

Breaking the Cycle:

A Strength-Based
Practice Guide
for Case Managers
Who Work with
Teen Parents



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**Breaking the Cycle: A Strength-Based Practice Guide for
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introduction

The Metro Council For Teen Potential

The Metro Council for Teen Potential (MCTP) is a community coalition that promotes a comprehensive, coordinated and community-wide strategy to foster youth development; and encourage young people to make healthier choices. MCTP members include many youth development organizations, the City School District, the City of Rochester, the Monroe County Health Department, the Rochester Monroe County Youth Bureau, and other concerned citizens and youth-serving institutions. Along with the University of Rochester and the City of Rochester, MCTP is a member of the Rochester Coalition Partnership for the Prevention of Teen Pregnancy, and receives major funding from the Centers for Disease Control and Prevention. Baden Street Settlement is the host agency for MCTP.

MCTP assists its member agencies in incorporating “best practice” models into their existing youth programs, conducts research-based needs assessments and identifies gaps in service. It supports multi-agency collaboratives that deliver services to young people, provides staff training and program evaluation, and coordinates a faith leaders networking project. A media campaign to reach out to young people, to share information about healthy choices, relationships and sexuality; and to encourage young people to make full use of community resources is in production for release in the fall of 2002.

the practice guide

for Case Managers Who Work With Teen Parents

“I’ve had my ups and downs. No money, no DSS case, no job, no clothes, but look how far I’ve gotten. Stressed out basically every single day. But I’ve learned how to keep my head up, meet many people, do many things, and be strong. Thanks for everything and thanks for every day of my life I was here.”

— C., a teen parent

One long-term priority of the Council has been to provide the necessary supports to teen parents to enable them to raise their children successfully, and to encourage them to postpone another pregnancy. The MCTP Planning Committee recognized the need for a set of guidelines for strength-based case management programs that work with teen parents. We developed this practice guide as a tool for case managers, supervisors and contract managers.

Reducing the high rates of teen pregnancy and teen birth has long been a priority public health concern for the City of Rochester. Over the past ten years, our community has adopted a number of strategies to educate and motivate teens to avoid early pregnancy. These strategies include increasing youth development supports (tutoring, mentoring, access to sports and arts and other recreational activities, after school programs, health education, career awareness); peer education programs; parenting classes to improve communication; media campaigns; and increasing young peoples’ access to reproductive health care. These strategies have been successful: in the City of Rochester, the total number of babies born each year to teen mothers (ages 15 to 19) has fallen from approximately 1,000 in 1990 to about 700 in 1999. The teen birth rate in the City of Rochester among girls ages 15 to 19 has fallen from about 13% in 1990 to about 9% in 1999.

These statistics should give us hope and renew our commitment to address this public health crisis. Young people, supported by our community, are making healthier choices. But the problem is far from solved. The teen birth rate in the City of Rochester is six times higher than the teen birth rate in the suburbs of Monroe County. The current 9% teen birth rate in the City of Rochester means that 700 babies are born to teen mothers each year. These 700 babies are more likely to grow up in poverty, have difficulty in school, have more health problems, to move frequently, to become victims of abuse and neglect, to become involved in crime, and to become teen parents themselves. Five years from now, these 700 babies will fill 27 City School District kindergartens. Children born to teen mothers make up almost one-quarter of the total enrollment in the City School District.

The social factors leading to teen pregnancy are complex, but the social costs of teen parenting are obvious. Teen parenting is associated with higher public assistance costs, higher medical costs, and higher foster care costs. The Robin Hood Foundation estimates that for the country as a whole, adolescent childbearing costs taxpayers \$6.9 billion each year. These costs include increased costs of public assistance, medical care, foster care, criminal justice involvement, and loss of tax revenue. (R. Maynard, pp 18-19.) Reducing the high teen pregnancy rates in our area will play a role in restoring our economic vitality.

One key strategy in reducing the teen birth rate is to provide the right supports to teen parents.

With the right supports:

- Teen parents are less likely to have a second teen birth; and
- The babies born to teen parents are less likely to become teen parents themselves.

