

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

Trainer Guide



December 31, 2018

Table of Contents

Acknowledgements.....	3
Introduction	4
Tips for Training this Curriculum.....	7
Agenda	9
Learning Objectives.....	10
Lesson Plan.....	11
Segment 1: Welcome.....	13
Segment 2: Personal Bias and the Role of the Child Welfare Practitioner.....	19
Segment 3: Strength-based Practice in Child Welfare.....	22
Segment 4: Intersection of Key Issues	25
Segment 5: Wrap up	31
Segment 6: Welcome Back	32
Segment 7: “Where there is breath, there is hope”	34
Segment 8: Stages of Change.....	37
Segment 9: The Role of the Social Worker in Addressing Key Issues	42
Segment 10: Transfer of Learning.....	45
Segment 11: Wrap up	46
Appendix	47
e-Learning Recall Activity Cards	47
Johnson Vignette.....	48
Intersection of Key Issues.....	49
Stages of Change and the Child Welfare Worker’s Tasks	51
General Home Visit Safety Tips	52
Case Scenario	53
Healing Neen Discussion Guide.....	55
Materials Checklist.....	56
Annotated Bibliography.....	57

Acknowledgements

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 (CRC) 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 Common Core Curriculum, as well as the latest version of this curriculum, please visit the California Social Work Education Center (CalSWEC) website: <http://calswec.berkeley.edu>

Introduction

Please read carefully as a first step in preparing to train this curriculum.

IMPORTANT NOTE: Each curriculum within the Common Core series is mandated and standardized for all new child welfare workers in the state of California. It is essential that all trainers who teach any of the Common Core Curricula in California instruct trainees using the standardized Training Content as provided. The training of standardized content also serves as the foundation for conducting standardized testing to evaluate and improve the effectiveness of new worker training statewide.

GENERAL INFORMATION

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.

The Common Core Curriculum model is designed to define clearly the content to be covered by the trainer. Each curriculum consists of a *Trainee's Guide* and a *Trainer's Guide*. Except where indicated, the curriculum components outlined below are identical in both the Trainee's and Trainer's Guides. The Trainee's Guide contains the standardized information which is to be conveyed to trainees.

For an overview of the training, it is recommended that trainers first review the Agenda and Lesson Plan. After this overview, trainers can proceed to review the activities for each training segment in the Trainer's Guide and the Training Content in the Trainee's Guide in order to become thoroughly familiar with each topic and the training activities. The components of the Trainer's and Trainee's Guides are described under the subheadings listed below.

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

Please note that each individual curriculum within the Common Core Curricula is subject to periodic revision. The curricula posted on the CalSWEC website are the most current versions available. For more information regarding the curricula, please contact CalSWEC at calswec_rta_cc@berkeley.edu(link sends e-mail).

COMPONENTS OF THE TRAINER'S AND TRAINEE'S GUIDES

Learning Objectives

The Learning Objectives serve as the basis for the Training Content that is provided to both the trainer and trainees. All the Learning Objectives for the curriculum are listed in both the Trainer's and Trainee's Guides. The Learning Objectives are subdivided into three categories: Knowledge, Skills, and Values. They are numbered in series beginning with K1 for knowledge, S1 for skills, and V1 for values. The Learning Objectives are also indicated in the Lesson Plan for each segment of the curriculum.

Knowledge Learning Objectives entail the acquisition of new information and often require the ability to recognize or recall that information. *Skill Learning Objectives* involve the application of knowledge and frequently require the demonstration of such application. *Values Learning Objectives* describe attitudes, ethics, and desired goals and outcomes for practice. Generally, *Values Learning Objectives* do not easily lend themselves to measurement, although values acquisition may sometimes be inferred through other responses elicited during the training process.

Agenda

The Agenda is a simple, sequential outline indicating the order of events in the training day, including the coverage of broad topic areas, pre-tests and/or post-tests, training activities, lunch, and break times. The Agenda for trainers differs slightly from the Agenda provided to trainees in that the trainer's agenda indicates duration; duration is not indicated on the agenda for trainees.

Lesson Plan (Trainer's Guide only)

The Lesson Plan in the Trainer's Guide is a mapping of the structure and flow of the training. It presents each topic and activity and indicates the duration of training time for each topic.

The Lesson Plan is divided into major sections by Day 1, Day 2, and Day 3 of the training, as applicable, and contains two column headings: Segment and Methodology and Learning Objectives. The Segment column provides the topic and training time for each segment of the training. The Methodology and Learning Objectives column reflects the specific activities and objectives that are covered in each segment. As applicable, each activity is numbered sequentially within a segment, with activities for Segment 1 beginning with Activity 1A, Segment 2 beginning with Activity 2A, etc.

Evaluation Protocols

It is necessary to follow the step-by-step instructions detailed in this section concerning pre-tests, post-tests, and skill evaluation (as applicable to a particular curriculum) in order to preserve the integrity and consistency of the training evaluation process. Additionally, trainers should not allow trainees to take away or make copies of any test materials so that test security can be maintained.

Training Segments (Trainer's Guide only)

The Training Segments are the main component of the Trainer's Guide. They contain guidance and tips for the trainer to present the content and to conduct each Training Activity. Training Activities are labeled and numbered to match the titles, numbering, and lettering in the Lesson Plan. Training Activities contain detailed descriptions of the activities as well as step-by-step tips for preparing, presenting, and processing the activities. The description also specifies the Training Content that accompanies the activity, and the time and materials required.

Occasionally, a Trainer's Supplement is provided that includes additional information or materials that the trainer needs. The Trainer's Supplement follows the Training Activity to which it applies.

Training Content (Trainee's Guide only)

The Training Content in the Trainee's Guide contains the standardized text of the curriculum and provides the basis for knowledge testing of the trainees. Training activities are labeled and numbered to match the titles and numbering in the Lesson Plan.

Supplemental Handouts

Supplemental Handouts refer to additional handouts not included in the Trainee's Guide. For example, Supplemental Handouts include PowerPoint printouts that accompany in-class presentations or worksheets for training activities. Some documents in the Supplemental Handouts are placed there because their size or format requires that they be printed separately.

References and Bibliography

The Trainer's Guide and Trainee's Guide each contain the same References and Bibliography. The References and Bibliography indicates the sources that were reviewed by the curriculum designer(s) to prepare and to write the main, supplemental and background content information, training tips, training activities and any other information conveyed

in the training materials. It also includes additional resources that apply to a particular content area. The References and Bibliography may include the following:

- All-County Letters (ACLs) and All-County Information Notices (ACINs) issued by the California Department of Social Services (CDSS);
- Legal References (as applicable); and
- General References and Bibliography

In certain curricula within the Common Core series, the References and Bibliography may be further divided by topic area.

Materials Checklist (Trainer's Guide only)

In order to facilitate the training preparation process, the Materials Checklist provides a complete listing of all the materials needed for the entire training. Multi-media materials include such items as videos, audio recordings, posters, and other audiovisual aids. Materials specific to each individual training activity are also noted in the Training Segments in the Trainer's Guide.

Posters (Trainer's Guide only)

Some curricula feature materials in the Trainer's Guide that can be used as posters or wall art.

Tips for Training this Curriculum

It is suggested that trainers review the annotated bibliography provided at the end of this guide. It will provide the foundational content regarding the specific areas of substance use disorders, intimate partner violence, and behavioral health disorders. Additionally, the trainer should review the videos provided for this training to become familiar with the video content. The trainer will lead a debriefing after each video in order to assist the trainee identifying the key learning points of the video.

As you train this material, keep in mind that it is less important that the trainees are experts in each content area and more important that they see the overlap among the challenges families may face related to substance use disorders, intimate partner violence, and behavioral health concerns. It is common that a family involved with the Child Welfare system will have more than one of these key disorders. Often the challenge is identifying which condition is more primary than the other. As you facilitate the training, make the point that families and youth generally have more than one of these conditions and that the conditions intersect and must be considered together.

TRAINING PREPARATION

It is **required** that the trainer preview the following e-Learning as prerequisite to the classroom:

1. Key Issues in Child Welfare Practice: Substance Use Disorders
2. Key Issues in Child Welfare Practice: Intimate Partner Violence
3. Key Issues in Child Welfare Practice: Behavioral Health

It is **recommended** that the trainer preview the following e-Learning(s) and/or classroom trainings prerequisites to training the classroom:

1. Introduction to Trauma Informed Practice e-Learning
2. Trauma Informed Practice classroom

It is **suggested** that you orient yourself to all the blocks in preparation for this training in order to make links and dig deeper into skill building:

1. Foundation
2. Engagement
3. Assessment
4. Case Planning and Service Delivery
5. Monitoring and Adapting
6. Transition

Contact your Regional Training Academy/UCCF for more information and to register for the eLearning modules as well as to access the classroom curriculum. Visit CalSWEC website for more information at: <https://calswec.berkeley.edu/programs-and-services/child-welfare-service-training-program/common-core-30>

FAMILY FRIENDLY LANGUAGE

Trainers are the example for modeling family friendly language for participants. The hope is that the language used in the classroom indicates that we work in partnership with families. Use words such as parents, young adults, youth, child, family rather than referring to people as clients. Choose words that model our belief that families involved in child welfare services are not separate from us as social workers, but part of our community. This is the goal of the California Child Welfare Core Practice Model as well and reflects the behaviors we want to see demonstrated in social workers' work with families. For more information on the Californian Child Welfare Core Practice Model visit the CalSWEC website at <http://calswec.berkeley.edu/california-child-welfare-core-practice-model-0>.

SAFETY ORGANIZED PRACTICE (SOP)

Some content in this curriculum was developed by the National Council on Crime and Delinquency (NCCD) and the Northern California Training Academy as part of the Safety Organized Practice Curriculum. Please note, not all California Counties are actively practicing Safety Organized Practice. However, the framework, principles and concepts are integrated throughout the curriculum as tools and best practices. Safety Organized Practice is a collaborative practice approach that emphasizes the importance of teamwork in child welfare. SOP aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members. A central belief in SOP is that all families have strengths. SOP uses strategies and techniques that align with the belief that a child and his or her family are the central focus, and that the partnership exists in an effort to find solutions that ensure safety, permanency, and well-being for children. SOP is informed by an integration of practices and approaches including:

- Solution-focused practice¹
- Signs of Safety²
- Structured Decision making³
- Child and family engagement⁴
- Risk and safety assessment research
- Group Supervision and Interactional Supervision⁵
- Appreciative Inquiry⁶
- Motivational Interviewing⁷
- Consultation and Information Sharing Framework⁸
- Cultural Humility
- Trauma-informed practice

¹ Berg, I.K. and De Jong, P. (1996). Solution-building conversations: co-constructing a sense of competence with clients. *Families in Society*, pp. 376-391; de Shazer, S. (1985). *Keys to solution in brief therapy*. NY: Norton; Saleebey, D. (Ed.). (1992). *The strengths perspective in social work practice*. NY: Longman.

² Turnell, A. (2004). Relationship grounded, safety organized child protection practice: dreamtime or real time option for child welfare? *Protecting Children*, 19(2): 14-25; Turnell, A. & Edwards, S. (1999). *Signs of Safety: A safety and solution oriented approach to child protection casework*. NY: WW Norton; Parker, S. (2010). *Family Safety Circles: Identifying people for their safety network*. Perth, Australia: Aspirations Consultancy.

³ Children's Research Center. (2008). *Structured Decision Making: An evidence-based practice approach to human services*. Madison: Author.

⁴ Weld, N. (2008). The three houses tool: building safety and positive change. In M. Calder (Ed.) *Contemporary risk assessment in safeguarding children*. Lyme Regis: Russell House Publishing.

⁵ Lohrbach, S. (2008). Group supervision in child protection practice. *Social Work Now*, 40, pp. 19-24.

⁶ Cooperrider, D. L. (1990). Positive image, positive action: The affirmative basis of organizing. In S. Srivasta, D.L. Cooperrider and Associates (Eds.). *Appreciative management and leadership: The power of positive thought and action in organization*. San Francisco: Jossey-Bass.

⁷ Miller, W.R., & Rollnick, S. (2012). *Motivational Interviewing*, (3rd Ed.). NY: Guilford Press.

⁸ Lohrbach, S. (1999). *Child Protection Practice Framework - Consultation and Information Sharing*. Unpublished manuscript; Lohrbach, S. & Sawyer, R. (2003). Family Group Decision Making: a process reflecting partnership based practice. *Protecting Children*. 19(2):12-15.

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.

Lesson Plan

Day 1

Segment	Methodology and Learning Objectives
Day 1, Segment 1 45 min 9:00 – 9:45 am Welcome	Activity 1A: Welcome Introduce goals of the training and explain logistics. Develop Group Agreements. Activity 1B: e-Learning Recall Activity Facilitate strength-based introduction pairs activity <i>PowerPoint slides: 1-5</i> <i>Learning Objective: K3</i>
Day 1, Segment 2 60 min 9:45 – 10:45 am Personal Bias and the Role of the Child Welfare Practitioner	Activity 2A: Pendulum Swing This segment addresses the impact of personal bias related to substance use disorder, intimate partner violence, and behavioral health concerns on engaging, assessing, and developing plans with children, youth, and families. <i>PowerPoint slides: 6-9</i> <i>Learning Objective: K4</i>
10:45 – 11:00 am 15 min BREAK	
Day 1, Segment 3 60 minutes 11:00 am – 12:00 pm Strength-based Practice in Child Welfare	Activity 3A: Strength-based Practice Activity 3B: Casework Components: Practice Behaviors This segment will address the Core Practice Model, Strength-based principles, and knowledge of Substance Use Disorders, Intimate Partner Violence, and Behavioral Health issues. <i>PowerPoint slides: 10-15</i> <i>Learning Objectives: K5, V1, V2</i>
12:00 – 1:00 PM 60 min LUNCH BREAK	
Day 1, Segment 4 150 min 1:00 – 3:45 pm Intersection of Key Issues	Activity 4A: Key Issues Infomercial Activity 4B: Intersection of Key Issues Application Activity This section will facilitate an understanding about the intersection of the three key issues facing child welfare. <i>PowerPoint slides: 16-25</i> <i>Learning Objectives: K3, S1, S2</i>
2:45 – 3:00 pm (within Segment 4) 15 min BREAK	
Day 1, Segment 5 15 min 3:45 – 4:00 pm Wrap up	Activity 6A This segment will wrap up Day 1 content and preview the next day's topics. <i>PowerPoint slides: 26-27</i>

Day 2

Segment	Methodology and Learning Objectives
Day 2, Segment 6 30 min 9:00 – 9:30 am Welcome Back	Activity 6A The trainer will conduct an introductory activity that reviews key points covered in day 1. <i>PowerPoint slides: 28-31</i>
10:15 - 10:30 am (within Segment 2) 15 min BREAK	
Day 2, Segment 7 135 min 9:30 am – 12:00 pm “Where there is breath, there is hope”	Activity 9A This segment will utilize a video: <i>Healing Neen</i> to facilitate understanding about the intersection of the three key issues facing child welfare. <i>PowerPoint slides: 32-34</i> <i>Learning Objectives: K4, K5, S1, S2, V1, V2</i>
12:00 - 1:00 pm 60 min Lunch BREAK	
Day 2, Segment 8 75 min 1:00 – 2:15 pm Stages of Change	Activity 7A This segment will cover the basics of the stages of change and what it means for your assessment. <i>PowerPoint slides: 35-41</i> <i>Learning Objective: K1</i>
2:15 - 2:30 pm 15 min BREAK	
Day 2, Segment 9 60 min 2:30 – 3:30 pm The Role of the Social Worker in Addressing Key Issues	Activity 8A This segment focuses on the role of the social worker in addressing key issues in child welfare practice. <i>PowerPoint slides: 42-47</i> <i>Learning Objectives: V1, V2</i>
Day 2, Segment 10 15 min 3:30 – 3:45 pm Transfer of Learning	Activity 10A Transfer of Learning activity <i>PowerPoint slide: 48</i> <i>Learning Objective: K2</i>
Day 2, Segment 11 15 min 3:45 – 4:00 pm Wrap up	Activity 11A Wrap up <i>PowerPoint slide: 49</i>

Segment 1: Welcome

Segment Time:	45 minutes
Activity Time:	1A: Welcome (15 minutes) 1B: e-Learning Recall Activity (30 minutes)
Trainee Content:	Agenda (page 5 in the Trainee Guide) Learning Objectives (page 6 in the Trainee Guide)
Materials:	Chart pad, markers, and tape (if doing Group Agreements) Question Cards for recall activity (Appendix, pg. 47)
Slides:	1-5

Description of Activity:

The trainer will facilitate a recall activity and introductions. The recall activity is an opportunity for trainees to tie this classroom training back to the e-Learning modules they took on Key Issues in Child Welfare (Substance Use Disorders, Intimate Partner Violence, and Behavioral Health).

