

Common Core 3.0
Key Issues in Child Welfare
Practice: Social Worker as
Practitioner

Trainee Guide



December 31, 2018

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Introduction to Common Core

Common Core curriculum and training for new child welfare workers in California is designed to be generalizable across the state, cover basic child welfare knowledge and skills, and is important for all CWS positions within an agency.

California's Common Core Curriculum for Child Welfare Workers is the result of the invaluable work and guidance of a great many people throughout the child welfare system in California and across the country. It would be impossible to list all of the individuals who contributed, but some groups of people will be acknowledged here.

The Content Development Oversight Group (CDOG) a subcommittee of the Statewide Training and Education Committee (STEC) provided overall guidance for the development of the curricula. Convened by the California Social Work Education Center (CalSWEC) and the California Department of Social Services (CDSS), CDOG membership includes representatives from the Regional Training Academies (RTAs), the University Consortium for Children and Families in Los Angeles (UCCF), and Los Angeles County Department of Children and Family Services.

In addition to CDOG, a Common Core 3.0 subcommittee comprised of representatives from the RTAs, the Resource Center for Family-Focused Practice, and counties provided oversight and approval for the curriculum development process.

Along the way, many other people provided their insight and hard work, attending pilots of the trainings, reviewing sections of curricula, or providing other assistance.

California's child welfare system greatly benefits from this collaborative endeavor, which helps our workforce meet the needs of the state's children and families.

The Children's Research Center provided technical support as well as The Structured Decision Making System that includes the SDM 3.0 Policy and Procedure Manual and Decision Making Tools. These resources are used in compliance with CRC copyright agreements with California. Additionally, content in this curriculum has been adapted from CRC's SDM 3.0 classroom curriculum to meet the training needs in California.

In compliance with the Indian Child Welfare Act (1978) and the California Practice Model, social workers must identify American Indian/Alaska Native children in the system. For an overview of *Implementing the Indian Child Welfare Act* view: <https://www.youtube.com/watch?v=BIQG65KFKGs>

The curriculum is developed with public funds and is intended for public use. For information on use and citation of the curriculum, please refer to: <https://calswec.berkeley.edu/programs-and-services/child-welfare-service-training-program/common-core-30>



FOR MORE INFORMATION on California's Core Curricula, as well as the latest version of this curriculum, please visit the California Social Work Education Center (CalSWEC) website: <http://calswec.berkeley.edu>

Curriculum Introduction

This 2-day curriculum focuses on introducing practitioners to their role in working with families experiencing substance use disorders, intimate partner violence and behavioral health issues. Throughout the training, the trainer will guide the trainees through the activities and facilitate active participation in the development of knowledge and skills related to engaging with families around these issues, teaming with family members and their supports, and assessing for these key issues.

Agenda

Day 1 – 6 hours

Segment 1: Welcome	9:00 – 9:45
Segment 2: Personal Bias and the Role of the Child Welfare Practitioner	9:45 – 10:45
Break	10:45 – 11:00
Segment 3: Strength-based Practice in Child Welfare	11:00 – 12:00
Lunch	12:00 – 1:00
Segment 4: Intersection of Key Issues	1:00 – 3:45
Break	2:45 – 3:00
Segment 5: Wrap up	3:45 – 4:00

Day 2 – 6 hours

Segment 6: Welcome Back	9:00 – 9:30
Segment 7: “Where there is breath, there is hope”	9:30 – 12:00
Break	10:15 – 10:30
Lunch	12:00 – 1:00
Segment 8: Stages of Change	1:00 – 2:15
Break	2:15 – 2:30
Segment 9: Role of the Social Worker as Practitioner	2:30 – 3:30
Segment 10: Transfer of Learning	3:30 -3:45
Segment 11: Wrap up	3:45 – 4:00

Learning Objectives

KNOWLEDGE

- K1.** The trainee will identify the stages of change and strategies for engaging and motivating family members experiencing substance use disorder, intimate partner violence, and/or behavioral health issues.
- K2.** The trainee will describe the role of the child welfare practitioner working with service providers, including:
 - a. Facilitating access to substance use disorder, intimate partner violence, and behavioral health services for parents/caregivers, youth, and children
 - b. Recommendations, management, and ongoing services for parents/caregivers, youth, and children (including psychotropic medication)
 - c. Psychotropic medication: over medication, interaction with other prescriptions, monitoring ongoing use, individual rights, and documentation that identifies current medications and prescribing doctors
- K3.** The trainee will recognize the relationship between substance use disorders, intimate partner violence, and/or behavioral health issues and identify effects in parents, family members and children.
- K4.** The trainee will identify how personal biases related to substance use disorder, intimate partner violence and behavioral health issues may impact engaging, assessing and developing plans with children, youth and families.
- K5.** The trainee will describe how using strength-based approaches and culturally relevant supports and interventions can improve outcomes for families struggling with substance use disorders, intimate partner violence, and/or behavioral health issues.

SKILLS

- S1.** Using a vignette, the trainee will be able to identify trauma-informed actions to provide safety and services to support families that experience substance use disorders, intimate partner violence, and behavioral health issues, including:
 - a. Protective capacities and actions to provide safety
 - i. Team Meetings
 - ii. Use of the Safety Network
 - b. Services to support the family
 - i. Substance use disorder services
 - ii. Intimate partner violence services for both the survivor and the person who batters
 - iii. Behavioral health services
 - iv. Educational and counseling services for youth who have a substance use disorder or are involved in intimate partner violence.
- S2.** Using a vignette, the trainee will be able to recognize indicators of teen dating violence and engage, assess, and develop a safety plan.