Research has shown that when impoverished and isolated teen mothers receive comprehensive services, including health care, and home-based social work and parenting supports, the parents and their children reap the benefits. In the longitudinal and randomized study of the Prenatal and Early Childhood Home Visitation Program in Elmira, the families enrolled in the program received nurse home visits from the time of pregnancy through their child's second birthday. The study showed that mothers enrolled in the program waited longer before becoming pregnant a second time, and were more likely to become employed by the time their child was four. The mothers enrolled who were at highest risk (low income and unmarried) had lower rates of child abuse through their child's fifteenth birthday; and were less likely to have problems with alcohol or drug abuse over the time of the fifteen year study. The 15 year old children of the mothers at highest risk (low income and unmarried) had fewer instances of running away, fewer arrests, and fewer sexual partners, and were less likely to drink alcohol, as compared to children of mothers at highest risk in the control group. (D. Olds, 1999, page 54-56).

Quality case management services for teen parents are designed to provide the comprehensive range of supports that teen parents need to break the cycle. Quality case management programs are strength-based, comprehensive, and of sufficient duration and intensity. These programs show results: with these services, isolated and impoverished teens finish their education, improve their parenting skills, stabilize their families, and find long-term employment. This guide summarizes the strength-based case management practices that will help teen parents overcome the difficulties they face to reach their goals; and that will help their babies grow up to be healthy and ready to learn in school.

Best Practices in Case Management Defined

A case manager is a "designated person or team who organizes, coordinates, and sustains a network of formal and informal supports and activities designed to optimize the functioning and well-being of people with multiple needs" (Moxley, as cited in Kirst-Ashman & Hull, 1994, p. 506).

"Case management can occur within a single large organization or within a community program that coordinates services among agencies" (Barker, 1995, p. 47).

Best practices require:

- A youth-centered approach. The goal is to provide youth and/or families the opportunity for self-determination to develop resources and empowerment within themselves, each other, and their communities.

self-determination: "an ethical principle ..., which recognizes the rights and needs of clients to be free to make their own choices and decisions" (Barker, 1995, p. 339).

empowerment: "...a collaborative effort in which staff and families engage in activities and relationships to actualize strengths and mobilize community resources." (Bartle, Couchonnal, Canda, & Staker (2002), p. 39). Also: "... a process of dialogue through which the client is continuously supported to produce the range of possibility that she/he sees appropriate to

his/her needs; that the client is the center for all decisions that affect her/his life” (Rose, as cited in Saleebey, 1992, p. 42).

- Intensity (refers to sufficient frequency of contact and quality of relationship).
 - David Olds Nurse Home Visitation Project – weekly or twice-a-month home visit.
- A comprehensive approach. Focus can include education, job training and job placement, parenting skills and child development, life skills, coping skills (communication, conflict resolution), housing, income supports, money management, health care for the mother (including referrals for contraception and reproductive health care), health care for the child, day care for the child, building a support network. Goals must be client-driven, and program must be adaptable.
 - Carrera Program – Children’s Aid Society
- A focus on client’s strengths and capabilities.
 - Charles Rapp – *The Strengths Model*
 - Walter Kisthardt – “The Strengths Model of Case Management”
 - Doman Lum – *Culturally Competent Practice*
 - Dennis Saleebey – *The Strengths Perspective in Social Work Practice*
- Service of sufficient duration.
 - David Olds Nurse Home Visitation Project – from pregnancy until child turns two
 - Parents as Teachers – begins at birth or prenatally and continues through the child’s third birthday or longer.
 - Carrera Program – Children’s Aid Society – engages adolescents over time, for three years or more.
- Appropriate linkages and referrals – both within family system and within and without the agency.
 - Rothman and Sager – *Case Management*
 - Kirst-Ashman & Hull – *Understanding Generalist Practice*
- Staff who are caring, flexible, respectful, culturally competent, and able to connect.
 - Walter Kisthardt – “The Strengths Model of Case Management: Principles and Helping Functions”
 - Gayla Rogers – “Educating Case Managers for Culturally Competent Practice”
 - Doman Lum – *Culturally Competent Practice*
- In a parallel process, staff must be nurtured, supported, empowered, and supervised.
 - Laurence Shulman – *Interactive Supervision*
 - Bartle, Couchonnal, Canda, & Staker, “Empowerment as a Dynamically Developing Concept for Practice: Lessons Learned from Organizational Ethnography”