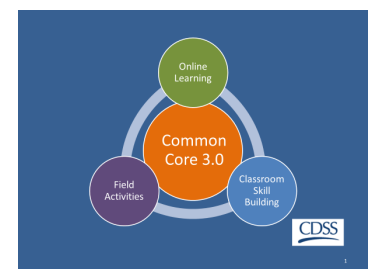
Before the activity



- ❑ Create or review Group Agreements. If you plan to develop Group Agreements, prepare your chart pad in advance with some initial agreements such as starting and ending on time, sharing the floor, etc. Leave space for the group to develop their own Group Agreements.
- ❑ For the recall activity, have enough of the Question Cards cut up to distribute one card to each table.

During the activity

Activity 1A: Welcome

- ❑ Welcome the trainees to the training and introduce yourself.
- ❑ If this is the first training for a cohort, you may wish to spend some time on logistics related to the training site (parking, bathrooms, etc.) and helping to set a productive tone through the development of group agreements (sharing the floor, being on time, etc.).



<p>❑ Refer the trainees to the training content <i>Agenda</i> (page 5 in the Trainee Guide) and <i>Learning Objectives</i> (page 6 in the Trainee Guide) and provide an overview of the Agenda and Learning Objectives for the day.</p>	<div data-bbox="1136 111 1502 373"> <p>Key Issues in Child Welfare Practice: Social Worker as Practitioner Day 1</p> <p>California Common Core Version 3.1 2017</p>  </div> <div data-bbox="1136 441 1502 703"> <p>Overview of the Day</p> <ul style="list-style-type: none"> • Introduction • Role of the Practitioner • Intersection of Key Issues • Key Issues Facing Youth • Motivation and Stages of Change </div>
<p>❑ If you are doing Group Agreements, go over the basic Group Agreements included on the slide and use chart pad paper to add agreements or modify those provided.</p> <p>❑ Offer the following brief explanations of the Group Agreements⁹ as needed (this will depend on whether or not this group has already worked to establish Group Agreements). This activity provides a model for the group work social workers will do with child and family teams, so you may wish to make that connection as well.</p> <ul style="list-style-type: none"> • Collaboration – We need partnership to have engagement and that works best if we trust each other and agree we are not here to blame or shame. We are here because we share a common concern for the safety and well-being of children. Remind them how this skill will be needed when working with families as they are the experts on their family. Social workers must be able to foster collaboration in order to complete a thorough assessment of the situation. Families need to feel trust before they honestly examine themselves and be able to look at a problem and their part in it. • Ask lots of questions – Point out that the trainer can't make the training relevant for each person because there are many people in the room with different experiences and different needs. Participants have to make it relevant for themselves by asking lots of questions and deciding how the experience might be helpful or not helpful to them. • Be Open to Trying New Things – As professionals, we feel more comfortable and competent sticking with what we know. We don't always like it when new things come along. Sometimes it feels uncomfortable to try new things so we tend to back away from the new thing telling 	<div data-bbox="1136 735 1502 1008"> <p>Group Agreements</p>  <ul style="list-style-type: none"> • Be collaborative • Ask lots of questions – let us know what you think • Be open to trying new things • Be willing to make mistakes • Maintain confidentiality • Be responsible for your own learning </div>

⁹ Shared by trainer Betty Hanna

<p>ourselves things like “she doesn’t know what she’s talking about...she has never worked in our community with the people we work with...” But to learn something new we have to do through the uncomfortable stage to get to the other side where it feels natural and comfortable. With this Group Agreement, they are agreeing to try new things even if they feel uncomfortable.</p> <ul style="list-style-type: none"> • Make Mistakes – As professionals we don’t like to make mistakes. And when we make mistakes we feel discouraged and beat ourselves up. But, if we are going to learn new things, we have to make mistakes. Even more important than the willingness to make mistakes is the willingness to admit we are wrong even when we don’t want to be. Growth requires that we are open to changing our minds based on new information received. We must also be willing to put our own ideas aside to fully hear the views of others. • Confidentiality – This is just a reminder that information about families or other trainees shared in the training room should be kept confidential. • Be responsible for your own learning – As adult learners we realize you come with knowledge, skills and experience. The intention of this curriculum is that you will have an opportunity to share this via large and small group discussions. Please come prepared to training having taken any prerequisite e-Learning or classroom trainings. Set aside this day for your learning, please do not bring work into the classroom, this is distracting to other trainees as well as to the trainer/facilitator. This includes being on time, sharing the floor, and cell phones off. • For this training: The trainer may want to add an agreement around stepping up and stepping back to allow for creating a safe environment in recognition of the fact that many people have been personally impacted by the topics covered in this module. 	
<ul style="list-style-type: none"> □ Introduce this activity by reminding trainees that they were introduced to the concepts of <i>Strength-based Practices</i>, <i>Family Friendly Language</i>, and <i>Cultural Considerations</i> in the e-Learning modules. • Ask trainees to summarize what is meant by Strength-based Practices Definition from e-Learning: <ul style="list-style-type: none"> ○ Concentrate on the inherent strengths of individuals and families by helping people deploy their personal strengths to aid their recovery and empowerment. ○ Are empowering alternatives to traditional practices ○ Eliminate labeling and stigmatizing language • Ask trainees to summarize what is intended by Family Friendly Language from e-Learning: <ul style="list-style-type: none"> ○ The reframing of the references to substance use disorders, intimate partner violence, and behavioral health using family friendly language is a reflection of incorporating strength-based language into the learning process. Because some terms get over used, misunderstood 	

<p>and become linked to negative stereotypes, it is important to use more neutral language whenever possible.</p> <ul style="list-style-type: none"> ○ Ask trainees why they think it is important to incorporate family friendly language into their practice. ● In addition to utilizing a strength-based approach and family friendly language in child welfare practice, it is essential that we consider the family in the context of the family's culture. When interviewing and engaging with the family and family's network it is important to ask about: <ul style="list-style-type: none"> ○ The family's cultural background ○ The family's immigration or acculturation status ○ The family's ethnicity, religion, socioeconomic status, age, gender, gender expression, sexual orientation, and geographic location <p>These factors shape the family's culture and will impact their interaction with the child welfare system. Although it might be a challenging conversation to start, finding out about these aspects of the family will help you understand them and connect them to culturally relevant services.</p> <p>❑ Ask that trainees keep these practices in mind throughout the training session. It is important for the trainer to model this. Ask trainees for permission to call out when these practices are not happening.</p> <ul style="list-style-type: none"> ● The trainer may need to revisit the Group Agreements to see if anything needs to be added to provide a safe space for this permission. 	
<p>Activity 1B: e-Learning Recall Activity</p> <p>❑ Explain the recall activity (see slide 5). This is a transfer of learning opportunity from the e-Learning modules on Key Issues.</p> <p>❑ Distribute the recall cards. You can have the trainees count off by sixes and create six groups or you can provide one card to each table group (if you have enough table groups) and ask them to discuss as a table. If it is a smaller training group, you can have them count off by threes and assign each group two questions. Instruct each group to read their card, recalling information from the e-Learning to answer the prompt on the card. Instruct each group to take notes about what they talked about. They will share this with the larger group after approximately 5 minutes. Ask the group to identify a spokesperson who will read their card prompt during the next part of the activity and share the group's answers.</p> <ul style="list-style-type: none"> ● For the larger group portion of the activity, facilitate a report out in card number order from 1-6 because the cards build on each other. ● After each group has spent 5 minutes discussing the prompt on the card, begin the report out. Start by having the group members introduce themselves (name and length of time in child welfare). After this brief introduction, the group's spokesperson will read the card prompt and the group's answers. If not identified by the group, be sure to highlight the key points below: ● Card #1: What are some of the ways children may be impacted by 	<div data-bbox="1146 911 1495 1171"> <p>Recall Activity</p> <ul style="list-style-type: none"> • Think about some of the key concepts from the e-Learning modules • In your group, read the card prompt and discuss the answers </div>

substance use disorders?

- Substance use disorders exist in 40-80% of families in which children are the victims of abuse.
- Children whose parents use substances are 3 times as likely to be abused and more than 4 times more likely to be neglected.
- Consequences for children:
 - Disruption of the bonding process
 - Emotional, academic, and developmental problems
 - Lack of supervision
 - Parentification
 - Social stigma
 - Adolescent substance use and delinquency
- Card #2: What is your role as a practitioner in assessing substance use disorders when working with families in child welfare?
 - Identify signs of substance use in the families you work with
 - Identify signs of neglect as a result of substance use in the home
 - Assess whether or not the child is safe in his or her home
 - Assess when it is safe for a child to return home
 - Monitor and communicate with the family about progress toward meeting the safety goal
 - Link parents to culturally relevant interventions and services to address substance use disorders
 - Develop safety plans with the family and their network that ensure child safety in the event of a relapse
 - Educate families, collaterals, service providers and colleagues about common misperceptions associated with substance use disorders.
- Card #3: How do substance use disorders, intimate partner violence, and behavioral health issues relate to child neglect?
 - The parent may be absent and unable to meet the child's needs for food, clothing, shelter, and supervision
 - The home may be dirty or unsafe
 - The child may have dental or medical problems that have gone unaddressed
 - Children may experience attachment disorders or behavioral issues
 - Failure to Thrive
 - Drug exposure (in utero and beyond)
- Card #4: What are the behaviors we see when intimate partner violence is present? Think about the power and control wheel referenced in the e-Learning.
 - Use of intimidation, emotional abuse, isolation, economic abuse, and/or coercion and threats
 - Justification of the abuse
 - Evidence of severe, recurring, or life-threatening abuse (broken bones, repeated bruises, threats with weapons, sexual abuse, or partner rape)

<ul style="list-style-type: none"> ○ Use of language that degrades, criticizes, or belittles the other ○ Control of the other person <ul style="list-style-type: none"> – Use of children to control the other person – Legal system – custody, finances ○ Threatening behavior or stalking <ul style="list-style-type: none"> ● Card #5: Describe how behavioral health disorders may impact children and your work with the family. <ul style="list-style-type: none"> ○ Children and parents in the child welfare system are often impacted by trauma ○ Behavioral health disorders may compromise a parent’s ability to make appropriate judgments about their child’s safety and appraise danger ○ Impaired decision-making and planning ability ○ Increased vulnerability to life stressors such as poverty, inability to focus on education, and inability to develop social supports ○ Parents may have a difficult time coping with their own child’s trauma and trauma triggers ○ Parents may seem disengaged or avoidant ○ Trauma responses can sometimes trigger impulsive or aggressive behavior (for both children and adults) ○ Children may have worse health, behavioral health, and developmental outcomes <ul style="list-style-type: none"> – Increased likelihood of behavioral problems, academic difficulties, health problems, and delays in cognitive and motor development ● Card #6: What are some of the strategies and tools social workers can use when working with families where substance use disorder, intimate partner violence, and/or behavioral health issues are present? <ul style="list-style-type: none"> ○ Teaming meetings ○ SDM tools ○ Safety Plan ○ Engagement of the family’s safety network ○ Consultation with substance use disorder, intimate partner violence, and behavioral health experts/specialists ○ Consultation with supervisors 	
--	--

Transition to the next segment: Personal Bias and the Role of the Child Welfare Practitioner

Segment 2: Personal Bias and the Role of the Child Welfare Practitioner

Segment Time:	60 minutes
Activity Time:	2A: Pendulum Swing (60 minutes)
Trainee Content:	Pendulum Swing Activity (page 7 in the Trainee Guide)
Materials:	Chart pad, markers, and tape
Slides:	6-9

Description of Activity:

This segment addresses the impact of personal bias related to substance use disorders, intimate partner violence and behavioral health concerns that may impact engaging, assessing and developing collaborative plans with children, youth, young adults, parents, Tribes, and the family's safety network.

The activity will use "1-2-4-all" model from Liberating Structures to facilitate discussion.

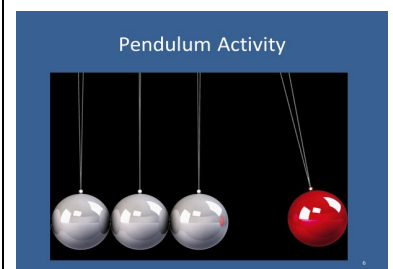
Before the Activity

Ensure you are familiar with the activity by reviewing the 1-2-4-all model at <http://www.liberatingstructures.com/1-1-2-4-all/>

During the activity

Activity 2A: Pendulum Swing Activity

- ☐ Begin this segment by letting trainees know that our interactions with families and behaviors in our practice can be impacted by our own thoughts, experiences, and beliefs. We often have strong feelings about topics like substance use, intimate partner violence, and behavioral health. These feelings can be a source of bias in child welfare, sometimes influencing the decisions being made.
 - Being labeled with a substance use disorder, living in a relationship with partner violence, and/or being diagnosed with behavioral health issues all carry stigmas.
 - Stigmas that we need to be aware of internally and externally so that, as social work practitioners, we can avoid making errors in child welfare practice.
- ☐ Ask the trainees to shout out factors that contribute to bias and chart their responses.