VALUES

- V1.** The trainee will support the involvement of families in decision-making processes about substance use disorder, intimate partner violence, and/or behavioral health issues.
- V2.** The trainee will foster strength-based approaches and culturally relevant supports and interventions to address substance use disorder, intimate partner violence, and behavioral health issues.
- V3.** The trainee will encourage working in partnerships providing multi-disciplinary and cross-system services in order to protect and support the safety of children, youth, young adults, and families that experience substance use disorder, intimate partner violence, and/or behavioral health issues.

Pendulum Swing Activity

Read the following statements and circle your initial “gut” response:

1. Parents who use drugs and/or alcohol **should/should not** have their child(ren).
2. Medication **is/is not** needed to treat behavioral health issues if the person works hard in therapy.
3. People who stay in relationships with intimate partner violence are **weak/strong**.
4. Survivors of intimate partner violence **should/should not** fight back or leave.
5. Young adults experimenting with drugs **is/is not** a big deal.
6. Using prescription medication **is/is not** safer than using illegal drugs like marijuana, methamphetamine or heroin.
7. Therapy **is/is not** the best way to treat behavioral health disorders.
8. People who batter **always/never** change.
9. Families and other people who give money to people with substance use disorders **are/are not** enabling them.

The Cycle of Addiction¹

Cycle of addiction is an addictive pattern that occurs when use of alcohol or drugs occurs in a behavioral pattern that becomes increasingly out of the control of the individual despite negative physical and lifestyle consequences and less and less satisfaction is gained from the behavior.

Physical addiction or dependence occurs when there is a physical reaction from withdrawal of a regularly used substance and individuals suffer from recurrent desires (cravings) for the drug. Physical addiction may be preceded by increased tolerance to the effects of alcohol or drugs, requiring increasing amounts of the substance to achieve desired effects and patterns of abusive or addictive use.

Models of the progression of addiction can be viewed from a **medical model** (viewing addiction as a progressive, fatal disease), a **social model** (from the 12-Step perspective), and a **psychological model** (a continuum between emotional pain and euphoria). All three models are similar in defining the behavioral progression of addiction that are described below.

Addiction progresses from early stages involving periodic **experimentation** to **occasional use, regular use, habitual use, addiction, or abuse** resulting in a variety of negative consequences such as physical disease, family problems such as family violence, child abuse and neglect, and family dysfunction, problems with employment, and law enforcement problems. Intervention can occur at any stage in the progression of the cycle.

Early Stages: From a starting point of non-use, the individual engages in social use or experimentation on a periodic basis. During this stage, the individual learns that chemicals can provide a temporary and predictable mood swing away from pain toward a feeling of wellbeing.

Features of this stage include:

- Use to calm anxiety and relieve emotional stress and pain
- Adaptation to using amount that results in desired effect
- Increase in tolerance over time
- Increase in amounts used during social situations or before an event
- Thoughts about next use of substance.

Social users may remain in this stage, learning to use the substance at appropriate times and places, to develop self-imposed rules about use that are adhered to, to control times, quantities, and outcomes of use of substances, and may suffer occasional physical effects (hangover) but no guilt about use.

Middle Stages: Social use progresses to a stage where the individual begins to lose control of their use and the outcome of use is no longer predictable. The individual may begin to rationalize their substance use because continued use places emotional pressure due to the conflict between behavior and the person's value system.

¹ Adapted from Substance Abuse and Child Welfare Practice, Central California Public Social Services Training Academy, November 2011

Features of this stage include:

- Growing preoccupation and anticipation of use
- Lifestyle changes to support continued use
- Efforts to control use through self-imposed rules that are regularly broken
- Sneaking or dishonesty about use
- Use in isolation
- Projecting of guilt or shame about use into aggression or blaming.

On a physical level, this individual may suffer from memory blackouts while under the influence, experiencing multiple physical effects including morning tremors and the need to use substances in the morning. The person at this stage may neglect their nutritional needs in favor of substance use.

Late Stages: At this stage, use of the chemical is necessary for the individual's survival, rather than to achieve the goal of wellbeing. Physical addiction can occur but is not necessary. The individual may consider employment and family responsibilities as interfering with use of substances.

Features of this stage include:

- Geographic escape and disappearance
- Lengthy and successive bouts of use
- Increasing awareness of use by others
- Actions in conflict with values or beliefs

There will be radical deterioration of family relationships and capacity to hold a job, repeated contact with law enforcement related to use of substances, and deterioration of health until death or until arrest or intervention occurs.

(Sources: 1995 Lecture by Dr. W. West, Chapman University, Vernon E. Johnson, D.D. (1986) "Intervention: A Step by Step Guide for Families and Friends of Chemically Dependent Persons," Dr. Charles M. Peterson: "Differences in Alcohol Metabolism Between Men and Woman." Harvey B. Milkman and Lloyd Dederer, Treatment Choices for Alcoholism and Substance Abuse and Pathways, Valley Presbyterian Hospital's Alcoholism Treatment Program.)

Teen Dating Violence

What are the Early Warning Signs of Teen Dating Violence?

