Sexual Abuse, 140
Bright Futures Tools for Social and Emotional Development	***Early Childhood Tool*** • Developing the Self: When To Seek Help, p. 4 • Family: When to Seek Help, p. 5
MCH Library Resources	• Child Abuse: Organization Resource List

PROMOTING RESILIENCY IN CHILDREN, FAMILIES AND COMMUNITIES:
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Worksheet for Scenarios 1 and 2

Part I: Work individually. Record your response on this worksheet. (20 minutes)

A. (10 minutes). Begin by reviewing the "*Selected content from Bright Futures and MCH Library Resources"* listed with your scenario. This will give you insight as to how the Bright Futures resources can provide information on relevant issues that you will face in your work. The materials from the MCH Library will point you in the direction of additional resources.

B. (10 minutes). Take the next 10 minutes to organize your thinking and become more comfortable with the resources and tools. Please simply jot down a few ideas for each question that will be shared in the group discussion to follow. The goal is to apply your new learning from the morning about family engagement, confidentiality and facilitated referral.

Using the resources that have been introduced in this workshop (as outlined in #19–*Inventory of Workshop Resources and Tools*):

How might you address family engagement?

•

•

How might you identify issues, concerns and strengths:

a. as an individual professional?

•

•

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- **Missouri Department of Mental Health**

b. in partnership with families?

•

•

c. In collaboration with team members?

•

•

How might you and the family address issues of confidentiality?

•

•

How might you support planning with the family? How could you and the family identify collaborative partners and supports?

•

•

How could you and the family identify and access needed services and supports (facilitated referral process)?

•

•

Part II: Table Discussion (20 minutes)

Choose a recorder and a facilitator. Discuss your responses to Part I. Record highlights from the group discussion on a flip chart. (20 minutes)

Part III: Large Group Discussion (15 minutes)

PROMOTING RESILIENCY IN CHILDREN, FAMILIES AND COMMUNITIES:
Connecting Schools, Public Health and Mental Health

Missouri Bright Futures

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Scenario 3: Trauma from Natural Disasters (for odd-number tables)

Recently a tornado did extensive damage to your community. While not every family was directly impacted by the tornado, everyone is related to or is close to someone impacted in a significant way. The community has had several town hall style meetings and it was suggested that a group be started for a select set of children in the elementary school to help them deal with the impact of the tornado.

	Selected content from Bright Futures and MCH Library Resources
Bright Futures in Practice: Mental Health Guide	***Developmental Chapters: Middle Childhood*** • Family: What Matters at Home, pp. 97-99 ***Bridge Chapters*** • Posttraumatic Stress Disorder, p. 194-201
Bright Futures in Practice: Mental Health Tool Kit	***Tools for Families*** • Tips for Parenting the Anxious Child p. 96
Bright Futures Tools for Social and Emotional Development	***Middle Childhood Tool*** • The Emerging Self: When To Seek Help, p. 2
MCH Library Resources	• Reaching Out to Children Following Disasters: Information Review

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- **Missouri Department of Mental Health**

Scenario 4: Obesity (for even-numbered tables)

Recently there has been a great deal of media attention on the obesity crisis among our children. In your high school you have noticed a number of children who would benefit from a group that addresses obesity and risk factors. You would like to have a school-based group for a select group of children who you are concerned about in terms of obesity.

	Selected content from Bright Futures and MCH Library Resources
Bright Futures in Practice: Mental Health Guide	***Developmental Chapters: Adolescence*** • Area of Concern: Eating Disorders, p. 135 ***Bridge Chapters*** • Obesity, pp. 244-247
Bright Futures in Practice: Mental Health Tool Kit	***Tools for Professionals*** • Pediatric Symptom Checklist, p. 16-19
Bright Futures Tools for Social and Emotional Development	***Adolescence Tool*** • Body Image and Eating Behaviors: When To Seek Help, p. 4
MCH Library Resources	• Overweight in Children and Adolescents: Knowledge Path

PROMOTING RESILIENCY IN CHILDREN, FAMILIES AND COMMUNITIES:
Connecting Schools, Public Health and Mental Health

Missouri Bright Futures

Spring Workshop 2006

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Worksheet for Scenarios 3 and 4

Part I: Work individually. (10 minutes)

Begin by reviewing the *Selected content from Bright Futures and MCH Library Resources* listed with your scenario. This will give you insight as to how the Bright Futures resources can provide information on relevant issues that you will face in your work. The materials from the MCH Library will point you in the direction of additional resources.