<ul style="list-style-type: none"> ❑ When assumptions, feelings, and possible biases are present, errors can occur in child welfare practice. ❑ In order to avoid making these errors, we must become aware of assumptions we have about families who experience substance use disorders, intimate partner violence, and/or behavioral health issues. ❑ Explain that in this activity we'll be looking at a list of statements to describe feelings about substance use disorders, intimate partner violence, and behavioral health concerns. Inform trainees that the statements are two extremes, kind of like a pendulum. Rarely in child welfare are the answers so black and white, but picking an extreme can help us think about bias more clearly. ❑ Refer trainees to the training content <i>Pendulum Swing Activity</i> (page 7 in the Trainee Guide). Ask trainees to work individually to pick between the two answers. Encourage them to respond with their initial gut feeling (5 minutes). 	
<ul style="list-style-type: none"> ❑ After 5 minutes, show slide 7. Prompt the class to find a partner and have a conversation about their choices by reflecting on what assumptions, feelings, and possible biases may be present based on their responses to each statement. <ul style="list-style-type: none"> • Walk around the room to monitor progress. These may be difficult conversations for new workers to be having. It is important to walk around the room and encourage/support discussion. • Allow 15 minutes for this dyad conversation. ❑ Then tell them that each pair needs to find another pair, not at their current tables, to talk to, and in groups of 4 answer the following question: <ul style="list-style-type: none"> • What are some ways that this could impact work with families? <ul style="list-style-type: none"> ○ Have trainees chart in small groups. ○ If the trainees are resistant to moving, this can be an opportunity to make a connection to all the transitions children and families are expected to experience with their interactions in CW: multiple placements, social workers, service providers, and schools. ○ Allow another 10 minutes for this conversation. Walk around the room and listen for participation. 	<div data-bbox="1149 764 1500 1026"> <p>Activity</p> <ul style="list-style-type: none"> • Reflect on what assumptions, feelings, and possible biases may be present based on your response to each statement. • What are some ways that this could impact your work with families? </div>
<ul style="list-style-type: none"> ❑ Bring the group back together for a 15-minute debrief. ❑ Show slide 8 and discuss common errors in child welfare. The following errors can happen in child welfare practice when we make assumptions or bias is present. These include: <ul style="list-style-type: none"> • Making a decision with insufficient information about the family. • Being biased toward remembering either the very first information or, paradoxically, the most recent. • Selectively remembering information that supports one's own beliefs. • Being reluctant to change one's mind and/or to revise previously made assessments even when given new information. • Fixing on one explanation/conclusion and looking only for information that confirms it or being too quick to dismiss new information that doesn't 	<div data-bbox="1149 1407 1500 1669"> <p>Common Errors in Child Welfare</p> <ul style="list-style-type: none"> • Making a decision with insufficient information • Remembering either the very first information or the most recent • Selectively remembering information • Being reluctant to change one's own mind • Focusing in on one explanation </div>

support it, rather than treating it as information that requires further testing.

❑ Facilitate the following debrief:

- In your conversations, did you identify any assumptions, feelings or possible biases that may be present?
 - The trainees can share generically about what they heard in their conversation, being careful not to call anyone out specifically OR they can share anything they identified about themselves.
- If so, why do you think it is important to understand that you have a bias?
- Ask trainees to state what they think the potential impact of bias is in their work with families?
 - Labeling
 - Incorrect information being entered into CWS/CMS
 - Information being omitted from the case file
 - Preferential or inequitable treatment of families
 - Children removed from home unnecessarily
 - Children left in unsafe situations
 - Longer stays in foster care
 - Delays to achieving permanency
 - Cultural considerations not examined
- How might this affect teaming and engagement with a family?

❑ Close this segment by summarizing: Knowing that we all come to this profession with assumptions, feelings, and biases based on our own experiences, how are you, as a social work practitioner, going to avoid having these impact your work with families?

- The trainer will want to emphasize the importance of:
 - Gathering information carefully and from multiple sources: reporting party, extended family members, case records, and other collateral sources
 - Considering alternative explanations
 - Family team meetings
 - Decision making/assessment tools
 - Trauma-informed practice and paying close attention to
 - Traumatic events in a person's life
 - Historical trauma
 - Ongoing examination and reflection of individual feelings and biases
 - Frequent consultation with your supervisor

Trainer Note: Make the connection that using the CPM practice behaviors can help social workers avoid these behaviors.

How do we avoid these errors?

WE can...

- Gather information
- Consider alternative explanations
- Utilize family team meetings
- Utilize assessment tools
- Use trauma-informed practices
- Examine own feelings and biases
- Consult with your supervisors

Transition to the next segment: Strength-based Practice

Segment 3: Strength-based Practice in Child Welfare

Segment Time:	60 minutes
Activity Time:	3A: Strength-based Practice (15 minutes) 3B: Casework Components: Practice Behaviors (45 minutes)
Trainee Content:	N/A
Materials:	California Child Welfare Core Practice Model Packet Chart pad paper, markers, and tape
Slides:	10-15

Description of Activity:

This segment will help trainees to make the link between the CA CPM and the child welfare practitioner's role in assessment of key issues and use of strength-based practice

Before the activity

Prepare chart paper for group discussion for Activity 3B. There will be 6 chart papers labeled with the following case work components:

1. Foundational
2. Engagement
3. Assessment
4. Teaming
5. Service Planning and Delivery
6. Transition

- Review the Child Welfare Core Practice Model Packet:
https://calswec.berkeley.edu/sites/default/files/cpm_packet_rev0816_p7.pdf

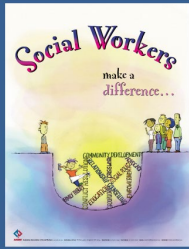
During the activity

Activity 3A: Strength-based Practice:

- ❑ Review the concept of strength-based practice on slide 10 by asking for volunteers to read each bullet point.
- ❑ Facilitate a discussion:
 - Thinking about a balanced assessment, why is it important to identify a family's strengths?

Strength-based Practice

- Identify family strengths and resources that can be used in providing services and supporting a family.
- Use family strengths as benchmarks to assess the status of a family over the course of time.
- Use community-wide strengths to develop resources in the community.
- "The goal of strength-based practice is to activate an individual's sense of responsibility for his or her actions...through a focus on potential rather than pathology." (Clark, 2001).

<ul style="list-style-type: none"> ❑ Move onto slide 11, again asking for volunteers to read each bullet point. ❑ Facilitate a discussion: <ul style="list-style-type: none"> • What are some of the resources that might be available to help a family who is impacted by substance use disorder, intimate partner violence, and/or behavioral health issues? <ul style="list-style-type: none"> ○ Think about resources that are both formal and informal. Remember: Services don't equal safety! What are some of the ways that communities and the family's safety network can provide support and enhance safety? 	<div data-bbox="1141 107 1507 373"> <h3>Building on Strengths</h3> <ul style="list-style-type: none"> • All families have strengths. • When families and their resources are involved in decision-making, outcomes can improve. • The family's culture is a source of strength. • Building on functional strengths already present in families results in more lasting changes in the family after the child welfare intervention is over. </div>
<ul style="list-style-type: none"> ❑ Move onto slide 12, again asking for volunteers to read each bullet point. ❑ Facilitate a discussion: <ul style="list-style-type: none"> • How can family strengths be used as benchmarks to assess the family's progress towards meeting the safety goal? • What are your thoughts about the idea that all families have strengths? Is this true 100% of the time? <ul style="list-style-type: none"> ○ The answer is YES, but give trainees an opportunity to think about it and respond. ○ This is an opportunity for the trainer to discuss possible biases that may be in the room. Sometimes we may have to work a little harder to find the strengths, but have faith that the strengths DO exist with every family you will work with. 	<div data-bbox="1141 501 1507 768"> <h3>Benefits of Focusing on Strengths</h3> <p>A strengths-based approach helps families:</p> <ul style="list-style-type: none"> • Feel the social worker is interested in their success • Think the relationship they are developing with the social worker is important • Feel more optimistic • Feel more able to make positive changes in their lives <p>(from Redko et al., 2007)</p> </div>
<ul style="list-style-type: none"> ❑ Close this activity by asking trainees: <ul style="list-style-type: none"> • How easy is it to work using strength-based practice? • What are some of the challenges you anticipate? • Where or from whom can you get support? 	<div data-bbox="1141 1031 1507 1297">  </div>
<p>Activity 3B: Casework Components: Practice Behaviors</p> <ul style="list-style-type: none"> ❑ Divide the trainees into 6 groups for this activity. You can have the trainees get back into their groups from earlier in the day if there were 6 groups. If you used 3 groups for the earlier activity, you will need to have the trainees count off by 6s to create 6 groups for this activity. <p>Ask trainees to refer to the California Child Welfare Core Practice Model (CPM) Classroom Resource packet. https://calswec.berkeley.edu/sites/default/files/cpm_packet_rev0816_p7.pdf</p> <ul style="list-style-type: none"> ❑ Remind trainees that an overview of the model was provided in the first training: Overview of Child Welfare Practice and CC 3.0. 	<div data-bbox="1141 1329 1507 1593"> <h3>Casework Components: Practice Behaviors Activity</h3> <ul style="list-style-type: none"> • Using your assigned Casework Component review the practice behaviors associated with the component: <ul style="list-style-type: none"> – Identify the CPM practice behaviors associated with assessment and support for families where substance use disorders, intimate partner violence, and/or behavioral health issues are present. </div>

<ul style="list-style-type: none"> ❑ Assign each group a CPM casework component and ask the group to look at the behaviors associated with their component. <ol style="list-style-type: none"> 1. Foundational 2. Engagement 3. Assessment 4. Teaming 5. Service Planning and Delivery 6. Transition 	
<ul style="list-style-type: none"> ❑ After each group has had a chance to review the behaviors, provide instructions for the activity. ❑ Give each group a piece of chart paper and some markers. Instruct the trainees to identify the CPM practice behaviors (for the casework component they have been assigned) associated with assessment and support for families where substance use disorder, intimate partner violence, and/or behavioral health issues are present. ❑ The task for the trainees is to design a poster that summarizes the key behaviors they identified. There are 4 rules: <ul style="list-style-type: none"> • The group can only use the one page of chart paper • Only pictures can be used (graphics, symbols, icons, or diagrams are okay; no letters, words, or numbers) • All team members must participate • The group will have 10 minutes to make their poster ❑ After 15 minutes, ask the groups to hang their chart paper around the room. Provide a few minutes for the trainees to look at the posters of other groups. Ask for a volunteer from each group to describe their poster and the behaviors that are represented. <p>TRAINER NOTE: During the report out, be sure to ask why this behavior is important when working with children and families who have been impacted by substance use disorder, intimate partner violence, and/or behavioral health issues.</p> <p>TRAINER NOTE: Remind trainees that these practice components reflect how Common Core 3.0 is designed and delivered.</p>	<div style="background-color: #2c5e8a; color: white; padding: 10px; border: 1px solid #2c5e8a;"> <p>Task for Activity: Design a Poster</p> <p>There are 4 rules:</p> <ol style="list-style-type: none"> 1. The group can only use the page of chart paper. 2. Only pictures can be used (graphics, symbols, icons, or diagrams are okay; no letters, words, or numbers). 3. All team members must participate. 4. The group will have 10 minutes to make their poster. </div>

Transition to the next segment: Intersection of Key Issues

Segment 4: Intersection of Key Issues

Segment Time:	150 minutes
Activity Time:	Activity 4A: Key Issues Infomercial (120 minutes) Activity 4B: Intersection of Key Issues Application Activity (30 minutes)
Trainee Content:	The Cycle of Addiction (page 8 in the Trainee Guide) Teen Dating Violence (page 10 in the Trainee Guide) Behavioral Health Resources (page 11 in the Trainee Guide) Culture and Behavioral Health (page 13 in the Trainee Guide) Alternative Treatment Modalities (page 15 in the Trainee Guide) The California Guidelines for the Use of Psychotropic Medication in Foster Care (page 18 in the Trainee Guide) Psychotropic Medication Scenario (page 19 in the Trainee Guide) Johnson Vignette (page 20 in the Trainee Guide, page 48 in Appendix) Intersection of Key Issues (page 21 in the Trainee Guide, page 49 in Appendix)
Materials:	Chart pad, markers, and tape Infomercial Packets: <ol style="list-style-type: none">1. Substance Use Disorders2. Intimate Partner Violence3. Behavioral Health Teen Dating Video: https://www.youtube.com/watch?v=IjDpQfSPB4A
Slides:	16 - 25

Description of Activity:

This segment will facilitate understanding about the intersection of the three key issues facing child welfare. Trainees will be in 3 groups. Each group will be assigned one of the key issues (substance use disorders, intimate partner violence, or behavioral health).


Before the activity

- ❑ Cue up Teen Dating Violence video: <https://www.youtube.com/watch?v=IjDpQfSPB4A>
- ❑ Research IPV protocols (especially protocols for teens experiencing IPV) and services in the local area

During the activity

<p>Activity 4A: Infomercial: Key Issues (120 minutes)</p> <ul style="list-style-type: none"> ❑ Introduce this segment by highlighting that so far, we have been talking about substance use disorders, intimate partner violence and/or behavioral health as separate issues within a family; however, they can co-occur. Co-occurring disorders can be challenging to identify, assess and case plan for with the family. ❑ It is important to remember services do not equal safety. Rigorous balanced assessments are essential for prioritizing needs with the family. ❑ Additionally, as the social work practitioner, you are not solely responsible for helping to address the family's needs. It is important to access the family's safety network, utilize teaming with the family as well as appropriate service providers, and incorporate strength-based, culturally relevant, trauma-informed practices. 	<div data-bbox="1141 111 1505 373"> <p>Intersection of Key Issues: What to Consider...</p> <ul style="list-style-type: none"> • Substance Use Disorder • Intimate Partner Violence • Behavioral Health </div>
<ul style="list-style-type: none"> ❑ Ask trainees to get into 3 groups of equal size. Explain that each group will be assigned one of the following topics for discussion: <ol style="list-style-type: none"> 1. Substance use disorders 2. Intimate partner violence 3. Behavioral health ❑ Once trainees have gotten into their groups, inform them that they will use the Trainee Guide content on pages 8-19 to research their assigned key issue (they may also use the internet if available and any other resources they may have). They have 25 minutes to become the expert utilizing this content to develop an "infomercial" that they will present to the rest of the class. ❑ Each group will have 15 minutes to present their infomercial. The infomercial should include information linking the issue to child welfare, the impact on children, and best practice responses from the child welfare system. ❑ Allow the groups to work, circulating around the room to provide encouragement and answer questions. 	
<p>Substance Use Disorders (15-minute presentation)</p> <ul style="list-style-type: none"> ❑ Show this slide after the group "infomercial," highlighting these key points if they are not covered. 	<div data-bbox="1130 1249 1524 1541"> <p>Substance Use Disorders Key Concepts</p> <ul style="list-style-type: none"> • Substance abuse is an issue that affects all of us. • There is always an underlying reason. • Most individuals with serious substance use issues begin using in adolescence. Chronic use can cause fundamental and permanent changes in the brain. • Primary classifications: Uppers, Downers, and All Arounders • There is a continuum: Mild – Moderate – Severe • Impact on children • Formal and informal treatment options </div>
<ul style="list-style-type: none"> ❑ Before moving onto the next presentation, refer trainees to the trainee content <i>The Cycle of Addiction</i> (page 8 of the Trainee Guide) and facilitate a large group discussion (10 minutes) utilizing the following questions: <p>Relapse is common with this population. What if a parent has a positive drug test result, but is sober for visits?</p> <ul style="list-style-type: none"> • How will you prepare for this in your practice? 	

