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Protective Services Caseworkers' Understanding of the DSM: Improving Risk Assessment through Professional Development Training

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Protective services caseworkers regularly make assessments about the risks that vulnerable children and adults may be facing in their homes. Based on those risk assessments, these caseworkers make decisions that have far-reaching implications for children, adults and their families. Caseworkers frequently obtain the critical, case-specific information necessary to make accurate risk assessments through professional collaborations—for example trained mental health professionals—and the effective use of this information requires an understanding of the collaborators' formal evaluations.

Mental health evaluations are presented in the multiaxial format of the Diagnostic and Statistics Manual (DSM) (American Psychiatric Association, 2000). The DSM, now in its fourth edition, provides a categorical system for mental disorders. The information is provided in five axes, which include the primary diagnosis, physical problems, and psychosocial stressors. In addition, a Global Assessment of Functioning (GAF) provides a numerical summation of the client's overall level of functioning at a specific point in time (Table 1.)

Table 1. The DSM-IV Multiaxial Classification

Axis I	Clinical Disorders Other conditions that may be a focus of clinical attention
Axis 2	Personality Disorders Mental Retardation
Axis 3	General Medical Conditions
Axis 4	Psychosocial and Environmental Problems
Axis 5	Global Assessment of Functioning

(American Psychiatric Association, 2000, p.25)

The DSM has become increasingly central within the U.S. environment of privatized health insurance and managed health care, where diagnoses are often a prerequisite for both specialist referrals and reimbursements for services rendered, and are central to agencies' mandates. As a result, the DSM is used by all mental health providers, social service agencies, and managed care organizations regardless of their setting or theoretical orientation. The diagnostic codes in the DSM are also referenced in the International Classification of Diseases (World Health Organization, 1994), which is used internationally for clinical, research and reimbursement purposes. It is therefore inevitable that protective services caseworkers will be presented with mental health evaluations using this classification system.

Despite the importance of the DSM, caseworkers often have not been trained to understand it. The great majority of social service caseworkers across the United States are making decisions about their clients without the advantage of a social work degree (Dhooper, Royse & Wolfe, 1990; Costin, Karger, & Stoez, 1996). This lack of information may seriously impede a caseworker's ability to collaborate with more highly trained professionals involved in the care of their clients. As well, the inability to understand the critical information contained in psychological and psychiatric reports may result in their making erroneous decisions about care plans and levels of risk for vulnerable children and adults. As a result, these evaluations may be substantially underused, and perhaps even misused, resources.

Thus, the need for this training arises as a consequence of larger, systemic problems found in child protective services, these include: conflicting

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goals of family privacy and child protection; the need for more sophisticated research to understand effective interventions for troubled families, and the need for a realignment of public priorities to address the larger social, economic, and cultural conditions associated with child abuse and neglect (Antler, 1981; Costin, Karger, & Stoez, 1996).

Review of the Literature

The literature addressing human service professionals and their application of mental health data can be divided into two groups: those with social work education backgrounds, referred to in this paper as 'social workers,' and non-social work educated staff, who enter into human services work with a variety of backgrounds, referred to here as 'caseworkers.' This overview of the literature considers both groups and highlights the following: individuals with a social work education may not have an understanding of the DSM despite their training, and non-social work educated individuals make up the majority of casework staff across the United States. Barriers to mental health interagency collaboration are also considered.

Social Work Educated 'Social Workers': Understanding Mental Health Assessments

Individuals with a social work education are better prepared to be effective child welfare caseworkers than are their non-degreed counterparts (Jordan Institute for Families, 1999; Cicero-Reese & Clark, 1998; Costin, Karger & Stoesz, 1996; Liberman, Hornby & Russell, 1988). However, when considering more specifically how prepared are individuals with a social work education for understanding and applying mental health assessment data, the most recent national review of course offerings in schools of social work, conducted in 1986, revealed that only one third of the schools (n=57) offered a specific course on the DSM (Raffoul & Holmes, 1986). This brings into question whether even social work educated individuals are fully prepared to understand mental health evaluations to the extent required to maximize their value. Kayser & Lyons (2000) states, "few social workers have received specific training on how best to use psychological assessment data in case planning decisions" (pp.198). The literature is not clear on the capacity for individuals with recent social work degrees to understand the DSM; however, we may conclude that the capacity of any social work graduate to do so may vary widely.