Part II: Targeted Approach – Table Discussion. Select a recorder and facilitator (15 minutes)

As a group, please discuss aspects of a targeted school-based initiative where specific children and youth will be identified who may benefit from participation in the program.

Using the resources that have been introduced *(see Inventory of Workshop Resources and Tools)* discuss, as a group, how would you address each of the following:

Record group responses to the following questions:

• How might you identify the children at risk?

• Discuss some ways in which you might address family engagement?

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• How might you identify issues, concerns and strengths of children in the targeted group?

• How might you and the family address issues of confidentiality?

What are the benefits and limitations of a targeted approach?

Part III: Divide your table in half (10 minutes)
Half of group discusses A: Promotion/Prevention Approach
Half of group discusses B: Individualized Care Approach

A: Promotion/ Prevention – Half Table Discussion. Select a worksheet recorder and facilitator.

How would you address this issue as a school-wide or community-wide initiative?

Record group responses to the following questions:

• How might you address family engagement?

• How might you approach planning? What collaborative partners and supports do families want?

What are the benefits and limitations of a promotion/prevention approach?

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B. Individualized Care Approach – Half Table Discussion. Select a worksheet recorder and facilitator.

What might you do if you notice a child for whom the group intervention is insufficient?

Record group responses to the following questions:

- How might you identify that child?

- How might you engage the family?

- How might you address issues of confidentiality?

- How might you handle a facilitated referral and to whom?

What are the benefits and limitations of an individualized care approach?

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Part IV: Whole Table Discussion- Setting Policy (10 minutes)

A and B share highlights of discussion.

As a table, you have now analyzed the process for program initiatives along three points of the continuum of care:
• promotion/prevention (school/community-wide intervention)
• targeted intervention (small group); and
• individualized care (treatment).

Discuss the following: Given limited time and dollars, where would you recommend that your community invest its resources? Try to reach a consensus.

Record your group's conclusion and rationale.

Conclusion:

Rationale:

Part V: Large Group Discussion (15 minutes)

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- **Missouri Department of Mental Health**

PROMOTING RESILIENCY IN CHILDREN, FAMILIES AND COMMUNITIES

Missouri Bright Futures: Spring Workshop 2006

Developed by Georgetown University National Technical Assistance Center for Children's Mental Health and Bright Futures at Georgetown University.
Facilitated by Cathy Ciano, Neal Horen, Ph.D., Ellen B. Kagen, MSW, and Rochelle Mayer, Ed.D.

Inventory of Workshop Resources and Tools

Books	***Family Engagement***	***Identification***	***Confidentiality***	***Planning (1st steps)***	***Facilitated Referral***
• *Bright Futures in Practice: Mental Health Guide*	✓	✓		✓	✓
• *Bright Futures in Practice: Mental Health Tool Kit*	✓	✓		✓	✓
Tools in Folder • Bright Futures Tools for Social & Emotional Development: infancy, early childhood, middle childhood, adolescence	✓	✓		✓	✓
• Bright Futures Referral Tool for Professionals				✓	✓
• Locating Community-Based Services to Support Children & Families Knowledge Path				✓	✓
• Missouri Community Connection				✓	✓
• MCH Library Resources		✓		✓	
Worksheets • Reframing Skills (8)	✓				
• Assessing Family Strengths Skills (9)	✓				
• Family Engagement & Trust Building Skills Checklist (10)	✓		✓		
• Exploring Family Culture (11)	✓				
• Missouri Confidentiality Form			✓		
• Facilitate Referral Checklist (15)					✓