<ul style="list-style-type: none"> • What else could be going on in this family? (help make the connection to trauma) • What cultural considerations need to be taken into account? <ul style="list-style-type: none"> ○ What attitudes, values and behaviors are normative in this family related to alcohol and/or substance use? ○ What attitudes, values and behaviors are normative in this family's culture related to being intoxicated or under the influence? ○ What attitudes, values and behaviors do you have about parents who use alcohol, drugs and/or other substances? <p>❑ As you facilitate the discussion, be aware of the inclusion of strength-based practices, family-friendly language, and cultural considerations. Ensure trainees are not making assumptions.</p>	
<p>Intimate Partner Violence (15-minute presentation)</p> <p>❑ Show this slide after the group infomercial, highlighting these key points if they are not covered.</p>	<div data-bbox="1149 590 1505 852"> <p>Intimate Partner Violence Key Concepts</p> <ul style="list-style-type: none"> • Safety first for adult survivors and children • Hold the person who batters accountable • Child being a witness is a traumatic and serious event • IPV is a learned behavior • Family violence is an equal opportunity • It's about power and control • Acknowledge survivor's right to choice • Advocate • Safety Planning </div>
<p>❑ Before moving onto the next presentation, facilitate a large group discussion (10 minutes) utilizing the following scenario and questions:</p> <p>Parents you are working with have a history of IPV and substance use disorder. They have been separated for 3 months and have been working on their case plan, which includes IPV services and substance use treatment. They want to get back together and have joint visits with their children.</p> <ul style="list-style-type: none"> • How will you prepare for this in your practice? • What else could be going on in this family? (help make the connection to trauma) • What cultural considerations need to be taken into account? <ul style="list-style-type: none"> ○ What attitudes, values, and behaviors are normative in this family related to power and control in the relationship? ○ What attitudes, values, and behaviors are normative in this family's culture? ○ What attitudes, values, and behaviors do you have about parents who are in abusive relationships? <p>❑ As you facilitate the discussion, be aware of the inclusion of strength-based practices, family-friendly language, and cultural considerations. Ensure trainees are not making any assumptions.</p>	

<ul style="list-style-type: none"> ❑ Before transitioning to the next presentation, refer trainees to the trainee content <i>Teen Dating Violence</i> (page 10 in the Trainee Guide) and facilitate the video and discussion on teen dating violence. ❑ Often in child welfare we are focused on the parents' behavior, but it is also important to recognize signs of relationship or dating violence in youth and young adults. Teen dating violence is a significant problem that occurs more often than most people realize. ❑ Ask trainees what they remember from the e-Learning or what they already know about teen dating violence? ❑ Teen dating violence isn't just between a young woman and young man. One in three young people — straight, gay and everyone in between — experience some form of dating abuse. ❑ Read slide 19 and ask trainees to imagine this is a young adult they are working with while watching the video. 	<div data-bbox="1141 107 1505 373"> <h3>Effects of Dating Violence</h3> <ul style="list-style-type: none"> • Symptoms of depression and anxiety • Engagement in unhealthy behaviors, such as tobacco and drug use, and alcohol • Involvement in antisocial behaviors • Thoughts about suicide </div>
<ul style="list-style-type: none"> ❑ Show the video. ❑ After the video, ask trainees: <ul style="list-style-type: none"> • How will you prepare to work with a teen experiencing dating violence in your practice? • What resources are available in your county? (Be informed of county protocols and prepared to speak to some local resources.) • What is your role? 	<div data-bbox="1141 705 1505 972"> <h3>Teen Dating Violence Key Concepts</h3>  </div>
<p>Behavioral Health (15-minute presentation)</p> <ul style="list-style-type: none"> ❑ Show this slide after the group infomercial, highlighting these key points if they are not covered. 	<div data-bbox="1141 1026 1505 1293"> <h3>Behavioral Health Key Concepts</h3> <p>Mental Health impacts everyone!</p> <ul style="list-style-type: none"> • Co-occurring: 4% of those with Mental health disorders also have both mental illness and addictive disorders (9.2 million adults) • Children, teens, and adults are affected • Use of psychotropic medication • Parenting with a disorder </div>
<ul style="list-style-type: none"> ❑ Refer trainees to the training content <i>Behavioral Health Resources</i> (page 11 in the Trainee Guide), <i>Culture and Behavioral Health</i> (page 13 in the Trainee Guide), and <i>Alternative Treatment Modalities</i> (page 15 in the Trainee Guide), and facilitate a large group discussion (10 minutes): <ul style="list-style-type: none"> • Ask the group to share a challenging example from one of their practice experiences focused on working with a family with behavioral health issues. • Pick one of the dilemmas you know is common to child welfare practice and ask the trainees: <ul style="list-style-type: none"> ○ How will you prepare for this in your practice? ○ What else could be going on in this family? (help make the connection to trauma) 	

<ul style="list-style-type: none"> ○ What cultural considerations need to be taken into account? <ul style="list-style-type: none"> – What attitudes, values, and behaviors are normative in this family? – What attitudes, values, and behaviors are normative in this family's? – What attitudes, values, and behaviors do you have about parents who have a Behavioral Health disorder? <p>■ As you facilitate the discussion, be aware of the inclusion of strength-based practices, family -friendly language, and cultural considerations. Ensure trainees are not making assumptions.</p>					
<p>■ Refer to the trainee content <i>The California Guidelines for the Use of Psychotropic Medication in Foster Care</i> (page 18 in the Trainee Guide) and facilitate a brief discussion on the pros and cons of psychotropic medication. This is just a brief opportunity to introduce this topic to new workers – something they need to be aware of and assess for. More training will be needed to learn more. Let trainees know there is a high-level overview e-Learning and a more in-depth classroom training available. If they are interested, they should connect with staff development and/or their supervisor.</p> <p>■ Let trainees know it is important to:</p> <ul style="list-style-type: none"> • Learn about safe medication use. • Monitor whether or not the medication is helping address identified symptoms. • Monitor side effects. • Make sure youth receive specialized behavioral health services in addition to medication. • Empower youth and give them a voice. • Learn about trauma and its effects. • Honor the youth's specific ethnic, racial, cultural and gender identity. • Ask lots of questions. <p>■ Based on this information, facilitate a discussion by asking:</p> <ul style="list-style-type: none"> • How will you prepare to address the use of psychotropic medications in your practice? • How will you advocate with youth regarding the use of psychotropic medication? <p>■ Refer trainees to the training content <i>Psychotropic Medication Scenario</i> (page 19 in the Trainee Guide) and ask them to work with a partner to review the brief scenario and answer the question.</p> <p>■ Facilitate a brief sharing of ideas before moving on to the next part of the segment.</p>	<div data-bbox="1141 447 1505 711" data-label="Complex-Block"> <p>Role of Psychotropic Medication</p> <table border="0"> <thead> <tr> <th>PROS</th> <th>CONS</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> Psychotropic medications are drugs that target the brain and affect a person's mind, emotions, moods, and behaviors. Studies have found them to be effective for specific conditions. </td> <td> <ul style="list-style-type: none"> There are potential serious side effects to many psychotropic medications Monitoring of medications is not always well coordinated across all individuals involved in youth's treatment. </td> </tr> </tbody> </table> </div>	PROS	CONS	<ul style="list-style-type: none"> Psychotropic medications are drugs that target the brain and affect a person's mind, emotions, moods, and behaviors. Studies have found them to be effective for specific conditions. 	<ul style="list-style-type: none"> There are potential serious side effects to many psychotropic medications Monitoring of medications is not always well coordinated across all individuals involved in youth's treatment.
PROS	CONS				
<ul style="list-style-type: none"> Psychotropic medications are drugs that target the brain and affect a person's mind, emotions, moods, and behaviors. Studies have found them to be effective for specific conditions. 	<ul style="list-style-type: none"> There are potential serious side effects to many psychotropic medications Monitoring of medications is not always well coordinated across all individuals involved in youth's treatment. 				

Activity 4B: Intersection of Key Issues Application Activity (30 minutes)

- ❑ Refer trainees to the training content *Johnson Vignette* (page 20 in the Trainee Guide and page 48 in Appendix) and ask them to read the Johnson vignette.
- ❑ Give them 3-5 minutes to read and then ask them to hold a table group discussion on the following questions (slide 24):
 - How do these three key issues intersect with each other?
 - How will you be able to identify the core issue(s) for each parent?
 - What is the impact on the child(ren)?
 - How is the caregiver's action impacting the child's safety?
- ❑ Use the training content *Intersection of Key Issues* (page 21 in the Trainee Guide) to facilitate a large group discussion about each group's findings for each of the questions.

Meet Julie, Charles, Kathy, and Joey



Now what?

- How do these issues intersect with each other?
- How will you be able to identify the core issue(s) for each parent?
- What is the impact on the child(ren)?
- How is the caregiver's action impacting the child's safety?

- ❑ Highlight the characteristics social workers need to be thinking about as they work with the family to develop a Case Plan. More on Case Planning in the following Blocks: Case Planning and Service Delivery, Monitoring and Adapting and Transition.
 - Emphasize the importance of:
 - Gathering information carefully and from multiple sources: reporting party, extended family members, case records, and other collateral sources
 - Consider alternative explanations
 - Utilize family team meetings
 - Utilize decision making/assessment tools
 - Use trauma-informed practice
 - Traumatic events in a person's life
 - Historical trauma
 - Continue to examine their own feeling and biases
 - Always utilize consultation with your supervisor

Characteristics of a Case Plan

- Collaborative
- Developmentally appropriate
- Includes youth and family voice
- Incorporate formal and informal supports and services
- Least restrictive setting and modalities
- Strength based, child centered, family focused, culturally relevant and trauma informed

Transition to the next segment: Day 1 Wrap up

Segment 5: Wrap up

Segment Time:	15 minutes
Activity Time:	15 minutes
Trainee Content:	N/A
Materials:	N/A
Slides:	26-27

Description of Activity:
Facilitate a closing activity.

During the activity

- ❑ Take the last few minutes of the class period to reflect on the information learned in the class.
- ❑ Ask trainees to share their take-aways from the training and how they will apply them in their work using the 3-2-1 activity in pairs:
 - Share 3 specific new ideas, tools or strategies that I might use in my work.
 - Share 2 specific things I learned or were reminded about my own challenges with
 - Share 1 lingering question about the concepts or content from today.
- ❑ Facilitate a report out.

Closing


- Share 3 specific new ideas, tools, or strategies that I might use in my work.
- Share 2 specific things I learned or was reminded about my own challenges with Critical Thinking.
- Share 1 lingering question about the concepts or content from today.

- ❑ Remind trainees that training starts at 9:00 tomorrow.
- ❑ Provide a brief preview of Day 2.
- ❑ Thank them for their hard work and participation.

See you tomorrow at 9:00am!

Preview of Day 2

- Stages of Change
- Role of the Social Worker
- "If there's breath, there's hope."



DAY 2:

Segment 6: Welcome Back

Segment Time:	30 minutes
Activity Time:	30 minutes
Trainee Content:	N/A
Materials:	Chart Paper, markers
Slides:	28-31

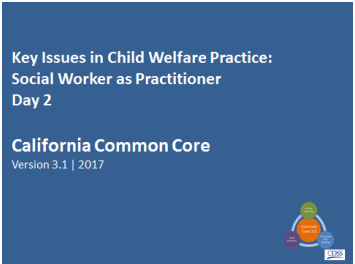
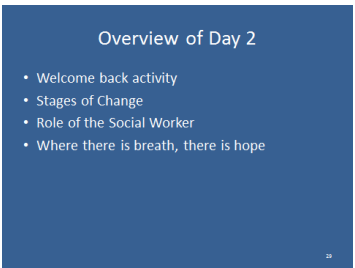
Description of Activity:


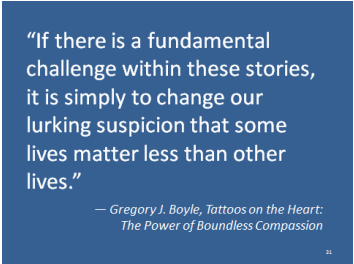
Trainees will participate in an opening activity that helps them to see the commonalities they share with others in the room. The activity will be used again later in the day after the Healing Neen video.

Before the activity

- ☐ Provide each group with chart paper and markers to prepare for the activity.

During the activity

<ul style="list-style-type: none"> <input type="checkbox"/> Welcome the group back to Day 2 of Key Issues in Child Welfare Practice. <input type="checkbox"/> Check to see if there are any questions from the previous day. 	
<ul style="list-style-type: none"> <input type="checkbox"/> Review the Agenda for the day. 	

