

OVERVIEW

Goal—The goal of Module 4 is to provide strategies that child welfare professionals can use to engage individuals in a change process when they are suspected of having a substance use or mental disorder, or co-occurring disorders. The module will describe skills that child welfare professionals can use to engage individuals from diverse communities whom they suspect might have a substance use or mental disorder, or co-occurring disorders, including information on supporting their connection to assessment and treatment services, as needed, and culturally appropriate ways to get these individuals connected with professionals who can conduct comprehensive assessments. This module will provide an understanding of assessment for these issues, what information workers should expect to learn from the comprehensive assessment, and how to use the information in case plans.

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 and 40 minutes

Learning Objectives—After completing Module 4, child welfare professionals will have an understanding of the following topics:

- Readiness to change
- Motivational interviewing techniques
- Culturally appropriate methods for building rapport
- Models/strategies for engagement in family support
- Resources for family to family linkages and support
- Treatment Services interventions and supports
- Assessment of substance use disorders and how to use the information in case plans
 - What it entails
 - Information to be gained
 - Resources for obtaining assessment
- Assessment of mental disorders and how to use the information in case plans
 - What it entails
 - Information to be gained
 - Resources for obtaining assessment
- Assessment of co-occurring issues and how to use the information in case plans
 - What it entails
 - Information to be gained
 - Resources for obtaining assessment

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

Purpose is to give participants access to the space. Each will prepare differently, arrive at different times. Conduct registration and distribute materials. Trainers get ready.

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

[Slide IV-1] Module 4: Engagement and Intervention with Parents Affected by Substance Use Disorders, Mental Disorders, and Co-Occurring Disorders

Trainer introduces him or herself. Invite participants to briefly introduce themselves (name, unit, office location, years in the system, etc.). If this same group has been together for other modules in this series, you might ask instead how they used information learned in previous sessions. If group is smaller than 12-15 people, you 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 4. Language for this overview is provided below, right before Presentation 12. Emphasize that child welfare professionals often work with families where one or more adults are experiencing substance use and/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) Thank you for being here today. This training curriculum has been designed specifically for child welfare professionals, with relevant information and opportunities to practice skills that will be useful to your work. In particular, this Module is designed to educate you about engaging with parents or primary caregivers who may experience substance use or mental disorders – we will talk about how to support help seeking; how to direct parents towards assistance; how to understand the impact of their disorders and their treatment. We all know that many of the families whose children come into state custody and those we watch over are experiencing some effects from substance use and/or mental disorders, and those disorders are treatable. This curriculum is designed to help you better help their parents succeed in treatment.

Today's session will include several informational presentations and several opportunities to talk about this information 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 12

15 – 35 minutes

Presentation 12: Readiness to change; Stages of change; Relapse; Enhancing parents motivation

20 min.

Deliver scripted presentation describing parental disorders. Slides IV-1 through IV-14. 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. Only answer questions to which you know the answer.

The training in this module assumes a basic understanding of substance use disorders, mental disorders and co-occurring disorders. Throughout this module we will refer to parents with substance use disorders, to parents with mental disorders, and to parents who have co-occurring substance use and mental disorders. In some ways, these are arbitrary distinctions since many of the families you see will be dealing with varying levels and combinations of these disorders. Also, we keep learning more ways in which the biological basis of substance use and mental disorders are similar. Thus the responses to both may often be similar. Let's begin though with a brief review of our understanding of parents with substance use and/or mental disorders. To help illustrate the concepts discussed in this module, we are going to use the vignette for Module 4, which deals with Jackie, Kendrid, Elise and Ramey.

Please take a moment now to read the vignette.

[Note to Trainer: As an additional discussion, you can ask participants the following questions:

- ***What are some things you can identify in this family that look familiar to you?***
- ***In whom do you identify mental health and/or substance use issues? Which ones?***
- ***Which behaviors of Elise may be reactions to her mother's conditions?]***

[Slide IV-2] Understanding Parents with Substance Use and/or Mental Disorders

Just as it is important for us to understand the needs and experiences of parents with substance use and/or mental disorders, it is also important for us to understand what might have led to, encouraged, or supported the substance use.

Many parents have experienced significant trauma or violence in their lives, which may be one reason they are in the child welfare system to begin with. And many parents with a substance use disorder may have an undiagnosed mental disorder, such as depression. In fact, parents may use substances to cope with a myriad of life problems. And this can make it more difficult for them to be motivated to change.

For example, parents may use substances to self-medicate the pain of loss and destruction in their lives (e.g., experiences of domestic violence). They may also be medicating the pain or discomfort of untreated health problems, anxiety, or depression.

Parents also may be using substances to deal with anger and discouragement about their inability to make "normal" progress with their lives. Some parents use substances to punish

themselves for failure. Others use substances to try to escape from perceived negative aspects of their lives.

[Note to Trainer: As an additional discussion, you can ask participants, “Which of these things might be at play with Jackie’s substance use?”]

Parents with mental disorders are all in different places with their disorders. Some might not be aware that they have a disorder. Some will embrace the knowledge that their feelings have a treatable explanation, while others will deny having any disorder. Some may recognize that they are different, and perhaps even acknowledge a disorder, but will reject any offers of help; some may have other family members or friends telling them the same thing, and they may have erected barriers to discussion or exploration. Still others may try to avoid talking about the disorder, responding to questioning through the effects of their disorder, giving answers designed to have the professional go away as quickly as possible.

Understanding all of these possibilities, the child welfare professional needs to ask careful, respectful questions and to evaluate the situation based on knowledge and experience. It is also important, however, to recognize that many parents with a mental disorder do acknowledge their disorder, have sought and cooperated with treatment, and are now on a path of recovery. That is where we want parents with disorders to be, and support by a child welfare professional may be critical to their success in raising their children safely.

[Slide IV-3] Parental Readiness to Change

All of these factors impact a parent’s readiness to change. Child welfare professionals need to become competent in assessing parental readiness to change. However, there is no simple yardstick that measures this important state of readiness. Understanding a particular adult’s readiness to change requires understanding of a broader set of beliefs. What are these beliefs?

First, everyone has a past; everyone has regrets. Pasts and regrets can have a strong impact in the present and the future.

Other experiences can also impact parents’ desire to get help. For example, parents of children involved with child protection agencies today may have been involved with helping systems when they were children, while others may have needed help from helping agencies but did not receive it. These early experiences may strongly impact the ability and willingness of parents to accept help to change.

Families investigated by child welfare professionals are often facing poverty, which can also affect both the ability and willingness to change.

The place to explore first is the person’s awareness of their substance use or mental disorder. Do they deny it to you or to others? Do they acknowledge it and talk about its impact in their life or on their child’s life? Have they sought help on their own? A person with self-awareness about their disorder is already well down the path towards recovery. A person who is denying the presence of a disorder may need to experience natural life consequences before recognizing the disorder.

[Slide IV-4] The Stages of Change

Change, such as adopting healthy behaviors, is rarely a single, sudden event that occurs during a moment of transformation. More frequently, change is a process. It occurs gradually in stages or cycles, such as the following stages of change (Prochaska and DiClemente, 1982):

- Precontemplation—in this stage, a person has no awareness of having a problem or needing to change;
- Contemplation—this is the initial recognition that a problem exists;
- Preparation—preparation is the conscious decision to make changes in recognition of the need to change;
- Action—these are the initial steps to change;
- Maintenance—maintenance is working to sustain changes over time; and
- Relapse—which is a return to previous problem behavior for some period of time.