Workshop sponsored by: • Missouri Department of Health and Senior Services, Heartland Public Health Education and Training Center and Heartland Center for Public Health Preparedness at St. Louis University School of Public Health, and Missouri Department of Mental Health

Maternal and Child Health Library

A virtual guide to MCH information

http://www.mchlibrary.info

TOPIC AREAS:

Access to health care
Adolescents
Asthma
Breastfeeding
Child development
Cultural sensitivity
Dental caries
Drug education
Early intervention
Family centered care
Genetic screening
Health care delivery
Health insurance
Immunization
Injury prevention
Low birthweight
Maternal health
Model programs
Neonatal screening
Nutrition education
Oral health
Pediatrics
Perinatal health
Qualitative evaluation
Reproductive health
Resource centers
School nursing
Spanish language resources
State MCH programs
Teratology
Tobacco use
Unplanned pregnancy
Urban MCH programs
Violence prevention
Women's health
Youth services
… and others

The Maternal and Child Health Library serves the maternal and child health (MCH) community with accurate, reliable, and timely information and resources. Health professionals, policymakers, family advocates, community service professionals, MCH/public health administrators, faculty and students, families, and the public have easy access to the MCH Library Web site for a variety of resources, including information compiled by library staff and pathways to the best MCH information available on other Web sites, from organizations, and in libraries. Resources include:

- **MCH Alert** – an electronic weekly, abstracted newsletter on current research, policies, and programs in the field.
- **Knowledge paths** – electronic resource guides on topics important to the MCH community.
- **MCHLine®** – the electronic catalog of the MCH Library, which includes over 17,500 print, audiovisual, and electronic resources in addition to historical materials dating from 1914.
- **MCH Links** – listings of Web resources in areas vital to MCH research and policy.
- **MCH Organizations** – a searchable database of over 2,000 government, professional, and voluntary organizations involved in MCH activities, primarily at a national level.
- **Organizations resource lists** – annotated lists of organizations that focus on key MCH topics.
- **Bibliographies** – annotated lists of materials on important topics in MCH.
- **Information assistance** – available via online, telephone, postal mail and e-mail to aid in locating resources for the busy MCH professional and the public.
- **Healthy Start program databases** – information on infant mortality resources and MCH research, training, and demonstration projects funded by MCHB.

The MCH Library is funded under a cooperative agreement with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. The physical collection is the Mary C. Egan Maternal and Child Health Library, one of six libraries located at Georgetown University in Washington, D.C.

Maternal and Child Health Library, Georgetown University
Box 571272, Washington, DC 20057-1272 Street address: 2115 Wisconsin Avenue N.W., Suite 601, Washington, D.C. 20007-2292
Telephone: (202) 784-9770 (9 a.m.-5 p.m.) Fax: (202) 784-9777 Email: info@mchlibrary.info

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• Databases
  • MCHLine®
  • MCH Organizations
  • MCH Projects
  • Healthy Start
  • MCH Alert
• Final Reports
• Healthy People 2010
• MCH Alert Newsletter
• MCH Links
• MCH Thesaurus
• Non-English Languages

Additional Resources
• Bright Futures
• Healthy Start
• MCH Oral Health Resource Center

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MCH Library Annotated Resource Guides and Information Products

MCH librarians have compiled the following information products of recent, high quality resources, tools, and links to other organizations to assist in staying abreast of new developments and conducting further research.