Researchers who study teen dating violence have identified several early warning signs that a dating relationship might be likely to turn violent. These warning signs do not mean a relationship will definitely turn violent. However, if you notice several of them in your relationship or partner, you may need to re-evaluate your dating relationship.

These warning signs include:

- ☐ Excessive jealousy.
- ☐ Constant checking in with you or making you check in with him or her.
- ☐ Attempts to isolate you from friends and family.
- ☐ Insulting or putting down people that you care about.
- ☐ Is too serious about the relationship too quickly.
- ☐ Has had a lot of bad prior relationships - and blames all of the problems on the previous partners.
- ☐ Is very controlling.
- ☐ This may include giving you orders, telling you what to wear, and trying to make all of the decisions for you.
- ☐ Blames you when he or she treats you badly by telling you all of the ways you provoked him or her.
- ☐ Does not take responsibility for own actions.
- ☐ Has an explosive temper ("blows up" a lot).
- ☐ Pressures you into sexual activity with which you are not comfortable.
- ☐ Has a history of fighting, hurting animals, or brags about mistreating other people.
- ☐ Believes strongly in stereotypical gender roles for males and females.
- ☐ You worry about how your partner will react to the things you say or you are afraid of provoking your partner.
- ☐ Owns or uses weapons.
- ☐ Refuses to let you to end the relationship.

Behavioral Health Resources²

Outside of the Western worldview, mental health and physical health are not only seen as inseparable, they are also considered deeply connected to community health, to the earth, and to the living and the dead. This means that a Western ‘talk therapy’ or ‘mental health’ intervention may not be understood or interpreted in the same way by someone who has a different cultural perspective.

It’s important to consider the following when addressing mental health or mental illness in the context of culture:

1. *Perspective of the Service Provider:* None of us is objective; we are formed by the cultures in which we are raised and in which we currently live. By virtue of our roles in child welfare, we also hold some level of power and authority in contrast to most, if not all, of the children, youth and families we serve.
2. *Perspective of the Child or Adult Family Member being served:* Children and families served by child welfare frequently have histories of trauma, whether one-time or ongoing. Immigrant families have often survived wars, as well as political and social unrest.

Child welfare workers (CWW) are in a unique position to help assess how cultural influences might be affecting the behavior of the children and families with whom they work. In some instances, they may even be able to show that the behavior that others see as indicative of mental illness in mainstream culture is not considered a sign of mental illness in a particular individual’s culture. And in other instances, workers will be able to help children and/or adult family members manage and overcome symptoms of mental illness by calling upon some of the family’s unique cultural resources and systems of supports.

The CWW must always evaluate mental health issues in their cultural context. For example, certain minority groups may evidence paranoia, which in fact is based upon real experiences of prejudice, discrimination, or even persecution. Avoid jumping to conclusions that someone is mentally ill because they express some suspiciousness. If the person expresses distrust, it is important to be empathetic and to try and understand the situation from the other person’s point of view. Similarly, in families where there has been interpersonal or domestic violence, a culture of distrust develops and is nourished by the abuser who isolates the family and often plays on insecurities to keep members of the family in a distrusting mode. This type of paranoia is not based in delusion but in learned behavior. Understanding the origins of the behaviors and the purpose it serves within the culture can make our work with children, youth and families more effective.

There are some cultural rituals that involve seemingly psychotic behaviors such as hallucinations, talking in tongues, and/or altered states of consciousness. Examples of this in various cultures come in a variety of forms. For instance, Native American cultures which employ a vision quest in their spiritual practices, fundamentalist religions that believe the spirit of God speaks through them in only a language God can understand, hearing the voices of the dead as a guardian angel or visitor from the other side, are all common practices in different cultures represented in the US. Taken in isolation, any of these examples could appear to be delusions or hallucinations.

As reported in the Surgeon General’s Mental Health Report (1999), cultural variations must be considered when interpreting signs and symptoms such as hallucinations, delusions, or bizarre behaviors. As the Surgeon General notes, “among members of some cultural groups, ‘visions’ or ‘voices’ of religious figures are part of normal religious

² Adapted from MENTAL HEALTH & MENTAL DISORDERS (Version 2.1, February 2015) California Common Core for Child Welfare Workers

experience. In many communities, ‘seeing’ and being ‘visited’ by a recently deceased person are not unusual among family members.”

Finally, in examining cultural implications the CWW must understand the culture that exists in mental health service provision. The attendance of regular appointments and possible periodic hospitalizations of a mental health nature are an integral part of this culture. Medication regimens, prescriptions and pharmacies become commonplace. Caretaking family members, case managers, therapists, physicians, transportation technicians, day treatment/partial hospitalization technicians and more become regular figures in the culture that has arisen around interventions with people living with mental illness.

The stigma and discrimination associated with the mentally ill are also part of the culture. It is not dissimilar to the culture of the medically fragile or the chronically ill medical patient. However, the one major difference is the stigma associated with the belief that somehow the mentally ill person is not as “good” in some way as everyone else. Whether “good” refers to ability to contribute in employment setting or to ability to parent or to ability to manage his/her own affairs, the stigma is greater for mental health concerns than for most medical concerns.

Implications for Child Welfare Practice:

- Strive to view all signs and symptoms through the cultural lens of the child, youth or family.
- Examine one’s own biases about mental illness and how these biases may affect practice with families living with mental illness.
- Consider supporting the use of alternative modalities in conjunction with ‘talk therapy’ that are culturally relevant - or are of interest to - the children, youth and families with whom we work.