<ul style="list-style-type: none"> ❑ Divide the trainees into groups of 4 or 5 people by having them count off. ❑ Tell the newly formed groups that their assignment is to find 10 things they have in common with every other person in the group. Emphasize that the 10 things held in common must have nothing to do with work. Let the trainees know that they can't use body parts or clothing. ❑ The group should pick someone who will act as a scribe and chart the commonalities on the chart paper provided. This should take about 10-15 minutes. ❑ Once the groups have finished, ask for a volunteer from each group to read their whole list to the larger group. 	 <p>Activity</p> <h2>Commonality</h2> <p><i>noun</i> com-mon-al-i-ty \kă-mə-'nā-lə-tē\</p> <p>Simple Definition of COMMONALITY</p> <ul style="list-style-type: none"> : the fact of sharing features or qualities : a shared feature or quality <p><small>Source: Vocabulary.com, licensed under CC BY-SA</small></p>
<ul style="list-style-type: none"> ❑ Highlight for the trainees that we share a lot of commonalities with others in the room. This is the same for the families and youth we work with. Let the trainees know that we want to emphasize commonalities with families, as we are all part of this community and the larger human race. We must relate to each other as fellow human beings first: each person is valuable, worthy of love and compassion, and deserving of respectful and dignified interactions. ❑ Read or have someone read the quote on the slide. Pause. ❑ This is one of the reasons we have made the shift from the use of the word “clients” to child, youth, parent, family, caregiver, etc. In this work, it is not about “us” and “them”. It is about connectedness to each other as members of the community and a true desire to see families in child welfare as the “same” as us rather than “different” from us. ❑ Make the link to change in terminology about substance use disorder, intimate partner violence, and behavioral health that was discussed in the e-Learning. 	 <p>“If there is a fundamental challenge within these stories, it is simply to change our lurking suspicion that some lives matter less than other lives.”</p> <p>— Gregory J. Boyle, <i>Tattoos on the Heart: The Power of Boundless Compassion</i></p>

Transition to the next segment: “Where there is breath, there is hope.”

Segment 7: “Where there is breath, there is hope”

Segment Time:	135 minutes
Activity Time:	115 minutes
Trainee Content:	Healing Neen Discussion Questions (page 22 in the Trainee Guide)
Materials:	Healing Neen video https://vimeo.com/15851924 Healing Neen Discussion Guide (appendix, page 55)
Slides:	32-34

Description of Activity:

The trainer will show the Healing Neen Video and facilitate a discussion with the trainees.


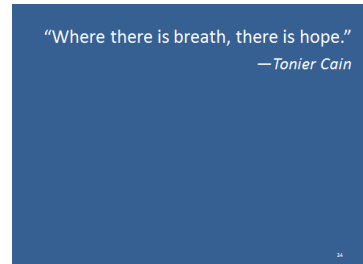
Before the activity

- ❑ Review the Healing Neen video. The video can be accessed at the following link: <https://vimeo.com/15851924>
- ❑ Review the Healing Neen discussion questions.

During the activity

- ❑ In preparation for the Healing Neen video, provide a little information about the link between trauma-informed practice and help for families who are impacted by substance use disorder, intimate partner violence, and behavioral health issues.
 - As a reminder from the Trauma-informed Practice training:
 - Just as many children in the child welfare system have experienced different kinds of trauma; many birth parents involved with child welfare services have their own histories of childhood and/or adult trauma.
 - Parents’ trauma history is often related to the trauma history of their children, especially in foster care.
 - The trauma may be expressed via substance use disorders, intimate partner violence, and behavioral health issues.
 - The more adverse childhood experiences one faces, the more challenging health and wellness become throughout the lifespan.
- ❑ In the video, you will hear Dr. Filetti state that it is important for us to have an “...understanding that the ‘thing’ that you’re dealing with that is the problem is really also someone’s attempted solution to traumatic experiences in life.”



<p>❑ Emphasize that most people are not using drugs or alcohol just because they like getting high. In most situations, they are attempting to escape thoughts and feelings that are often overwhelming and scary.</p>	
<p>❑ Prepare the trainees for the video by letting them know that they will have an opportunity to view the entire video, not just segments. The entire video is about 54 minutes and will be broken up into 5 sections. Between each section, trainees will be utilizing the discussion questions to talk about Neen’s experiences and how they relate to the key child welfare issues of substance use disorder, intimate partner violence, and behavioral health issues.</p> <p>❑ Facilitate a visualization for the trainees before starting the video. Ask them to close their eyes for a moment, if they are comfortable. Read the following:</p> <ul style="list-style-type: none"> You have been assigned a new case. As you are reviewing the case note summary from the previous worker you learn that the mother for the 6-year-old child has: <ul style="list-style-type: none"> Been abused as a child herself A history of prostitution A history of drug addiction 83 arrests 66 convictions A history of intimate partner violence relationships 4 children previously removed from her care and in permanent plans, and Has a history of chronic homelessness Picture this person in your mind. Take a moment and think of some of your initial reactions and thoughts about this person. [PAUSE] Take notice...Do you have a positive view of this person? Do you feel hopeful that this mother will be able to change and care for her child? Are you already seeing the outcome for this mother and child? What is it? When you are ready, open your eyes. <p>❑ Once the trainees are ready to proceed, tell them that they are about meet the mother for their new case. Her name is Neen.</p>	
<p>TRAINER NOTE: facilitate a 15-minute break at some point before the end of the segment. You can consider a break between Segments 3 and 4 or wherever seems most appropriate for your group.</p> <p>❑ Prior to showing the video, refer trainees to the training content <i>Healing Neen Discussion Questions</i> (page 22 in the Trainee Guide).</p> <p>❑ Show segment 1 of the video: Beginning – 12:42</p> <ul style="list-style-type: none"> At 12:42, pause the video and ask the trainees to discuss segment 1 questions in their table groups. Allow approximately 10 minutes for the discussion. Bring the group back together and facilitate a large group debrief using the 	

<p>prompts and key highlights from the Healing Neen Trainer Discussion Guide.</p> <p>❑ Show Segment 2 of the video: 12:43 – 24:24</p> <ul style="list-style-type: none"> • At 24:24, pause the video and ask the trainees to discuss Segment 2 questions in their table groups. Allow approximately 10 minutes for the discussion. • Bring the group back together and facilitate a large group debrief using the prompts and key highlights from the Healing Neen Trainer Discussion Guide. <p>❑ Show Segment 3 of the video: 24:25 – 34:29</p> <ul style="list-style-type: none"> • At 34:29, pause the video and ask the trainees to discuss Segment 3 questions in their table groups. Allow approximately 10 minutes for the discussion. • Bring the group back together and facilitate a large group debrief using the prompts and key highlights from the Healing Neen Trainer Discussion Guide. <p>❑ Show segment 4 of the video: 34:30 – 51:40</p> <ul style="list-style-type: none"> • At the end of the video, ask the trainees to discuss Segment 4 questions in their table groups. Allow approximately 10 minutes for the discussion. • Bring the group back together and facilitate a large group debrief using the prompts and key highlights from the Healing Need Trainer Discussion Guide. 	
--	--

Transition to the next segment: Stages of Change

Segment 8: Stages of Change

Segment Time:	75 minutes
Activity Time:	75 minutes
Trainee Content:	Stages of Change (page 23 in the Trainee Guide, page 51 in Appendix)
Materials:	Trans-Theoretical Model of Behaviour Change video https://www.youtube.com/watch?v=oO80XyBDrI0 Chart pad paper, markers, and tape
Slides:	35-41

Description of Activity:

The trainees will learn about the Stages of Change and how they may be seen in the families involved in child welfare services.

Before the activity

- ❑ The trainer may want to review the *Child Protective Services: A Guide for Caseworkers Manual* (DePanfilis, D., Salus, M. 2003) from the Child Abuse and Neglect User Manual Series
 - <https://www.childwelfare.gov/pubPDFs/cps.pdf>
- ❑ Cue up the video “Trans-Theoretical Model of Behaviour Change,”
<https://www.youtube.com/watch?v=oO80XyBDrI0>
- ❑ Place chart pad pages around the room with the following headers:
 - Precontemplation
 - Contemplation
 - Determination
 - Action
 - Maintenance

During the activity

- ❑ To set the stage for this part of the training day, review the following key points:
 - We want to assume good intentions. Most parents are not trying to deliberately hurt or harm their children. They may not be able to safely care for their children, but it isn’t because they don’t want to.
 - Even parents who make poor choices generally want what is best for their children.
 - Just because a parent is not able to safely care for their children does not mean that they are bad people or don’t care about their children.

Assume Good Intentions!

- Most parents want to be good parents and, when adequately supported, they have the strength and capacity to care for their children and keep them safe.
- Parents want what is best for their children.

- ❑ Before reviewing the Stages of Change, let's take a look at the core conditions that are essential to the helping relationship: empathy, respect, and genuineness. "A social worker's ability to communicate these three core conditions will strongly influence whether they will build a relationship with the children and family that is characterized by cooperation or a relationship that is hostile and distrustful." (Child Protective Services: A Guide for Caseworkers, p.17, 2013)
- ❑ Empathy builds trust and openness and helps to establish rapport with the family.
- ❑ Many families and children fear and distrust the social service system. It is essential for the social worker to communicate respect for each person's potential. The social worker should believe that all people have strength, internal resiliency, and capacity to make changes.
- ❑ Genuineness refers to social workers being themselves. It's important to be consistent in what they say and do, non-defensive, and authentic. Genuineness helps the children and families to see the social worker as another human being similar to themselves.
- ❑ We cannot expect families to share their most personal information with us if they cannot trust us.
- ❑ Ask the trainees to think about how they can demonstrate empathy, respect, and genuineness when they work with families. Ask each table to discuss this. Allow 5-10 minutes for the discussion.
- ❑ After the table group discussions, ask the whole group how they can demonstrate empathy? How can they demonstrate respect? How can they demonstrate genuineness?
 - Social workers can demonstrate empathy by:
 - Paying attention to verbal and non-verbal cues
 - Communicating an understanding of the children's and family's message
 - Showing a desire to understand
 - Discussing what is important to the children and family
 - Referring to the children's and family's feelings.
 - Social workers can demonstrate respect by:
 - Valuing the individual family members as people, separate from any evaluation of their behavior or thoughts.
 - Helping to draw out the family's strengths
 - Believing in the family's ability to change
 - Understanding and identifying the critical cultural values important to the family
 - Supporting identified cultural values and incorporate them into the case plan
 - Social workers can demonstrate genuineness by:
 - Being themselves and not taking on a role or acting contrary to how they believe or feel
 - Making sure that their non-verbal and verbal responses match

Building the Relationship

"Here is what we seek: a compassion that can stand in awe at what the [families we work with] have to carry rather than stand in judgment at how they carry it."

— Gregory J. Boyle, Tattoos on the Heart: The Power of Boundless Compassion

• What can you do to demonstrate:

- Empathy?
- Respect?
- Genuineness?

Think about how this may be different for parents, youth, and children.

Child Protective Services: A Guide for Caseworkers, 2003

<ul style="list-style-type: none"> ○ Using non-verbal behaviors, such as eye contact, smiles, or sitting forward in the chair, to communicate trustworthiness and acceptance ○ Being able to express themselves naturally without artificial behavior ○ Being non-defensive 	
<ul style="list-style-type: none"> ❑ Building rapport is key to gathering information to inform your assessment, especially when it comes to substance use disorder, intimate partner violence, and behavioral health issues. These issues are all highly personal and families understandably may not want to share information with the child welfare agency at first. They may be experiencing feelings of guilt, shame, or embarrassment. Take this into consideration when you are working with families. ❑ Review the content on slide 37. 	<div data-bbox="1144 252 1507 516"> <h3>Ways to Build Rapport</h3> <ul style="list-style-type: none"> • Be open-minded • Find out what is important to the family • Use mirroring • Listen to the family's explanation of the situation without correcting or arguing • Ask questions <p><small>Child Protective Services: A Guide for Caseworkers, 2003</small></p> </div>
<ul style="list-style-type: none"> ❑ Review the content on slide 38. 	<div data-bbox="1144 571 1507 835"> <h3>Ways to Build Rapport (cont'd)</h3> <ul style="list-style-type: none"> • Clarify expectations and purposes • Clarify commitment and obligations to the working relationship • Acknowledge difficult feelings, and encourage open and honest discussion of feelings • Be consistent, persistent, and follow through • Promote participatory decision-making (team meetings) <p><small>Child Protective Services: A Guide for Caseworkers, 2003</small></p> </div>
<ul style="list-style-type: none"> ❑ Introduce the Stages of Change with the video: <i>Trans-Theoretical Model of Behavior Change</i> (https://www.youtube.com/watch?v=oO80XyBDrl0). The intent is to not get caught up in this specific model, but to provide a visual expression of the stages of change. ❑ After watching the video, ask trainees to reflect on Neen's story, ask them to identify examples of the stages of change demonstrated in Neen's story: <ul style="list-style-type: none"> • Pre-contemplation • Contemplation • Decision to Change/Preparation • Action • Maintenance • Relapse (mentioned in video as part of the Maintenance Stage) ❑ Refer trainees to the training content <i>Stages of Change</i> (page 23 in the Trainee Guide) ❑ Ask them to take a few minutes to review the description and also the social worker actions. ❑ Facilitate a discussion with the trainees to identify where parents may be at these different points in time during the life of a case: <ul style="list-style-type: none"> • Initial Removal / Investigation • Voluntary Family Maintenance • Family Reunification • Family Maintenance • Permanency Planning ❑ There are no wrong answers in this discussion. The degree to which parents or youth are ready to change varies over time. We should never assume that 	<div data-bbox="1144 865 1507 1129"> <h3>Stages of Change</h3> <p><small>Child Protective Services: A Guide for Caseworkers, 2003</small></p> </div>

<p>parents whose children are in permanency planning are not able or willing to change.</p> <ul style="list-style-type: none"> ❑ Since most families are involved in child welfare services involuntarily, they usually enter the system at the precontemplation stage. By the end of the investigation, it is hoped that the social worker has helped the family to move to the contemplation or determination stage. It is essential for families to be at the determination stage when developing an intervention or safety plan. 	
<ul style="list-style-type: none"> ❑ Using slide 41 as a prompt, instruct the trainees to visit each of the charts around the room and add an idea about how they can support a parent or youth in each stage of change. Encourage them to be specific. ❑ Allow 10 – 15 minutes for this activity. ❑ Ask for a volunteer to read each of the charts. Try to encourage additional discussion about what may be different for a family in emergency response and for a family in permanency planning. ❑ Note for the trainees that movement through the stages of change is not always linear. People often move back and forth between stages. ❑ It is important for the social worker to help the family maintain a sense of hope, as that is ultimately what helps the family to continue to move through the stages of change. <ul style="list-style-type: none"> • If people are hopeless, helpless, depressed, and overwhelmed, they are unlikely to make the changes we want them to make in order to keep their children safe. ❑ Rather than seeing people as either having motivation toward positive change or not having it, we prefer to talk about a continuum of motivation. 	<div data-bbox="1143 390 1507 655"> <h3>Walk-about Activity</h3> <ul style="list-style-type: none"> • Think of one way that YOU can support a parent or youth in each stage of change. • Be Specific! • Visit each chart and write your idea. </div>
<ul style="list-style-type: none"> ❑ Discuss the concept of a lapse and relapse. <ul style="list-style-type: none"> ○ Lapse: a period of substance use ○ Relapse: the return to problem behaviors associated with substance use ❑ It is important to note that a urine toxicology test will not tell you whether the individual has had a lapse versus a relapse. ❑ Whenever there has been a lapse or relapse related to substance use disorder, intimate partner violence, or behavioral health issues, it is critical for the social worker to help the parents and their safety team identify the specific factors that preceded their lapse or relapse: What were the emotional, cognitive, environmental, situational, and behavioral precedents that led to relapse? ❑ Social workers can help by planning for the potential of relapse and ensuring for the safety of the child. It is important to identify possible triggers and develop a prevention plan. ❑ If a relapse occurs, the social worker should help the parent and their team assess if the treatment plan was adequately addressing cultural, ethnic, or language issues. Recovery can often be enhanced and sustained by incorporating healing and support systems from the parent's culture. 	<div data-bbox="1143 1108 1507 1373"> <h3>What about relapse?</h3> <p>Lapse vs. relapse</p> <ul style="list-style-type: none"> • Relapse can be an opportunity to enhance recovery • Try a trauma-informed response vs. punitive response <ul style="list-style-type: none"> – What happened? – What were you thinking of at the time? – What have you thought about since? – Who has been affected by what you have done? In what way? – What do you think you need to do to make things right? <p>http://www.urp.edu/news/2016-time-to-think-using-restorative-questions</p> </div>