The literature contains studies exploring social workers' learning of the DSM through continuing education (Dziegielewski, Johnson & Webb, 2002) and computer-based technology (Patterson & Yaffe, 1993). However, little information appears in the literature regarding specific efforts to train child or adult protection caseworkers on the DSM for the purpose of better understanding mental health evaluations.

Non-Social Work Educated 'Caseworkers': Understanding Mental Health Assessments

Research reflects that the majority of caseworkers in child welfare across the United States do not have a social work degree to rely upon for interpreting mental health evaluation reports (Dhooper, Royse & Wolfe, 1990; Costin, Karger & Stoesz, 1996; Cicero-Reese & Clark, 1998). Costin, Karger & Stoesz (1996) explored the educational backgrounds of child welfare caseworkers nationally, and found that approximately 27% of caseworkers are trained in social work at bachelor or master level. Likewise, Cicero-Reese & Clark (1998) studied the question in a central Pennsylvanian child welfare agency, and found that of those who were employed as child welfare caseworkers for longer than two years, only 26% had a bachelor or master degree in social work (n=38). Dhooper, Royse & Wolfe (1990), in their survey of the Kentucky Department of Social Services, found that 17% of their randomly selected cases (n=437) involved a caseworker with bachelor or master of social work. Hence, only a small proportion of child welfare caseworkers are equipped to make the best use of the critical information contained in psychological and psychiatric reports, as even the level of DSM familiarity of those who have a social work degree is in question.

Kayser & Lyons (2000) affirm that the skills and knowledge required to adequately utilize psychological evaluation information may be lacking in child protection caseworkers. The literature does not address the question of the proportion of adult protective services caseworkers with social work education.

Barriers to Interdisciplinary Collaboration

Studies that explore the barriers to effective collaboration between child protective services caseworkers and mental health specialists name several components that impede the relationship between the two (Kayser & Lyons, 2000; Holt, Grundon & Paxton, 1998; Paxton, Grundon, & Holt, 1999). Most notably, the latter two studies refer to the disconcerting degree of consensus that is exhibited in meetings between mental health professionals and protection caseworkers, suggesting that these "inhibited conversations" and "striking absence of dissent" (p.173) are due to the power differential that exists between the two entities, where the mental health specialist is the expert, and the caseworker the repository of information (Hallett, 1995 in Paxton, Grundon & Holt, 1999).

Rationale for the Training

The literature suggests that a firm grasp of the DSM is required to make the most of the information presented in mental health evaluations, and to maximize the use of valuable resources (Raffoul & Holmes, 1986; Kayser & Lyons, 2000). "Because resources such as time and money are always limited, any attempt at improving a system such as that involving [mental health] specialist assessments in child protection should focus first upon improving the efficiency and effectiveness of resource use" (Holt, Grundon & Paxton, 1998, p. 271). Making full use of these reports enables protective services caseworkers to make decisions that take into account all information available, and to most effectively communicate with the mental health professionals providing these evaluations. Because the majority of protection caseworkers do not have social work degrees (Raffoul & Holmes, 1986), and because even those who do may not have the knowledge and skills necessary for this task (Dhooper, Royse & Wolfe,1990; Costin, Karger & Stoesz, 1996; Cicero-Reese & Clark, 1998; Holt, Grundon & Paxton, 1998; Kayser & Lyons, 2000), a training course is required to succinctly and effectively teach these caseworkers the requisite knowledge and skills.

In addition, it is hoped that with increased knowledge about mental health assessments caseworkers will be more empowered to discuss and question the conclusions made by mental health evaluators about their mutual clients (Holt, Grundon & Paxton, 1998).

For the above reasons, the Protective Services Training Institute of Texas (PSTI), sponsored by a consortium of Texas graduate schools of social work (the University of Houston, the University of Texas at Austin and Arlington) identified a need to provide a professional development training course to help state-employed child and adult protective services caseworkers employed by the Texas Department of Protective and Regulatory Services (TDPRS) to develop basic familiarity with the structure, content and usefulness of the DSM.

It is imperative to mention that the rationale for the training occurs in the context of a larger debate about the appropriate role and scope of child protective services. There are ongoing debates about the appropriate scope of intervention and proposals for reconfiguring it.

The remainder of this paper will describe the educational competencies, application activities and accompanying resources of a professional development training course offered regularly by PSTI throughout the state and intended to meet these needs (Levine & Davidson, 2001). It qualifies for social work licensing education credit, has been modified for graduate schools of social work advanced practice classes, and was presented at a national conference. Originally presented as a day-long, six-hour session, the training workshop

described herein is adaptable to a wide variety of social work education contexts.