Culture and Behavioral Health³

Cultural Formulation Interview⁴

While originally designed for mental health professionals to use in making an assessment of the individuals or families they work with, questions from the Cultural Formulation Interview can be used by child welfare workers to delve more deeply into some of the beliefs and values which children, youth and families hold about mental health and mental illness, treatment, and support.

INTRODUCTION

"I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers."

CULTURAL DEFINITION OF THE PROBLEM

1: What brings you here today? *If the individual gives few details or only mentions symptoms or a medical diagnosis, ask further:* People often understand their problems in their own way, which may be similar to or different from how doctors or other people describe the problem. How would you describe your problem?

2: Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?

3: What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

4: Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?

Prompt further if required: Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes...

5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?

7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By **background or identity**, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your ethnic background, your physical characteristics (skin color, body and/or facial hair, markings on the body), your gender or sexual orientation, your faith or religion, or your abilities or disabilities.

³ Adapted from MENTAL HEALTH & MENTAL DISORDERS (Version 2.1, February 2015) California Common Core for Child Welfare Workers

⁴ Adapted from the Diagnostic & Statistical Manual of Mental Disorders, Fifth Ed., pp. 752-754.

8. For you, what are the most important aspects of your background or identity?
9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP-SEEKING

11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?
12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice or healing have you sought for your [PROBLEM]? What types of help or treatment were most useful? Not useful?
13. Has anything prevented you from getting the help you need? (For example, money, work, or family commitments, stigma or discrimination, or lack of services that understand your language or background?)

CULTURAL FACTORS AFFECTING CURRENT HELP-SEEKING

14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?
16. Sometimes doctors (or other service providers) and individuals/families misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything we can do to provide you with the support(s) you might need?

Alternative Treatment Modalities⁵

ACUPUNCTURE

Acupuncture is a traditional medicine that's been practiced for thousands of years. Although methods can vary, it typically involves insertion of thin metal needles through the skin leading to stimulation of specific points on the body. At least 3 million adults nationwide use acupuncture every year, according to the latest estimates. There are very few side effects and among other things, it is effective in controlling some types of pain and improving response to conventional therapies used to treat depression.^{6, 7}

ART THERAPY

Art therapy is a behavioral health treatment modality in which the art therapist works with people to use art making to address specific concerns (including managing behavior and addictions, developing social skills, improving reality orientation, reducing anxiety, and increasing self-esteem).⁸ Art therapy can be especially helpful in treating trauma related challenges: "Many verbal and nonverbal methods used in art therapy support the successful neurobiological processing of ... traumatic narrative and imagery, as do sensorimotor experiences that engage the nonverbal components of a person's traumatic memory."⁹

CHI GUNG (aka QIGONG)

Chi Gung (also known as Qigong) involves a series of focused motions and postures done in concert with specific breathing patterns. The movements and breathing are completed with a goal of mindfulness that serves to improve and strengthen physical and emotional regulation. Studies show that practitioners experience positive effects including improved blood pressure, heart rate, and lung function, as well as improvements in blood test results related to cholesterol and triglycerides. Emotionally, practitioners experience stress reduction and improved capacity to cope with anxiety.¹⁰

DANCE MOVEMENT THERAPY

Dance movement therapy (DMT) uses music and simple movement to achieve sensory stimulation and low-impact exercise. In use in Western treatment settings since the mid 20th century, DMT has shown promise as a treatment for mild depression and may benefit those who have emotional and physical symptoms related to trauma. It is also used to help improve responses to more traditional treatments for medical problems (e.g., cancer, heart disease, neurological problems, and chronic pain, among others).¹¹

EXERCISE

Studies show that even mild physical exercise (e.g., 15 minutes of low impact cycling), can have positive benefits related to physical health, emotional well-being (including feeling happier, exhibiting a more positive affect, finding hope, resolving identity related concerns, and taking an active role in recovery processes), and cognitive ability (improved memory and capacity for recall).^{12, 13}

⁵ Adapted from MENTAL HEALTH & MENTAL DISORDERS (Version 2.1, February 2015) California Common Core for Child Welfare Workers

⁶ Vickers, A.; Cronin, A.; Maschino, A.; Lewith, G.; MacPherson, H.; Foster, N.; Sherman, K.; Witt, C.; Linde, K. (2012). Acupuncture for chronic pain: Individual patient data meta-analysis. *Archives of Internal Medicine* 172(19):1444-1453.

⁷ Kwon, C.; Choi, E.; Kim, J.; Chung, S. (2015). Trends of Tuina therapy on depression and its efficacy. *Journal of Oriental Neuropsychiatry*, 26:3, pp. 251-266.

⁸ American Art Therapy Association, 2013. <http://arttherapy.org/upload/whatisarttherapy.pdf>

⁹ Hass-Cohen, N.; Findlay, J.; Carr, R.; & Vanderlan, J. (2014). "Check, change what you need to change and/or keep what you want": An art therapy neurobiological-based trauma protocol. *Art Therapy* 31:2, 69-78.

¹⁰ Matos, L.; Sousa, C.; Gonçalves, M.; Gabriel, J.; Machado, J.; and Greten, H. (2015). Qigong as a traditional vegetative biofeedback therapy: Long-term conditioning of physiological mind-body effects. *BioMed Research International*, v.2015.

