OVERVIEW

Goal—The goal of Module 1 is to provide child welfare professionals with a contextual knowledge of a range of co-occurring needs that may be experienced by parents involved in the child welfare system. This module discusses the importance of using a family-centered approach to identify and respond to the variety of needs experienced in an entire family. This module will discuss the prevalence of substance use (alcohol and other drugs) and mental disorders, as well as co-occurring disorders, and will address many other issues that may co-exist for families in the child welfare system, including family violence, trauma, physical health, poverty, crime, etc. The module will reference materials describing the differential impact of these issues on families of color. A discussion of how to determine priorities among families' needs is included.

Methods: PowerPoint presentations (or overhead/transparencies); large group and small group discussions.
Training Aids: Projector and computer, disk with PowerPoint file (or overhead and transparencies); flip chart with markers; participant notebook.
Time: 2 hours, 50 minutes

Learning Objectives—After completing Module 1, child welfare professionals will have an understanding of the following topics:

- Principles of both family-centered and culturally competent practice
- How addressing the needs of both parents and children can impact successful family outcomes
- Prevalence of substance use disorders in the general population, in the child welfare population, and in communities of color
- Prevalence of mental disorders in the general population, in the child welfare population, and in communities of color
- Prevalence of co-occurring substance use and mental disorders in the general population, in communities of color and in the child welfare population
- NASMHPD/NASADAD four-quadrant framework for conceptualizing co-occurring substance use and mental disorders
- Difficulty in differentiating co-occurring substance use and mental disorders
- Other issues that frequently co-occur with child welfare involvement, and/or substance use and mental disorders:
    - Family violence
    - Trauma
    - Physical health issues
    - Poverty
    - Crime
- Prioritizing response and intervention for families with multiple needs
- Exploring personal and agency/system values regarding substance use and mental disorders
    - Personal experience/history
    - Stigma
    - Bias

Prior to start ***Meet and greet, registration***

Purpose is to give participants access to the space. Conduct registration and distribute materials. Trainers get ready.

0 – 15 minutes ***Introductions; Purpose; Ground Rules*** **15 min.**

Trainer introduces him or herself. Invite participants to briefly introduce themselves (name, unit, office location, years in the system, etc.). If group is smaller than 12-15 people, trainer could invite them also to briefly describe their interest in this training. If group is larger than 40-50 people, individual introductions are likely to take too much time.

Describe the purpose of Module 1. Language for this overview is provided at the beginning of the presentation scripts, right before Presentation 1. Emphasize that child welfare professionals often work with families where one or more adults are experiencing substance use or mental disorders and this training is intended to prepare them to better help such adults recover from the effects of their disorder and function appropriately as parent or caregiver. The bottom line goal is safe care of children. The language provided also describes four simple ground rules for the training session. After presenting them, the trainer may ask the group if there are any other ground rules important to them.

Good morning! (afternoon; evening) I want to thank you for being here today—and welcome you to a training curriculum that has been designed specifically for you, child welfare professionals. This course is going to give you both information and opportunities to practice skills that will be useful to you in your work.

Today you'll hear several informative presentations and have several opportunities to talk about this information and how it is relevant to your work with each other in small groups and as a whole group. In our time together, I ask that we: 1) treat each other with respect; 2) talk only one at a time; 3) give each person the opportunity to participate; and 4) think about how to take new learning back to your job responsibilities.

PRESENTATION 1

15 – 40 minutes ***Presentation 1: Parental Disorders: prevalence; categories; characteristics*** **25 min.**

Deliver scripted presentation describing parental disorders. Slides I-1 through I-20. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on to the following discussion. Keep answers brief. Trainer should only answer questions to which you know the answer.

[Slide I-1] Substance Use Disorders, Mental Disorders and Co-Occurring Disorders Training

This Module is going to focus on the challenges faced by parents or primary caregivers who may be experiencing substance use or mental disorders. We'll talk about how to recognize the possibility of such disorders; how to seek help for parents; and how to understand the disorders and treatment. We all know that many of the families whose children come into state custody are experiencing some effects from substance use and/or mental disorders, and those disorders are treatable. This curriculum is designed to help you help them succeed in treatment.

[Slide I-2] Substance Use Disorders, Mental Disorders and Child Welfare

For a long time, child welfare professionals have been concerned about the effects of substance use on children and families. That's in large part because parents who abuse or are dependent on drugs often have trouble providing a safe and nurturing environment for their children. But what is less understood is that many of these same parents may also have a co-occurring mental disorder. "Co-occurring disorders" refers to coexisting substance use and mental disorders. Although substance use disorders and mental disorders can impact individual families to varying degrees, there are also common challenges that families—and child welfare professionals—need to be aware of and to address thoughtfully. To that end, we are going to discuss the overall impact of each of these disorders on child welfare.

> Note: Most parents with substance use or mental disorders are not involved with the child welfare system. However, child welfare professionals frequently identify substance abuse as a factor in child abuse or neglect cases and commonly identify mental disorders in parents.

Child welfare professionals and substance abuse or mental health treatment professionals sometimes share clients. Case plans for these shared clients need to be coordinated and mutually supportive. Addressing the needs of the parents, children, and other family members can improve outcomes for the whole family, in terms of both recovery for parents and safety, permanency and well-being for children.

So, stick with us. This training is going to provide strategies and information that can help you build and expand partnerships with treatment professionals that can improve outcomes for both children and their families.

[Slide I-3] Spectrum of Addiction

Alcohol and other drug use exist on a continuum—moving from *substance use* to *abuse* to *dependence.* The differences between these are based on the number and type of negative consequences associated with the substance use. The process begins with experimental use. At this point, the person experiences the positive effects of the psychoactive substance, effects such as euphoria. As the person continues to use, however, he or she may begin to experience some of the negative physical and/or psychological consequences of substance use. These might include a driving intoxicated charge or waking up on New Year's day with no recall about the night before.

Despite these negative consequences, some people will continue to use, trying to capture that initial euphoria. These people run a risk of becoming dependent on the substances. Using more of the substance to get the same effect and in some cases using the substance more often, these people will experience much more of the negative physical, psychological and social effects with fewer and less intense positive effects. So, why do people continue to use substances even when the negative effects outweigh any positive effects? Two reasons: physical dependence on the substance and the changes in their brain chemistry (which we will discuss soon).

[Slide I-4] *Prevalence of substance use disorders*

The National Survey on Drug Use and Health (or the NSDUH) provides new data every year on drug use in the United States. The NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is an agency of the U.S. Public Health Service and a part of the Department of Health and Human Services (DHHS). The survey

provides yearly national and state level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use (SAMHSA, 2005). From year to year, it also asks other health-related questions, including questions about mental health.

The NSDUH uses criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) to distinguish between substance abuse and substance dependence. According to the DSM, substance abuse is "problematic use without compulsive use, significant tolerance, or withdrawal," whereas substance dependence involves "compulsive use, with or without tolerance and withdrawal" (American Psychiatric Association [APA], 2000).

Substance abuse is a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)
- The symptoms have never met the criteria for Substance Dependence for this class of substance (APA, 2000).

In this training, we will use the term “substance use disorders” to refer to what some people might call “substance abuse” or “addiction.” We’ll use this term because it includes the spectrums of substance abuse and dependence as defined by the APA’s DSM diagnostic criteria (American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR; American Psychiatric Association, 2000).

According to the 2010 NSDUH, in that year an estimated 22.1 million persons aged 12 or older had been were classified with substance dependence or abuse (9.7% of the total population; SAMHSA, 2010). Of these, 2.9 million were dependent on or abused both alcohol and illicit drugs, 7.1 million were dependent on or abused only illicit drugs, and 17.9 million were dependent on or abused only alcohol. This slide also shows the break down of substance abuse or dependence between the 12-17 year olds, 18-25 year olds and 26 and older age groups (SAMHSA, 2010).

[Slide I-5] 2009 Treatment Admissions

In 2009, there were 1.96 million admissions to publicly funded treatment for abuse of alcohol and drugs (Office of Applied Studies [OAS], 2006). Women represented 31.8% (N=623,624) of those admissions. This slide shows how many people received treatment and the primary substance for which they received treatment.

[Note to Trainer: Point out the discrepancy between the number of people who needed treatment (22.5 million persons) and the number of publicly funded treatment admissions (1.88 million admissions). These numbers represent the significant gap between those

who need treatment and those who receive treatment. As an optional discussion, you can ask participants to discuss this discrepancy and its implications for child welfare practice.]

[Slide I-6] 2004 Treatment Admissions by Gender

We can also look at the distribution of treatment admissions by gender. On this slide you can see the break down within the major categories for men versus women. As you can see, women represent anywhere from 26 to 46% of treatment admissions for alcohol, cocaine (smoked and non-smoked), marijuana, and heroin and other opiates (OAS, 2009). Men are more likely to be admitted for treatment for these substances—with 54 to 74% of treatment admissions. However, in the amphetamines category, which includes methamphetamine and other stimulants, there is much less discrepancy. Treatment admissions are 46% women versus 54% men (OAS, 2009). We'll talk more later about the special considerations related to methamphetamine use.

- If you want to learn more about treatment admissions, you can review the SAMHSA *Treatment Episode Data Set (TEDS) Highlights 2009*. The link is provided on your resource list.