- Reasonable caseloads.
 - David Olds – 25 families
 - Child Welfare League of America: *Standards of Excellence for Services for Adolescent Pregnancy Prevention, Pregnant Adolescents and Young Parents* – 20 to 25 cases
 - Experience in Rochester tells us that case loads for case managers who use best practices and work intensively with high-need teen parents must be restricted to 10 to 15 cases. Agencies polled include SPCC-TAPPS, Family Resource Centers, Hillside Children’s Center (AIY), Melita House of Mercy Residential Services
- Incorporate home visiting.
 - Walter Kisthardt – “The Strengths Model of Case Management: Principles and Helping Functions”
 - Gayla Rogers – “Educating Case Managers for Culturally Competent Practice”
- Supported by a public commitment.
- Access to culturally competent mental health services.
 - Gayla Rogers – “Educating Case Managers for Culturally Competent Practice”
- The style of work and relationships with clients needs to be adapted to the cultural values of different groups.
 - Gayla Rogers – “Educating Case Managers for Culturally Competent Practice”
 - Doman Lum – *Culturally Competent Practice*

Phases of Work in Case Management

- **Intake:** through outreach and/or referral
- **Engage:** convey “I care” and “I can help”
- **Assess:** client needs and resources
- **Plan:** goals, services, and service plan
- **Intervene:** direct services and indirect services
- **Monitor:** needs met and resource effectiveness
- **Evaluate:** whether goals are achieved
- **Terminate:** with client and deal with endings

INTAKE

The initial contact with the client, either through outreach or referral; the process of securing relevant information about the client (demographics), composing a psycho-social health history (when needed), identifying and “clarifying the presenting problem as viewed by the client and as understood by the (case manager)” (Rothman & Sager, 1998, p. 42), eliciting client strengths and coping strategies, and determining the fit of the client’s needs to the agency’s services. This process needs to be undertaken in a way that is sensitive to the client’s situation, culture, and emotional and physical state (Rothman & Sager, 1998).

ENGAGE

The case manager needs to develop trust by conveying respect and a sense of concern and competence, transmitting the messages “I care” and “I can help” (Rothman & Sager, 1998, p. 44). Providing an immediate concrete service can further reinforce these messages. It is important to define and clarify respective roles; it is equally important that client and case manager seek a shared understanding of expectations which are realistic. Timing is important; “three days is suggested as a maximum delay” (Rothman & Sager, 1998, p. 45) from the initial contact to the first interview/appointment. Clients who have had past negative experiences in seeking a service may feel powerless and fearful, and the case manager needs to be sensitive to this possibility (Rothman & Sager, 1998).

Rothman and Sager (1998) suggest techniques for engagement:

- Clarify the situation by:
 - asking the client to state (or perhaps write) exactly what s/he expects of case manager and of self,
 - restating the client’s communication to establish a shared understanding,
 - stating (or writing) the general responsibilities of each as discussed,
 - discussing any differences and coming to an agreement on each person’s role.
- Respond to the client as a unique person with a focus on understanding the client and his/her situation.
- Recognize negative feelings by letting the client know that his/her feelings are acceptable and realistic in the situation (pp. 46–47).
- Give clients the choice of accepting or rejecting the service.
- Be flexible in your manner.
- Respond to client’s personally perceived needs: housing, money, food, and physical safety.
- Be willing to move slowly and carefully at the client’s speed. They need time to develop trust.
- Do everything with the client rather than to him/her or for him/her.
- Strive to build trust. (Cohen, as cited in Rothman & Sager, 1998, p. 47)

ASSESS

Assess what client needs from her/his informal and formal resources. Focus on client’s strengths, potentialities and capabilities. Assess client’s skills that need to be maintained and those to be enhanced. View the client as the expert on her/his life and culture.

Assess capability of client’s informal support group (family and friends) to meet client’s needs (food, shelter, social and emotional support). Assess kind of assistance immediate and extended family can give and how well informal systems will interact with formal systems. (Kirst-Ashman & Hull, 1994)

Assess resources of formal support systems with “focus on availability, adequacy, appropriateness, acceptability, and accessibility of resources,” (Moxley, as cited in Kirst-Ashman & Hull, 1994, p. 511).

Assessment should be individualistic and comprehensive and especially participatory (client involvement, with self-determination) (Kirst-Ashman & Hull, 1994).

PLAN

According to Kirst-Ashman & Hull (1994), service plans jointly developed and which are workable need to incorporate:

- client's needs prioritized,
- goals and objectives of service,
- resource systems that will be involved,
- time frames for delivery of services and achievement of goals,
- outcome measures to evaluate achievement of goals,
- specific tasks assigned so it is clear who is responsible for what (p. 512).