¹¹ Jeong, Y.; Hong, S.; Lee, M.; Park, M.; Kim, Y.; and Suh, C. (2005). Dance movement therapy improves emotional responses and modulates neurohormones in adolescents with mild depression. *International Journal of Neuroscience*, 115:12, 1711-1720.

¹² Hogan, C.; Mata, J.; Carstensen, L. (2013). Exercise holds immediate benefits for affect and cognition in younger and older adults. *Psychology and Aging*, Vol 28(2): 587-594.

HERBAL MEDICINE

Using plants for curative purposes is a traditional form of treatment used for centuries that is still common today. Although sometimes seen as an alternative treatment, many mainstream pharmaceuticals are developed using plant-based components. There is evidence that herbal remedies can be effective for treating a variety of concerns; for example, recent research identified valeriana and hops as helpful for relieving stress related symptoms.¹⁴

HYPNOTHERAPY

Hypnotherapy can be used as a therapeutic intervention that engages the subconscious mind in driving change in thoughts, feelings, or actions. Research findings support use of hypnotherapy to treat emotional distress, pain, and surgical recovery, and to decrease reliance on pain medication.¹⁵

MASSAGE (E.G., TUINA, etc.)

Recent research indicates that massage practices such as tuina can be more effective than conventional treatment for relieving symptoms of depression and extending treatment benefits over time. Furthermore, used in conjunction with conventional treatments such as anti-depressant medication, tuina can improve outcomes over either individual treatment used alone.¹⁶

MINDFULNESS PRACTICE (E.G., MINDFULNESS-BASED INTERVENTIONS, MBIs)

Mindfulness practice originated in Eastern traditions and refers to intentionally seeking a heightened level of awareness or consciousness by seeking to maintain a clear focus on the present moment and accept the experiences that exist in that moment. Mindfulness practice can be used in conventional psychotherapy through identified mindfulness-based interventions that serve to improve feelings of well-being and decrease specific symptoms such as stress related symptoms. Recent research shows that MBIs are effective in treating concerns such as anxiety, depression, stress, and chronic pain.¹⁷

MUSIC THERAPY

Music therapy uses shared music related activity to build a therapeutic bond between the therapist and participant to allow for non-verbal expression and processing of emotions. Research identifies positive benefits such as improved general mental state and improved social functioning for music therapy, especially when used in conjunction with other interventions. In particular, music therapy has decreased negative symptoms among people with schizophrenia and decreased symptoms of depression.¹⁸

SHAMANS/SHAMANISM (a form of Indigenous Healers, Folk Healers, Traditional Healers)

Historically, the shaman served as a religious leader and healer using dance, music, and altered states of consciousness to promote improved emotional and physical health. Similar to the connections made in art and music therapy, a therapeutic connection between shaman and individual is made non-verbally facilitating expression of emotions through a cathartic event.¹⁹

T'AI CHI CH'UAN (aka TAIJI or TAI CHI)

Tai Chi is a Chinese martial art practiced for both its defense training and its health benefits. It involves sequences of

¹³ Soundy, A.; Freeman, P.; Stubbs, B.; Probst, M.; Coffee, P.; Vancampfort, D. (2014). The transcending benefits of physical activity for individuals with schizophrenia: A systematic review and meta-ethnography. *Psychiatry Research*, 220:1-2, 11-19

¹⁴ Gasparinia, M.; Aurilia, C.; Lubian, D.; Testa, M. (2016). Herbal remedies and the self-treatment of stress: An Italian survey. *European Journal of Integrative Medicine*, 8:4, pp. 465-470.

¹⁵ S. Tefikow, S.; Barth, J.; Maichrowitz, S.; Beelmann, A.; Strauss, B.; Rosendahl, J. (2013). Efficacy of hypnosis in adults undergoing surgery or medical procedures: A meta-analysis of randomized controlled trials. *Clinical Psychology Review*, 33:15, pp. 623-636.

¹⁶ Kwon, C.; Choi, E.; Kim, J.; Chung, S. (2015). Trends of Tuina therapy on depression and its efficacy. *Journal of Oriental Neuropsychiatry*, 26:3, pp. 251-266.

¹⁷ Gu, J.; Strauss, C.; Bond, R.; Cavanagh, K. (2015). How do mindfulness-based cognitive therapy and mindfulness-based stress reduction improve mental health and wellbeing? A systematic review and meta-analysis of mediation studies. *Clinical Psychology Review*, 37, pp. 1-12.

¹⁸ Gühne, U.; Weinmann, S.; Arnold, K.; Becker, T.; Riedel-Heller, S. (2015). S3 guideline on psychosocial therapies in severe mental illness: evidence and recommendations. *European Archives of Psychiatry and Clinical Neuroscience*, 265: 3, pp. 173-188.