[*Note to trainer: To make this information more specific to your State, look at the SAMHSA TEDS data for people that entered treatment in the most recent data available. TEDS provides information on the demographic and substance abuse characteristics of the 1.96 million annual admissions to treatment for abuse of alcohol and drugs in facilities that report to individual State administrative data systems. TEDS is an admission-based system, and TEDS admissions do not represent individuals. Thus, for example, an individual admitted to treatment twice within a calendar year would be counted as two admissions. TEDS is available at http://wwwdasis.samhsa.gov/webt/newmapv1.htm]*

[Slide I-7] Prevalence of Substance Use Disorders by Race/Ethnicity

Now, let's look at the rates of treatment need by race and ethnicity. These rates also come from the National Survey on Drug Use and Health. In 2010, you can see that rates of current illicit drug use among those needing treatment varied significantly among the major racial/ethnic groups (SAMHSA, 2010). The rates presented here are for people needed treatment for alcohol or illicit drug problems. The rate was highest among American Indians or Alaska Natives (*15.5%*) and persons who reported two or more races (*7.7%*). Rates were *7.9%* for Whites, *8.3%* for Hispanics, and *6.5%* for Black/African American. Asians had the lowest rate, at *3.3%*. Native Hawaiians or Other Pacific Islanders were *4.7%* in 2010.

- If you'd like to learn more about rates of substance use, you can review the results from the *2010 National Survey on Drug Use and Health: National Findings*. The link is provided on your resource list.

[Slide I-8] 2009 Treatment Admissions by Race/Ethnicity

On this slide you can see the proportion of those by race or ethnicity who received treatment in 2009. The majority – or 60.2%--of those who received treatment were for White (non-Hispanic) (OAS, 2009). Black (non-Hispanic) individuals constituted 20.9% of treatment admissions, 14.1% were Hispanic or Latino, 2.2% were American Indian or Alaska Native, .96% were Asian Pacific Islander, 1.1% were reported as "other or unknown", and .57% reported that they were more than one race.

- To learn more about treatment admissions, review the SAMHSA *Treatment Episode Data Set (TEDS) Highlights 2009*. The link for this is on your resource list.

[Slide I-9] Children Living with One or More Substance Using Parent

This next graph is from the 1999 Report to Congress – *Blending Perspectives and Building Common Ground*. It shows the variety of ways that "children of substance abusers" can be defined (U.S. Department of Health and Human Services [USDHHS], 1999). This report used the same APA DSM-IV diagnostic criteria used in the NSDUH survey. According to the NSDUH report, 8.3 million children in the United States live with at least one parent who is dependent on alcohol and/or needs treatment for an illicit drug (OAS, 2009; OAS, 2003). This figure remained consistent between the 2003 and 2009 national reports.

[Note to Trainer: These numbers are not mutually exclusive. Children may fall into several categories at the same time. This slide simply illustrates the various ways children can be exposed to a parental substance use disorder. As an optional discussion, ask participants what implications each category may have for child welfare practice.]

The statistic that is perhaps most important is the 8.3 million children who live with a parent who is dependent on alcohol or needs treatment for drugs. This translates to *11%* of the kids in our country. If 11% of kids, 3 out of every elementary school classroom, are going home to a parent who is alcoholic or needs treatment for drug abuse, how does child welfare handle this issue when that same family comes to their attention due to abuse or neglect? What is the standard for when a child should be removed in the context of parental addiction? All of us in this room may have different opinions about what those standards should be, but these are critical issues we need to consider as we devise and implement policies and practices that will work best for children and their families.

[Slide I-10] Substance Use Disorders in the Child Welfare Population

Of the 1.96 million people who received publicly funded treatment for abuse of alcohol and drugs in 2010, over half, or approximately 58%, of those in treatment are parents (Brady & Ashley, 2005; Hser, Huang, Teruya, & Anglin, 2003). We don't have national data on the number of children among persons in treatment or on the number of parents at risk for perpetrating child abuse and neglect, since these numbers are not federally required data elements. But, based on the number of adults in treatment and the likely percentage of those who are parents, we can estimate that 1.14 million people admitted to treatment (58% of 1.96 million) were parents of minor children. A study in California (Hser et al., 2003) found that 27.1% of parents in treatment had one or more of their children removed (approximately 307,860-parents nationally, if the 27.1% is applied to 1.14 million treatment admissions). Of these parents in treatment, 36.6% had their parental rights terminated (approximately 112,677 parents nationally, if the 36.6% if applied to the 307,860 estimated number of parents).

**[*Note to trainer: As noted, there are no national data on the number of children among persons in treatment or on the number of parents with substance use disorders involved in child welfare cases. The information presented here are estimates based on several National and State prevalence studies. To make this information more specific to your State, look at the SAMHSA TEDS data for people that entered treatment in the most recent data available. TEDS is available at http://wwwdasis.samhsa.gov/webt/newmapv1.htm. The data are usually 2 years behind the current year. Take the total number of individuals entering treatment in your State*

and apply the percentages presented here to demonstrate the estimated number of parents in treatment in your State, the estimated number of parents in treatment who had a child removed, and the estimated number of parents in treatment who had their parental rights terminated.

For example, if your State TEDS data revealed approximately 100,000 treatment admissions in one year, then

- ***58,000 of those treatment admissions were parents (58% of the total treatment admissions for that year)***
- ***27,100 were parents that had at least one child removed (27.1% of the estimated 58,000 parents), and***
- ***9,919 had their parental rights terminated (36.6% of the estimated 27,100 parents with at least one child removed)*****].**

There is only one published study reporting the prevalence of substance use disorders among families involved with child welfare but where the children have not been removed from the parent(s)' custody (e.g., in-home cases). These data come from the National Study on Child and Adolescent Well-Being (or NSCAW), which has collected data from a nationally representative sample of children in the child welfare system (Gibbons, Barth, & Martin, in press). The NSCAW assessed caregivers' substance dependence using the Composite International Diagnostic Interview Short Form (CIDI-SF) and questions from a child welfare worker interview. The CIDI-SF evaluates criteria of substance dependence in the year prior to the data collection. Overall, 11.1% of caregivers whose children lived at home with them had a substance use disorder (Gibbons et al., in press). This rate is similar to the percentage of children in the general population (11%) who are living with a parent who is alcoholic or needs treatment for illicit drug abuse (USDHHS, 1999).

The NSCAW also looked at substance abuse problems among caregivers of different races or ethnicities who had retained custody of their children (Libby, Orton, Barth, Webb, Burns, Wood & Spice, 2006). Substance use disorders were least prevalent among Hispanic (6.1%) and American Indian (7.5%) caregivers. Caucasian (13.2%) and African American (11.3%) caregivers had the highest prevalence of substance abuse problems.

There are a few things that are important to know about this study. For example, child welfare workers in the NSCAW study did not identify a substance abuse problem among 61% of caregivers who actually met DSM-IV criteria for alcohol or drug dependence (Gibbons et al., in press). Child welfare workers were even more likely to miss potential alcohol or drug problems among caregivers who used but were not dependent on the substance. On the other hand, child welfare workers were significantly more likely to identify substance abuse problems with in-home open cases compared to in-home closed cases (Gibbons et al., in press). Likewise, among cases in which children have been removed, a higher percentage of parental substance use disorders is often reported.

[Slide I-11] Substance Use Disorders in the Child Welfare Population

Over the last decade, several studies reported substance use with various methods and operational definitions of substance abuse.

Murphy and colleagues (1991) required that substance abuse be noted in reports from a psychiatrist or psychologist or in a court-ordered screening before they would include a case in their study. In their sample of 206 cases from Boston, they found that in 43% of the cases at least one of the parents had a documented problem with either alcohol or drugs. The

percentage rose to 50% when they included the cases in which allegations of substance use were in a court report. Parents with documented substance abuse were significantly more likely than non-substance-abusing parents to have been previously referred to child protective agencies; to be rated by court investigators as presenting high risk to their children; to reject court-ordered services; and to have their children permanently removed (Murphy et al., 1991).

A study by the U.S. General Accounting Office (GAO) in 1994 found that in a random sample of case files from California, New York, and Pennsylvania, 78% of foster care cases that were reviewed had at least one parent who was abusing drugs or alcohol (U.S. Government Accounting Office [GAO], 1994). At the request of the Senate Finance Committee, another study by the GAO reviewed case records in Los Angeles and Chicago in 1998. They estimated that about two-thirds of all foster children in both California and Illinois had at least one parent who abused drugs or alcohol, and most had been doing so for at least five years. Most of these parents abused one or more drugs such as cocaine, methamphetamines, or heroin.

In another study, Besinger and colleagues (1999) defined substance abuse to include any known history of substance abuse and therefore found higher rates of substance-abusing parents in their study. They studied case records of 639 urban children placed in out-of-home care due to maltreatment and reported that 79% of children in foster care had a parent with "parental substance abuse."

McNichol and Tash (2001) reported that the percent of children in specialized foster care with a primary reason of parental substance abuse was 14%. Another 76% of children were "affected in some way by parental substance abuse."

Sun and colleagues (2001) explored the impact of alcohol and other drug use (AOD) by caregivers on CPS case substantiation. They looked at 2,756 families from the Department of Family and Youth Services in a particular county in Nevada. They found that only 11% of investigated cases and 16% of substantiated cases had an indication of caregiver AOD use. They also found that CPS cases with indications of AOD use were more likely to be substantiated than cases without AOD use. The authors attributed the low prevalence rate to the fact that social workers in Nevada are not required to document AOD use in their case records.

Rittner & Dozier (2000) found a similarly low rate of 11.2% caregiver substance abuse among 447 children in kinship care while under CPS supervision in a large urban southeastern county. Women who delivered substance-exposed newborns represented 32.9% of total complaints. Caregivers were considered substance abusers if records referred to arrests for possession of substances, if paraphernalia was found at the residence, or if evaluations provided by substance abuse programs indicated substance abuse histories. The requirement of possession or paraphernalia may explain the low prevalence rates found in this study. It is unclear why the prevalence rate would be so low when the substance abuse treatment evaluations were also used. It might be that some caregivers in this study may not have completed an AOD assessment or that CPS failed to inform the treatment provider about details in the case regarding the caregivers' suspected or alleged substance abuse. Thus, if the caregiver denied having a substance abuse problem, the AOD treatment provider would have no information to justify further assessment.