INTERVENE

Direct services may include: counseling, crisis intervention, examination of strengths and how to use them to meet needs, support for difficult decision-making, encouragement to achieve goals or confrontation re: failure to follow through with goals, practical assistance (emergency transportation, etc.) (Moxley, as cited in Kirst-Ashman & Hull, 1994).

May serve in many different roles as determined by client need: teacher, resourcer, counselor, advocator, broker, planner.

Indirect services may include: linking client with needed resource, advocating with various systems on behalf of client, working with resource systems so that they become more responsive to client's need, addressing any of the client's concerns/obstacles to using a resource (Kirst-Ashman & Hull, 1994).

MONITOR

Case manager continues to communicate with client and resource systems, formal and informal, to determine whether service plan is being completed and goals met; may need to re-contract with client and service providers and rewrite service plan. "The primary focus is on how services are provided," and the communication and coordination of these services (Kirst-Ashman & Hull, 1994, p. 517).

EVALUATE

Determine with client whether goals are achieved. Determine if case management services were appropriate and effective (surveys). Decide if resource systems that served the client will continue or if others need to be established (Kirst-Ashman & Hull, 1994).

TERMINATE

End with client and deal with feelings and issues around endings; may need to do with resources as well. Close the record with completion of all paperwork.

Follow up in three to six months to enhance gains made and to prevent a return to previous needs. (Kirst-Ashman & Hull, 1994).

Factors which influence effective service delivery:

- small case loads, “Over twenty-five begin to reduce the effectiveness and quality of services ...,” (Berkeley Planning Associates, as cited in Kirst-Ashman & Hull, 1994, p. 518),
- extent of case manager’s responsibilities clearly laid out, (Kirst-Ashman & Hull, 1994, p. 520)
- effective supervision,
- stress and burnout,
- skill and motivation of worker,
- level of engagement with client, (Kirst-Ashman & Hull, 1994)

What are Strengths?

1. What people have learned about themselves, others, and their world as they have struggled with life issues and situations (Peele & Brodsky, 1991, as cited in Saleebey, 1997, p. 51).
2. Personal qualities, traits, and virtues that people possess (sense of humor, creativity, loyalty, independence, patience) (Wolin & Wolin, as cited in Saleebey, 1997, p. 51).
3. “What people know about the world around them, from those things learned intellectually or educationally to those that people have discerned and distilled through their life experiences (Saleebey, 1997, p. 51).
4. The talents that people have, such as singing, gardening, hobbies (Saleebey, 1997, p. 51).
5. Cultural and personal stories as sources of strength, comfort, and guidance (Aptheker, 1989, as cited in Saleebey, 1997, p. 51). Cultural approaches to helping and accounts of trauma and survival as sources of meaning (Saleebey, 1997, p. 51).
6. “pride... people who have leapt over obstacles, who have rebounded from misfortune and hardship...” (Saleebey, 1997, p. 51).

Principles and Elements of the Strengths-Based Model of Case Management

1. Focus of helping is on the strengths and capacities of each consumer, not on their labels and weaknesses; a problem does not constitute all of a person’s life (Kisthardt, 1997, p. 98).
2. The consumer/case manager relationship, which is primary, is one of collaboration, mutuality, and partnership — interdependence. It is helpful if the case manager does not assume the expert role but is real in the relationship (Kisthardt, 1997, pp. 98).
3. The consumer is the director of the helping process, not a “case being managed.” A more appropriate term for “case manager” might be “community-living consultant” (Kisthardt, 1997, p. 99). Interventions are based on self-determination and the consumer’s understanding of the situation.
4. All human beings possess the inherent capacity to learn, grow, and change; they have the right to take supported risks and to fail, to make mistakes and learn from them (Kisthardt, 1997, pp. 99-100).

5. The helping activities in this approach are designed to occur in the community, not in the confines of a building (Kisthardt, 1997, p. 100). More can be learned about informal and formal resources and the consumer when in her/his environment. Research... has consistently demonstrated that meeting the person in the community is important (Bond, McDonel, Miller, & Pensec, 1991; Bond, McGrew, & Fekete, 1995; Bush, Langford, Rosen, & Gott, 1990; Kisthardt, 1993, as cited in Kisthardt, 1997, p. 100).
6. "The entire community is viewed as an oasis of potential resources to enlist on behalf of consumers. Naturally occurring resources are considered as a possibility before segregated or formally constituted... resources" (Kisthardt, 1997, p. 100).