As we go through this part of the presentation, we will also discuss some things child welfare workers can do to support or help motivate parents in each stage of change.

[Slide IV-5] Six Stages of Change

Motivation to change and motivational interventions go hand in hand through the change process. It can be helpful to view change as a circular, multi-level process. As illustrated here, the stages of change can be understood as a wheel made up of wedges. Change often begins at the Precontemplation Stage and continues through Contemplation, Preparation, Action, and Maintenance Stages. Ideally, there is a final exit at the maintenance stage to enduring recovery. However, it may take some people longer than others to reach that final Maintenance Stage (Prochaska and DiClemente, 1982).

The change process is not static, with individuals typically moving back and forth between stages. Different people will move through the stages at different rates, but it is relatively uncommon for people to linger in the early stages, once issues have received visible attention.

As changes take place, it is also common for persons to fluctuate between stages. And motivation may change over time within each individual, both in its' source and strength. In fact, it is very common for persons in recovery from a substance use or mental disorder to have a "lapse," where the behaviors or symptoms recur for a period of time, threatening the person's recovery but not necessarily stopping it (Annis, 1990; Larimer, Palmer and Marlatt, 1999).

A key reason to use this model of change is because it helps parents with substance use or mental disorders see that lapses are part of a process to long-term recovery and safe, successful care of the family's children (Tims, Leukefeld and Platt, 2001).

If you become aware that a parent has lapsed, the most important action you can take is to help the person reconnect to treatment resources and supports and perhaps to change the existing treatment and supports to better assist the person's recovery. In short, if the plan isn't working, change it. It is not necessarily that the parent is "resistant" to change, but that more support is needed to identify motivating factors and appropriate services.

Child welfare workers may be able to assist parents in becoming open to positive change by recognizing where the parent is in the wheel of change and intervening appropriately

It is important here to note that one person can be in multiple stages of change about multiple issues. Providing assistance for the issue the client feels most ready to change, and

accomplishment of that change, provides further motivation and encouragement to tackle some of the more difficult problems (Brown, Melchior, Panter, Slaughter, and Huba, 2000).

[Slide IV-6] Lapse vs. Relapse

There is an important difference between “*lapse*” and “*relapse*” (Annis, 1990; Larimer, Palmer and Marlatt, 1999). A *lapse* may include a temporary return to substance use or return of symptoms of the mental disorder, after which the parent returns to treatment or re-engages in the recovery process and does not return to the pattern of behaviors that led to such detrimental consequences. Many parents in child welfare lapse and when child safety has not been compromised, the lapse can be used as a critical intervention point in the parent’s longer-term recovery.

A *relapse*, on the other hand, is characterized by an ongoing pattern of continued substance use or symptoms of the mental disorder, despite negative consequences. Recovery remains possible for persons in relapse, and relapse is not uncommon, but recovery is challenging for persons experiencing a relapse, their families, and involved treatment professionals

[Slide IV-7] Relapse – 1

For the substance use disorder treatment provider, *relapse* can also be seen as one step toward recovery and can be an integral part of the treatment process. In reality, parents may need to work their way toward increasing periods of sobriety despite experiencing relapses.

Mental health treatment professionals recognize that “chronic and persistent” mental disorders may reappear in regular or in unpredictable patterns, reflecting the interaction between the person’s capabilities and the environment. Symptoms simply may persist in some form. Again, the key is reconnecting the person to appropriate treatment and support resources, or supporting the existing connections.

[Slide IV-8] Relapse – 2

On the other hand, for the child welfare professional, *relapse* or the presence of a “chronic and persistent” mental disorder may present a serious risk to the parent’s ability to have children remain safely in the home. Relapse may mean the parents have not yet demonstrated that they are reliable enough to care for their children and that they may not meet the court deadlines for doing so. Child welfare professionals are rightly concerned that children may not be safe when being cared for by parents who are abusing substances.

Still, relapse in people with substance use and/or mental disorders is common and should be prepared for, as much as possible. But remember, although a relapse plan can mitigate concerns for their children, it may not completely alleviate them.

When a parent does relapse, you may want to have some understanding of what led to it in order to know the next course of action. A discussion with the parent about what was happening at the time and what stress factors were present can provide some information on how to support the parent in the future.

[Slide IV-9] Relapse – 3

One thing that child welfare, substance use disorder treatment and mental disorder treatment professionals have in common is that they work with parents who are likely to experience guilt when they relapse because they have not yet demonstrated the ability to care for their children safely. They may have taken steps forward in treatment and in planning for relapse, but they

may also have taken steps backward in reunification. These conflicting messages can confuse and discourage parents who are trying to get their lives together by participating in treatment.

[Note to Trainer: Please refer to Module 6, Presentation 20 for more information on how a safety plan can address the possibility of a parent's relapse, and what components the safety plan might include.]

In addition to guilt, many parents who relapse – and other family members – can experience depression, anxiety, helplessness, distrust, and self-blame. Child welfare workers should be alerted to such effects and prepared to provide support. Relapse can be an opportunity to intervene and re-assess treatment and recovery needs. The child welfare worker can assist the process by working with the parent(s) and other treatment professionals to create a safety plan that addresses the possibility of relapse. Doing so may prevent or limit problem escalation.

[Slide IV-10] The Change Process - 1

Again, change is a process that has multiple stages (Prochaska and DiClemente, 1982). Remember, people often begin at the Precontemplation Stage and work through the remaining Stages (Contemplation, Preparation, Action, and Maintenance), with a final exit at the Maintenance Stage to enduring recovery.

It is really important that parents in the child welfare system are motivated to engage in and maintain treatment because requirements of Federal and State statutes do not allow much time to be lost in relapse before decisions are made about the permanent care of abused and/or neglected children.

Child welfare professionals can help motivate clients to move from one stage of recovery to the next. Although the primary responsibility for motivating parents in treatment rests with the treatment program, child welfare professionals can really help parents maintain the motivation to meet the court's timetables so that they have the best possible chance of regaining custody of their children. Often, during the Precontemplation and Contemplation Stages, the child welfare worker is the primary motivator, especially if the parent has not yet begun to participate in treatment

[Slide IV-11] The Change Process – 2

Because motivation is a cyclical process that changes over time, and people move back and forth among different stages, it is important to help parents:

- Understand where they are in the stages of change,
- Discover what will help them move to the next stage, and
- Understand that they may move back and forth between stages and that this is normal.

There are specific things that you can do to enhance a parent's motivation to begin and maintain treatment and recovery efforts. And you can intervene with parents during any of the six stages of change to motivate them to:

- Continue to work toward the requirements of the dependency court,
- Maintain the safety and well-being of their children, and
- Develop the parenting skills they will need to retain or regain custody of their children.

The child welfare worker, substance abuse or mental health treatment professional, or other significant people in the life of a parent can support their motivation to change. The key is to use

a nonconfrontational and nonjudgmental approach that supports the parent and relationship building. Many of the skills of Motivational Interviewing are based on the social work practices of expressing empathy and using reflective listening strategies (Miller and Rollnick, 1991), which you may already be familiar with.

[Note to Trainer: As an additional discussion, you can ask participants, “At what stage of change do Jackie and Kendrid appear to be with respect to the dynamics in their own lives? Which aspects do they appear to me most ready to change? Which aspects are they least motivated to change?”]

[Slide IV-12] Enhancing Parents' Motivation

How can you motivate parents to look for and get engaged in appropriate treatment? First, you can encourage parents to seek treatment. Once a screening suggests that a substance use and/or mental disorder might exist and an assessment confirms a diagnosis, child welfare workers have a key responsibility to motivate parents to seek treatment and help them find the most appropriate treatment options.