On the other hand, in a recent study using a random sample of 443 children with substantiated child abuse or neglect in an urban setting, Jones (2005) found that 68% of the children had mothers who abused alcohol or drugs and 37% of them had mothers who abused both.

[Note to trainer: As an optional discussion, ask participants what they believe to be the percentage of child welfare cases that involve parental substance use disorders. Note the discrepancies and the similarities between the way participants will define the problem (i.e. whether they discuss substance use, abuse, dependence, addiction, needs treatment, or a particular substance) and their estimates. In advance, you can investigate whether the State or local child welfare agency has any data (e.g. risk and safety assessments, assessments of family needs, or other available data) that document the prevalence of substance use disorders in child welfare cases. Engage participants in discrepancies between their estimates and agency data.]

We need to realize that the prevalence of substance use disorders among parents in the child welfare system does not tell us the nature or extent of the disorders or how parents' substance use might affect the risk or safety factors we associate with child abuse or neglect. The existence of a substance use disorder does not in itself provide enough information to base decisions about the custody status of children or about how the parents' substance use disorder should be addressed in the case plan so that reunification might occur.

[Note to trainer: Modules 2 and 4 will have more detail on identifying the nature and extent of the issue and how the issue can be addressed in the case plan.]

[Slide I-12] Prevalence of Mental Disorders

For the purposes of this training, we are going to use the term "mental disorders" to refer to what some people might call "mental illness" or "mental health issues." This is because the term "mental disorders" includes the spectrums of mental illnesses defined by the diagnostic criteria of the American Psychological Association, the same DSM-IV criteria used in the substance abuse surveys we just reviewed [Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR); American Psychiatric Association, 2000].

[Slide I-13] Rates of Serious Psychological Distress

According to the 2004 National Survey on Drug Use and Health (the NSDUH), an estimated 21.4 million adults aged 18 or older suffer from Serious Psychological Distress (or SPD) (SAMHSA 2005). SPD is an overall indicator of non-specific psychological distress. This 21.4 million represents 9.9% of all adults in 2004. The figure is similar to the rate of 9.2% in 2003 but higher than the rate of 8.3% in 2002. The highest rates of SPD in the NSDUH occurred among adults age 18-25 (*13.7%*).

[Note to Trainer: Past year SPD is an overall indicator of nonspecific psychological distress that is constructed from the K6 scale administered to adults aged 18 or older in the National Survey on Drug Use and Health (NSDUH). The K6 scale consists of six questions that gather information on how frequently a respondent experienced symptoms of psychological distress during the 1 month in the past year when he or she was at his or her worst emotionally. Responses to these six questions are combined to produce a score ranging from 0 to 24, where a score of 13 or greater is considered SPD. This cutoff is based on research suggesting that scores above this threshold provide an indicator of serious mental illness. Although previous reports from the Substance Abuse and Mental Health Services Administration (SAMHSA) have referred to this measure as "serious mental illness (SMI)" and research has shown that the measure is highly correlated with measures of SMI, SAMHSA has determined that it is appropriate to report these estimates (for 2002, 2003, and 2004) as the prevalence of SPD, not SMI. Thus the information presented here is not an overview of the prevalence of diagnosable mental

disorders, but the prevalence of this overall indicator of nonspecific psychological distress.

It is important to know that persons who were in long-term intensive residential psychiatric or other institutional care for their mental disorders at the time of the interviews were not included in the study (SAMHSA, 2005). This small group would represent the adults with the most serious disorders and the least resources to address them. It is also important to note that SPD (Serious Psychological Distress) is not a diagnosable disorder. A diagnosable disorder can encompass a broad range of conditions including anxiety disorders, personality disorders, as well as mood disorders and schizophrenia.]

In 2006, 10.5 million adults aged 18 or older (4.8%) reported an unmet need for treatment or counseling for mental health problems in the past year. This included 4.8 million adults who did not receive mental health treatment and 5.6 million adults who did receive some type of treatment or counseling for a mental health problem in the past year. That is, about 20% of the 23.8 million adults who received treatment for a mental health problem in the past 12 months reported an unmet need. (Unmet need among adults who received treatment may reflect a delay in treatment or a perception of insufficient treatment.)

[Note to Trainer: Point out the discrepancy between the number of people who had an SPD and the number of people who reported an unmet treatment need. As an optional discussion, you can ask participants to discuss this discrepancy and its implications for child welfare practice.]

[Slide I-14] Rates of Serious Psychological Distress

In gender comparisons, the highest rates of SPD occurred among female adults (males *7.7%*; females *12.0%;* SAMHSA, 2005). Among racial/ethnic groups in 2003, rates of SPD were highest among adults identifying themselves Hispanic or Latino (*10.8%*) or White (*10.3%*). Prevalence was lower in persons identifying themselves with two or more races (*8.7%*), Black or African American (*8.1%*), and Asian (*6.7%*). Rates for American Indian, Alaska Native, Native Hawaiian or other Pacific Islander were either collected with low precision or otherwise not reported. A simple, 6-question section of the NSDUH was used to determine these rates. While there is good methodological research to show that these questions are a good predictor of mental disorders (SAMHSA, 2005), persons of different racial or ethnic groups may respond differentially to the questions, which might have had an impact of the findings.

[Slide I-15] Prevalence of Mental Disorders

Rates of SPD in the 2004 NSDUH were highest among persons who were unemployed (*19.0%*; SAMHSA, 2005). It is worth noting that rates of SPD among adults in 2004 were higher in small metropolitan areas (12.0%) than in large metropolitan areas (8.9%). The rate in non-metropolitan areas was 9.7%. The rates did not seem to vary a whole lot across regions of the county, with 9.6% in the South, 9.7% in the Northeast, 10.1% in the Midwest, and 10.5% in the West (SAMHSA, 2005).

[Slide I-16] Mental Disorders Among Parents in the Child Welfare System

It is difficult to know how many families are reported to child protective services and become involved with the child welfare system because of mental disorders. This may arise later in the case and may be noted in the case notes, but often is not required or included in data that child

welfare professionals collect. Although there is not much research that documents the prevalence of mental disorders among parents whose children are involved in the child welfare system, most front-line child welfare professionals know anecdotally that there are significant numbers of parents with such disorders.

In 2005, Wells and Shafran published findings from their study of 173 Cleveland, Ohio, mothers whose children were in the custody of the child welfare system. They found that 24.9% of the mothers exhibited psychiatric symptoms in the clinical range, which means if assessed they would have been diagnosed with a mental disorder. Wells and Shafran believe this percentage to be low – that the mothers interviewed were likely to have underreported these symptoms or problems. They also related this group of mothers to lower pay, if employed, and higher risk factors for other psychosocial problems. Finally, and somewhat troubling, only 38% of those mothers with clinically significant psychiatric symptoms were receiving mental health services at the time of the study, suggesting the presence of significant unmet needs among this population.

[Slide I-17] ***Prevalence of Co-Occurring Substance Use and Mental Disorders***

The 2004 NSDUH examined the relationship between SPD—serious psychological distress– and substance use, as well as the relationship between SPD and substance abuse and dependence (SAMHSA, 2005).

The survey found that adults who used illicit drugs in the past year were more than twice as likely to have had SPD in that same year as adults who did not use an illicit drug (*20.6 and 8.3%*, respectively; SAMHSA, 2005). This pattern of higher SPD rates among illicit drug users was observed within most demographic subgroups.

Likewise, in 2004, adults with SPD were more than twice as likely as those without SPD to have used an illicit drug in the past year (SAMHSA, 2005). Among persons with SPD, *27.6%* used an illicit drug in the past year, while the rate was *11.8%* among those without SPD. This slide breaks down the use of illicit drugs, cigarettes, and alcohol for those who had a SPD in the past year versus those who did not have a SPD in the past year.

Although SPD was not strongly related to alcohol use overall (*52.1 vs. 53.3%*, respectively; SAMHSA, 2005), it was correlated with binge alcohol use, which was defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days. Among adults with SPD, 30.3*%* were identified as binge drinkers compared with *23.2%* of adults without SPD.

[Slide I-18] ***Prevalence of Co-Occurring Substance Use and Mental Disorders***

Those data were for substance use. In addition, SPD was highly correlated with substance dependence or abuse. Among adults with SPD in 2004, *21.3%* were dependent on or abused alcohol or illicit drugs, while the rate among adults without SPD was only *7.9%* (SAMHSA, 2005). Adults with SPD were more likely than those without SPD to be dependent on or abuse illicit drugs (*9.2 vs. 2.0%*) and alcohol (*16.6 vs. 6.9%*).

Difficulties in differentiating co-occurring substance use and mental disorders

It is challenging for the most skilled professional to understand how a substance use disorder and a mental disorder might interact within one individual's experience. One, or even several, assessment appointments may not provide accurate or adequate information about the dynamics associated with co-occurring disorders. Furthermore, many treatment professionals

have been well-trained to understand substance use disorders or mental disorders, but only a small minority of professionals have been trained to understand both areas. Generally, professionals are most likely to focus on what they best understand, so a person trained in mental disorders will focus more on identifying that type of need, while a person trained in substance use disorders will focus more on those needs.