The Module

Competencies

In this training, child and adult protective services caseworkers are provided with a basic overview of the DSM-IV-TR to improve their understanding of clients' mental health evaluations, advance collaboration with mental health evaluators, and sharpen their clinical judgment skills when conducting risk assessments and developing care plans. This training aims to facilitate these improvements through a) understanding the purpose of the DSM; b) comprehending the multiaxial components of an assessment and common mental health diagnoses; c) interpreting diagnostic codes and using the DSM as reference when reading mental health evaluations; d) understanding the meaning of a numerical GAF score; and e) applying this information to their casework practice. The purpose was not to teach caseworkers to provide diagnostic assessments, but to clarify their role as key players in assessing risk, which requires a full understanding of mental health assessments.

Topic Areas

The following five curriculum topic areas match the above competencies to maximize participants' learning: 1) An overview of the DSM-IV-TR; 2) Multiaxial assessments 3) Deciphering codes and diagnoses; 4) Global assessment of functioning; 5) Applications to the workplace. The following paper will outline creative, participative and non-threatening learning activities that can be used to effectively teach each topic area.

Format

Instructional Strategies for Adult-Centered Learning

Theories that focus on the principles of adult-centered learning offer useful guidelines for developing strategies to achieve an effective application of training content to participants' specific work contexts (Rycus, 1978; Curry, 1994; Cartney, 2000). In brief, to effectively integrate knowledge into practice, adult learners require approaches to content and format that are distinct from the more didactic, traditional approaches to education (Rycus, 1978; Knowles 1980; Vinokur-Kaplan, 1986; Zemke & Zemke, 1991; Pike, 1994; Curry, 1997). In particular, Curry et al (1994) identify four typical ways people learn: cognitive learning through fact-based information and observation; affective learning when feelings are engaged; behavioral learning through the practice of the content; and environmental learning through externally reinforcing influences. These authors suggest that to be most effective, learning methods must target all learning styles when designing curricula. It is this integrated approach that forms the basis for the instructional strategies within this curriculum, which aimed to take into account these adult learning styles.

Because many of the activities in this training require group work, it is most successful to have participants seated in groups of between five and seven members, preferably with a table for each group. Ideally, participants will each have a copy of the DSM-IV-TR. One manual per three participants is the least number of copies that should be used when facilitating these activities.

1. An Overview of the DSM-IV

In this initial section, the instructor presents a brief introductory lecture addressing what is the DSM-IV-TR, emphasizing that any mental health assessment is impacted by a professional's ethnic, gender and cultural context, and that striving to fully understand the context of a behavior before making judgments is critical to minimizing this assessment bias.

This section emphasizes that the DSM is a living document. The content of the DSM reflects and responds to dynamic factors in the environment, including advances in biological psychiatry, changing societal views about what defines a mental disorder or deviant behavior, and demographic trends. For example, the inclusion of homosexuality as a diagnostic category reflects the impact of empirical

data, changing social norms, and a politically active gay community in the United States. Homosexuality was included in the first two editions of the DSM but as result of the above factors was removed. The next edition of the DSM III (1980) then added a new diagnostic category; ego-dystonic homosexuality. In response to numerous professional criticisms this new diagnostic category was entirely removed by 1986 (Herek, 2003). A vestige remains; the current DSM IV TR still contains a diagnostic category, Sexual Disorder NOS (302. 92) which provided as an example of diagnostic criteria, persistent and marked distress about sexual orientation (American Psychiatric Association, 2000, p. 582).

The evolving nature of the DSM is further reflected in the inclusion of Appendix I in the most current edition (American Psychiatric Association, 2000, pg. 897). This Appendix contains an outline of cultural formulation, intended to address the difficulties of applying the diagnostic criteria in a multicultural environment. It also contains the Glossary of Culture-Bound Syndromes which "denote recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category ... which are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations" (pg. 898).

Through this introduction, participants are also encouraged to not feel intimidated by the technical tone and size (943 pages) of the DSM, and to develop a comfort level with critically evaluating the diagnostic categories contained therein. To illustrate, select diagnostic categories are highlighted, e.g. dependant personality disorder, which may unnecessarily pathologize individuals because of their gender, race or class (Caplan & Gans, 1991).