Child welfare workers can use motivational enhancement strategies to encourage parents' willingness and commitment to engage in treatment. Motivational enhancement strategies emphasize parents' ability to voice personal goals and values in ways that elicit their own motivation to change, and to make choices among options for change (CSAT, 2006). Collaborative work with attorneys and courts can also help in motivating parents.

Next, you can encourage parents to stay in treatment. As treatment begins, in coordination with treatment counselors, child welfare workers can use motivational enhancement strategies to encourage parents to stay in treatment, respond appropriately to relapse, and sustain recovery. One thing you can do is help parents understand the consequences of not meeting the requirements of the dependency court and providing assurance that their children are safe and in good care.

[Note to Trainer: As an additional discussion, you can ask participants, “Where is the ambivalence in Jackie and in Kendrid? How can you tell?”]

[Slide IV-13] Motivational Tasks

I'd like to ask you to refer to the Handout called *Motivational Tasks for Child Welfare Workers*. This handout describes the stages of change and identifies motivational tasks for the child welfare worker to address with the parent (SAMHSA, 2004).

In the Precontemplation Stage, the parent has no perception of having a problem or a need to change. So, what can the child welfare worker do? At this stage, you can increase the parent's perception of the risks and problems with their current behavior and raise awareness about their behaviors. Here, generalized discussions about risks to children caused by a parent's behavior can help move the process along.

[Notes to Trainer: As an additional discussion, you can ask participants, “How might you do this with Jackie?”]

In the Contemplation Stage, the parent first recognizes that their behavior may be a problem but feels ambivalent about change. At this stage, the child welfare worker can help the parent

identify reasons to change and the risks of not changing, and help parents see that change is possible and achievable.

The interventions for the remaining stages of change are relatively straightforward for caseworkers. In the Decision to Change Stage, the parent makes a conscious determination to change and has identified some motivation for change. The child welfare worker can help the parent identify the best actions to take and support their motivations for change.

In the Action Stage, the parent takes steps to change. The child welfare worker can help the parent implement their strategies and support the steps they take, particularly by linking them to community treatment professionals.

In the Maintenance Stage, the parent is actively working on sustaining change strategies and maintaining long-term change. The child welfare worker can help the parent to identify triggers and use planned strategies to prevent relapse.

During the Lapse or Relapse stage, the parent slips, or lapses, from their plan to change or returns to previous problem behavior patterns in the form of a relapse. The child welfare worker's job is then to help the parent re-engage in the Contemplation, Decision, and Action Stages.

In all of these areas, the child welfare professional should work in partnership and collaboration with the substance abuse or mental health treatment professional. For specific strategies that can be applied in each stage, please refer to the *Additional Resource: Motivational Strategies*.

[Note to trainer: If time allows, the Additional Resource: Motivational Strategies could be used as an exercise. The trainer could ask participants to suggest motivational strategies child welfare workers might use to achieve the motivational tasks within each of the stages of change. Use the handout to round out the discussion and compare the strategies participants suggested against the strategies.]

[Slide IV-14] Motivational Enhancement Tools: FRAMES

Let's look for a moment at a specific approach to supporting a parent's motivation to get treatment. This is called Motivational Enhancement Tools: FRAMES. It is based on the stages of change and describes brief and simple motivational enhancement interventions that can be easily incorporated into child welfare services (Miller, 1995). These interventions are called the FRAMES strategies, which stands for Feedback, Responsibility, Advise, Menu, Empathy, and Self-Efficacy.

- F is for Feedback, which means providing feedback to parents regarding their impairment or risk behavior.
- R is for Responsibility, which means presenting information and choices so that parents understand they are responsible for their change.
- A is for Advise, which means the child welfare worker provides guidance on how the parent can progress through the change process.
- M is for Menu, which means offering parents a menu of treatment and self-help alternatives.
- E is for Empathetic, which means ensuring that the child welfare worker uses an empathetic and nonblaming style when interacting with parents.
- S is for Self-Efficacy, which means the child welfare worker facilitates the self-efficacy or positive empowerment of parents.

Once questions have been addressed, move the whole group into a discussion about their own motivations. Lead the discussion by asking the group:

- **To think about the last time they tried to change a habit.**
- **To raise their hands if they ever tried to quit smoking, tried to eat healthier, tried to go to the gym or exercise more often.**
- **To share experiences of success and failure in those endeavors.**
- **What factors assisted or supported you when you attempted to establish new habits and what factors made that new habit difficult?**
- **To consider whether they know people who continue to smoke despite knowledge of the health effects, or if they know people with diabetes or high cholesterol who do not change their eating and exercising habits despite knowledge of the health effects.**
- **To consider whether and how the ease or difficulty of beginning might be affected if they are beginning something new and it is really important to their health or otherwise.**

Next, ask the group to now consider a person (such as Jackie) who is suffering from physical dependence on drugs or alcohol, or someone who has a co-occurring substance use and mental disorder. Given what we know about the brain chemistry of substance use disorders and the effects of co-occurring disorders, how would that impact a parent’s ability to change behavior. Ask the group:

- **“How might you use the FRAMES concepts with Jackie?”**

To stimulate further discussion, you might ask any of the following questions:

- **What do you imagine it is like for a caregiver to seek or enter treatment for their own problems, when acknowledging their problems might make it more difficult for them to keep or regain their children?**
- **What supports might be needed to make receiving care more possible, more successful?**

The GOAL of this discussion is to help participants recognize that motivation is a reflection of complex and sometimes overwhelming internal factors. Try not to let one participant dominate the discussion; draw in others to the discussion.

To bring closure to this discussion, emphasize that one important role of child welfare professionals is to help motivate parents to address their own needs so that they can more safely and effectively raise their children.

PRESENTATION 13

55 – 75 minutes

Presentation 13: Motivational interviewing techniques; Strategies for family engagement in services; Building rapport; Resources and supports for families **20 min.**

Deliver scripted presentation on motivational techniques and engagement strategies. Slides IV-15 through IV-26. This presentation describes a variety of approaches to motivating parents to engage in services that will help them address substance use and/or mental disorders. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on. Keep answers brief. Only answer questions to which you know the answer.

[Slide IV-15] Engaging Parents in Treatment: A Continuous Practice

In this presentation, we are going to discuss models and strategies for engaging family support and how to connect families with helpers who are appropriate to their needs.

Engaging parents and families in treatment is a continuous process for child welfare workers. It includes screening parents for potential substance use or mental disorders, motivating parents to engage in and remain in treatment, and helping parents to sustain recovery.

Child welfare workers do not need to wait for substance abuse treatment or mental health treatment to occur first, before other interventions can occur. In the past, the parent was often sent for treatment first, under the assumption that the parent returns for the next step in the child welfare process when they are "cured." Federal legislation (ASFA) for child welfare and child abuse and neglect, and the tightened time requirements for changes by families involved in the child welfare system, means that all interventions need to happen concurrently, and all need to be embedded in child welfare case planning. In persons with co-occurring disorders, it may be appropriate to develop an integrated treatment approach to address parental needs comprehensively.

Child welfare professionals must remain involved with the parent throughout the treatment and recovery process, promoting reunification as long as reunification remains the appropriate goal. Child welfare professionals, along with substance abuse and mental health treatment professionals and the dependency courts, have important roles and responsibilities and make important decisions during each stage of this process. When child welfare workers understand what brings parents into treatment and the ongoing process of engaging parents in treatment, they are better able to help parents meet dependency court timetables and ensure ongoing child safety and well-being.