Finally, the broader fields of substance use disorder treatment and mental disorder treatment do not always view co-occurring disorders in the same ways. Many mental health professionals believe that persons with untreated mental disorders may use alcohol and/or other drugs in an attempt to self-medicate for the mental disorder, a strategy that is rarely successful. Their focus of treatment would be the mental disorder, believing that the substance use disorder will resolve itself once the underlying mental disorder is addressed. On the other hand, many substance use treatment professionals believe that the existence of a mental disorder may be irrelevant to a substance use disorder. Their focus of treatment would be the substance use disorder, in the belief that such a disorder must be specifically treated regardless of any mental disorders. It is important for child welfare professionals to learn as much as possible about the training and approaches of treatment professionals to whom they will refer parents for assessment and treatment.

The key point to keep in mind when confronted with substance use or mental disorders in a family is that the presence of one disorder does not mean that another disorder does not exist. For example, a parent that presents with a substance use disorder may have a co-occurring mental disorder, even if that mental disorder is not immediately apparent. Substance use and mental disorders are both complex and can co-exist at different levels of severity.

[Slide I-19] NASMHPD/NASADAD Co-Occurring Substance Abuse Disorder and Mental Disorder Conceptual Framework

A recent report to Congress describes the Co-Occurring Substance Abuse Disorder and Mental Disorder Conceptual Framework that was developed by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD; SAMHSA, 2002).

Although this framework was not designed to classify or diagnose individuals, it can be very helpful in thinking about co-occurring disorders. The framework illustrates how individuals can experience different levels of severity for substance use and mental disorders and what that means in terms of where services are likely to take place and how services should be coordinated (CSAT, 2005). The severity of each type of disorder lies on a continuum of low severity to high severity. Service coordination can be viewed on a continuum of consultation, collaboration and integrated services.

Quadrant I includes persons with a low severity mental disorder and a low severity substance use disorder. Care for persons in this quadrant typically takes place in primary health care settings (SAMHSA, 2002).

Quadrant II includes persons with a high severity mental disorder and a low severity substance use disorder. Care for persons in this quadrant typically takes place within the mental health treatment system (SAMHSA, 2002).

Quadrant III includes persons with a low severity mental disorder and a high severity substance use disorder. Care for persons in this quadrant typically takes place within the substance abuse treatment system (SAMHSA, 2002).

Quadrant IV includes persons with a high severity mental disorder and a high severity substance use disorder. Care in this quadrant may take place in state or private hospitals, jails/prisons, and emergency rooms (SAMHSA, 2002).

Based on the severity of the disorders and where the care will take place, SAMHSA, in 2005, recommended three levels of coordination among substance abuse, mental health and primary health care treatment systems to address the needs of individuals who have both mental health and substance use disorders:

- Consultation is recommended primarily for persons in Quadrant I (both disorders less severe): Providers can rely on informal relationships to make sure that both mental disorders and substance use disorders are addressed. This is especially important with regard to identification, engagement, prevention, and early intervention. Consultation can include such things as a telephone request for information or advice regarding the etiology and clinical course of depression in a person abusing alcohol or drugs.
- Collaboration is recommended primarily for persons in Quadrants II and III (where one disorder is more severe and the other less severe): In collaboration, providers develop more formal relationships to ensure that both mental disorders and substance use disorders are included in the treatment regimen. An example of such collaboration might include interagency staffing conferences where representatives of both substance use and mental disorder treatment agencies contribute to the design of a treatment program for an individual with co-occurring disorders and then both participate in service delivery.
- Integrated Services are used primarily for persons in Quadrant IV (when both disorders are more severe): In these cases, relationships are expanded among mental and substance use disorder treatment providers to merge the contributions of professionals in both fields into a single treatment setting and regimen (CSAT, 2005).

The SAMHSA report to Congress highlights the need for integrated services that include medications and psychosocial treatments to address serious co-occurring disorders.

- To learn more, review the Report to Congress and information available from the Center for Substance Abuse Treatment on co-occurring disorders. The links can be found on your resource list.

[Slide I-20] Additional Stressors

Many parents have a combination of characteristics that can contribute to substance use or exacerbate symptoms of the mental disorder and consequently these can further jeopardize the safety and well-being of their children:

- Co-occurring substance use and mental disorders, such as PTSD (Post Traumatic Stress Disorder), anxiety disorders, depression, and bipolar disorders, can affect the daily behavior of parents toward their children and their ability to focus on their children's needs.
- The relationship between poverty, substance use and mental disorders is not well-defined. Some studies suggest that the stress of poverty increases the likelihood that substance use and mental disorders may develop, while some information suggests that substance use and mental disorders increase the likelihood of poverty. Either way, having limited educational, vocational, and fiscal resources make the consequences of substance use and mental disorders more visible—and certainly can affect parents' ability to earn a living and provide for their children.
- Parents may also be involved with the legal system for criminal activities. These criminal activities may be a result of substance use (e.g., possession of an illegal substance),

may be related to an effort to obtain money for purchasing illicit substances (e.g., prostitution or theft), or may be a result of a mental disorder. Criminal involvement can affect parents' ability to provide for their children (because of incarceration) and, depending on the type of criminal involvement (e.g., selling drugs), may put the children at risk through contact with dangerous individuals or dangerous situations. One caveat. It is important for us to be aware that, despite media attention connecting violence and mental disorders, the vast majority of persons with severe mental illnesses are neither criminals nor violent. If someone with a mental disorder is incarcerated it is more likely to be for a crime of non-compliance, such as loitering, trespassing, or resisting authority.

- Parents may suffer from a variety of physical health issues—some of which may be a result of substance use. For more information on the physical effects of substance use, take a look at the Handout *Physical and Psychological Effects of Substance Use*. However, physical health issues may also be an effect of having limited financial resources and thus lacking appropriate health care. Physical illnesses can affect as parent's stamina and the ability to care for children over a period of time.
- Difficult and traumatic life experiences—things like childhood experiences of abuse or neglect, domestic violence, or homelessness--may have interrupted the parent's development as a child. And they may have deprived them of normal parental role models and life experiences.
- Finally, mothers may present characteristics unique to their gender, something we'll talk about in the next presentation.

40 – 60 minutes ***Facilitated Group Discussion*** **20 min.**

Once questions have been addressed, move the whole group into a discussion about their personal experience with persons with substance use or mental disorders. Given that we all know someone, either personally or professionally, who has a substance use or mental disorder, begin by asking the following question:

- ***What individuals do you know who have experienced a substance abuse problem, a mental illness, or both?***

This discussion is not intended to pressure individuals to self-disclose. Most people will have a professional experience to share and, depending on how well the group knows each other, some may feel comfortable sharing personal experiences. If additional questions are needed to stimulate discussion, you might ask any of the following questions:

- ***How do you know them?***
- ***What do you know about the beginning or the origin of their problem(s)?***
- ***How did your feelings about that person change when you first learned of their problem(s)?***
- ***What do you know about any efforts they made to get help?***
- ***How did their problem or their effort to get help affect your judgment of them?***
- ***How does all of this affect your attitudes about parents with such problems?"***

The GOAL of this discussion is to help participants personalize the realities of substance use or mental disorders. It is desirable to have participants share their attitudes about persons with disorders because some may begin to question their own negative attitudes, making them better able to work with and support parents in recovery. Try not to let one participant dominate the discussion; draw in others to the discussion.

To bring final closure to this discussion, emphasize that our individual attitudes strongly impact how we choose to work with persons experiencing substance abuse and/or mental disorders. It is important to understand our own individual attitudes about these issues if we are to be helpful to persons experiencing them.

PRESENTATION 2

60 – 85 minutes ***Presentation 2: Special areas of consideration; family-centered practice; cultural competence*** **25 min.**

Deliver scripted presentation on special areas of consideration. Slides I-21 through I-36. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on. Keep answers brief. Trainer should only answer questions to which you know the answer.

[Slide I-21] Family Centered Practice: Cultural Competence

While fathers certainly play an important role in their children's lives, most parents with active case plans in the child welfare system are mothers. Because of the high rates of substance use and mental health disorders among these mothers, it is important to understand the unique challenges they face, including issues related to their children.

In this presentation, I am going to talk about three areas that child welfare professionals need to understand if they are going to fully address the needs of dependent children. First, what are the unique considerations of women with substance use disorders? Second, how do co-occurring disorders, trauma, and domestic violence relate to women's substance abuse? Third, what key research-based approaches to treatment are available for women?

We will then briefly discuss some other special areas of consideration, including fathers, American Indian families, methamphetamine labs, and cultural issues.

[Slide I-22] Unique Considerations for Women

Women tend to have a lower threshold for the physical effects and addiction to alcohol and other drugs than men (CSAT, 2001; NIDA, 2000; CSAT, 1999; Blanchard, 1998). In many cases, women use alcohol or other drugs for a shorter time than men before becoming addicted. Part of this may be due to physiological differences. Using alcohol as an example, women absorb and metabolize alcohol differently than men. In general, women have less body water than men of similar body weight, so that women achieve higher concentrations of substances in the blood after consuming equivalent amounts.

- To learn more, review the National Institute for Alcoholism and Alcohol Abuse (NIAAA) Alcohol Alert on women and alcohol. The link is on your resource list.

[Slide I-23] ***Women's Experiences of Co-occurring Disorders, Trauma, and Domestic Violence***

Women who have had challenging life experiences, such as childhood abuse, trauma, domestic violence, or a combination of these can be at higher risk for substance use disorders.

Childhood abuse

A number of studies suggest that women with substance-related problems are more likely to report a history of childhood abuse—physical, sexual, and/or emotional—than are women without substance-related problems (Covington & Kohen, 1984; Miller, Downs, and Testa, 1993; Rohsenow, et al., 1988; Hein & Scheier, 1996; Langeland & Hartger, 1998; CSAT 1997).