Knowledge Paths

Web sites, publications, databases, discussion groups, and journal citations. (selection criteria)

- Adolescent Pregnancy Prevention
- Adolescent Violence Prevention
- Asthma in Children and Adolescents
- Autism Spectrum Disorders
- Child and Adolescent Health Insurance and Access to Care
- Child and Adolescent Nutrition
- Children and Adolescents with Special Health Care Needs
- Diabetes in Children and Adolescents
- Domestic Violence
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Infant Mortality
- **Locating Community-Based Services to Support Children and Families**
- Mental Health in Children and Adolescents
- Oral Health and Children and Adolescents
- **Overweight in Children and Adolescents**
- Physical Activity and Children and Adolescents
- **Postpartum Depression**
- Preconception and Pregnancy
- Racial and Ethnic Disparities in Health
- Spanish-Language Health Resources | En Español
- Knowledge Path Feedback Form

MCH Alert

Weekly electronic newsletter summarizing recent research, findings, policy developments, publications, programs and initiatives

- Read current or past issues
- Search the MCH Alert
- Subscribe
- MCH Alert Feedback Form

Information Review

- Reaching Out to Children Following Disasters

Annotated Bibliographies

Print, audiovisual, and electronic resources, drawn from MCHLine®.

- Abstinence Education
- Adolescent Mental Health
- Adolescent Pregnancy Prevention
- Adolescent Prenatal Care
- Adolescents with Special Health Care Needs
- AIDS/HIV in Pregnancy
- Breastfeeding and Working Mothers
- Breastfeeding: Consumer Education Materials
- Breastfeeding Promotion, Support, and Education
- Bullying
- Child Developmental Screening
- Childhood Nutrition
- Children's Health Insurance
- Children's Mental Health
- Children with Special Health Care Needs
- Children with Special Health Care Needs: Child Care
- Children with Special Health Care Needs: Guidelines and Standards
- Children with Special Health Care Needs: Managed Care
- Cost Effectiveness of MCH Programs
- Cost Effectiveness of Prenatal Care
- Culturally Competent Services
- Early Childhood Development
- Effective Program Practices
- Healthy People 2010
- Home Visiting and Resource Mothers
- Immunizations
- Infant Mortality
- Mental Health in Primary Care
- Neonatal Screening
- Nutrition and Physical Activity for Women
- Nutrition During Pregnancy
- Outreach Programs and Strategies
- Prematurity
- Prenatal Care
- Racial and Ethnic Disparities in Health
- School Health Education
- School Health Services
- Sexuality Education
- Smoking During Pregnancy
- Smoking/Tobacco Use Prevention
- Statistics Sources
- Substance Abuse During Pregnancy
- **Terrorism**
- Women's Health
- Women's Health: Consumer Education Materials
- Annotated Bibliographies Feedback Form

Organizations Resource Lists

Topical contact information and activities, drawn from MCH Organizations database.

- Adolescent Pregnancy and Parents
- Adolescent Violence Prevention
- Adoption and Foster Care
- AIDS/HIV
- Breastfeeding
- **Child Abuse**
- Child, Adolescent, and Maternal Mortality
- Child Care
- Child Safety
- Children with Special Health Care Needs
- Consumer Health Materials: Sources
- Culturally Competent Services
- Eating Disorders
- Effective Community Programs
- Environmental Health
- Family Resource Centers
- Funding Sources
- Genetics
- Infant Mortality Prevention
- Injury Prevention
- Maternal Morbidity and Mortality
- Non-English Language Materials: Sources
- Nutrition
- Oral Health
- Parenting
- Prenatal Care
- School Health
- Spanish Language Materials: Sources
- Statistics Sources
- Substance Abuse
- Organizations Resource Lists Feedback Form

MCH Links

Categorical contact information and activities, drawn from MCH Organizations database

- Advocacy
- Consumer Health and Safety
- Data
- Federal Government
- General Information Resources and Libraries
- MCH Policy and Research Centers
- National MCH Resource Centers
- Professional Associations
- State Information
- MCH Links Feedback Form

Other Resources

- Non-English Languages
- MCH Thesaurus

For comments and suggestions, please use the Comments/Feedback form.

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Your Link to Missouri Resources .... And More!

Today is Tuesday, March 28.