¹⁹ Clift, S. Camic, P. (Eds.). (2016) *Oxford Textbook of Creative Arts, Health, and Wellbeing: International Perspectives on Practice, Policy, and Research*. Oxford University Press: Oxford, UK.

flowing movements coupled with changes in mental focus, breathing, coordination, and relaxation. It is an evidence-based intervention that can reduce depressive symptoms, stress, anxiety, and mood disturbances. Some research has also shown benefits related to insomnia and substance abuse.²⁰

YOGA

Yoga is a form of mindfulness practice that facilitates passage through prescribed sets of body movements with a focus on balance, strength, stretching, and breathing. Research shows that yoga has a positive impact on physical health and fitness, cognition, executive function, and ability to concentrate. Yoga has also been shown to have positive impact on emotional states by improving self-regulatory capacities and decreasing stress related symptoms such as rumination, intrusive thoughts and emotional arousal.²¹

²⁰ Abbott, R. and Lavretsky, H. (2013). Tai Chi and Qigong for the Treatment and Prevention of Mental Disorders. *Psychiatric Clinics of North America*, 36:1, pp. 109-119.

²¹ Shirley Telles, S.; Singh, N.; Bhardwaj, A.; Kumar, A.; Balkrishna, A. (2013). Effect of yoga or physical exercise on physical, cognitive and emotional measures in children: a randomized controlled trial. *Child and Adolescent Psychiatry and Mental Health*, 37:37.

The California Guidelines for the Use of Psychotropic Medication in Foster Care

Components of a Treatment Plan

The development, implementation, and execution of a Treatment Plan includes, but is not limited to, the following individuals: the child; the child's parents (when appropriate), the child's caregiver, the prescriber, care coordinator, therapist, school staff, CWS social worker, pediatrician, attorney, public health nurse, probation officer, case manager, CASA, and other members of the child's support network or CFT (as indicated).

A best practice (Malone Localio, Huang et al., 2012, Radley Finkelstein & Stafford, 2006)²⁷, treatment plan includes the following:

- a. The child's diagnosis (if indicated) and a conceptualization of the child's emotional, cognitive, and/or behavioral dysregulation based on the child's history of abuse, neglect, and/or removal from the home.
- b. The child's baseline strengths and needs.
- c. Target symptoms: stated in practical and everyday language as agreed to by the child, family, and their support network or CFT.
- d. Client-driven short and long term treatment goals: stated in ways that can be observed and measured on a regular basis by specified means.
- e. Treatment interventions: evidence-supported treatments; additional psychosocial interventions such as substance abuse prevention or treatment, case management, informal mental health services, educational or behavioral services, and/or extra-curricular and recreational activities. All identified treatments and interventions should have start dates. Psychotropic medications (if part of the Treatment Plan) also should include a re-assessment date. If medications are utilized, the dosage and medication monitoring schedule must be specified.
- f. Treatment and intervention periodic review and reassessment: formal treatments, e.g. (HHS 1996) evidence-supported psychotherapeutic treatments as well as psychotropic medications, are periodically reviewed by the child, family, and additional supportive collaterals (e.g., the Child and Family Team) as indicated.
- g. Updated medication treatment plans must be communicated as an attachment to the JV220, as well as shared with the child/youth, family, caregiver, and child welfare social worker and/or probation officer for distribution to all necessary parties in accordance with HIPAA (HHS 1996).

Psychotropic Medication Scenario

Tyler, a youth you have been working with for the last 6 months, tells you that he has been “cheeking” his Risperdal medication for the last month. He tells you he feels better without the meds and his care provider has not reported any problem behaviors.

How would you respond/handle this?

Johnson Vignette

The Johnson family is comprised of:

- Julie, mother
- Charles, father
- Joey (age 1)
- Kathy (age 3)

The case was opened by the child welfare agency as a voluntary family maintenance case. The agency received a referral regarding a violent fight between the parents where the father, who was intoxicated and admitted to drinking a 6-pack of beer, had struck the mother on the face while holding Joey.

You have been assigned this case and see the following notes in the file from the initial investigating social worker:

Issues and concerns:

- Substance abuse of parents (mother – meth and father – alcohol)
- Lack of medical care for the child
- Mother’s mental health/instability
- Parent’s Intimate Partner Violence

You note the following: Two weeks before the initial referral for the intimate partner violence incident between the parents, the mother was hospitalized (5150) for trying to stab herself with a knife in front of 3-year-old Kathy. A referral was not received for this incident. Joey and Kathy both have severe asthma and had not seen the pediatrician for 3 months despite their wheezing prior to the agency’s intervention. The children have since seen the pediatrician and are taking medication for their asthma.

Current status of the parents:

Mother is currently in a 90-day in-patient substance abuse treatment facility with the two children and father is taking a batterer’s class to address intimate partner violence.

Intersection of Key Issues

Behavioral Health and Substance Use Disorders

1. Co-occurrence of specific mental health condition and substance abuse problem
2. Dual diagnosis is a term for when someone experiences a mental illness and a substance abuse problem *simultaneously*.
3. Because there are many combinations of disorders that can occur, the symptoms of dual diagnosis vary widely. The symptoms of substance abuse may include:
 - a. Withdrawal from friends and family
 - b. Sudden changes in behavior
 - c. Using substances under dangerous conditions
 - d. Engaging in risky behaviors when drunk or high
 - e. Loss of control over use of substances
 - f. Doing things you wouldn't normally do to maintain your habit
 - g. Developing tolerance and withdrawal symptoms
 - h. Feeling like you need the drug to be able to function

Some Notes:

- ✓ Either substance use disorders or behavioral health issues can develop first.
- ✓ A person experiencing a behavioral health condition may turn to drugs and alcohol as a form of self-medication to improve the troubling mental health symptoms they experience.
- ✓ Research shows, though, that drugs and alcohol only make the symptoms of mental health conditions worse.
- ✓ About a third of all people experiencing behavioral health issues and about half of people living with severe mental illnesses also experience substance use disorder. These statistics are mirrored in the substance use disorders community, where about a third of all people who abuse alcohol and more than half of all people who abuse drugs report experiencing a behavioral health diagnosis.
- ✓ Men are more likely to develop a co-occurring disorder than women. Other people who have a particularly high risk of co-occurring disorders include individuals of lower socioeconomic status, military veterans and people with more general medical illnesses.