[Slide IV-16] Family Engagement Wraparound - 1

One emerging "best practice" for engaging families and connecting them with appropriate services from the field of mental health care is referred to as the "wraparound" approach (New Freedom Commission on Mental Health, 2003). As the name implies, in this approach everything done on a person or family's behalf is "wrapped around" them – it is organized and coherent; it is comprehensive; it is responsive to their strengths and needs; and it is carefully designed to be of maximum benefit to them.

The strategies for family engagement on this slide are adapted from a training course in wraparound techniques used across service systems in a particular metropolitan area (Wisconsin Department of Health and Family Services & Bureau of Community Mental Health, 2001).

The wraparound approach is also a team approach and brings together all persons and entities that may be able to understand and respond to the needs of the child and family. It also works with the family, as defined by the child and parent(s) or legal guardians. In other words, family may include a wide range of people besides parents and siblings. With parental permission and as far as you are able, you should engage these family members in the helping process. And work with the child and the family from the beginning, and throughout any crisis, assessment, service or support involvement.

The job of the team is to respond to the needs of the family and to help them establish goals that should lead to a better quality of life for the child and family on their own terms. This means first doing a careful assessment. Appropriate assessment includes input from anyone who may have useful information about a child or family, and it includes family advocacy when available. It should consider information about the child and family from multiple sources and settings, historic care information, family experience and tradition, and resources available – before moving to service planning decisions.

[Slide IV-17]. Family Engagement Wraparound - 2

And what kind of services and supports are needed? The easy answer: tailor all of your interventions to the child/family needs, resources and wishes! You also want to keep the child with his/her family, whenever that is safe and possible, and in the home community, if at all possible. It is also important to integrate formal and clinical services with informal, neighborhood-based supports; all of these are important to the success of each child and family.

[Slide IV-18] Family Engagement Wraparound - 3

In addition to planning for services, a wraparound strategy also recognizes that crises will arise and that families need a plan for how they will address them. As you develop a crisis plan, be sure that the support is readily accessible and effective. This may be the tool that keeps a family together. So all service plans for families should include a crisis plan, prepared to help manage predictable events.

A couple of other principles of the wraparound approach:

- All team members are accountable to one another – including the children and parents – for their actions.
- Child- and family-serving systems are most effective when they actively collaborate with one another to meet the needs of children and their families, engaging with each other on behalf of the community and in support of the most effective use of public (taxpayer-supported) funds.
- A management structure to handle feedback, analysis, and reporting, is necessary to evaluate the impact of the team, the services and the supports on the lives of community members.

[Note to Trainer: As an additional discussion, you can take 20 minutes to discuss with participants “How might you arrange for wraparound services for Jackie’s family?”]

- If you want to learn more, you can visit the Milwaukee County Behavioral Health Division website for a description of Wraparound Milwaukee. The link is provided on your resource list.

[Slide IV-19] Engaging Parents in Treatment Models/Strategies – 1

When parents in the child welfare system are in treatment, you need to work closely with the treatment professionals who are providing care to them. This can ensure that the children remain safe and that parents are able to meet the requirements of the dependency court, while still achieving their treatment and recovery goals.

What does this mean? Because many needs and issues may arise during the treatment process, child welfare workers need to be aware of any needs that are identified in treatment and to ensure that referrals are being made and parents are participating in services. For example, parents are likely to need assistance:

- To identify personal and family issues related to their substance use and/or mental disorders where they need help and
- To access and follow up referrals made by child welfare professionals and/or treatment professionals.

[Note to Trainer: Refer to Module 5, Presentations 16 and 17 for more information on communication responsibilities between the child welfare and treatment agencies regarding safety planning, case planning, and treatment progress, including what each can expect from the other]

[Slide IV-20] Engaging Parents in Treatment Models/Strategies – 1

One strategy that has been shown to be effective in drug abuse treatment, called motivational enhancement, can also be very useful in working with parents. This strategy is based on sessions with parents to provide supportive feedback designed to strengthen their commitment to change.

How can child welfare professionals use motivational enhancement approaches to help parents obtain needed services? Here are just a few ways:

- Work with the parent and children to identify additional needs.
- Continue to develop rapport and build trust with parents.
- Recognize and affirm positive behaviors, however small or isolated.
- Ensure continued, frequent, and safe visitation between parents and children. Visitation is vital for both children and parents, and every effort needs to be made to encourage and support positive visitation experiences between children and parents. Dependency courts usually take into serious consideration the extent to which parents make the effort to visit their children, and a lack of visitation could harm a parent's movement toward reunification. It is important that visitation is not presented as a "reward" for "good behavior" by parents, or used as a punishment tool against parents.

One motivational interviewing technique that you can employ is the use of open-ended versus closed questions. Closed questions tend to elicit "yes" or "no" responses. Open-ended questions tend to elicit more detailed responses that can illuminate what stage of change the parent is in and the parent's perspective. Asking closed questions, or attempting to lecture, teach or confront parents can promote further or intensified resistance to change.

[Optional Role-Play Session to practice asking open-ended questions:

- **Ask for a volunteer to help demonstrate using open-ended questions.**

- Demonstrate using open-ended questions by asking the volunteer about how he or she got into the counseling field, his or her last vacation, or another topic.
- After several minutes of demonstrating, ask participants whether they have any observations or questions.

The Trainer or a volunteer then plays the role of Jackie, and the other participants practice asking Jackie open-ended questions about her substance use and mental health status, for example: “Tell me what concerns you about your drug use?”]

[Note to Trainer: Learning to ask open-ended questions is a critical component for child welfare professionals in both developing rapport and opening dialogue with a parent in from an unbiased perspective. If you would like to offer a more detailed training on motivational see the Center for Substance Abuse Treatment publication, Enhancing Motivation for Change Inservice Training, DHHS Publication No. (SMA) 06-4190. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006. This publication is available online at <http://download.ncadi.samhsa.gov/Prevline/pdfs/SMA06-4190.pdf>]

[Slide IV-21] Engaging Fathers

Engaging parents is a critical task for child welfare professionals and fostering healthy relationships between fathers and their children is integral to the family’s recovery from substance use or mental disorders. You can support these relationships through outreach, screening and referral to assessment and treatment, casework, and engaging fathers in permanency planning.

You can also use what you now understand about key issues regarding substance use treatment for the fathers. Be sure you know how to help fathers obtain appropriate treatment that will support optimal outcomes for children and families.

In addition to motivational strategies with both parents, fathers often need specific interventions to foster their engagement in the child welfare services and treatment for their substance use disorders.

- It is critical to debunk the attitude fathers may have that "the mother (alone) will deal with the children."
- It is important to establish that the father needs to take responsibility for his own recovery on behalf of his children.
- It is essential to portray recovery as a process separate from the child welfare case. Stress that recovery does not automatically result in reunification; however, reunification will not occur without recovery. Reunification is a byproduct of recovery, rather than the sole impetus. ***[Note to trainer: This is an important point to emphasize. If time allows, this may be an opportunity to generate discussion about recovery as a goal independent of the child welfare case.]***
- Regardless of a mother's case plan or her attempts to reunify, the father who has not lost permanent custody still has responsibilities towards the children.

[Slide IV-22] Engaging Fathers - 2

Here are a few other special considerations for working with fathers:

- First, if both parents have substance use or mental disorders, each parent needs his or her own gender-specific counselor, and they should be in separate treatment programs.