According to Saleeby (1997), there are some essential elements of strengths-based practice, which include: Acknowledge the pain... there is real use and purpose in addressing, acknowledging, reexperiencing, and putting into perspective the pains and trauma of one's life... But the purpose is always to look for the seeds of resilience and rebound, the lessons taken away from adversity — the cultural, ethnic, and familial sources of adaptability.

Stimulate... Narratives of Resilience and Strength... what they have done, how they have survived, what they want, what they want to avoid, (pp. 54–55)

Strategies that Promote Effective Engagement from the Consumer's Perspective:

- Talk to people... do not interview them
- Try to convey acceptance and validation
- Look for opportunities to help people with immediate wants and needs
- Be sensitive to consumers' culture, gender, age, and other factors of their distinctive being. (Kisthardt, 1997, pp. 102–133)

Recordkeeping and File Management

- Progress notes are interim case entries that provide an updated description of the worker's interaction with the consumer and any progress made toward goals, changes in the consumer's situation, in the service plan, and services provided. They can vary in length depending on their purpose.
- Case and progress notes are typed; when handwritten, write legibly, with no errors in spelling or grammar; use black ink, but not a felt-tip pen.
- Use full date of month/day/year where referring to any date.
- Keep progress notes in chronological order, without blank spaces between notes (there is not a blank space between the note and worker's signature).
- Worker signs progress notes, using full name and title.
- Put a line through any blank spaces in the progress note.
- Correct errors with a single straight line through the error, write error, initial and date; never use whiteout or scribble over an error.
- Make sure consumer's name is on each progress note sheet.

- Make timely entries; any entry in a record must show the date of entry, not the date of contact.
- When referrals are made to other agencies, agency and worker involved are named.
- Always give source of information, e.g., from consumer, other professional, significant other of consumer.
- Always keep records in the agency. Don't leave them on desk, in office for others to read; records are kept in locked files or room.
- Write objective, descriptive observations, not opinion/diagnosis/feelings, unless worker indicates they are worker's thoughts or impressions, and then use a phrase such as, "The writer thinks ..." or "It appears that..." Do not label consumers as resistant, lazy, etc. Avoid slang, sexist language, and abbreviations.
- Keep entries concise and focused, to the point, but not so general no one knows what has happened or what was planned.
- Progress notes should note that the agency's policy on confidentiality and informed consent was discussed. Worker should obtain release forms, signed by youth (and legal guardians as needed), for information-sharing with medical, educational, and other needed services. Release of information is specific and time-limited.
- Progress notes should include: factual information, progress note for each contact, phone calls, referrals to and from, summary of critical events/issues, service planning, action taken, worker interventions, cancelled/failed appointments, and discharge action/ planning.
- Forms are developed for intake, assessment, service plan, progress notes, and closure; they need to be concise, not repetitive, and easy to use.
- Progress notes are never to be falsified.
- Progress notes create accurate records of service contact and demonstrate professional practice standards and quality of care.
- The record, including the progress notes, is a document that is legally admissible in court proceedings.
- New York State consumers have a right to ask to see their record. Therefore, progress notes contain only information that can be readily shared with the consumer.

(Kirst-Ashman & Hull, 1994; Wilson, 1976)

Incorporating Cultural Competence into Case Management

Gayla Rogers (1995) points out that

Ours is a multicultural society, but it is not a pluralist society in that neither public sentiment nor public policy supports cultural diversity. Thus, case managers must incorporate knowledge of cultural norms and cultural variability with practices that respect and account for individual difference. Inherent in this combination is the need to understand the effects of oppression, discrimination, anglocentric explanations of human behavior, and unequal or restricted access to economic and political power, services, and resources. (p. 61)

Skills for Culturally Competent Case Managers

- Ability to be self-aware — to tune into one’s stereotypical thinking.
- Ability to identify difference as an issue — to raise subject matter and openly discuss taboo topics such as racial identity.
- Ability to accept others – to be comfortable with a wide range of people, their values, and behaviors.
- Ability to individualize and generalize – to enter another person’s cultural frame of reference, to understand, cognitively and affectively, the experience of oppression, discrimination, and its impact on people.
- Ability to advocate – to argue for culturally appropriate services from other systems. (Rogers, 1995, pp. 64-65)