Disaster Relief Services | Disaster Relief Volunteer Opportunities | Job Opportunities

Search for services, organizations, and other resources.

First, please select a resource location . . .

All Locations

○ County or
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View Regions

. . . then decide if you wish to search by key word OR search by topic.

Search by Key Word

(Please select one.)

◉ Subjects
○ Resource Names

Search by Topic (Please select one.)

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○ Business
○ Consumer Services
○ Criminal Justice/Legal
○ Education
○ Environmental Quality
○ Health Care
○ Income Security
○ Individual and Family Life
○ Mental Health Care and Counseling
○ Organizational/Community/International
○ Target Populations

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Links to useful information that can help you select resources and services.

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Text-Only Index

Community Connection includes thousands of resources, but we're still growing! If you don't find what you're looking for, try these search tips, or **Contact CC** to suggest resources to be listed. Inclusion in this Web site does not constitute an endorsement by Community Connection, nor does omission imply a lack of endorsement by Community Connection. Partial funding provided by University of Missouri Extension.

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Ted Gallion, Coordinator

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Your Link to Missouri Resources .... And More!

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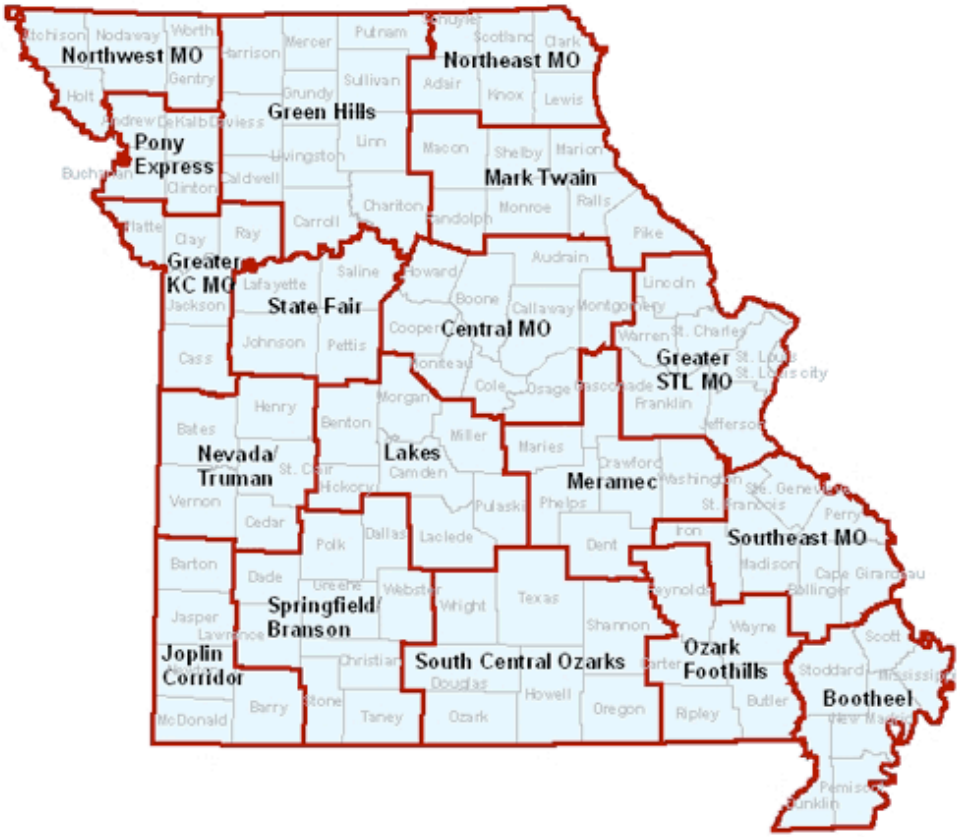
Click on the map or the list below to select the location for **Parenting** resources.