- In fact, fathers-only groups and activities can provide opportunities to create social support networks that can be very helpful to the fathers.
- You need to emphasize that the father should not use the mother as the focus of co-dependency or as a sole support system. Rather, the father needs to use his own support system.
- It is critical for fathers to have opportunities to continue reaching out to professionals and other supports, regardless of life circumstances. One outreach strategy is to meet with fathers in their homes or other places in the community and assuring access for those who are hesitant to enter into treatment.

[Note to Trainer: As an additional discussion, you can ask participants, “How might you use these concepts in working with Kendrid?”]

[Slide IV-23] Building Trust - 1

The most important thing a child welfare professional can do may be building a relationship of trust and mutual respect where the worker supports and encourages the parent to receive needed treatment. There is no “right” way to build such a relationship, except to be accessible, to listen, and to demonstrate that you care about their personal and family well-being.

Child welfare professionals can try the following activities to help parents accomplish needed tasks and also to earn the trust of parents and families. This list contains some activities that you may already do to help clients—and maybe some new ones as well:

- Identify community resources that can help parents with various types of issues and problems. Include details about access, types of services, requirements for participation, costs, availability, location, transportation, and childcare.
- Refer parents to services and help them make contact, obtain transportation and childcare assistance, and follow up to learn whether they contacted the organization, received the service, and whether they were helped.
- Develop a safety plan for children with the parents, if needed.

[Slide IV-24] Building Trust - 2

And here are some more ideas:

- Keep all appointments you make with parents and update them promptly on any changes in your schedule. Return all phone calls and follow through by providing any promised resources.
- Inform the parents of procedures to communicate with treatment professionals. Let them know when you communicate with other treatment professionals and review the content of those conversations and plans.
- Have joint meetings with the parent, substance use and/or mental disorder treatment professional and child welfare professional to discuss goals and plans together.

A word about culturally appropriate methods for building rapport. When you are working with parents to help them seek and/or accept needed treatment, cultural considerations may, again, be very important. As described in Module 1, culture includes a person’s or family’s *beliefs, traditions* and *values* – simply put, things that are important to them (SAMHSA, 1994). When a helper engages with a person or family, all efforts must be made to demonstrate respect for them, even though some people and some circumstances may test the helper’s ability to do that. It is helpful to ask simple questions to help to identify these beliefs, traditions and values, and then it is helpful to use those as topics to connect positively with them.

When adults or families come to an office to meet with a worker, they are entering an environment quite different from their home. Likewise, when helpers enter someone's home, they are entering an environment that may be unfamiliar. In both instances, child welfare professionals should take the lead in educating/guiding and in learning about the things that are important to the family. Investing time to engage respectfully with a family during initial contacts will pay dividends over time in service outcomes and cost-effectiveness

[Note to Trainer: As an additional discussion, you can ask participants “How would you approach this with Jackie and Kendrid? How do you handle home visits so that these are respectful and minimally intrusive?”]

[Slide IV-25] Family Advocacy–Peer Support 1

There are many family advocacy resources, at the national, state, and local levels, with some focused specifically on substance use and/or mental health issues. The resources in each state are somewhat different, but there are some common advocacy groups focused on substance use and/or mental disorders that focus on children, adults, or families, with state and, in some cases, local chapters.

A very important group in caring about persons with alcohol disorders is Alcoholics Anonymous (AA). AA is an organization of peer-organized, peer-led groups at the community level that bring together people who have recognized their own addiction and want to give or receive support in their sobriety using a well-known Twelve-Step methodology. AA groups are local, managed by people in the organization primarily on a volunteer basis. To learn about AA groups in your community, all you have to do is to look in the phone book under “Alcoholics Anonymous.” When you call, you can learn about times and places of meetings. You can also visit their website at <http://www.alcoholics-anonymous.org>. Similarly, Narcotics Anonymous (NA) uses a peer-led approach to connect and help people with substance use disorders other than alcohol. You can also visit their website at <http://www.na.org>.

Related to Alcoholics Anonymous is a group for family and friends who care about people with alcohol disorders that follows the same philosophy; it is called Al-Anon. Like AA, Al-Anon is peer-organized and peer-led, but it is dedicated to supporting people who are coping with alcoholism in loved ones. Again, a call to the “Alcoholics Anonymous” number will provide information about local Al-Anon meetings.

Yet another related group is Al-Ateen, which offers support groups and other activities for offspring of persons with alcohol-related disorders, helping them cope and giving them support. Child welfare professionals involved with children whose parents have alcohol disorders may provide an important service to those children by introducing them to local Al-Ateen groups. Again, you can get information about local groups by calling your local number for “Alcoholics Anonymous.”

Faces & Voices of Recovery is a group that works to support, mobilize and organize advocates who are working in the field of substance abuse. Their goals are to:

- develop and implement public policies that support recovery from addiction to alcohol and other drugs;
- break down barriers that hinder access to recovery;
- change public attitudes to prioritize addiction recovery; and
- show the public and policymakers that recovery is happening for millions of Americans and their families in communities across America.

[Note to Trainer: You can use the websites to find your local AA, NA, Al-Anon and Al-Ateen groups and their respective schedules. Use this information to create a handout for participants.]

[Slide IV-26] Family Advocacy—Peer Support – 2

The organizations on this slide advocate for those with mental health disorders.

The National Alliance of the Mentally Ill (NAMI) has state chapters in every state and local chapters in many communities. Its mission is the eradication of mental illness and the improvement of the quality of life of all whose lives are affected by these diseases. NAMI provides programs and services across the country for people whose lives have been affected by serious mental illness.

- *State and Local NAMIs*—NAMI's 1,200 affiliate organizations provide local services, support and other opportunities for consumers and their families.
- *Education, Training and Peer Support Center*—NAMI offers education and training programs and services for consumers, family members, providers and the general public. These include Family-to-Family, Peer-to-Peer, NAMI Support Group, In Our Own Voice and more.
- *Consumer Support*—NAMI empowers and educates mental health consumers to address issues around care, treatment, services, mutual support and consumer rights.
- *Child and Adolescent Action Center*—NAMI created the Child & Adolescent Action Center to focus attention on systems reform and to help and support families.
- *NAMI on Campus*—NAMI on Campus is a network of student-led mental health awareness, education, and advocacy groups tailored to the needs of individual college communities.
- *Multicultural Action Center*—NAMI's MAC Center works to raise awareness and remove barriers to mental illness services for members of racial and ethnic minorities.
- *NAMI Legal Center*—The NAMI Legal Center provides lawyer referrals as a service to its members and the general public.
- *Veterans Resource Center*—NAMI provides the resources for veterans and active duty military members, as well as their families, friends, and advocates.
- *Missing Persons Support*—Resources and support for locating missing persons with mental illness.
- *For Providers*—To help mental health professionals assist consumers and families further, NAMI has created this section of the NAMI Web site especially for you.
- *Information Helpline*—Trained volunteers provide information, referrals, and support to all who have questions about or are affected by serious mental illness. Call 1-800-950-NAMI.

Mental Health America (or MHA, but formerly known as the National Mental Health Association) has state chapters in every state and local chapters in many communities. MHA's programs help it to fulfill its mission of "promoting mental health, preventing mental disorders and achieving victory over mental illness through advocacy, education, research and services." The program goals are to educate the public, encourage reform and promote the use of effective local and regional prevention and recovery programs. Some of the programs that MHA sponsors include:

- Campaign for America's Mental Health programs and activities
- Mental Health America's Annual Meeting
- Mental Health America's Advocacy Programs

- Mental Health America's Prevention and Recovery Programs

MHA also offers information and resources to respond to frequently asked questions by consumers and providers like:

- How do I find mental health therapy services/treatment?
- How do I find a support group in my community?
- How can I get more information about medications?
- How can I get help paying for my prescriptions?
- How do I find inpatient or residential treatment?
- How can I find out about clinical trials?
- What can I do if I'm dissatisfied with my mental health therapy services/treatment?