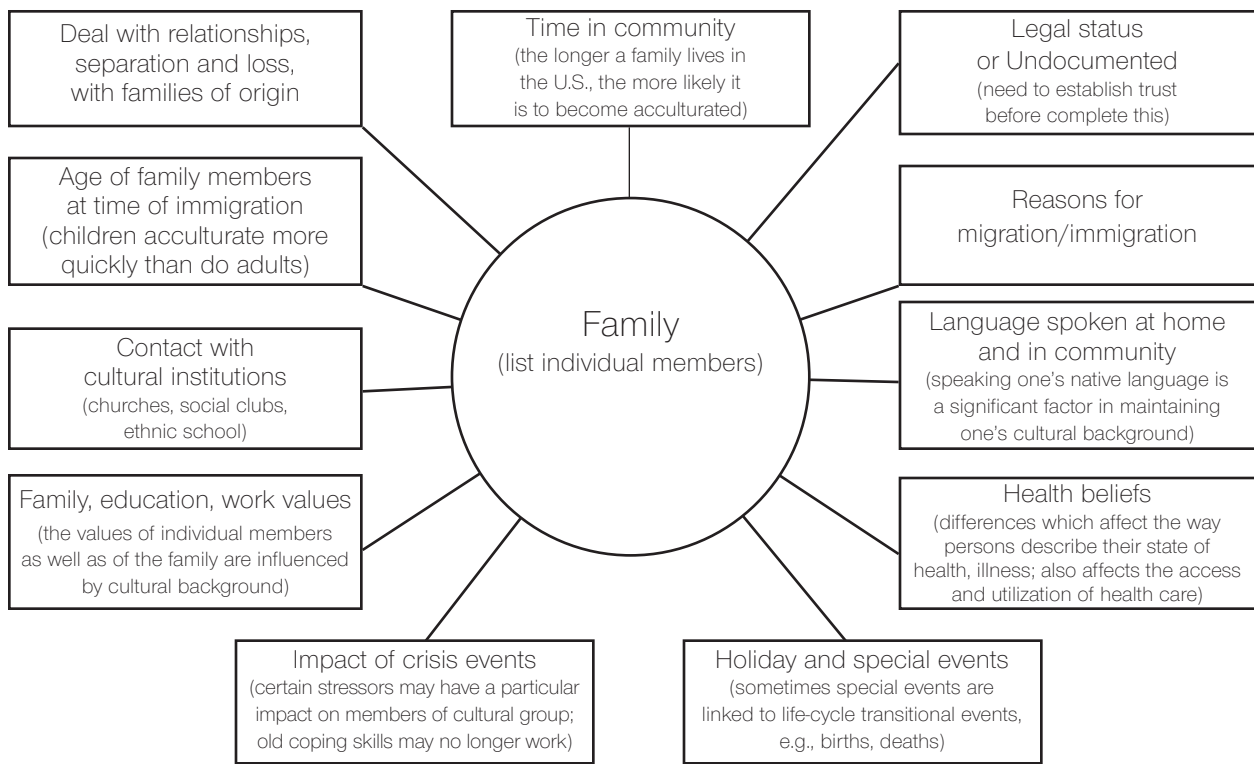
“The realization that culture permeates the ways in which people interpret, make meanings, and relate to others is significant for case managers in performing all their functions throughout the delivery cycle” (Rogers, 1995, p. 65). Becoming culturally competent is a developmental process, a journey that involves time, commitment, and a learning environment supportive of opportunities to safely share experiences and struggles when working with someone of a different culture (Rogers, 1995). Education and training, through experiential and knowledge workshops, consultation with members from diverse cultural groups, exposure in working with consumers of different cultural groups, accessing various sources of information (literature and media materials), classes in social work programs, and cross-cultural supervision, are needed in this journey toward cultural competence.

Culturagrams to Assess and Empower Culturally Diverse Families

Overgeneralization in terms of racial or ethnic group characteristics does not lead to greater understanding of the culturally diverse family. Clearly, it is not sufficient to describe one family as Hispanic and another as black while professing sensitivity to cultural differences. A Puerto Rican family that has lived in the United States for 30 years may be very different from a Mexican family that came to the United States without legal documentation in the past year. An African American family that relocated from a small southern town to a northern city will be unlike a Haitian family. Use of the culturagram helps the social worker clarify differences among individuals and families from similar racial and ethnic backgrounds. (Congress, 1994, p. 533)

The culturagram enables practitioners to understand different aspects of culture (institutions, language, values, religion, patterns of social and interpersonal relationships) in terms of a specific family (Congress, 1994).