Suggested Experimental Exercise to Develop Awareness of Diagnosis Bias in the DSM

To create an experience that enables participants to understand all these above points, they are asked to think of a behavior that, if seen out of context, would most likely be interpreted by those around them as abnormal, perhaps even pathological. For example, imagine encountering a person who is screaming, with eyes tightly shut and arms waving wildly in the air. In many places, this behavior would be interpreted as alarming and very unusual. However, on a roller coaster ride, it would be absolutely appropriate. Participants describe to their small group the example behavior they thought of, and the group guesses what the context would be in which this behavior would be normal.

Following this activity, a large group discussion is facilitated, sparked by the questions: "How might the gender, culture, race, class, religion, and age (etc.) of the mental health professional influence the diagnostic procedure?" and "What is normal, and who decides?"

2. Multiaxial Assessment

The mental health classification scheme of the DSM-IV is reported in a multiaxial format. There are 5 axes which each refer to different aspects of a patient's mental, physical and social condition (see Table 1). This is foundational information for participants, and the focus of this section is to develop their firm grasp of the mulitaxial format. Axis V, commonly referred to as the Global Assessment of Functioning, is distinct enough to be addressed in a later section.

To begin this section, the instructor gives an overview of the mulitaxial format, and participants are provided a page that explains the criteria for the first four axes.

Suggested Experimental Exercise to Learn Axes I-IV Using Multiaxial Case Scenarios

In this application activity, small groups of participants aim to match individual mental illness behaviors, outlined in their unique case scenario, to a basic list of diagnoses. The instructor directs the participants to choose the appropriate diagnosis (es) per axis for their unique case scenario using the diagnostic criteria in the DSM-IV-TR. Each

group has a different case scenario, and therefore different diagnoses per axis.

Materials include: (1) One case scenario per small group. Case scenarios in *The DSM-IV Casebook* (Spitzer et al, 1994) may help in formulating case scenario ideas. Each case scenario has at least one diagnosis for each axis. (2) A fill-in-the-blanks multiaxial assessment form for each case scenario, which identifies the number of diagnoses per axis that the particular case scenario requires. (3) A total list of the diagnoses for all the case scenarios, divided into axes I-IV (axis V, the Global Assessment of Functioning, is addressed in separate exercises), is given out to the class. This is used as the master list from which participants select their relevant diagnoses. The list has page numbers next to each diagnosis for easy reference to the DSM.

After groups have read their case scenarios, it is helpful to begin by asking them to find the appropriate diagnoses for only Axis I. This allows for questions, and provides an opportunity for clarification before the groups move on to the next three axes. If some groups complete the whole activity before others, the instructor can ask them to review their case scenarios again, this time listing what specific evidence they have based their diagnoses on. Groups present their conclusions on flip chart paper or overhead transparency and explain their rationale. To conclude this activity, the answers and rationales for each case scenario are distributed to each group for further clarification. This activity generally requires sixty minutes to complete.

3. Codes and Diagnoses

Diagnoses within the DSM-IV are each indicated by a unique diagnostic code. These are also included in the ICD-10, an international classification system for all diseases (World Health Organization, 1994). Frequently, mental and physical health assessments indicate only the diagnostic codes without naming the diagnosis itself. Readers of these evaluation reports must be familiar with how to find these codes in the DSM.

Suggested Experimental Exercise to Comprehend DSM Diagnostic Codes by Matching Codes and Diagnoses

This activity both takes participants through the process of discovering the diagnosis related to each code, as well as reinforces their new knowledge of the multiaxial system. Participants follow this four step activity in their small groups. First, taking the list of ten DSM codes given to each small group, they research the diagnosis for each code using the "Appendix F: Numerical Listing" in the DSM-IV-TR (American Psychiatric Association, 2000, p. 857). Second, they identify which axis it belongs to, based on both the "DSM-IV Classification" (American Psychiatric Association, 2000, p.13) and their learning of the multiaxial format from the previous activity. Third, they write down the code and diagnosis on a sticky note, one code and diagnosis per sticky note. Fourth, they post the sticky note under the appropriate axis on the instructor's pre-prepared flip chart, which is displayed in a viewable location.

Materials necessary for this activity include: (1) One sticky notepad per group; (2) A posted flipchart page, with four sections indicating Axis I, Axis II, Axis III, Axis IV; (3) One pre-prepared index card per group with ten diagnostic codes on each per small group; (4) A master answer list for the instructor.