The National Federation of Families for Children's Mental Health (FFCMH) has state chapters in almost every state and local chapters in many communities. Its primary mission is to provide and sustain leadership for a nationwide network of family-run organizations, including advocacy for children and families who experience mental illness/emotional disturbance/psychiatric illness.

At the local level, your community may offer any in a broad range of organizations that provide family support groups and other activities designed to bring families and caregivers together to support and help each other. The organizations listed on this slide offer many groups and activities like this across communities. Many states also have omnibus advocacy organizations uniquely implemented within each state. Most states have legal rights organizations intended to protect the rights of persons with various disabilities and other special needs – either type of organization could be a good resource. You need to learn about all of these groups in your community and share that knowledge with parents, peers, and supervisors.

[Note to Trainer: You can use the websites to find your State and local chapters, as well as their respective services. Use this information to create a handout for participants.]

75 – 95 minutes Facilitated Group Discussion 20 min.

Depending on the time available and the way the conversation develops, use one or both of the following discussions during this time.

DISCUSSION 1: Begin the discussion by asking, "The change process is unique for each person affected by substance abuse and/or mental disorders. What is your threshold for acceptable progress toward change to you as a person? What is your threshold for acceptable progress toward change to you as a child welfare professional?"

To stimulate discussion, you might ask any of the following questions:

- ***When a caregiver is confronted with the child safety consequences of their substance abuse or mental disorder and does not immediately agree to change, how do you feel?***
- ***When a caregiver indicates an eager desire to change, how do you feel?***
- ***What basis do you use to decide how much you trust the caregiver's expression of a desire to change problematic behaviors, whether they are reluctant or eager?***

The GOAL of this discussion is to help participants think about their own reactions to an individual's motivation to change while listening to others share their reactions. Try not to let one participant dominate the discussion; draw in others to the discussion.

DISCUSSION 2: What is your experience, personal or professional, with relapses? How are you affected by that experience?"

To stimulate group discussion, you might ask the following:

- **Persons with substance abuse disorders may be successful in abstaining for a short or long period of time, and then may relapse. Persons with mental disorders may manage their disorder without difficult symptoms for a short or long period of time, and then re-experience their symptoms. How does that unpredictability affect you?**
- **When they relapse, how do you relate to them?**
- **How do you trust them?**

The GOAL of this discussion is to help participants better understand their own attitudes about persons who appear to backslide in their recovery process, possibly preparing them to set those attitudes aside and be more helpful to certain parents during and after relapse. Try not to let one participant dominate the discussion; draw in others to the discussion

To bring closure to this discussion, mention that relapse is often a part of a forward recovery process for many persons with substance use and/or mental disorders and does not automatically mean they have "failed" in their recovery. Emphasize that ASFA timelines put a lot of pressure on parents to change quickly, making their motivation to change a key factor in their recovery and reunification with their children (if that is a case goal). Child welfare professionals can effectively help parents find and sustain motivation to change.

95 – 110 minutes Break 15 min.

PRESENTATION 14

110 – 135 minutes Presentation 14: Screening and assessment of disorders; case planning 25 min.

Deliver scripted presentation on screening and assessment of substance use and/or mental disorders and using such information in case planning. Slides IV-27 through IV-51. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on. Keep answers brief. Only answer questions to which you know the answer.

[Slide IV-27] Screening Substance Use Disorders: Screening and Assessment

In this presentation we're going to look separately at screening and assessment of substance use disorders and of mental disorders. We're separating them out here because the screening and assessment processes are not exactly the same for these two types of disorders.

We will begin with substance use disorders and point out that screening and assessment both collect different information and serve different purposes. Substance abuse *screenings* are done with brief, rapidly administered tools, while *assessments* are comprehensive processes designed to identify critical areas to be addressed in a parent's treatment plan. Child welfare professionals frequently conduct screenings. Assessments for substance use disorders should be conducted by qualified substance abuse treatment professionals

[Slide IV-28] Screening: The Role of Child Welfare Professionals

Child welfare professionals play a very important role when they screen for substance use disorders in parents. When a report of child abuse or neglect is investigated, emergency response workers or investigators are generally the first helpers to see the parents. These child welfare professionals may have the best opportunity and the primary responsibility to conduct the initial screening of parents for potential substance use disorders. If you are in this position, you may observe overt signs and symptoms as part of the initial screening and assessment for child abuse and neglect.

Screening can also be performed by other agencies that may be working with parents, such as mental health, maternal and child health, or criminal justice system agencies. Substance abuse treatment agencies do not usually conduct screenings, although some agencies have collaborative partnerships with other agencies that do conduct them.

When a screening indicates a potential substance use disorder, you or another child welfare professional should refer the parent to a substance use disorder treatment provider for further assessment. At that time the substance use treatment provider may provide a referral to the most appropriate treatment or assessment program.

[Note to Trainer: Check your Child Welfare Agency handbook or manual regarding the specific protocols and procedures used in your agency.]

[Slide IV-29] Who Needs To Be Screened?

Who needs to be screened? Substance use screenings tend to be viewed in two main ways. In one approach, child welfare professionals try to determine which parents might have a problem with substance use and conduct the screening for those parents they have identified to determine if their hunch is true. Alternatively, child welfare professionals can assume that everyone involved with child maltreatment may be at high risk for substance-related problems and therefore screen everyone, and then rule out individuals who do not appear to be at risk for substance use problems. Evidence demonstrates that the second approach should be followed.

And in fact, child welfare professionals are encouraged to err on the side of screening anyone who raises questions about possible substance use problems, identifying those who may be at risk and ruling out those not at risk. Although caseworkers should follow agency protocols, all individuals may be subject to screening for potential substance use disorders.

Remember -- a substance use disorder screening only determines the risk or probability that a parent has a substance use disorder and whether more in-depth assessment by treatment professionals is needed. It is not a diagnosis.

[Slide IV-30] Effective Screening Tools

Screening is a combination of observation, interviews, and the use of a standardized set of questions, such as those you will find in screening tools available to child welfare professionals. Child welfare workers routinely carry out screening and assessment for child maltreatment, involving interviews, observations, and document reviews. In fact, your agency may already have a specific tool in use. As part of the assessment for child maltreatment, a screening tool for substance use disorders can be added.

In general, an effective screening tool has the following characteristics (Brown, Leonard, Saunders and Papasoulotis, 1997; DeHart and Hoffmann, 1995, 1997; Ewing, 1984):

1. It is easy to administer. – For example, it can be memorized and administered orally without reference to a written form; it can be administered separately or worked into other screening checklists or tools, as appropriate; and it contains no more than four to six questions.
2. It is capable of detecting a problem. – This means that it contains key questions best known to indicate that a substance use disorder exists, such as the following:
 - Questions that address unintended use and/or desire to restrict use (control of use/abuse): "Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?" "Can you stop drinking without a struggle after one or two drinks?"
 - Questions about some form of consequences of use or concerns about such consequences (consequences of use/abuse): "Have people annoyed you by criticizing your drinking or drug use?" "Have you ever felt bad or guilty about your drinking?" "Have you ever lost a job because of drinking or drug use?"
3. It is inexpensive and does not require much time to administer. – Or much paperwork to record.
4. It is fast and simple. – It can be completed quickly without need of explanations and directions to respond.
5. It is designed for use with a broad range of individuals. Includes those with all types of substance use disorders, across diverse populations. Some screening tools focus only on alcohol and may not be appropriate for screening for other substance use disorders.