The culturagram helps social workers understand the diversity of cultural beliefs among family members. Such knowledge can be used to understand and reconcile differences. Family members may not even be aware that other family members have differing values and beliefs. (Congress, 1994, p. 536)



(culturagram adapted from original by Congress, 1994, p. 532)

Questions which might facilitate completion of the culturagram:

1. What brought you to the United States? Why did you decide to leave [country of origin]? (if applicable)
2. How long have you lived in the United States? In this community? (if applicable)
3. Do you have a green card? Sometimes social workers can help people secure a green card. (if applicable)
4. How old were you when you came to the United States? (if applicable)
5. What language do you speak at home? In the community?
6. What clubs/groups do you belong to?
7. When you are sick, what do you do? Where and to whom do you turn for help?
8. What kinds of family parties do you have? What holidays do you celebrate? How do you celebrate?
9. What particular events have been stressful for your family?
10. Do you believe everyone should have a high school/college education?
11. What do you believe is the role of the father in the family?

(Adapted from Congress, 1994, p. 537)

SOURCES

- Barker, Robert. (1995). *The Social Work Dictionary* (3rd ed.). Washington, D.C.: NASW Press.
- Bartle, E., Couchonnal, C., Canda, E., & Staker, M. (2002). Empowerment as a dynamically developing concept for practice: Lessons learned from organizational ethnography. *Social Work*, Vol. 47, No. 1, January, 32-43.
- Carrera, Michael (1995). Preventing Adolescent Pregnancy: in Hot Pursuit. *Siecus Report*, Vol. 23, Number 6, Aug.-Sept.
- Congress, Elaine P. (1994). The Use of Culturagrams to Assess and Empower Culturally Diverse Families. *The Journal of Contemporary Human Services*, 46, 531-538.
- Early, T., & GlenMaye, L. (2000). Valuing families: Social Work Practice with Families from a Strengths Perspective. *Social Work*, Vol. 45, No. 2, March, 118-130.
- Kirst-Ashman, Karen K., & Hull, Jr., Grafton H. (1994). *Understanding Generalist Practice*. Chicago: Nelson-Hall.
- Kisthardt, Walter. (1997). The Strengths Model of Case Management: Principles and Helping Functions. In Dennis Saleebey (Ed.), *The Strengths Perspective in Social Work Practice* (pp. 97-113). White Plains, NY: Longman.
- Maynard, Rebecca A. *Kids Having Kids, A Robin Hood Foundation Special Report on the Costs of Adolescent Childbearing*, (1996). Robin Hood Foundation, NY, NY, 18 – 20.
- Lum, Doman. (1999). *Culturally Competent Practice*. Pacific Grove, CA: Brooks/Cole
- Olds, David; Henderson, Charles; Kitzman, Harriet; Echenrode, John; Cole, Robert; Tatelbaum, Robert (1999) *Prenatal and Infancy Home Visitation by Nurses: Recent Findings*, The Future of Children, David and Lucile Packard Foundation, Spring/Summer, 1999, 54-56.
- Rapp, Charles. (1998). *The Strengths Model*. NY: Oxford Press.
- Rogers, Gayla. (1995). Educating Case Managers for Culturally Competent Practice. *Journal of Case Management*, Vol. 4, No. 2, Summer, 60-65.
- Rothman, Jack, & Sager, Jan Simon. (1998). *Case management*. Needham Heights, MA: Allyn & Bacon.
- Saleebey, Dennis. (1992). Beginnings of a strengths approach to practice. In Dennis Saleebey (Ed.), *The Strengths Perspective in Social Work Practice* (pp. 41-44). White Plains, NY: Longman.
- Saleebey, Dennis. (1997). The Strengths Approach to Practice. In Dennis Saleebey (Ed.), *The Strengths Perspective in Social Work Practice* (pp. 49-57). White Plains, NY: Longman.
- Shulman, Lawrence. (1993). *Interactive Supervision*. Washington, D.C.: NASW Press.
- Wilson, Suanna J. (1976). *Recording, Guidelines for Social Workers*. NY: The Free Press.

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This report was written by the MCTP Planning Committee (a list of members follows in the Appendix), and supported by a grant from the Centers of Disease Control and Prevention, Division of Reproductive Health.

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appendix:

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