<ul style="list-style-type: none"> ❑ Relapse is an opportunity for intervention and may be part of enhancing recovery. ❑ A trauma-informed response by the social worker and the family team can help when a challenging behavior is present. You can consider using the following questions to help explore what happened that lead to the lapse or relapse: <ul style="list-style-type: none"> • What happened? • What were you thinking about at the time? • What have you thought about since? • Who has been affected by what you have done? In what way? • What do you think you need to do to make things right? ❑ Facilitate a discussion with trainees about possible trauma-informed responses to relapse and possible punitive responses to relapse. <ul style="list-style-type: none"> • Trauma-informed Responses: <ul style="list-style-type: none"> ○ Schedule a team meeting to discuss a possible safety plan ○ Utilize the restorative questions and allow the parent or youth to make a plan for how to make things right ○ Discuss next steps for preventing relapse and ensuring safety ○ Include the team members in the safety and relapse prevention planning ○ Help the parent to re-engage in the contemplation, decision, and action stages • Punitive Responses: <ul style="list-style-type: none"> ○ Reacting harshly towards the parent after a relapse ○ Shaming/blaming the parent for the relapse ○ Removing the children from the parent’s care or restricting visitation prior without bringing the team together ○ Seeing relapse as a win-lose situation for the parent and the child welfare agency ○ “Gotcha” types of reactions to the discovery of relapse 	
---	--

Transition to the next segment: The Role of the Social Worker in Addressing Key Issues

Segment 9: The Role of the Social Worker in Addressing Key Issues

Segment Time:	60 minutes
Activity Time:	60 minutes
Trainee Content:	Stages of Change (page 23 in the Trainee Guide, page 51 in Appendix) General Home Visit Safety Tips (page 24 in the Trainee Guide, page 52 in Appendix) Case Scenario (page 26 in the Trainee Guide, page 53-54 in Appendix)
Slides:	42-47

Description of Activity:

The trainer will review the role of the social worker in assessing for key issues.

Before the activity

- ❑ The trainer may want to review the following manual:
<https://www.childwelfare.gov/pubPDFs/substanceuse.pdf>.



During the activity

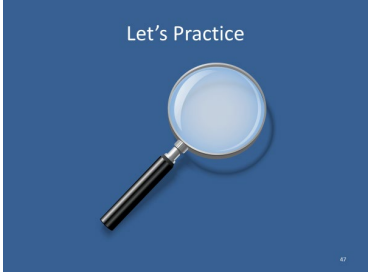
- ❑ Let's begin the section by exploring some key take-aways about the role of the social worker when working with parents and youth when substance use disorders, intimate partner violence, and/or behavioral health disorders are present.
 - Social workers are not expected to be experts on substance use disorders, intimate partner violence, and behavioral health disorders. Social workers will learn more about these topics as they have more time on the job. Social workers are encouraged to consult with their supervisor and other agency/community partners with expertise with these key issues.
 - You can't create a plan with just the people you are worried about. If you are considering a safety plan when substance use disorder, intimate partner violence, and/or behavioral health issues are present, you **MUST** have other members of the family's team as part of the safety plan. Teaming is critically important for safety planning.
 - Safety is paramount. You must always consider the safety of the children when assessing key issues. By utilizing the SDM safety definitions on a regular basis and completing SDM tools as indicated for the case, you will be able to determine if there is a safety threat related to substance use disorder, intimate partner violence, and/or behavioral health issues. If a safety threat is present, a safety intervention will be necessary. The safety intervention may be a safety plan or placing the children in out-of-home

The Role of the Social Worker

Key take-aways:

- You are not expected to be an expert – consult with your supervisor or other agency/community partner who has expertise in substance use disorder, intimate partner violence, and/or behavioral health disorders.
- You can't create a plan with just the people you are worried about.
- Safety is paramount.

<p>care.</p> <ul style="list-style-type: none"> Ask the trainees to brainstorm some resources in their agency or community that can assist them in assessing for substance use disorder, intimate partner violence, and/or behavioral health issues. The trainer will chart the trainees' responses. Be sure to emphasize the importance of consultation with the supervisor around these issues. 	<p>What are some resources available to you in your county?</p> 
<ul style="list-style-type: none"> One of the roles of the social worker is to complete in-home safety assessments. This happens when responding to a referral or completing face-to-face contacts with children and families in their home. When completing an in-home assessment, the following are some indicators of possible substance use that social workers should be familiar with: <ul style="list-style-type: none"> A report of substance use is included in the CPS call or report Drug paraphernalia (e.g., a syringe kit, charred spoons, a large number of liquor or beer bottles) The scent of alcohol or drugs A child or other family member reports alcohol or drug use by a parent A parent appears to be under the influence of a substance, admits to having a substance use disorder, or show other signs of addiction or abuse (e.g. needle marks) 	<p>In-Home Safety Assessment</p> <p>Indicators of possible substance use:</p> <ul style="list-style-type: none"> A report of substance use is included in the CPS call or report Drug paraphernalia (e.g., a syringe kit, charred spoons, a large number of liquor or beer bottles) The scent of alcohol or drugs A child or other family member reports alcohol or drug use by a parent A parent appears to be under the influence of a substance, admits to having a substance use disorder, or shows other signs of addiction or abuse (e.g., needle marks)
<ul style="list-style-type: none"> While social workers will receive some information about social worker safety in another e-Learning class, it is important to be aware of some general home visit safety tips when social workers are working with families experiencing multiple issues such as substance use disorders, intimate partner violence, and behavioral health issues. Ask the trainees to take a few minutes to review the training content <i>General Home Visit Safety Tips</i> (page 24 in the Trainee Guide). After the trainees have finished reading, ask them if they have any questions. Trainees should also be encouraged to review substance use disorder, intimate partner violence, and behavioral health protocols within their agency. 	<p>Social Worker Safety</p> <ul style="list-style-type: none"> Review General Home Visit Safety Tips 
<ul style="list-style-type: none"> Something for trainees to remember is that substance use disorders are often masked by other problems, such as behavioral health conditions or intimate partner violence, and can be overlooked if those other problems are more apparent. The opposite can also be true; a substance use disorder may mask other problems such as intimate partner violence or disabilities. If substance use disorder is suspected, the social worker may complete a substance use disorder screening tool with the family (if appropriate) or refer the person for a substance use disorder assessment that will help provide information about interventions and treatment that will be helpful to the person. Highlight the link between intimate partner violence, substance use disorder, and 	<p>How do Intimate Partner Violence, Substance Use Disorders, and Behavioral Health intersect?</p> <ul style="list-style-type: none"> When IPV is experienced, it is related with depression, suicidality, generalized anxiety disorder, and PTSD. IPV is associated with increased substance use, and increased substance use is associated with an increased risk of IPV. It is recommended that interventions for IPV, substance use disorder, and behavioral health be integrated and trauma informed. Development of strong social networks have been reported to be helpful.

<p>behavioral health. These key issues are often co-occurring.</p> <ul style="list-style-type: none"> ❑ Integrated and trauma-informed interventions have been proven to be effective. The use of teams to increase the family’s social/safety network is recommended. 	
<ul style="list-style-type: none"> ❑ Have the trainees form groups of 3 to work with the case scenario. ❑ Refer trainees to the training content <i>Case Scenario</i> (page 26 in the Trainee Guide) and ask them to read Part I of the scenario and determine 3-5 next steps. Next steps can include identifying information that they need for their assessment, as well as concrete actions by the social worker. Allow 10 minutes to read the scenario and discuss next steps. Ask for one of the tables to report out. The remaining tables can add anything that the first group did not mention. <ul style="list-style-type: none"> • Facilitate a discussion with the group. ❑ Ask the trainees to read Part II of the scenario. Ask one person to play the role of the parent, one person to play the role of the social worker, and one person to observe. Practice having a discussion with the parent about what happened. Allow 5-10 minutes for this practice opportunity. <ul style="list-style-type: none"> • Facilitate a discussion with the group. ❑ Ask the trainees to read Part III of the scenario. Ask each group to identify 3-5 possible interventions and ways to include the safety network in the plan. What might the safety plan look like? How would you support the parent in getting back to the contemplation, decision, and action Stages of Change. 	

Transition to the next segment: Transfer of Learning

Segment 10: Transfer of Learning

Segment Time:	15 minutes
Activity Time:	15 minutes
Trainee Content:	Personal Learning Statements (page 28 in the Trainee Guide)
Slides:	48

Description of Activity:

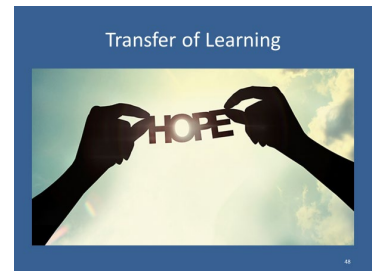
The transfer of learning activity will link the trainees back to the beginning activity about commonality.

Before the activity

- ❑ Review the morning activity and ensure that the charts are still around the room.

During the activity

- ❑ Ask trainees to think about the visualization they did prior to the “Healing Neen” video. Was Tonier Cain, the speaker and trauma-informed care advocate, the person they saw?
- ❑ Help make the link for trainees that sometimes we see the labels and the stereotypes that go along with them rather than the human being with infinite potential.
- ❑ Ask trainees to think about the list of commonalities that we came up with this morning. The charts should still be around the room, so you can prompt them to take a look at what they came up with earlier. Ask them to take a marker and revisit the charts. Ask them to place a check-mark next to anything that is a commonality with Neen. Invite the trainees to add any commonalities to one of the charts, even if it was not one identified earlier.
- ❑ The purpose of this activity is to help the trainees to see themselves and the families they work with as the same rather than different.
- ❑ **Be sure to debrief the activity.** After the trainees have placed their check marks on the charts, ask them if there was anything that surprised them? What possible biases about families came up as part of this activity? What can social workers do to create a space of hope for families and see them as part of the human community worthy of value?
- ❑ Following this discussion, refer trainees to the training content *Personal Learning Statement* (page 28 in the Trainee Guide) and ask them to complete their Personal Learning Statements in the Trainee Guide. Allow approximately 5-10 minutes.



Transition to the next segment: Wrap up

Segment 11: Wrap up

Segment Time:	15 minutes
Activity Time:	15 minutes
Slides:	49

Description of Activity:

Wrap-up for the day.

During the activity

- ❑ Ask the trainees if they have any remaining questions about what they learned over the past two days.
- ❑ Thank the trainees for attending and have them complete the regional Participant Satisfaction Survey.



Appendix

e-Learning Recall Activity Cards

What are some of the ways children may be impacted by substance use disorders?	What is your role as a practitioner in assessing substance use disorders when working with families in child welfare?
How do substance use disorders, intimate partner violence, and behavioral health issues relate to child neglect?	What are the behaviors we see when intimate partner violence is present? Think about the power and control wheel referenced in the eLearning.
Describe how behavioral health disorders may impact children and your work with the family.	What are some of the strategies and tools social workers can use when working with families where substance use disorder, intimate partner violence, and/or behavioral health issues are present?

Johnson Vignette

The Johnson family is made up of Julie, mother, Charles, father, and two children, Joey (age 1) and 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 front the initial investigating social worker:

Issues and concerns:

- Substance use disorder of parents (mother – drugs and father – alcohol)
- Lack of medical care for the child
- Mother’s behavioral 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 from 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 Substance Use Disorder 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 behavioral health condition and substance use disorder
2. Dual diagnosis is a term for when someone experiences a behavioral health condition and a substance use disorder *simultaneously*.
3. Because there are many combinations of disorders that can occur, the symptoms of dual diagnosis vary widely. The symptoms of substance use disorder 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 disorder or behavioral health problems 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 behavioral health symptoms they experience.
- ✓ Research shows though that drugs and alcohol only make the symptoms of behavioral health conditions worse. - See more at: <https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Dual-Diagnosis#sthash.0Gh69g1R.dpuf>
- ✓ About a third of all people experiencing behavioral health conditions and about half of people living with severe behavioral health conditions also experience substance use disorder. These statistics are mirrored among people with substance use disorders; about a third of all alcohol abusers and more than half of all drug abusers report experiencing a behavioral health problem.
- ✓ Men are more likely to develop a co-occurring disorder than women. Other people who have a particularly high risk of dual diagnosis include individuals of lower socioeconomic status, military veterans and people with more general medical illnesses.

Intimate Partner Violence Intersection with Alcohol and Drugs

- ✓ 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 IPV victims
- ✓ Overlap of IPV and AOD problems is 50 percent
- ✓ Incidents more likely to result in death

Use of Substances in the batterer

- ✓ 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.
 - (<http://www.psychiatrictimes.com/articles/role-substance-abuse-intimate-partner-violence#sthash.DZMsrpzP.dpuf>)

Stages of Change and the Child Welfare Worker's Tasks¹⁰

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 the Maintenance Stage)	Slips (lapses) from change strategy or returns to previous problem behavior patterns (relapse)	Help parent re-engage in the contemplation, decision, and action stages

¹⁰ *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 Tips¹¹

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
- 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.

¹¹ *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

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 use disorder 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 use disorder treatment for Lisa and out-patient substance use disorder treatment for Tom. Tom and Lisa were also ordered to participate in parenting, a behavioral health assessment and recommended treatment, and an intimate partner 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 three 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 up Monique, Tommy, and Robert 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.