Trauma

Many women with substance use disorders have experienced physical or sexual victimization in childhood or in adulthood. And studies have shown that, among people with substance abuse problems, those with histories of childhood abuse are more likely to suffer from trauma and post-traumatic stress disorder—or PTSD (Brady, Kileen, Saladin, Dansky and Becker, 1994; Hien & Levin, 1994; Bernstein, 2000). Alcohol or drug use may serve as a form of self-medication for people with PTSD and other mental disorders.

- To learn more, review trauma-informed information at the National Trauma Consortium. The link is provided on your resource list.

[Slide I-24] ***Women's Experiences of Co-Occurring Disorders, Trauma, and Domestic Violence***

Domestic Violence

In addition to coming from a background of abuse or trauma, women who abuse substances are also more likely to become victims of domestic violence (Miller, et al., 1989). Victims of domestic violence are also more likely to become dependent on tranquilizers, sedatives, stimulants, and painkillers and are more likely to abuse alcohol (Start & Flitcraft, 1988).

State laws vary in the degree and definition of the mandatory involvement of the family if substantiated domestic violence is a factor in the child welfare cases. You really need to understand the laws in your State as you assist families in finding and making good use of treatment for domestic violence issues.

Co-Occurring Disorders

Conditions associated with childhood abuse and neglect, which may co-occur with substance use disorders, include anxiety, depression, and PTSD, as well as dissociative disorders, personality disorders, self-mutilation, and self-harming (CSAT, 2000). We will cover these disorders in Module 3 of this curriculum. Among individuals with substance abuse problems, more women than men have a second diagnosis of mental illness (CSAT, 2001). Women may experience any one of these conditions, or a combination of several.

[Slide I-25] ***Research-Based Approaches for Treating Women***

Findings from the SAMHSA/CSAT Women, Co-Occurring Disorders, and Violence Study highlight the need to acknowledge women's roles as parents, provide them with coordinated services, integrate their children into their treatment, provide parenting education, and focus on strengths. Let’s talk about these approaches one at a time.

Treatment Models

Treatment for women needs to be relationship-based. Peer support, family support and affinity groups are common characteristics needed for supportive change to occur. Treatment also needs to address concrete services, such as child care, transportation, economic support and vocational/job services (Werner, Young, Dennis and Amatetti, 2007).

Parenting Role

Treatment for mothers with substance use disorders must address their roles as parents. Many of these women have not learned to be good parents, may not know about normal child development, and may have unrealistic expectations of their children (Kassebaum, 1999).

Others may have been positive parents. However, their positive parenting abilities may have been compromised because of the loss of balance and wellness caused by the addiction, particularly as the substance use cycle intensifies.

When a parent has a substance use disorder, numerous safety considerations arise for the children, which child welfare professionals are responsible for addressing. These issues are discussed further in Module Six. Treatment programs that accommodate women and children are generally more successful at establishing trust and engaging mothers (SAMHSA, 2001). It is essential for women to feel safe and assured that their children are being cared for during the treatment process.

[Slide I-26] Research-Based Approaches for Treating Women

CSAT Women and Children Programs: Highlights

What are some of the characteristics of effective treatment programs that serve women and their children (SAMHSA, 2001)?

- Comprehensive and holistic planning and delivery of services.
- Coordination with transition services, such as housing and employment, that can assist with relapse prevention.
- Nurturing environment with peer and staff support.
- Professionally trained staff.
- Individualized and flexible treatment services.
- Long-term residential treatment. When long-term residential treatment is indicated, through substance abuse screening and assessment, as the appropriate level of care, this setting can provide additional benefits to women who have come to the attention of child welfare services. For example, this setting can enable parents to maintain supervised parenting relationships throughout their treatment, as well as provide for the comprehensive and coordinated services mentioned above.
- Phased treatment, keeping pace with changes made by the individual.
- Other approaches (e.g., case management, group emphasis, cultural and gender-appropriate focus, and family-focused).

    - To learn more, review highlights from the Residential Substance Abuse Treatment for Pregnant and Parenting Women. The link is provided in your resources list.

Summary of Women's Unique Issues

To summarize: people with substance use problems experience a similar set of issues related to the addiction, treatment, recovery, and relapse processes. In addition, women with substance use disorders have unique considerations, starting with a lower threshold for substance use and addiction than men (CSAT, 2001; NIDA, 2000; CSAT, 1999; Blanchard, 1998).

As I noted earlier, many women with substance use problems have experienced childhood abuse in the form of physical, sexual, and/or emotional trauma (Covington & Kohen, 1984; Miller, et al., 1993; Rohsenow, et al., 1988; Hein & Scheier, 1996; Langeland & Hartger, 1998; CSAT 1997a). These experiences often lead to PTSD or other mental health problems—in addition to substance abuse—that require professional intervention (Brady, et al., 1994; Hien & Levin, 1994; Bernstein, 2000).

In addition to having co-occurring mental disorders that require professional treatment, women with substance use disorders have an increased likelihood of becoming victims of domestic violence. Conversely, women victims of domestic violence have an increased likelihood of having substance use disorders (Miller, et al., 1989; Start & Flitcraft, 1988).

Relationships are integral to recovery. For women in treatment, relationships with counselors and therapists, peer relationships with other women, and a relationship with a higher power (a component of Alcoholics Anonymous and Narcotics Anonymous) are major contributors to recovery. In addition, women in treatment often need to address parenting issues, which may have been compromised because of their substance use.

[Slide I-27] Special Areas of Consideration: Teenagers in the Child Welfare System

Although this training focuses on parents in treatment for substance use and/or mental disorders, we need to acknowledge the children and older youth who may also be involved in treatment and with child welfare services. As we consider the youth who are part of families involved with child welfare and youth involved in independent living programs, we need to recognize that many of these youth may also need support, prevention, or treatment services.

This training does not address the treatment, legal, and court processes for youth in the juvenile justice or criminal justice system. For information regarding these topics, you can visit the Permanency Planning for Children Department Website of the National Council of Juvenile and Family Court Judges, as well as the Office of Juvenile Justice and Delinquency Prevention Website. Treating Teens: A Guide to Adolescent Drug Programs. The links are provided on your resource list.

[Slide I-28] Special Areas of Considerations: Involvement of Fathers

Fostering healthy relationships between fathers and children is integral to a man's recovery from substance use and mental disorders and the development of parenting skills. Although mothers are most often the individuals in treatment and may be reluctant to involve fathers, especially if there are safety concerns, both parents should be involved with child welfare and treatment services whenever possible. Both parents should also be involved in the lives of their children to the extent that children are safe and protected. Furthermore, the dependency court and child welfare systems are mandated to locate absent fathers.

[Slide I-29] Special Areas of Consideration: American Indian Children and Families

Special provisions of the Indian Child Welfare Act (ICWA) are designed to address the unique legal status and rights of American Indian children and families as members of federally recognized Indian tribes. The content of this training, while general in its coverage of treatment systems, does contain some preliminary information regarding related child welfare issues for American Indian children and families.

If the population you serve includes members of American Indian tribes, we encourage you to learn more by visiting the National Indian Child Welfare Association (NICWA) Website http://www.nicwa.org/ so that you can best meet the needs and honor the culture and values of American Indian children and families.

[Slide I-30] Issues Specific to Methamphetamine

Methamphetamine is a highly addictive stimulant associated with serious health and psychiatric consequences, including heart damage and brain damage, impaired thinking and memory problems, aggression, violence, and psychotic behavior. Methamphetamine is also associated with the transmission of infectious diseases such as HIV/AIDS and hepatitis (Rawson and Anglin, 1999).

In 2004, an estimated 1.4 million persons (or 0.6% of people aged 12 or older) had used methamphetamine in the past year, and 583,000 (or 0.2%) had used in the past month (SAMHSA, 2005). Between 2002 and 2004, the number of people who had used methamphetamine in the past month (in other words, “current users”) remained relatively stable. However, during the same 2002 to 2004 time period, the number of past month methamphetamine users who met the DSM IV (Diagnostic and Statistical Manual) criteria for substance abuse or dependence in the past year increased from an estimated 164,000 (or 27.5% of past month methamphetamine users) in 2002 to 346,000 (or 59.3%) in 2004 (SAMHSA, 2005).

As you may recall from earlier in this session, treatment admissions for amphetamines, which include methamphetamine and other stimulants, were 8.1% of all treatment admissions in 2004 (OAS, 2006). Of the total number of individuals admitted to treatment in 2004 for methamphetamine, 45% are women. This percentage of female admissions is higher than the percentage of female admissions associated with any other drug except tranquilizers, sedatives and other opiates. Other opiates include nonprescription use of methadone, codeine, morphine, oxycodone, hydromorphone, meperidine, opium, and other drugs with morphine-like effects. The implication is that more children are likely to be affected by a parent’s use of methamphetamine since caretakers are often predominately female.

Child welfare workers are seeing growing numbers of children and families affected by a parent’s use of methamphetamine. And methamphetamine presents hazards above and beyond those of other illicit drugs. Methamphetamine is inexpensive and relatively easy to make, with ingredients that are relatively easy to obtain. But the chemicals, production process and the waste generated by the production of methamphetamine in clandestine labs pose serious dangers to public safety and the environment. Some of these dangers are toxic poisoning, chemical and thermal burns, fires and explosions. One pound of methamphetamine produces six pounds of toxic waste and this waste may be introduced into the environment by burning or dumping. Children living in a home being used to produce methamphetamine are exposed to significant health risks.

[Slide I-31] Methamphetamine: Situations for Children

In addition to these risks, it is really important for child welfare to understand how a parent's methamphetamine use can affect his or her children. Here are a few situations you need to think about (Young, 2006):

- The parent may use or abuse methamphetamine (episodic use);
- The parent may be chemically dependent on methamphetamine;
- The mother may use methamphetamine while pregnant with the child;
- The parent may "cook" methamphetamine in the home;
- The parent may sell, transport, or distribute methamphetamine (traffickers); and/or
- The parent may manufacture large quantities of methamphetamine (superlabs).