[Slide IV-31] Screening Questions: UNCOPE

One example of a screening tool is the UNCOPE (Hoffmann, Hunt, Rhodes and Riley, 2003). UNCOPE consists of six questions:

- U – Have you continued to use alcohol or drugs longer than you intended?
- N – Have you ever neglected some of your usual responsibilities because of alcohol or drug use?
- C – Have you ever wanted to cut down or stop using alcohol or drugs bur couldn't?
- O – Has your family, a friend or anyone else ever told you they objected to your alcohol or drug use?
- P – Have you ever found yourself preoccupied with wanted to use alcohol or drugs?
- E – Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger or boredom?

Scoring is simple – *Two or more* positive responses indicate possible abuse or dependence and a need for further assessment

[Slide IV-32] Conducting the Screening

It is important to note that the accuracy of the information you obtain from this process is determined largely by the way in which you handle the screening instrument itself. If it is another

piece of paper in a packet that the parent must fill out, it is unlikely that the information obtained will be helpful. If the screening is conducted as a separate process and introduced to the parent with a thorough explanation of what it is and how the information will be used, it is more likely to be answered to the best of the parent's ability.

Listening and reflecting are a critical piece of this process as well. You might need to ask clarifying questions that can lead a parent to a new understanding of the connections between different life events and beliefs about their own capabilities. For many people, this may be the first time they have articulated some of these ideas out loud. In this way, the screening can be an intervention in and of itself, helping a person move from pre-contemplation to contemplation to action.

In opening the dialogue with a parent about their substance use, a child welfare professional can also take a brief substance use history. For each of the major substances (i.e., alcohol, cocaine, marijuana, heroin, other opiates, amphetamines, other stimulants, hallucinogens, tranquilizers, sedatives, and inhalants), the child welfare worker can ask when the parent first used each substance, for how long, how frequently, and what the positive and negative effects were. You want to ask open-ended questions to elicit the parent's point of view.

[Note to Trainer: If time permits, ask participants to engage in a role-play exercise to practice taking a brief substance use history. The Trainer or a volunteer can play the roll of Jackie, and participants can practice asking her open-ended questions. Participants can also pair up and take turns playing the role of Jackie and asking questions.]

[Slide IV-33] Screening Results

The screening is not an end in itself. You should combine the results you get from screening tool with other observations and interviews about substance use to determine the impact on the safety of children. More specifically, you are assessing the extent to which:

- The children are in a life-threatening living situation that may be caused by parents who abuse substances and leave their children unattended or uncared for.
- The child is viewed very negatively by the parent, particularly when the child's emotional or physical needs interfere with the parent's search for or use of substances.
- The family cannot meet the basic needs of the child because financial resources are being used to purchase substances.
- The parent or someone living in the home exhibits harmful behavior toward a child, particularly when they are under the influence of substances.

[Slide IV-34] Assessment Process

The purpose of an assessment is to determine the nature and extent of issues that affect the functioning of the individual parent and to come up with a treatment plan. Trained mental disorder treatment professionals conduct mental health assessments, and trained substance use treatment professionals conduct substance use assessments. You should become familiar with the professionals in your community who are qualified to conduct assessments.

Substance abuse treatment and mental disorder treatment professionals typically will not address the relationship between the substance use or mental disorder and the ability of the parent to provide appropriate care to their children. It is important to ask a referral question when you make a referral or an assessment. Otherwise, the assessment may not yield the kind of information that will be important for case planning. For example, most substance use disorder assessments will result in a diagnosis of use, abuse or dependence, and will recommend an appropriate level of care.

[Slide IV-35] Changing Needs and Treatment

Screening and assessment are often ongoing processes. Parents' treatment and level of care are based on their treatment needs, which drive the treatment process. Since treatment needs change over time, assessment and treatment planning are ongoing processes.

[Slide IV-36] Assessment for Substance-Related Disorders

Once a screening – along with other assessments – indicates that there might be a substance use problem, the child welfare worker needs to refer parents to a substance use disorder treatment professional for a complete assessment, which can lead to treatment recommendations, if appropriate.

Substance use assessments are generally a combination of individualized interviews and formal instruments. The substance use assessment interview includes questions that reflect criteria for substance-related disorders, as defined by the Diagnostic and Statistics Manual of Mental Disorders-4th Edition (DSM-IV; American Psychiatric Association [APA], 2000). The treatment professional may also conduct assessments for co-occurring disorders, if applicable, and for treatment planning and placement. These comprehensive assessments are designed to determine current treatment needs and level of care.

- To learn more, review the National Institute on Alcohol Abuse and Alcoholism (NIAAA) report, *Alcohol Problems in Intimate Relationships: Identification and Intervention—A Guide for Marriage and Family Therapists*. The link is provided on your resource list.

[Slide IV-37] Developing Case Plans - 1

There are three main pieces of information a child welfare worker can expect from the substance use disorder treatment provider as a result of an assessment, which will be helpful to know when developing case plans:

1. Whether the parent met diagnostic criteria for substance abuse or dependence
2. Recommendations for the level of care
3. Treatment plan for comprehensive services

Developing effective case plans that address underlying problems can help child welfare professionals assess the safety and well-being of children throughout the life of the case. It can also help motivate parents to enter and continue treatment.

[Slide IV-38] Developing Case Plans - 2

Child welfare professionals already know the importance of establishing an initial relationship with parents that demonstrates an interest in and concern about their well-being. They also know how to use social work competencies, such as documentation, observation, and interviews, to determine what has happened to the parents and children and to establish a case plan.

Child welfare workers can use these techniques with parents and children to explore issues relevant to substance use disorders, focusing especially on the parents' feelings about safety and their experiences with trauma. Some child welfare agencies may already have specific protocols and procedures in place, which can then be expanded to incorporate some of these issues, as appropriate.

[Slide IV-39] Mental Health Assessment

Now let's talk for a few minutes about the ways in which mental health assessments can be conducted, what you can expect, and how to use that information in case planning.

A mental health assessment, by a qualified mental health professional, means that an individual's mental, emotional and behavioral processes are compared to the criteria listed for various recognized disturbances in the Diagnostic and Statistics Manual of Mental Disorders, 4th Edition (DSM-IV; APA, 2000), which I mentioned earlier. This book and the criteria it presents were developed and are constantly reviewed by psychiatrists and other mental health professionals to keep pace with new knowledge.

If the professional determines that an individual's mental, emotional or behavioral processes match the criteria listed in the DSM-IV, then they are given a diagnosis (or more than one). A diagnosis includes a name label (e.g., "depression") and a number (e.g., 314.03), referencing the DSM-IV's organizational system, now also used extensively for billing processes.

It is very important to be aware that determining a mental health diagnosis is not an exact science, and there continue to be variations in how different qualified professionals apply the criteria in the DSM-IV. Some individuals can go to three different professionals and receive three (or more) different diagnoses.

In more practical terms, an assessment is used to determine whether an individual's mental or emotional state or their behavioral are causing difficulties for them or for others around them. It is very possible that a parent could be found not to have a diagnosable mental disorder, even though they may present risk to their children for other reasons. Or a parent may be diagnosed with a disorder that does not put any additional risk on their children.