Intimate Partner Violence Intersection with Substance Use Disorders

- ✓ It is two problems – one doesn't cause or explain the other
- ✓ Disinhibition
- ✓ Victim self-medication
- ✓ Similarities and differences in characteristics
- ✓ One-third to one-half of batterers also have AOD problem
- ✓ Women who abuse substance are more likely to be DV victims
- ✓ Overlap of IPV and AOD problems is 50%
- ✓ Incidents more likely to result in death

Use of substances in the person who batterers

- ✓ It is known that many IPV episodes involve alcohol or drug consumption.
 - Kaufman Kantor and Straus (1990) found over 20% of males were drinking prior to the most recent and severe act of violence. Fals-Stewart (2003) found that on days of heavy drug use, physical violence was 11 times more likely.
 - Victims of IPV report that the offender had been drinking or using illicit drugs (Miller, 1990; Roberts, 1998). Miller (1990) reported that offenders of IPV typically use alcohol and have a dual problem with drugs.

Healing Neen Discussion Questions

SEGMENT 1:

- What was the impact of Barbara's substance use disorder on Neen?
- Thinking about the women's stories you just heard, what are some of the ways that substance use disorder, intimate partner violence, and behavioral health issues contributed to their incarceration? Think about this from a child's perspective as well as an adult's perspective.

SEGMENT 2:

- Describe the relationship between Adverse Childhood Experiences (ACEs) and substance use disorders, intimate partner violence, and behavioral health issues.
- How is substance use a symptom of the underlying need for Neen?
- Describe the relationship between ACEs and some of the behavioral health issues that were shared. How do the behavioral health issues present themselves?
- What are some of the ways that "systems" caused more trauma to Neen? How do you think this impacted her ability to trust people who said they wanted to help her?
- As a social worker, how would you approach Neen, knowing what you do about her past? How would you develop rapport with her?
- Thinking about the child welfare system, what are some of the ways that our system causes trauma, which may trigger youth or parents, leading to continued substance use, relapse, or behavioral health symptoms?

SEGMENT 3:

- What are some of your thoughts about how Neen interacts with Barbara?
- Do you have any worries about Neen having contact with Barbara? If so, how does this impact Neen and her daughter?

SEGMENT 4:

- What role would the social worker play in addressing substance use disorders and behavioral health (if this was a family you were working with)?
- How can social workers be trauma informed when helping families address substance use disorders, intimate partner violence, and behavioral health?
- How did substance use disorder, intimate partner violence, and behavioral health intersect in Neen's story? How were the three key issues inter-related?
- What about Neen's story impacted you the most?
- What about Neen's story inspired you?

Stages of Change and the Child Welfare Social Worker's Tasks²²

Parent's Stage	Stage Description	Tasks
Pre-contemplation	No perception of having a problem or needing to change	Increase parent's understanding of risks and problems with current behavior; raise parent's doubts about behavior
Contemplation	Initial recognition that behavior may be a problem and uncertain about change	Discuss reasons to change and the risks of not changing (e.g., removal of child)
Decision to change/ Preparation	Conscious decision to change; some motivation for change identified	Help parent identify best actions to take for change; support motivation for change
Action	Takes steps to change	Help parent implement change strategy and take steps
Maintenance	Actively works on sustaining change strategies and maintaining long-term change	Help parent to identify triggers of SUD and use strategies to prevent relapse
Relapse (mentioned in video as part of Maintenance)	Slips (lapses) from change strategy or returns to previous problem behavior patterns (relapse)	Help parent re-engage in the contemplation, decision, and action stages

²² *Protecting Children in Families Affected by Substance Use Disorders*. U.S. Department of Health and Human Services, Administration of Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect. (2009) Pg. 47

General Home Visit Safety Tips²³

Families experiencing multiple issues (e.g., SUDs, behavioral health concerns, intimate partner violence, criminal behavior) can pose a safety concern for child welfare social workers going into homes to assess risk and safety. While on a home visit, social workers should remember the following safety tips:

- Ensure that your supervisor knows the time and place of the appointment and the expected time of return.
- Dress appropriately and in a manner that blends into the community.
- Walk close to buildings or close to the curb in an effort to have at least one safe side. Stay away from bushes, alleys, and dark corners, if possible.
- Know the route in and out of the area by examining a map or by talking with others beforehand. Do not wander or appear lost or confused.
- Park as close to the home as possible and in a way that helps ensure an easy exit. Keep the car keys in hand while entering and exiting the home so they are easily available.
- Be aware of your surroundings at all times. Enter and leave homes carefully, noticing doors, windows, neighbors, loiterers, and anything or anyone that may be a risk to safety.
- If unsure of the safety or surroundings of the location, move to another spot by suggesting taking a break or getting a cup of coffee and finish talking there.
- Attempt to keep a clear path to an exit.
- Be aware of dogs that may pose a threat.
- Follow your intuition and take action if feeling afraid or threatened. Leave the home or call 911 if necessary.
- Have access, if possible, to technology that may assist with safety issues (e.g., GPS systems, cell phones).