Each of these situations poses a different risk and requires a different response. Of all of these, however, the greatest numbers of children are exposed through a parent who uses or who is dependent on the drug. Relatively few parents "cook" the drug. In the 4-year period of 2000 to 2003, 2,881 children were taken into protective custody after being found at a meth lab (Office of National Drug Control Policy, 2006). Compare this to the 1.2 million children taken into protective custody during that same 4-year period.

When we get to Module 6, we will discuss the issues of how children are affected by parental substance use is discussed in more depth.

[Slide I-32] Issues Specific to Methamphetamine

Even though the incidence may be rare, child welfare workers must still be aware of the potential for chemical exposure during home visits and ensure that their own personal safety is protected. Here are some of the signs that methamphetamine is being manufactured in the client's home (Webber, 2006):

- The presence of laboratory equipment.
- Large quantity of pills containing ephedrine or pseudoephedrine (e.g., Tedral, Primatene, Sudafed).
- Chemical odor.
- Containers of chemicals not commonly found in a home such as:
    - Red phosphorus;
    - Acetone;
    - Liquid ephedrine;
    - Ether;
    - Iodine;
    - P2P (phenyl-2-propanone).

[Slide I-33] Issues Specific to Methamphetamine

    - A large quantity of household chemicals such as Lye, Drano or paint thinner.
    - Chemicals usually found on a farm (e.g., anhydrous ammonia).
    - Residue from "cooking" of methamphetamine.

[Slide I-34] Issues Specific to Methamphetamine: Worker Safety

There are steps you should take when you are in the home or working with families potentially affected by methamphetamine use or addiction (Webber, 2006):

- Inform your supervisor and co-worker(s) that you will be visiting a client with a history of making/using methamphetamine.

    - You may also want to have someone accompany you on the visit.
- Carry a cell phone.
- Arrange for someone to check on you if you don't call in by a pre-arranged time.
- If you feel unsure of your safety, leave the home.
- Do not let client get between you and an exit.
- Park your car so that you cannot be boxed in.
- Do not argue with or antagonize client.
- Do not position yourself in the client's peripheral vision area or where the client cannot see you.
- Do not move suddenly.

[Slide I-35] Issues Specific to Methamphetamine: Worker Safety

- Tell the client what you are doing and why.
- Ask permission if you want to go to another area of the client's dwelling or look in cabinets (e.g., to ensure food is in the house).
- Watch for:
    - Signs that client is becoming upset, angry or suspicious;
    - Scratch marks or scabs, particularly on client's hands and arms (may be evidence of tactile hallucinations or indicate a prior episode of stimulant psychosis);
    - Evidence of hallucinations;
    - Strong chemical odors.

[Slide I-36] Issues Specific to Methamphetamine: Worker Safety

You also want to become familiar with the symptoms of stimulant use or methamphetamine paraphernalia:

- Increased breathing and pulse rate
- Sweating
- Rapid/pressured speech
- Euphoria
- Hyperactivity
- Dry mouth
- Tremor (shaking hands)
- Dilated pupils
- Lack of appetite
- Insomnia/lack of sleep
- Bruxism (teeth-grinding)
- Depression ("the crash" that occurs when the drug wears off)
- Irritability, suspiciousness, paranoia
- Visual and auditory hallucinations
- Formication
- Presence of white powder, straws, injection equipment

[Note to trainer: Formication is the illusion or hallucination that insects are crawling on or under the skin. Formication is a symptom of some psychoses as well as drug and alcohol abuse, where it is also known as "coke bugs."]

To learn more, see the links in your resource list to these articles:

- Webber, R. *Working with Methamphetamine Abusers: Personal Safety Recommendations and Procedures*.

- Otero, C., Boles, S., Young, N., and Dennis, K., *Methamphetamine Addiction, Treatment, and Outcomes: Implications for Child Welfare Workers*.

85 – 100 minutes ***Break*** **15 min.**

100 – 120 minutes ***Facilitated Group Discussion*** **20 min.**

Once the group is back together after the break, begin a whole group discussion by asking, "When you are working with families impacted by child abuse and/or neglect, how do you react to learning a family member has a mental or substance abuse disorder?"

If additional questions are needed to stimulate group discussion, you might ask any of the following questions:

- ***Is your willingness to help them changed? In what ways?***
- ***Have your ideas about how to help them changed? In what ways?***
- ***What implications do you see from ASFA timeline requirements for families with substance abuse and/or mental disorders?***

The GOAL of this discussion is to have them give voice to attitudes that may affect their ability to help a parent move towards recovery goals. By listening to each other, some will think about changing attitudes they hold in directions more helpful to parents they are working with. Do not pressure people to express changed views if they do not feel they can. Ask participants to be aware of how these views can affect their work with families. Try not to let one person dominate the discussion.

To bring final closure to this discussion, emphasize that our personal attitudes carry over into our work and that those attitudes impact our work with families impacted by abuse or neglect. Challenge participants to reflect on those attitudes and decide if they want to make any changes. Encourage workers to talk with supervisors and managers about attitudes.

PRESENTATION 3

120 – 140 minutes ***Presentation 3: Prioritizing interventions; personal and agency values*** **20 min.**

Deliver scripted presentation on competing "clocks" or timelines facing parents, collaboration, and personal and agency values. Slides I-37 through I-49. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on. Keep answers brief. Trainer should only answer questions to which you know the answer. The GOAL of this presentation is help workers understand the many different pressures faced by a parent with a substance use or mental disorder when also involved with the child welfare system.

[Slide I-37] Prioritized Interventions: Personal and Agency Values

The goal of this presentation is to help you understand the pressures that face parents in the child welfare system who also have substance abuse or mental health disorders. We are going to do this by talking first about the competing "clocks" or timelines facing parents, then about

collaboration, and finally about personal and agency values. We will also talk briefly about the impact that stigma has on families dealing with substance abuse.

[Slide I-38] Multiple Clocks in the Lives of Families

Families involved in the child welfare system are often involved with other systems as well—and each system has timelines that parents must adhere to. These systems, as well as their children's development, can be thought of as ticking clocks—clocks that can be at odds with one another.

For example, the Adoption and Safe Families Act (or ASFA) is a Federal law that has shortened the time that a child can remain in out-of-home care without a decision about his or her legal custody. This law has had repercussions for parents who need treatment for their substance use and/or a mental disorder. Parents have a relatively short time to demonstrate that they are able to care for their children. However, recovery from substance use and/or mental disorders is not always a quick or direct process. In fact, treatment and recovery timelines constitute an independent "clock" that ticks as parents participate in treatment.

A summary of each of the timetables, or clocks, parents must adhere to makes it clear that these represent potentially competing requirements.

Recovery timetable

The recovery timetable relates to the parent's timetable for appropriate treatment and recovery, whether that is substance abuse treatment, mental health treatment or treatment for co-occurring disorders. Some mental disorders are life-long and require ongoing active participation in recovery services and supports. Some parents are not ready for treatment. Others are experiencing primary substance use disorders with co-occurring mental health disorders, past traumatic experiences, or a history of domestic violence and have a long road ahead of them. Still others have relapsed or have chronic and persistent mental illness but are still working on their recovery. And many of these parents have timetables that are incompatible with the child welfare reform deadlines.

Child welfare/court timetable

The child welfare/court timetable relates to the time limits parents with children in the foster care system have to develop a safe and nurturing family environment to which their children can be returned, before losing permanent custody. Permanency is essential for a child's successful development, and a year is a long time in a child's life. Permanency may depend on whether parents can maintain an environment that will prevent child abuse and neglect, thus keeping parents and children together. The 12-month timetable under ASFA may not be sufficient for parents to complete treatment or to demonstrate sufficient stability to care for their children.

These timelines are mandated by Federal law (e.g., ASFA). Additional State statutes vary from State to State. For example, in some States the 12-month timetable for infants and young children may be shortened.

Welfare reform timetable

The welfare reform timetable reflects requirements for how long a TANF recipient can receive cash welfare benefits before she must find work, and the total number of years she can receive these benefits in a lifetime.

- Some of these time limits trigger a termination of benefits, while others trigger benefit reductions. Some are lifetime limits, and others are limits within a given period, such as 18 months within a 60-month period. For detailed information about each State's time limits, see the Urban Institute's publication, *One Year After Federal Welfare Reform: A Description of State TANF Decisions as of October 1997.* A table that lists the time limit for receipt of income support by State is provided in the handout *Additional Resource: TANF Time Limits Until Work Requirement*.
- This timetable may challenge a parent's time for completion of treatment, or it may compel parents to give treatment a lower priority in their lives. In turn, this can affect child welfare outcomes.

Child's developmental timetable

The child's developmental timetable relates to a child's developmental stages. For example, the critical period of brain development occurs before birth and in infancy, and young children achieve much of their bonding or attachment during the first 18 months of life. By the time children are 3 years of age, they have formed much of their sense of trust and security. By the time children are 9 years of age, the chances for adoption are greatly reduced. It is a challenge to help secure safe and nurturing homes for children while allowing adequate time for the parents' treatment for substance use or mental disorders.

These clocks represent the major timetables parents need to abide by—and clearly this can pose major challenges. Because of the constraints families with multiple needs face, it is important that systems work together, or collaborate, to come up with a single shared strategy so that families can remain intact, reunify, or move toward an alternative placement if necessary.

When systems collaborate on a regular basis, it also becomes easier to identify which families are being served by multiple providers and helps all players work to help these families.