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- Central MO
- Greater KC MO
- Greater STL MO
- Green Hills
- Joplin Corridor Area
- Lakes
- Mark Twain
- Meramec
- Nevada/Truman
- Northeast MO
- Northwest MO
- Ozark Foothills
- Pony Express
- South Central Ozarks
- Southeast MO
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SECOND REGULAR SESSION
[TRULY AGREED TO AND FINALLY PASSED]
SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 1003

92ND GENERAL ASSEMBLY
2004

3472S.04T

AN ACT

To repeal sections 208.152, 208.204, and 630.210, RSMo, and to enact in lieu thereof four new sections relating to the children's mental health reform act.

Be it enacted by the General Assembly of the State of Missouri, as follows:

630.097. 1. The department of mental health shall develop, in partnership with all departments represented on the children's services commission, a unified accountable comprehensive children's mental health service system. The department of mental health shall establish a state interagency comprehensive children's mental health service system team comprised of representation from:

(1) Family run organizations and family members;

(2) Child advocate organizations;

(3) The department of health and senior services;

(4) The department of social services' children's division, division of youth services, and the division of medical services;

(5) The department of elementary and secondary education;

(6) The department of mental health's division of alcohol and drug abuse, division of mental retardation and developmental disabilities, and the division of comprehensive psychiatric services;

(7) The department of public safety;

(8) The office of state courts administrator;

(9) The juvenile justice system; and

(10) Local representatives of the member organizations of the state team to serve children with emotional and behavioral disturbance problems, developmental disabilities, and substance abuse problems;

The team shall be called "The Comprehensive System Management Team". There shall be a stakeholder advisory committee to provide input to the comprehensive system management team to assist the departments in developing strategies and to ensure positive outcomes for children are being achieved. The department of mental health shall obtain input from appropriate consumer and family advocates when selecting family members for the comprehensive system management team, in consultation with the departments that serve on the children's services commission. The implementation of a comprehensive system shall include all state agencies and system partner organizations involved in the lives of the children served. These system partners may include private and not-for-profit organizations and representatives from local system of care teams and these partners may serve on the stakeholder advisory committee. The department of mental health shall promulgate rules for the implementation of this section in consultation with all of the departments represented in the children's services commission.

2. The department of mental health shall, in partnership with the departments serving on the children's services commission and the stakeholder advisory committee, develop a state comprehensive children's mental health service system plan. This plan shall be developed and submitted to the governor, the general assembly, and children's services commission by December, 2004. There shall be subsequent annual reports that include progress toward outcomes, monitoring, changes in populations and services, and emerging issues. The plan shall:

(1) Describe the mental health service and support needs of Missouri's children and their families, including the specialized needs of specific segments of the population;

(2) Define the comprehensive array of services including services such as intensive home-based services, early intervention services, family support services, respite services, and behavioral assistance services;

(3) Establish short and long term goals, objectives, and outcomes;