In situations where drugs and alcohol may be an issue in the family or the surrounding community:

- Go to the home with another caseworker or law enforcement officer, particularly if the home is in an area known for a high rate of criminal drug activity.
- Know the local signs that indicate a drug deal is occurring. In such situations, do not enter the home without law enforcement personnel.
- Be aware of homes or other living environments that may be used as a clandestine drug factory. Do not attempt to investigate such places alone, and immediately contact the police or sheriff if such a lab is suspected. Anyone without proper training and protective gear should stay at least 500 feet away from any suspected laboratory.

The following are signs of a possible lab:

- Strong or unusual chemical odors
- Laboratory equipment, such as glass tubes, beakers, funnels, and Bunsen burners
- Chemical drums or cans in the yard
- A high volume of automobile or foot traffic, particularly at odd hours

²³ *Protecting Children in Families Affected by Substance Use Disorders*. U.S. Department of Health and Human Services, Administration of Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect. (2009) Pg. 30

- New, high fences with no visible livestock or other animals.
- If one or both parents appear to be intoxicated, high, incoherent, or passed out, ensure the safety and supervision of the children. Once that has been accomplished, it is appropriate to reschedule the appointment. It may be appropriate to call the supervisor for guidance.

Case Scenario

PART I:

Lisa and Tom are an African American non-married couple who are living together with their 5 children. Their children are Monique (age 8), Tommy (age 7), Robert (age 4), Delilah (age 1), and Vanessa (age 6 months). Lisa and Tom's children initially came to the attention of the Department of Social Services when Delilah and Lisa tested positive for methamphetamine at the time of Delilah's birth. Prior to Delilah being born, the Department had received 6 prior referrals alleging neglect and substance abuse by the parents. One of the previous referrals for neglect was founded, but the family was referred to community resources and a case was not opened.

After Lisa and Delilah tested positive for methamphetamine, a Team Decision Making Meeting was held. It was determined that placement of the children was necessary. After the TDM meeting, a petition was filed on behalf of Delilah, Monique, Tommy, and Robert and they were removed from the care of their parents. The children were placed with their maternal aunt, who has been a source of support for the family.

Both Lisa and Tom were ordered to participate in Family Reunification Services, which included inpatient substance abuse treatment for Lisa and out-patient substance abuse treatment for Tom. Tom and Lisa were also ordered to participate in parenting, a mental health assessment and recommended treatment, and a domestic violence assessment and recommended treatment.

While the children were in out of home care, the parents participated in their court-ordered services and regularly visited with the children. They had some setbacks early on due to positive drug tests but have been receiving positive progress reports from service providers over the last 6 months. Additionally, Lisa gave birth to another child, Vanessa. Vanessa was not drug exposed and her parents have been meeting her needs. She was not removed from their care. At the 12-month review hearing, Monique, Tommy, Robert, and Delilah were returned home on an extended visit and Family Maintenance was eventually ordered.

The family has been participating in Family Maintenance Services for the past two months. Tom is working fulltime and the family has a moderately furnished apartment. Lisa stays at home with the children while Tom works. The children appear to be well-cared for when the social worker sees them and they state they are really happy to be home with their mom and dad.

This morning, the social worker received a telephone call from Lisa. She stated she has missed her last two drug tests. This is new information, as the social worker had not yet requested drug testing results for the family this month. When asked why she had missed 2 drug tests, Lisa stated it is because she thought the test would be positive for methamphetamine if she tested. Lisa admitted to using 3 times in the past two weeks. She stated she has been really stressed out with caring for all of the children. She has been experiencing a lot of anxiety lately, especially since there have been some arguments between her and Tom about money and the kids. There has been some yelling, but nothing physical. Lisa said the children were not with her when she used and that they were with Tom or her sister. Lisa told the social worker that Tom does not know about what has happened. She wants help to address her relapse.

PART II:

The social worker has made arrangements to go to Lisa's home to speak with her. Monique, Tommy, and Robert are all in school. Delilah and Vanessa spent the night at Jenny's (maternal aunt) house last night and are still there.

When the social worker arrives, she finds the house to be a little messy, but it does not appear to pose a threat to the children's safety. There is no evidence of drug paraphernalia or drugs in the home. Lisa starts to cry when she sees the social worker. In order to help figure out what can happen next, the social worker needs to understand more about what prompted Lisa to use drugs.

PART III:

After the social worker met with Lisa, she helped Lisa to talk with Jenny and Tom about what was going on. They agreed that Jenny would pick Monique, Tommy, and Robert up from school and bring them back to her house. She also agreed to keep Delilah and Vanessa for another night. Tom was very angry with Lisa and agreed to stay with his sister until a meeting with the safety team could be scheduled.

A team decision-making meeting was held the next day. Lisa brought her N/A sponsor with her to the meeting, as well as her next-door neighbor who sometimes helps with the kids. Tom, Jenny, and Jenny's husband also come to the meeting to discuss the recent relapse and if a safety plan could be developed.

Personal Learning Statement

Some questions I still have about Key Issues in Child Welfare Practice are...

I can find more information about Key Issues at my agency by...

As a result of this training I will...

My key take away from this training is...