When we get to Modules 4 and 5, we will discuss strategies that can help the child welfare and treatment systems collaborate.

[Slide I-39] ***Benefits of Collaboration***

I think we have established that many of the parents in our child welfare systems have substance use or mental disorders, or both—and we should also be clear that treatment and recovery are clearly in the best interest of their children. Likewise, many studies show that parents' involvement with their children and families is integral to recovery. Therefore, it benefits parents, children, and families when child welfare professionals collaborate with treatment professionals to sustain and strengthen family relationships.

Current best practices in the treatment of substance abuse, mental disorders, and co-occurring disorders emphasize screening and assessment, collaboration, consultation, and the integration of services (NASMHPD/NASADAD Conceptual Framework). When more than one disorder exists, they also stress the importance of ongoing partnership-building between substance use and mental disorder treatment programs.

Building collaborative relationships with treatment agencies is time and labor intensive, but the benefits are clear. The investment will lead to better understanding of our families and the challenges they are facing, better planning, and more effective monitoring. In the end, these partnerships will contribute to better outcomes for our families and more efficient service.

Collaboration in case planning and information sharing can include child welfare professionals, substance abuse treatment providers, mental health treatment providers, court professionals and professionals from other related services.

One thing you should know: substance use and mental disorder treatment services are not coordinated in many States and localities. This means that if you are working with a family that is affected by a substance use disorder, a mental disorder, or co-occurring disorders, you may have to interact independently with substance use and mental disorder treatment agencies.

[Slide I-40] Types of Collaboration

What does collaboration look like?

Although system and agency collaboration does not always occur, there are important kinds of collaboration that you, as an individual child welfare professional, can accomplish with treatment professionals who are working with the same parents. Just a few possibilities include:

- Consultation to exchange information about resources, systems, requirements, and clients;
- Coordination to schedule activities and requirements with each other's requirements in mind;
- Cooperation and agreement to work toward common outcomes for specific consumers by developing a common or joint plan;
- Collaborative strategies to carry out a commonly defined and supported set of agency or system outcomes.

[Slide I-41] Benefits of Collaboration

Families benefit when child welfare professionals understand something of a parent’s substance use and/or mental disorders and how their treatment works—and when they collaborate with the agencies that provide this treatment. Here are a few of the benefits:

Collaboration improves family engagement. Parents with substance use or mental disorders who are not involved in the child welfare system often know their children are in trouble or endangered. They may avoid or leave treatment for fear of losing their children. When child welfare and treatment professionals collaborate and can each explain to parents how treatment can help them provide for their children's safety and well-being, this can help engage and retain parents in the treatment process. This support is particularly important for parents of infants and young children who may not have access to other helping adults.

Collaboration improves planning and enhances family outcomes. Parents with substance use or mental disorders are almost always affected by relationships with children, partners, parents, and siblings, and may be dealing with trauma and co-occurring disorders as well. Understanding the context of a parent's substance use or mental disorder will help child welfare professionals work with treatment professionals to come up with approaches that can improve the outcomes for children and families.

Collaboration reduces family stress. Parents with substance use or mental disorders can be stressed by their parenting responsibilities, which can actually contribute to abuse or neglect. Child welfare professionals can help these parents with strategies that will help them with their responsibilities and prevent future abuse or neglect. This type of work can also reduce the chance of relapse—and improve the chances of family reunification.

Collaboration helps families meet requirements. The requirements of child welfare and dependency courts can differ from treatment requirements. This puts additional pressure on parents who are trying to meet all the requirements, which can prompt relapse and jeopardize the chance that they will meet these requirements. By communicating with the parent's treatment provider, child welfare professionals can increase the provider's awareness of these competing pressures, which will help parents meet Federal and State timelines and achieve their goals regarding their children.

Collaboration improves information sharing. Treatment professionals are often asked to give child welfare professionals information about a person's progress in treatment or to testify in court, which raises issues of confidentiality. By collaborating with child welfare colleagues, treatment professionals can identify how to share critical information that will help the parent without violating confidentiality requirements.

And speaking of confidentiality, child welfare professionals who work with parents with substance use disorders should develop a good understanding of Federal legislation and the State laws that are in place to carry out the Federal legislation. For example, you need to understand the Federal substance abuse treatment confidentiality regulations and Health Insurance Portability and Accountability Act (HIPAA) privacy laws [*see Module Five for more information*].

You'll also want to understand the Federal Child Abuse Prevention and Treatment Act (CAPTA) requirements, which include guidelines for reporting prenatal exposure, and your State's policies and procedures used to respond to the CAPTA requirements.

At the same time, you need to be sure that you understand your own agency's policies and procedures and learn about any interagency agreements and protocols.

[Slide I-42] Exploring Personal and Agency/System Values

Concerns of Child Welfare Professionals

Remember that treatment for substance abuse, treatment for mental disorders, and child welfare emerged from different philosophies and approaches. As a simple example, addiction professionals who are in recovery may reveal their history of recovery to their clients, while mental health and child welfare professionals typically do not discuss their personal backgrounds with families.

[Slide I-43] Exploring Personal and Agency/System Values

Parents who are struggling with early recovery may need help with fairly concrete and specific steps. This may make some child welfare professionals uncomfortable because it seems to be in conflict with their social work training.

[Note to Trainer: Depending on their training, child welfare professionals may be uncomfortable with the idea of providing specific guidance to parents because it will sound too similar to the idea of providing "advice." The guidance described herein differs in that parents involved with the child welfare system need to clearly understand what is expected of them. The child welfare worker provides guidance by being detail-oriented in the specific behaviors and activities that are expected of parents.]

However, parents who have a substance use disorder and who are under the ASFA clock to meet statutory deadlines set by the dependency court may need very specific guidance. When you are working with these parents, you may find that they are experiencing cognitive problems with attention, memory retention, or even processing of information, especially during early abstinence. For example, you will need to help these parents understand what is being asked of them, the best way to achieve their desired goals, and the consequences of not actively working to achieve these goals. You may also need to develop some strategies and skills you can use to increase their motivation.

[Note to Trainer: See Module 4 for more information, including strategies to enhance parents' motivation].

[Slide I-44] Personal-Professional Dimensions of Substance Use and Mental Disorders

Many of us know someone who has a substance use disorder or a mental disorder. And we all bring to our work our own personal perspectives, including views and experiences of addiction and mental illness from our families. But we need to be mindful about how our viewpoint may affect the way we view our clients. Remember that each person's experience with substance use and mental disorders is unique and that what worked for you or for your family may be different from what will work for other families.

It's important to discuss this issue regularly with your supervisor to ensure that your personal experiences do not interfere with your ability to work objectively with families. This work is difficult and it is normal for it to bring out emotions or feelings about past experiences. The important thing is not to stop having the feelings but to identify and discuss them with your supervisor so that they do not interfere with your professional work.

[Note to Trainer: It may not be easy for some participants to discuss these issues with their supervisors, particularly if they are unsure of their supervisor's perspective.]

[Slide I-45] Stigma

Another aspect of personal and agency/system values that must be discussed is stigma. People with mental disorders are often seen in a wide range of negative ways because of misconceptions about what it means to have a mental illness. In fact, fears about judgment or stigma make it difficult for some people to seek or accept treatment. Likewise, persons experiencing substance use disorders may be viewed in their communities as "choosing to do it to themselves." Often, these people don't understand how addictions form or the factors that contribute to addiction, again making it more difficult for those persons to seek treatment. Persons with co-occurring disorders are likely to suffer from both kinds of stigma, making it even more difficult for them to seek or accept treatment.

As a start, child welfare workers need to be aware of their own biases about these disorders and not let such biases negatively affect their work with children and families. But more is needed. The profession needs to recognize the wider community environment and its effects on parents who may need help for a disorder, if we are going to help parents seek and accept the help they may need so that they can care appropriately for their children. Child welfare professionals must become advocates on behalf of their families against stigma.

[Note to Trainer: As an additional discussion, you can bring the concept of stigma back to the previously mentioned gaps in need for treatment versus received treatment. Ask

participants, how might these gaps be related to stigma? How does stigma affect not only child welfare practice, as well as individual perceptions and policy-making?]

[Slide I-46] Family Centered Practice

Principles of Family Centered Practice and Cultural Competence

Most families and extended families, even those with substance abuse and mental disorders, have strengths and resources that can be identified and used to help the children. Let's talk for a few minutes about the principles of family centered practice (Tannen, 1996). As an introduction, let me first say that these principles describe a way of serving families that sets high goals. They describe service provision unlike what most of us have experienced, whether we receive help or give it. But they also describe a broad set of principles that can drive the way we plan, deliver, manage, and evaluate services. Every step we take towards these principles improves the life outcomes experienced by individual children and families.

1) Family centered practice builds community. This means that all system activities are aimed at bringing people together within the community, forging links to benefit community members who have needs. Recipients of services and helpers all feel part of something larger than themselves, than their own family, which builds hope and gives meaning (Tannen, 1996).

2) Family centered practice builds support and hope. None of us can survive alone; each person and family is part of an interdependent community. But families experiencing serious or multiple stressors often have fewer active connections to the community. Families like this need front-line help to build concrete supports within the community. Strengths are recognized and reinforced, small changes are rewarded, and the belief that things can improve is part of every helping action (Tannen, 1996).

3) Family centered practice supports families as service designers. This means that program decisions are made in response to the needs and wishes expressed by families, as long as child, family and community safety can be maintained. As Naomi Tannen (1996) so eloquently put it, "What affects families includes families."