When all the groups have completed their tasks, the instructor reviews each chosen diagnosis per code, and its corresponding axis. All groups help each other find the correct answer, when any one group's sticky note is incorrect. In addition to the value of practicing where to find coded diagnoses and reviewing the axes, the movement required for this activity effectively counteracts the diminished energy that exists following a lunch break, and provides a "hidden stretch break" for restless participants (Pike, 1994). Twenty minutes is sufficient for this activity.

4. Global Assessment of Functioning Score

The Global Assessment of Functioning (GAF)

score is identified on Axis V. It is the rating of a person's overall functioning on a scale of 0-100, and is a clinician's judgment of an individual's functioning in psychological, social and occupational life areas (American Psychiatric Association, 2000). An important use of the GAF score is that it provides a global assessment that allows one to compare over time an increase or decrease in functioning.

Following the instructor's explanation of the GAF score to begin this section, each participant reads over the GAF assessment categories (American Psychiatric Association, p. 34). The instructor then engages in a short discussion with the large group to ensure participants understand the functioning areas being discussed.

Suggested Experimental Exercise to Increase Participants' Ability to Apply a GAF Score.

The learning activity developed for this topic area marks an important change in the focus of the training session, from theoretical concepts and concrete content to real people whose lives are genuinely and wholly impacted by their mental illness. On video, participants view several interviews with different people who are experiencing active symptoms of their mental illnesses. After each interview, participants discuss the impact of the client's illness on their ability to function in life, and then attempt to assign a GAF score. The ethical implications of teaching non-mental health specialists how to assess a client using a GAF score is discussed in a later section of this paper.

The training video recommended for use in this section was created for professionals who are learning to diagnose clients using the DSM-IV (American Psychological Association, 1994). The makers, with full authorization from the patients, have videotaped people with various psychiatric disorders being interviewed respectfully on an individual basis by a psychiatrist. The instructor chooses four interview vignettes based on the diagnoses participants encounter most commonly with their clients.

After every vignette, each table must come to a consensus as they assign that person a GAF score. The small groups' GAF score answers are then discussed in a large group, providing the opportunity to clarify the subtle differences between scores.

Suggested Experimental Exercise to Apply Knowledge to Risk Assessment

Following each discussion of the client's GAF score, the instructor asks participants to relate the score to their specific job functions. For example, child protection caseworkers may use this and other information from a mental health assessment, to assess a parent's "capacity to adequately care for their children" and "whether it is safe and prudent to return a previously abused children" to the parents' care (Kayser & Lyon, 2000). Questions include "Given this GAF score and what you know about the client, what degree of risk a child in this person's custody would be in, and why?" For adult protection caseworkers, questions include "What services would this person require in order to be capable of continued living alone?" An average of twenty minutes of discussion time per vignette is recommended.

5. Applications to the Workplace

In addition to the GAF being a critical score to understand when reading evaluation reports, it can also be a helpful gauge that caseworkers can use themselves to track their clients' progress over time. The GAF score participants determine is not for use beyond their own involvement with the client, as the intended participants for this training are not legally sanctioned to provide mental health evaluation. Nevertheless it is a useful way to organize information about a client for tracking purposes.

Suggested Experimental Exercise to Practice a GAF Assessment Interaction

Critical for professional development training to be successful is the transfer of learning from the training room to the workplace. Practicing new behavior and new thinking increases the likelihood that participants will apply their new skills and knowledge when they return to their workplace (Pike, 1994). These final two activities synthesize the information learned throughout the day, and apply it to a realistic workplace context, confirming

the relevance and usefulness of the day's learning.

After explaining the areas most relevant to the GAF score based on a handout entitled "Areas to Guide GAF Questioning" (see: Appendix 1) (Levine & Davidson, 2001), participants are asked to think of a client on their caseload who has a mental health diagnosis, and assign that client a GAF score. They are then instructed to find a partner, determine who is 'the caseworker' and who 'the client' is, and 'the client' takes on the character of their own client. 'The caseworker' interviews 'the client' for five minutes, asking questions that cover the areas to determine a GAF score. Following the skills practice, 'the caseworker' assigns a GAF score to this 'client,' and the two participants compare scores. They then exchange roles and repeat the skills practice. This activity requires thirty minutes.