Healing Neen Discussion Guide

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?
- How would you approach Neen as a social worker, 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?

SEGMENT 5:

- 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?

Materials Checklist

- ☐ Easels
 - ☐ Chart paper, preferably with self-adhesive
 - ☐ Markers
 - ☐ Tape
 - ☐ Post it Notes (sticky)
 - ☐ 1 set of e-Learning recall activity question cards
- Child Welfare Core Practice Model Packet:
https://calswec.berkeley.edu/sites/default/files/cpm_packet_rev0816_p7.pdf
- ☐ Infomercial Packets for each group:
 - Substance Use Disorders
 - Intimate Partner Violence
 - Behavioral Health

Videos:

- *Dating Violence Key Concepts*, <https://www.youtube.com/watch?v=ljDpQfSPB4A>
- *Healing Neen*, <https://vimeo.com/15851924>
- *Trans-Theoretical Model of Behavior Change*, <https://www.youtube.com/watch?v=oO80XyBDrl0>

Annotated Bibliography

Internet Resources

<https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Dual-Diagnosis#sthash.0Gh69g1R.dpuf>

<http://www.psychiatrytimes.com/articles/role-substance-abuse-intimate-partner-violence#sthash.DZMrpzP.dpuf>

http://www.cdc.gov/violenceprevention/intimatepartnerviolence/teen_dating_violence.html

<http://www.iirp.edu/news/1976-time-to-think-using-restorative-questions>

Intimate Partner Violence

Casanueva, C., Martin, S. L., Runyan, D. K., Barth, R. P., & Bradley, R. H. (2008). Quality of maternal parenting among intimate-partner violence victims involved with the child welfare system. *Journal of family Violence*, 23(6), 413-427.

This study looks at the relationships between mothers (n=1,943) who report IPV and the quality of their parenting for children under 10 years old. The study found that women who were no longer victims of IPV had significantly better parenting scores compared to those who were experiencing DV. The women studied are from the NSCAW data.

Carpenter, G. L., & Stacks, A. M. (August 01, 2009). Developmental effects of exposure to Intimate Partner Violence in early childhood: A review of the literature. *Children and Youth Services Review*, 31, 8, 831-839

This study reviews literature on social-emotional development and physiological/neurological development in early childhood and the impact IPV and trauma have on certain domains of development. The study further highlights the importance of routine screening by CW services and the importance of early intervention, particularly on young children who are at an impressionable stage.

Coohey, C. (2007). What Criteria Do Child Protective Services Investigators Use to Substantiate Exposure to Domestic Violence? *Child Welfare*, 86(4), 93-122.

This study explores what criteria CPS investigators use to substantiate allegations of IPV in child welfare. The study identifies risk factors that substantiate allegations that the child was put in harm's way due to DV. It also identifies risk factors that substantiate that there was failure to protect the child. It looks at both behaviors that demonstrate appropriate actions were taken by the victim to protect the child(ren) and behaviors that indicate the caregiver failed to protect the child(ren).

Child Welfare Information Gateway (2014). Domestic Violence and the Child Welfare System Retrieved January 11, 2016 from <https://www.childwelfare.gov/pubPDFs/domestic-violence.pdf>

The Children's Bureau 2014, identifies two definitions for intimate partner violence. Starting with IPV as defined by the Women's resource Rape Assistance Program. Intimate Partner Violence (IPV) as defined by the U.S. Centers for Disease Control and Prevention (CDC), and Family Violence as defined by the National Council of Juvenile and Family Court Judges' (NCJFCJ's).

Approximately 30 million children in the US will be exposed to some type of family violence before the age of 17. There is 30 to 60 percent overlap of child maltreatment and intimate partner violence. Children who are exposed to IPV may experience behavioral, social and emotional problems, cognitive and attitudinal problems, long-term problems such as higher rates of delinquency and substance use. The effects of IPV may also depend on the nature of the violence, age of the child, elapsed time since exposure, gender, presence of child physical or sexual abuse.

A challenge with IPV Interventions is that often services (from child welfare or IPV programs) are provided to one individual in the family, the victim or child. This approach may not help rebuild family relationships or strengthen protective factors. An intervention where a child is removed from the home, for example, can further traumatize the child(ren). The Children's Bureau suggest more coordinated and comprehensive services where family-serving organizations and IPV programs collaborate to provide services that meet the needs of the family and remove redundancy. It also recommends following trauma-informed approach and provides two links for more information:

[The National Center on Domestic Violence, Trauma and Mental health \(NCDVTMH\): Creating Trauma-Informed Services: Tip sheet Series.](#)

*Adapted from the Domestic Violence and Mental Health Policy Initiative's 2008 *Children Exposed to Domestic Violence: A Curriculum for DV Advocates* (written by Patricia Van Horn, JD, PhD). Chicago, IL: DVMHPI.

[Children's Bureau National Resource Center for Child Protective Services \(NRC CPS\)](#)

It is challenging responding to issues of IPV for many reasons. Families are often reticent to disclose there in IPV and workers may not properly screen or identify IPV.

Casanueva, C., Smith, K., Ringeisen, H., Dolan, M., & Tueller, S. (2014). Families in need of domestic violence services reported to the child welfare system: Changes in the National Survey of Child and Adolescent Well-Being between 1999–2000 and 2008–2009. *Child abuse & neglect*, 38(10), 1683-1693.

This study provides a longitudinal comparison of services provided to mothers who were victims of IPV and whose children remained home. The cohorts compared in this study are from the NSCAW I (n=3,625) and NSCAW II (3,351) study. The study found a 15% decline of mothers who reported abuse. The study did not find significant changes in caseworker identification of DV.

Hazen, A. L., Connelly, C. D., Edleson, J. L., Kelleher, K. J., Landverk, J. A., Coben, J. H., & Nuzzkowski, M. A. (2007). Assessment of intimate partner violence by child welfare services. *Children and youth services review*, 29(4), 490-500.

This study examines the relationship between the characteristics of a representative sample of 75 child welfare agencies (referred to in the study as Primary Sampling Units) across the US and their variations policies and practices for assessing intimate partner violence.

Data from this Study comes from the Children and Domestic Violence Services (CADVS) study which is a supplemental study of the National Survey of Child and Adolescent Well-Being (NSCAW). Data for this study was conducted through interviews of with key informants.

Characteristics include County Size, Urbanicity (urban, rural), Poverty level and Administration (county or State). IPV Assessment practices include whether All Families who enter the system are assessed for IPV, Written police for IPV, guidelines in risk assessment for children exposed to IPV, and mechanism to monitor assessment of IPV.

Practices for assessment of IPV include:

- Percentage of families assessed for intimate partner violence

- Stages in CWS case when assessment is conducted (Screening, investigation, assessment, case opening, placement, service plan review, case closure)
- Stage at which majority of assessments are conducted (screening, investigation 75%, Assessment 11.1%, case opening, other).
- Types of forms containing questions on intimate partner violence
- Written policy on assessment of IPV
- Monitoring conducted on assessment of IPV
- Stages at which monitoring is conducted.

Fully 31% of female caregivers interviewed in this study reported that they experienced intimate partner violence while child welfare workers only identified 12% of the families who experienced intimate partner violence. This study found that most agencies (75%) focus their screening efforts during initial investigation and only 25% conducted screening in all stages of the case. Assessing for IPV only in the beginning of the case may lead to under identifying cases of IPV. Hazen, et. al., point out that national policy organizations recommend that screening for IPV should be conducted in every stage of the child's case, from beginning to end. Screening at different stages of the case is important because violence can begin at any point during the family's or child's case and families can initially be reticent to disclosure that violence exist in the home due to stigma, embarrassment, fear over repercussions of reporting, and fear of reprisal from the perpetrator.

Kohl, P. L., Edleson, J. L., English, D. J., & Barth, R. P. (2005). Domestic violence and pathways into child welfare services: Findings from the National Survey of Child and Adolescent Well-Being. *Children and Youth Services Review*, 27(11), 1167-1182.

This study explores the role of co-occurring IPV and CM in CWS using data from the National Survey of Child and Adolescent Well-being and uses worker reports of active IPV or a history of IPV with CM type, substantiation, and placement of children into out of home care.

In a study referenced by Kohl, et al. found that 47% IPV was present in almost half (47%) of cases accepted for investigation and assigned a moderate to high level of risk. The study questions how CWS responds to children of IPV homes.

This study attempts to answer five questions:

- What maltreatment classification is given to children with co-occurring child maltreatment and exposure to intimate partner violence?
- Are families with CM and IPV more likely to have substantiated cases of maltreatment?
- Is IPV a critical factor influencing decisions made by the child welfare worker?
- What is the relationship of IPV to other family and environmental risk factors?
- What family characteristic, including IPV predict placement into out of home care?

Kohl, et al. found that IPV is often one many risk factors in families entering CWS and appears to have only a minor role in influencing the decision of child welfare workers.

Lawson, J. N. (2014). *Domestic Violence as Child Maltreatment: Differential Risks and Outcomes among Cases Referred to Child Welfare Agencies for Domestic Violence Exposure* (Doctoral dissertation, University of California, Berkeley).

Lawson (2014) states that more information is needed on how child welfare processes cases referred for IPV exposure to implement appropriate policies and interventions to meet the needs of these families.

She analyzes three groups of cases:

1. Where IPV was the sole maltreatment allegation reported.
2. Where IPV was alleged concurrently with other types of maltreatment.
3. Where only other maltreatment was reported.

The study further addresses two questions:

1. What are the differential demographics, risk factors, and outcomes of CPS cases reported for IPV (alone or with other allegations) compared to cases reported for other maltreatment types?
2. Is the presence of IPV as a maltreatment allegation an independent predictor of key child welfare outcomes after controlling for demographic and risk variables?

This study finds that in aggregate cases that involve IPV have higher rates of substantiation yet are not more likely to receive CW services and less likely to result in OOH placement. Cases alleging only IPV exposure as maltreatment have low levels of caseworker-assessed risk and other risk factors. Cases with Alleged IPV in concurrence with other types of maltreatment have high levels of caseworker-assessed risk and other risk factors.

Lawson (2014) points out that it is important for CW agencies and IPV programs to collaborate in providing assistance to families of IPV. However, she notes that CWS and IPV programs often have competing priorities that might interfere with how services are provided to families of IPV and is therefore important to identify and discuss what the goals for the family are.

Lee, J. j., Kolomer, S., & Thomsen, D. (2012). Evaluating the Effectiveness of an Intervention for Children Exposed to Domestic Violence: A Preliminary Program Evaluation. *Child & Adolescent Social Work Journal*, 29(5), 357-372. doi:10.1007/s10560-012-0265-1

This study looks at the preliminary evaluation findings of a 10-session group intervention program (the Superheroes) designed for children (6-11) who have been exposed to intimate partner violence. The program promotes five primary outcomes: a. alleviation of guilt/shame, b. improvement of self-esteem, c. establishment of trust/teamwork skills, d. enhancement of personal safety and assertiveness skills, and e. abuse prevention. The study identifies a framework for intervention work with this population of children. It identified the need for accessible, appropriate measures, the need for an intervention planning phase, the need to identify and clarify intervention goals, evaluation instrumentation, participant selection, and strategies to solicit participation, sustain membership, and secure posttest data.

Ogbonnaya, I. N., Finno-Velasquez, M., & Kohl, P. L. (2015). Domestic violence and immigration status among Latina mothers in the child welfare system: Findings from the National Survey of Child and Adolescent Well-being II (NSCAW II). *Child Abuse & Neglect*, 39197-206. doi:10.1016/j.chiabu.2014.10.009

Ogbonnaya, Finno-Velasquez, and Kohl (2015) explore the experience of intimate partner violence and immigration status (legal n=39, unauthorized n=77, naturalized n=30 and US-born n383) among Latina mothers in the child welfare system using case outcomes. This study uses data from the National Survey of Child and Adolescent Well-being II.

Ogbonnaya, et.al, find that intimate partner violence is not accurately accounted for in families with unauthorized immigrant mothers. Unauthorized Latina immigrants were more likely than US-born Latinas to have rates of alleged intimate partner violence as the primary maltreatment type however they did not differ from the other groups in rates of substantiation for intimate partner violence.

Renner, L. M., & Slack, K. S. (2006). Intimate partner violence and child maltreatment: Understanding intra-and intergenerational connections. *Child Abuse & Neglect*, 30(6), 599-617.

This study analysis the extent to which IPV and different form of CM occur within and across childhood and adulthood for a high-risk group of women from the Illinois Families Study (IFS), which follows families who received TANF benefits. The study finds that there is a weak to moderate associations between various form of violence within generations, but a stronger association with the theory of learned helplessness. Based on these findings the researchers recommend that interventions for children victims of violence should address behavior or beliefs associated with continued or future victimization.

Substance Use Disorders

Akin, B. A., Brook, J., & Lloyd, M. H. (2015). Co-Occurrence of Parental Substance Abuse and Child Serious Emotional Disturbance: Understanding Multiple Pathways to Improve Child and Family Outcomes. *Child Welfare*, 94(3).

This study examines the prevalence and the effect parental substance use disorder has on families in CW with children who suffer from serious emotional disturbances. The study found that parents affected by substance use disorder struggled in areas related to socioeconomics, parental trauma, parental behavioral health, and social support compared to those who did not have problems with substance use disorders. The findings suggest that interventions aimed at helping these families need attend to both children and the parent's behavioral health needs.

Child, H., & McIntyre, D. (2015). Examining the Relationships between Family Drug Court Program Compliance and Child Welfare Outcomes. *Child Welfare*, 94(4).

“This study looked at data from 206 families participating in a FDC in Sacramento County, California. Four compliance measures were examined individually and collectively, after controlling for participant characteristics, using logistic regression models to determine how FDC participation benchmarks impact child reunification. This study found the best predictors of reunification was participation in support group meetings and negative tests for substance use. These findings indicate that initiatives designed to address the needs of families affected by child maltreatment and substance use should take into account and support engagement in informal, community-based activities as well as formal, clinically focused interventions.”

Brook, J. (2015, January). Family Drug Courts: An Innovative Service Delivery Strategy for Child Welfare-Involved Substance-Affected Families. In *Society for Social Work and Research 19th Annual Conference: The Social and Behavioral Importance of Increased Longevity*. Sswr.