4) Family centered practice blurs boundaries between "helpers" and "recipients". Boundaries that protect helpers and customers are important, but rigid separations between "professionals" and "clients" are often aimed at keeping power within service agencies. To the extent possible, people who need services should be empowered to be in charge of their lives, including services they may receive. In a family centered model, front-line practice is flexible and responsive to input from families on a day-to-day basis (Tannen, 1996).

5) Family centered practice views family members as providers, as helpers. Everyone has strengths and abilities and child welfare professionals should definitely identify and use the resources in all families, helping them to help themselves (and perhaps others). Service agencies can even hire family members as staff or as consultants to their staff. Front-line practice is supported by those who have "been there", and such expertise is respected and rewarded, whether through stipends and cost reimbursement or simply in the way system helpers talk with and about such families (Tannen, 1996).

6) Family centered practice views service simply as people helping people. Status and power do not reside exclusively in persons with high degrees or extensive training, although education and training are valuable. Any family may be impacted by abuse or neglect, substance use or

mental disorders, and any person in the community may become the key helper to an individual or family with such needs (Tannen, 1996).

[Slide I-47] Family-Centered Practice 2

7) Family centered practice uses all existing resources as creatively as possible. All communities and helping systems operate with finite resources, so the maximum benefit must be pulled from each resource. Preventing problems is more effective than solving them; addressing needs early is more effective than letting them evolve into a crisis. Existing resources are combined and shared, as possible, and each community entity is recognized for the contributions it can and does make to community well being (Tannen, 1996).

8) Family centered practice maintains meaningful records. Record keeping is important, but paperwork must be kept to a minimum. Necessary paperwork should capture meaningful information in as concise and efficient a method as possible. Records should not be aimed at meeting system needs, but rather at meeting family needs in the simplest, quickest manner possible. Front-line practitioners should seek informed consent by families to share useful information among helpers, minimizing the need for families to tell their personal stories over and over in order to receive needed help. All records about a family should be accessible to them (within the law), and helpers should maintain respect for the significance of recorded personal information (Tannen, 1996).

9) Family centered practice does not allow waiting lists. There are not always enough persons with the necessary skills to meet community demand for certain services (such as treatment for substance use and/or mental disorders), so helping agencies must develop flexible and creative ways to respond to expressed needs. Leaving someone with no help must be unacceptable to the community. Front-line practice must be adaptable, utilizing non-traditional supports and existing community resources to ensure that families expressing needs receive a helpful response from the community (Tannen, 1996).

10) Family centered practice requires that helping staff be treated in the same ways as staff are asked to treat those receiving their help. Helping agencies and systems must respect their front-line staff for their strengths and contributions, maintaining hope towards the fulfillment of the agency or system mission. System planning includes input from those who touch families directly, taking advantage of their knowledge and experience. Agency environments are thoughtfully maintained to be supportive and helpful to the helpers (Tannen, 1996).

11) Family centered practice includes meaningful evaluation activities. It is important that every member of every system and agency be involved in an ongoing process of evaluation. Staff at all levels of an organization must be encouraged to “do better today than we did yesterday, better tomorrow than we did today.” Maintaining a practice because it is how something has always been done leads only to decreasing impact. Training and ongoing supervision are provided to front-line staff in ways that encourage the development of necessary competencies. Systems expand approaches that demonstrate effectiveness and decrease activities that show poor or no results (Tannen, 1996).

12) Family centered practice ensures that services are accessible and responsive. Crisis driven services are least likely to have long-term benefit, and crises can be decreased by broad access to services and supports and by ensuring that services are responsive to the strengths and needs of the families being served. Services must be provided when they are needed, where they are needed, in the amounts needed (Tannen, 1996).

13) Family centered practice encourages and develops interagency collaboration. No one helper or helping system can meet all the needs of a community. Many families with one need have other needs as well. As you are assisting a family in one area of need you are likely to identify other needs and must respond in some way to those other needs. Therefore, front-line and supervisory staff need opportunities to learn about all community resources, and relationships between individuals and agencies must be deliberately promoted by system planners (Tannen, 1996).

Again, these principles reflect long-term goals in system development. But every act, every decision made by front-line staff can benefit from these principles, and families will be better served, family-by-family, day-by-day.

[Slide I-48] Understanding Family Culture

To shift to a related and important topic, culture must always be taken into account when determining whether an individual or family might need help for a substance use or mental disorder.

Culture has been defined as "the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people" (SAMHSA, 1994). Culture shapes how people see their world and structure their community and family life. A person's cultural affiliation often determines the person's values and attitudes about health issues, responses to messages, and even the use of alcohol, tobacco, and other drugs. A cultural group consciously or unconsciously shares identifiable values, norms, symbols, and ways of living that are repeated and transmitted from one generation to another (SAMHSA, 1994).

Race and ethnicity are often thought to be dominant elements of culture. But the definition of culture is actually broader than this. People often belong to one or more subgroups that affect the way they think and how they behave. Factors such as geographic location, lifestyle, and age are also important in shaping what people value and hold dear (SAMHSA, 1994).

Culture provides people with a design for living and for interpreting their environment. Personal culture is an important consideration for many reasons.

First, persons in some cultures will not talk about their internal thoughts and feelings with anyone at all, or perhaps only with close family. Asking direct questions about topics important to the child welfare worker may result in shame, offense, or a big smile that hides completely how that person feels about the question, none of which helps resolve difficulties that may exist. Care must be taken to show respect for cultural differences in all questions directed towards persons involved with the child welfare system.

Second, persons in some cultures may view what is widely accepted as mental illness as a spiritual experience and thus seek help only from a spiritual leader, if at all; persons in some cultures may view substance use as a tool of spirituality. These beliefs do not mean that a possible substance use or mental disorder should be ignored or downplayed, but they may mean that the person or family has no understanding of why we would want to “treat” these behaviors. A balance must be found between knowledge of the physical reality of substance use and mental disorders and respect for the culture of each individual and family involved with the child welfare system.

Third, persons in some cultures may be unwilling to ask for help from others, especially from strangers and/or professionals, but will accept help when it is offered in a way that is respectful to their beliefs.

[Slide I-49] Cultural Considerations

What is "cultural competence?" Cultural competence refers to a set of skills—both academic and interpersonal–that allow individuals to understand and appreciate cultural differences and similarities within, among, and between groups (SAMHSA, 1994). **[Note to trainer: you may need to repeat this]**

For our purposes, cultural competence also requires a willingness and ability to draw on the values, traditions, and customs of a community and to work with knowledgeable persons from the community as we develop interventions, communications, and other supports for that community (SAMHSA, 1994).

No training course in "Cultural Competence" can teach you a complete set of beliefs, traditions and values that apply to all the members of any specific group (like all people of color, or all Native Americans, or all people who speak Spanish). Culture lives at the family level, with older generations passing along their traditions, beliefs and values to younger generations.

Each family's beliefs, traditions and values are unique and child welfare professionals can only learn about them by asking questions, as respectfully as possible, and then using what is learned through the answers to those questions to help the family.

Child welfare workers must also learn to understand their own values and biases in order to successfully work in the context of other cultures. At the same time, there may be instances where a family's beliefs, traditions or values place someone's safety at risk (this could be a child or another person), and when that happens, safety is always the highest priority. In that case, it is possible that by intervening, by pointing out any dangers involved, families can and will chose to change their beliefs, traditions or values.

At the bottom line, each child welfare professional must strive to respect the beliefs, traditions and values held by the families you serve, as long as they do not compromise safety, even if there is conflict with your beliefs, traditions or values. Thoughtful supervision will also help you promote family involvement in all decision-making processes.

To learn more, you might want to review the following publications (the links are in your resource packet:

- *Potential Measures/Indicators of Cultural Competence*, a comprehensive matrix by the Health Resources and Services Administration (HRSA) containing cultural competence measures, indicators, and resources.
- *The National Clearinghouse for Alcohol and Drug Information Technical Assistance Bulletin: Following Specific Guidelines Will Help You Assess Cultural Competence in Program Design, Application, and Management.*
- *TAP 10: Rural Issues in Alcohol and Other Drug Abuse Treatment.* This TAP Contains descriptions of innovative programs that engage a variety of diverse populations.

140 – 160 minutes Facilitated Group Discussion 20 min.

Once questions have been addressed, move the whole group into a discussion about their knowledge about persons with substance use or mental disorders. Begin by asking, "Regardless of where you are in your career with child welfare, what have you learned about mental disorders? About substance use disorders?"

If additional questions are needed to stimulate discussion, you might ask any of the following questions:

- ***What training have you received in these areas?***
- ***What are the organizational attitudes demonstrated by managers, supervisors and co-workers about family members with these kinds of disorders?***
- ***What have you learned about these kinds of disorders from personal experience?***
- ***In what additional areas would you like training to better prepare you to assist families impacted by substance abuse and/or mental disorders?***

The GOAL of this discussion is to help participants recognize knowledge they have about substance use or mental disorders. We learn about such issues in many different ways, at different times, and it can be helpful to invite people to connect the content of this training with other knowledge they have acquired over time. Try not to let one participant dominate the discussion; draw in others whenever possible.

To bring final closure to this discussion, emphasize that successful child welfare professionals are proactive in seeking and mastering competencies that contribute to effective work. Encourage them to set personal goals for learning more about substance use and/or mental disorders.

160 – 170 minutes *Closing Discussion* 10 min.

Briefly review the areas that have been covered in this training session, focused on developing a better understanding of parents with substance use and/or mental disorders. Ask the group what new things they have learned in this session that they can take with them and apply to their work with families. Ask the group whether they have changed any personal attitudes as a result of this session. The GOAL of this brief discussion is to help participants think about what they will take away from the session. At the end, thank them all for participating. If they will be receiving more modules in this series, you might remind them of what comes next, and when.