Suggested Experimental Exercise to Make Case Recommendations using Mental Health Evaluations

In this activity, participants apply their learning to a fictitious mental health evaluation report and make case recommendations. To begin, the instructor presents a client's case history to the class, and outlines the key decisions regarding the case that are being considered at this time. A fictitious mental health evaluation report about this client is then distributed, in the style of a report they would commonly encounter in their own clients' file. Based on all the axes and explanations within this report, the participants are asked to list all the concerns and strengths they can identify, and develop an opinion about the best direction for the case. This activity can be done individually or in pairs, and when participants are done, their conclusions and supporting arguments are discussed in a large group.

Ethical Considerations

This training includes learning activities in which participants assigns multiaxial diagnoses to fictitious clients, and designates GAF scores. The primary purpose of these learning activities is to enable participants to learn the information by practically applying it to real life circumstances. This training does not intend to equip participants to be capable of diagnosing their clients, and it is imperative that the instructor expresses this fact, and regularly delineates the limitations of the participants' expertise and the extent of their knowledge. When participants are encouraged to become proficient at assigning a GAF score to their clients in this training, there is an additional purpose to this goal. These activities are introduced not only to increase their capability of understanding the implications of a GAF score in a mental health assessment, but also to provide them with a gauge they can use themselves to assess clients' progress over time. Again, because they are not licensed to provide mental health assessments themselves, it is imperative that the instructor clarifies these parameters carefully. The ethical obligation of the instructor is to ensure to the best of their capacity that these skills are being taught only to participants who will respect their limitations with this information.

Participant Workshop Evaluations

At the conclusion of every workshop, participants completed an evaluation form which lists ten positively-worded statements related to the presentation and content of the workshop and provides a five-point response scale, ranging from (1) 'strongly disagree' to (5) 'strongly agree.' Participants rated this course highly, and the application activities, intended to facilitate participants' transfer of learning from the classroom to their practice context, are shown to be relevant to participants' work environment. To summarize, 110 participants responded over a two-year period with a mean overall response rate of 4.3, a response that falls between 'agree' and 'strongly agree'. More specifically, participants indicated that 91% agreed or strongly agreed to the statement, "I feel my time in training was well-spent"; 94.3% agreed or strongly agreed to the statement, "I am more confident in my knowledge about this topic"; and 93% agreed or strongly

agreed to the statement, "I plan to apply this knowledge to my specific job situation" (Protective Services Training Institute, 2001 and 2002).

Future Research

Further research is needed to discover participants' perceptions of the usefulness of their training experience, with formal follow-up conducted longitudinally following their attendance to evaluate their ongoing perceptions of the applicability of their training experience, and the degree of learning that effectively transferred from the workshop to their daily practice. It is hoped that as a result of this training, caseworkers' increased knowledge will be an empowering factor in their collaborative efforts with mental health practitioners, and will enable them to participate more actively and be more likely to voice dissent if necessary, in case conferences where these evaluators are present. Evaluations of this training did not address the topic of participants' level of empowerment, and further research to address participants' feelings of self-efficacy regarding their understanding of mental health assessment and their ability to make risk assessments after being trained on the DSM would clarify if this is indeed a relevant outcome. In addition, research related specifically to adult protective services caseworkers and their level of understanding of the DSM, absent from the literature, would be helpful in establishing and meeting their specific training needs.

Conclusions

Child and adult protective services caseworkers are in critical positions of responsibility to accurately assess the level of vulnerability of individuals on their caseloads. Understanding formal mental health evaluations enables these caseworkers to make a more accurate assessment of the level of risk each vulnerable child or adult may face, and may empower caseworkers to converse with mental health evaluators about their reports. This understanding must include a comprehension of the basic structure and content of the DSM, as this is the basic classification system for mental health evaluations. The training module described herein is composed of key components of the DSM presented using adult-learning strategies, and was developed to enable protective services caseworkers to better understand mental health evaluations; improve their collaborative skills with mental health evaluators, and improve their clinical judgment and critical thinking skills when conducting risk assessments. Workshop participants evaluated this training highly, indicating strong satisfaction with the experience.

Appendix 1: Areas to Guide GAF Questioning

Psychological
Anxiety, depression
Impaired reality, delusions, hallucinations
Suicidal thoughts
Sleep disturbances
Physical-poor hygiene, disheveled

Occupational
Level of functioning
Conflicts
Able to keep job, stay in school, work
Ability to do tasks expected of them

Social
Avoidance of friends/family
Arguments; frequency, severity
Physically acting out behavior
Level of satisfaction of personal relationships
Level of parenting functions
Quality of support system; kin, religion

(Levine & Davidson, 2001)

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