(4) Describe and define the parameters for local implementation of comprehensive children's mental health system teams;
(5) Describe and emphasize the importance of family involvement in all levels of the system;
(6) Describe the mechanisms for financing, and the cost of implementing the comprehensive array of services;
(7) Describe the coordination of services across child serving agencies and at critical transition points, with emphasis on the involvement of local schools;
(8) Describe methods for service, program, and system evaluation;
(9) Describe the need for, and approaches to, training and technical assistance; and
(10) Describe the roles and responsibilities of the state and local child serving agencies in implementing the comprehensive children's mental health care system.
3. The comprehensive system management team shall collaborate to develop uniform language to be used in intake and throughout provision of services.
4. The comprehensive children's mental health services system shall:
(1) Be child centered, family focused, strength-based, and family driven, with the needs of the child and family dictating the types and mix of services provided, and shall include the families as full participants in all aspects of the planning and delivery of services;
(2) Provide community-based mental health services to children and their families in the context in which the children live and attend school;
(3) Respond in a culturally competent and responsive manner;
(4) Emphasize prevention, early identification, and intervention;
(5) Assure access to a continuum of services that:
(a) Educate the community about the mental health needs of children;
(b) Address the unique physical, behavioral, emotional, social, developmental, and educational needs of children;
(c) Are coordinated with the range of social and human services provided to children and their families by local school districts, social services, health and senior services, public safety, juvenile offices, and the juvenile and family courts;
(d) Provide a comprehensive array of services through an integrated service plan;
(e) Provide services in the least restrictive most appropriate environment that meets the needs of the child; and
(f) Are appropriate to the developmental needs of children;
(6) Include early screening and prompt intervention to:
(a) Identify and treat the mental health needs of children in the least restrictive environment appropriate to their needs; and
(b) Prevent further deterioration;
(7) Address the unique problems of paying for mental health services for children, including:
(a) Access to private insurance coverage;
(b) Public funding, including:
a. Assuring that funding follows children across departments; and
b. Maximizing federal financial participation;
(c) Private funding and services;
(8) Assure a smooth transition from child to adult mental health services when needed;
(9) Coordinate a service delivery system inclusive of services, providers, and schools that serve children and youth with emotional and behavioral disturbance problems, and their families through state agencies that serve on the state comprehensive children's management team; and
(10) Be outcome based.
5. By August 28, 2007, and periodically thereafter, the children's services commission shall conduct and distribute to the general assembly an evaluation of the implementation and effectiveness of the comprehensive children's mental health care system, including an assessment of family satisfaction and the progress of achieving outcomes.

1988	1991	1994	1998	1999	2000	2001	2002	2003	2004	2005	
Born to 16 y.o. mother		1st Report to CPS Unsubstantiated	Report to CPS-Removed from Home		Mother diagnosed with Migraines, High BP	Returns Home from foster care					FAMILY
I was so excited to hav baby, until he ca then I cried e first th	I felt better about myself after two parent s groups but that group ended du cuts.		My phone was turned off. No c called me to talk about B placement; home s because I mis	I was sent to parenting classes where they t to use a sticker system to control m behavior. My pastor said th was really confused worse.							
	Enrolled in Head Start		Begins receiving Special Ed. Services; Labeled Emotionally Disturbed; Speech Language Deficits noted		Earning A's and B's	Reported to be in classroom for MR		Earning D's and F's	Multiple suspensions, detensions, Corporal Punishment		SCHOOL
Guidance counselor g me back in school Billy was born out a mon follow	I tried to get in touch with the referral for t developmental assessment, but anymore. I got anothe scheduled. M appo		I did not make the IEP meeting because I had a court appointment to get a restraining order on m								
Born Prematurely		Diagnosed with Juvenile onset diabetes			Diagnosed as Morbidly Obese	Failure to keep yearly appointments (2003-2004)					PHYSICAL HEALTH
						The pediatrician that Billy was really attached to left the clinic. The new person yelled at me for not giving him gluten-free food, but my food stamps did not					
				Assault 3rd Degree Tampering Property Damage 12/99 bicycle theft		burglary- took $20; Shoots kid w/ BB Brandishes fake; gun	shoplifts cigar	shoplift mom reports altercation - theft of BB gun	Displays sexual misconduct	Sexual Assault	JUVENILE JUSTICE
		Psychiatric Admission Subsequent to assaulting teacher		Begins Outpatient Treatment				Inpatient subsequent to self-mutilation in detention; Gedeon 20 mg bid, Lamictal 50 mg Wellbutrin SR 150 mg imipramine 25 mg bid	2 admissions within 2 months; suicide attempt, threatening others. Diagnoses: Depressive Disorder, NOS; Impulsive Control Disorder; Conduct Disorder; Mild Mental Retardation.		MENTAL

Billy returned to my home on a whole slew of medications. He same child I remembered. He was sluggish, angry, and difficult to understand when he spoke. I was in a job training program in order to maintain my TANF benefits and needed to work at night. I don't know if he was taking his medications or even coming home at night, because I needed to work to pay for our Section 8 housing or we would be evicted.