Family Drug Courts: An Innovative Service Delivery Strategy for Child Welfare-Involved Substance- Affected Families
<https://sswr.confex.com/sswr/2015/webprogram/Paper22628.html>

Purpose: Substance use disorder affected families are frequently cited as the most challenging families to serve within the child welfare context. These families typically experience lower child reunification with birth parents, longer stays in foster care, and greater likelihood of reunification failure. Historically, these cases have been adjudicated in traditional child welfare courts. Given the complexities of families with substance use disorder, traditional courts may be insufficient for handling these hard-to-treat cases and Family Drug Courts (FDCs) are proliferating as an alternative to traditional courts. A growing body of evidence suggests that FDCs may be more effective than their traditional counterpart at reunifying these families;

However, prior studies have been limited in their methodological rigor. The purpose of this study is to rigorously examine whether participation in a Family Drug Court is associated with improved outcomes.

Results: Outcome data suggest that FDC participation significantly influenced reunification outcomes. Life tables indicate that substantially more FDC children achieved reunification than the comparison group. At 401-600 days after removal, 46% of the FDC group reunified compared to 17% of comparison cases. At 601-800 days after removal, 54% of the FDC group versus 21% of the comparison group was reunified. The Cox regression indicates that FDC children were significantly more likely to reunify than comparison cases (H.R.=2.78, $p<.001$; median effect size: 2.50-4.00), after controlling for covariates. The hazard ratio reveals that FDC children were 1.78 times more likely to reunify than comparison group children.

Implications: Using the most rigorous evaluation tools at the disposal of researchers in child welfare—a setting where randomized controlled trials are often unfeasible—this study adds to the growing body of literature suggesting that Family Drug Courts are an effective service delivery strategy for meeting policy driven goals with

this challenging population. As Family Drug Courts continue to expand, the role of social work within the court structure, and implications for social work practice models need to be the subject of future research.

Drabble, L. (2007). Pathways to collaboration: Exploring values and collaborative practice between child welfare and substance abuse treatment fields. *Child Maltreatment*, 12(1), 31-42.

This study examines specific factors that may facilitate collaboration between child welfare and substance use disorder treatment delivery systems. The study found that respondents from the child welfare and substance use disorder fields held different values and belief about drug use and drug-using parents, funding, and planning and measurement of outcomes.

Green, B. L., Rockhill, A., & Furrer, C. (2007). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review*, 29(4), 460-473.

“In this statewide longitudinal study of 1911 women who had children placed in substitute care, we examined the influence of three key factors in the treatment process on child welfare outcomes.

Results indicated that when these women entered treatment more quickly, spent more time in treatment, or completed at least one treatment episode, their children spent fewer days in foster care and were more likely to be reunified with their parents. These findings were significant even controlling for families' levels of risk including treatment and child welfare history, substance use frequency and chronicity, and demographic risks. Implications of these findings for improvements in the way that treatment services are provided to women in the child welfare system are discussed.”

Hanson, K. E., Saul, D. H., Vanderploeg, J. J., Painter, M., & Adnopoz, J. (2015). Family-Based Recovery: An Innovative In-Home Substance Abuse Treatment Model for Families with Young Children. *Child Welfare*, 94(3).

“Family-based in-home treatment can effectively meet the needs of mothers and fathers struggling with the dual challenges of substance use disorder recovery and parenting infants and toddlers. This article describes one such program, Family-Based Recovery (FBR), which integrates substance use disorder treatment for parents and infant mental health intervention with the goal of preventing child maltreatment and family disruption. Program design, implementation, and results are provided.

Outcome data suggest that FBR is a promising model”.

Marsh, J. C., Smith, B. D., & Bruni, M. (2011). Integrated substance abuse and child welfare services for women: A progress review. *Children and youth services review*, 33(3), 466-472.

“A review of empirical literature reveals improvements in service utilization and outcomes for women when substance use disorder and child welfare services are integrated. The increased use of substances by women involved in the child welfare system has resulted in a call for integrated, coordinated, evidence-based practices. Since the late 1990s, specific system- and service-level strategies have been developed to coordinate and integrate the provision of substance use disorder and child welfare services such that women are remaining in treatment longer and are more likely to reduce substance use and be reunited with their children. The strategies reviewed provide useful guidelines for developing components of effective, evidence-based programs for substance involved women in the child welfare system.”

Neger, E. N., & Prinz, R. J. (2015). Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations. *Clinical psychology review*, 39, 71-82.

“This review focuses on 21 outcome studies that tested dual treatment of substance use disorder and parenting. A summary of theoretical conceptualizations of the connections between substance use disorder and parenting provides a backdrop for the review. Outcomes of the dual treatment studies were generally positive with respect to reduction of parental substance use and improvement of parenting.... This study makes some consideration on the involvement of families with CW.

Snyder, S. M., & Smith, R. E. (2015). Do physical abuse, depression, and parental substance use influence patterns of substance use among child welfare involved youth? Substance use misuse. *Substance use & misuse*, 50(2), 226-235.

This study examines patterns of substance use among youth in CW by looking at the history of physical abuse, parental substance use, depression [in youth], and demographic characteristics. Data from the NSCAW II was used in this study. The study did not find that parental substance contributes to polysubstance use in CW youth. The researchers suggest that there may be other risk factors beyond parental substance use disorder that may determine patterns of substance use among these youths.

Ungemack, J., Giovannucci, M., Moy, S., Ohrenberger, K., DeMatteo, T., & Smith, S. (2015). Making It Work Without a Family Drug Court: Connecticut's Approach to Parental Substance Abuse in the Child Welfare System. *Child Welfare*, 94(5), 107-123.

“Parental substance abuse presents complex challenges for the child welfare system and courts.”

This article describes the State of Connecticut’s experience implementing the Recovery Specialist Voluntary Program (RSVP), a recovery support program designed to confront the problem of parental substance use disorder within the child welfare system without a family drug court. The state-level collaboration efforts, system changes, factors affecting development and implementation of RSVP, program participants, and preliminary outcomes are described.”

Worcel, S. D., Furrer, C. J., Green, B. L., Burrus, S. W., & Finigan, M. W. (2008). Effects of family treatment drug courts on substance abuse and child welfare outcomes. *Child Abuse Review*, 17(6), 427-443.

Abstract: “The paper examines whether court, child welfare and treatment outcomes differed for 301 families served through three FTDCs as compared to a matched sample of 1,220 families with substance use disorder issues who received traditional child welfare services.... “Overall, the study found that FTDC mothers had more positive treatment outcomes than similar mothers who were not served by the FTDC. FTDC mothers were more likely to enter substance use disorder treatment services than were non-FTDC mothers, entered treatment more quickly after their initial court petition than did non-FTDC mothers, spent twice as much time in treatment than did non-FTDC mothers and were twice as likely to complete at least one treatment episode than non-FTDC mothers. In addition, data from the study indicate that FTDCs influence a key child welfare variable of interest: FTDC children were significantly more likely to be reunified with their mothers than were unserved children. Copyright © 2008 John Wiley & Sons, Ltd.”

Behavioral Health

Aciri, M., Gopalan, G., Lalayants, M., & McKay, M. M. (2015). Depression and Service Use Among Caregivers Dually Involved in the Child Welfare and Mental Health Systems. *Social work in mental health*, 13(5), 481-494.

The purpose of this study was to investigate the prevalence of depression, use of behavioral health services, and correlates of service use among caregivers who are dually involved in the child welfare and child behavioral health systems. This study analyzed baseline data from 129 caregivers who reported child welfare system involvement and were participating in a Multiple Family Group service delivery model to reduce childhood disruptive behavior disorders. Seventy-eight (60.5%) of caregivers met or exceed the clinical cut-off for depression; of them 50 (64.1%) reported utilizing behavioral health services for their emotional health. Race, employment status, and Center for Epidemiologic Studies Depression Scale score were significantly associated with lifetime behavioral health services use. Depression rates exceeded those found among caregivers involved in either the child welfare or child behavioral health systems. Rates of service use were higher than found in existing research. As expected, racial differences and depression were associated with service use; contrary to

expectations, full-time employment was not associated with service use. Discrepancies between this study and existing research are discussed, as are practice, policy, and research implications.

Kessler, M. L., & Ackerson, B. J. (2005). Wraparound services: an effective intervention for families impacted by severe mental illness. *Journal of Family Social Work, 8*(4), 29-45.

Abstract. Children and families impacted by severe behavioral health problems have multiple strains that effect family functioning, child safety, and parental rights. Traditional services for children and families struggling with severe behavioral health problems have not achieved success in improving family functioning and keeping families intact. Wraparound is a philosophy and a system of care with a promising evidence base that could enhance collaboration of child welfare, behavioral health, and community services to work more effectively with families impacted by severe behavioral health problems.

Kohl, P. L., Jonson-Reid, M., & Drake, B. (2011). Maternal mental illness and the safety and stability of maltreated children. *Child abuse & neglect, 35*(5), 309-318.

Abstract: Objective: Children of mothers with behavioral health problems are at risk for multiple untoward outcomes, including child maltreatment and foster care placement. The purpose of this analysis was to determine the association between maternal behavioral health problems and children's long term safety and stability.

Results: New reports were more likely for children of mothers with behavioral health problems, regardless of diagnosis. While overall 67% of children had a new report over the course of their childhood, rates ranged from 80 to 90% for children of mothers with behavioral health problems and occurred within a shorter time frame than for other children. In the multivariate models, mood (HR= 1.41, $p < .001$) and anxiety disorders (HR= 1.32, $p < .05$) placed children at greater risk for new reports. The proportion of children with foster placements was more than double for children of mothers with behavioral health problems than for other children. In the multivariate model, anxiety disorders were strongly associated with the risk of placement (HR= 1.75, $p < .001$).

Conclusions and Practice implications: Important differences in safety and stability were found between children of mothers with and without behavioral health problems, as well as some variability across diagnoses.

Since these mothers had already received services our findings suggest that access is not enough. The services they are receiving or have received may be an ineffective approach to helping them parent safely.

Lewin, L., & Abdrbo, A. (2009). Mothers with self-reported axis I diagnoses and child protection. *Archives of Psychiatric Nursing, 23*(3), 200-209.

Purpose: To describe mothers with serious behavioral health problems and their children, who are involved with child protective services. Findings: The most frequently occurring diagnoses in these mothers were polysubstance dependence (39.3%) and dual diagnoses (behavioral health problems with substance use disorder ;19.7%).

There was an overrepresentation of African American mothers (60%) compared with the county population and a greater prevalence of child neglect (59.0%) compared with national prevalence. Most mothers and children had been exposed to intimate partner violence (62.6%). Behavioral health services were seldom utilized, and foster care was the most common placement (36.5%). Also, there was close spacing of the age of the children, with an average of 1.25 years between siblings. Conclusions: Identifying common descriptive factors of mothers with behavioral health problems can assist in responding to mothers with serious behavioral health problems and their children. There is a need to coordinate services of the Department of Child and Family Service and behavioral health providers that address parenting and the support of children.

Libby, A. M., Orton, H. D., Barth, R. P., Webb, M. B., Burns, B. J., Wood, P., & Spicer, P. (2006). Alcohol, drug, and mental health specialty treatment services and race/ethnicity: A national study of children and families involved with child welfare. *American Journal of Public Health, 96*(4), 628-631.

Abstract: We used data on a national sample of children involved with child welfare systems to compare American Indian caregivers with White, Black, and Hispanic caregivers in their need for, and receipt of, specialty alcohol, drug, and behavioral health treatment. American Indian caregivers were significantly less likely to receive services than were Hispanic caregivers ($P < .05$) but not significantly less likely than were White or Black caregivers. Child placement, child age, and caregiver psychiatric comorbidity were significantly associated with service receipt.

Park, J. M., Solomon, P., & Mandell, D. S. (2006). Involvement in the child welfare system among mothers with serious mental illness. *Psychiatric Services.*

Objective: This study sought to determine the association between maternal schizophrenia and major affective disorders (serious behavioral health problems) and child custody arrangements in a sample of Medicaid-eligible mothers. Results: Among the 4,827 mothers, 7.2 percent had a serious behavioral health problems and 4.4 percent had other psychiatric diagnoses. More than 14 percent of mothers with serious behavioral health problems received child welfare services, compared with 10.8 percent of those with other psychiatric diagnoses, and 4.2 percent of those without a diagnosis. After the analyses adjusted for a past inpatient episode, race or ethnicity, and age, mothers with serious behavioral health problems were almost three times as likely to have had involvement in the child welfare system or to have children who had an out-of-home placement.

Conclusions: The results suggest the urgent need for increased planning and coordination between the child welfare and behavioral health systems, including provision of parenting support as part of behavioral health treatment for mothers.

Reupert, A., Green, K., & Maybery, D. (2008). Care plans for families affected by parental mental illness. *Families in Society: The Journal of Contemporary Social Services, 89*(1), 39-43.

Abstract: The process of establishing care plans for families affected by parental behavioral health problems is outlined in this article. Based on the feedback of families involved, the original objective of developing crisis plans was broadened to incorporate “care” components. Accordingly, family care plans included planning for possible future crises, such as a parent’s hospitalization, as well as long term goals, for example, education plans for the children. It was found that identifying both crisis and care components enhanced existing social supports within the family and involved pre-negotiating and coordinating agency supports for family members. The general principles and basic components of family care plans are outlined, and the implications for workers’ roles conclude the article.

Stromwall, L. K., Larson, N. C., Nieri, T., Holley, L. C., Topping, D., Castillo, J., & Ashford, J. B. (2008). Parents with co-occurring mental health and substance abuse conditions involved in Child Protection Services: clinical profile and treatment needs. *Child Welfare, 87*(3), 95.

Abstract: This article reports findings of an exploratory study of 71 parents with substance use disorders involved in a child dependency court. Over half (59%) of the parents had a co-occurring behavioral health condition. Parents with co-occurring conditions (PWCC) differed in several important ways from those with only substance use disorders. PWCC were also more likely than their case managers were to report a need for behavioral health treatment. Implications for child welfare practice and research are offered.

Park, J. M., Solomon, P., & Mandell, D. S. (2006). Involvement in the child welfare system among mothers with serious mental illness. *Psychiatric Services.*

Objectives: This study examined service delivery to parental caregivers with behavioral health problems,

substance use problems, or both. The study sought to determine whether, once need is identified, suitable services are offered and then provided. Results: Of parents with behavioral health problems, 77.9% were offered services and 84.0% of those were provided services. Of parents with substance use problems, 65.7% were offered

treatment and 67.5% of those were provided it. Other problems included lack of parenting skills, lack of education and job skills, parent-child conflict, and lack of income. Significant associations were found between caseworkers' identifying problems and offering relevant services.

Caregivers with substance use problems were less likely to be offered substance treatment services than caregivers with both behavioral health and substance use problems. Conclusions: The child welfare system may facilitate service use for caregivers. More research is needed to understand the process of service delivery to caregivers, including why services are not offered to some caregivers and why some services are not provided after being offered. Future research should examine why caregivers with substance use problems are vulnerable to not receiving treatment and whether and how service use varies for other problems not examined in this study.