When a professional conducts a mental health assessment they will ask questions that are much like those asked when taking a social history, asking about past and current thoughts, moods and emotions. Very specific questions related to the criteria for specific mental illnesses will also be asked, and the professional has been trained to interpret answers to those questions in the context of diagnostic criteria.

[Slide IV-40] MH Assessment Outcomes

The outcome of a mental health assessment can include a number of things.

- A diagnostic label, along with a number code that coincides with the DSM-IV's system for coding such labels.
- Multiple diagnostic labels, suggesting the person meets the criteria for more than one mental illness, which is very possible.
- Recommendations for treatment, based on the type of mental disorder that has been identified and any other factors that were identified during the assessment.
- Recommendations for further assessment. There are often questions about whether a biological basis for a mental disorder can be identified, and that may require further testing and/or assessment by a professional with more specialized skills and tools (such as a neurologist). Certain professionals can also have expertise in particular diagnoses, and a specialized assessment may help focus a more effective course of treatment.
- Recommendations for other service agencies (such as child protection or justice systems) about how they can respond most effectively to the person's mental disorder.

[Slide IV-41] Reactions to MH Assessments

Professionals working in other helping systems often have one of two common reactions to mental health assessment reports:

- 1) Some don't feel as if they have enough information to understand the person and what he or she needs, or how they can be helpful.
- 2) Others feel that there is too much jargon—too much specialized terminology and unfamiliar acronyms.

If you get a report like this, you should know that it is always appropriate to request additional or clarifying information, and you may or may not receive helpful information in return. If you are still unclear, you need to find additional information through other resources. You can consult professionals, managers, or the internet. And when using the internet try to make use of sources connected to national professional organizations, such as the American Psychiatric Association, the American Psychological Association, the National Mental Health Association, etc.

[Slide IV-42] Child Welfare Case Planning

When a mental health assessment leads to a diagnosis (or multiple diagnoses) and recommendations for treatment, a child welfare case plan should include whatever actions might be needed to help that individual get the recommended treatment, hopefully within their community and in a timely manner by a professional qualified to respond to their needs. This might include a wide menu of supportive actions.

A child welfare professional may be able to address social, economic, motivational, or other needs that would help the person accept and receive the recommended treatment, while child safety is monitored. If parents show motivation to become better able to care for their children, try to take advantage of that motivation – it can be very powerful.

[Slide IV-43] NASMHPD/NASADAD Co-Occurring Substance Abuse Disorder and Mental Disorder Conceptual Framework

Now we need to look at what happens when a parent is suspected or found to have both substance use and mental disorders, called “co-occurring” disorders. Most simply, this term recognizes that some persons have complex needs, including multiple serious needs, such as having mental and substance use disorders at the same time.

On this slide is the Co-Occurring Substance Abuse Disorder and Mental Disorder Conceptual Framework developed by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). As you may recall from Module 1, this framework is not for the purpose of classifying or diagnosing individuals, but it can be used as a way to help you think 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 for 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.

Within the behavioral health field (which includes treatment for substance use disorders and for mental disorders) there are differences in belief about the frequency with which serious co-occurring disorders occur. Generally speaking, mental disorder treatment professionals believe there is a fairly high rate of co-occurrence, while substance use disorder treatment professionals believe the rate is fairly low.

Mental health professionals generally believe that many individuals with mental illnesses may use alcohol/drugs (legal and/or illegal) to “self-medicate”, which simply means that the person

feels better when taking a certain drug (or drugs, including alcohol). Substance use treatment professionals emphasize the importance of viewing substance use disorders as a problem independent of any mental disorders and therefore in need of independent treatment. Unquestionably, when a parent is experiencing both a substance use disorder and a mental disorder, treatment is going to be more complicated than when they are experiencing one or the other.

For the parents in Quadrant IV, the mental health and substance abuse treatment fields will bear more of the responsibility for their treatment and care. For the quadrant IV parents, child welfare professionals should be included on the team to ensure that the safety, permanence and well-being of the child(ren) are considered.

However, the parents you are working with are more likely to be in Quadrants I, II or III. Unfortunately, because their disorders are less severe, there may be less service coordination, and often fewer services are available overall. You will likely be more involved in identifying services and linking parents to those services because in most communities the system does not often exist to provide those linkages across systems. It is particularly important when you are working with a parent in Quadrant I to obtain consultation from treatment professionals so that a plan for addressing the disorder is included in your case planning and monitoring. For parents in Quadrants II or III more direct collaboration with treatment professionals in planning and service delivery will increase the success of the child welfare plan.

[Slide IV-44] Assessment of Co-Occurring Disorders

Co-occurring disorders can be assessed in one of three ways. The least common way is a joint assessment of a substance use and mental disorder by one professional who is qualified to make such assessments. This is less frequent because many systems are not organized in a way that provides assessment for both at the same time. However, some communities have made efforts toward bridging that gap and providing a team approach toward assessment, service delivery, and care management.

The second way is an assessment of a substance use disorder by a substance abuse treatment professional, with a referral and subsequent assessment for a mental disorder from a mental health professional. The third way is an assessment of a mental disorder by a mental health professional, with a referral and subsequent assessment for a substance use disorder by a substance abuse treatment professional. In these cases, substance abuse and mental health treatment professionals would conduct their respective assessment process and provide the resulting information as discussed above.

So a mental health assessment may or may not include an assessment of drug use, and a substance use assessment may or may not include an assessment of mental health.

Ask the treatment providers in your community how they are certified, and what their training and licensure enables them to do. In addition to not being cross-trained, treatment professionals do not always actively look for co-occurring disorders. Thus, you can't assume that receiving an assessment for one disorder automatically rules out the existence of the other. Also remember that treatment professionals are often observing parents in the clinic setting, whereas a child welfare professional is visiting the family in their home environment. Trust your clinical instincts. If you suspect a co-occurring disorder, you should advocate for appropriate assessments.

[Note to Trainer: As an additional discussion, you can ask participants, "How would you go about assessing Jackie's treatment needs?"]

[Slide IV-45] Co-Occurring Disorders and Case Planning

Case planning that takes co-occurring disorders into consideration needs to include information provided from the assessments, such as the diagnoses, level of care and any treatment plans. There could be more than one plan if separate agencies are providing the substance abuse and mental health treatment. As mentioned earlier, a child welfare professional's role may be to address social, economic, motivational, or other issues that might hinder or enable the person to accept and receive the recommended treatment, while child safety is monitored.

Because there are two somewhat separate professional fields (substance abuse and mental health), an individual with co-occurring disorders may receive conflicting recommendations from professionals in both fields, making recovery and effective case planning more difficult. In such circumstances, child welfare professionals are encouraged to plan a meeting of all involved professionals to share information, coordinate care, and educate each other. Teams that come together regularly in partnership with the person receiving services and others who care about them can be a powerful way of developing support for an individual's recovery from the most complex disorders.

Current research suggests that the most effective treatment for an individual with co-occurring disorders will address all disorders, using a coordinated, consultative and/or integrated approach, depending on the severity of the combination of the substance use and mental disorders (CSAT, 2005). It is possible to recover from these challenging co-occurring disorders and become functional in ways that support families and contribute to the community. But this recovery will depend, in part, on support from the community, and ongoing supports may be needed on a recurring or continuous basis.

[Slide IV-46] Issues to Explore With Children

Children of parents with substance use disorders may have specific risk factors that should be included in child welfare's assessment of the family's strengths and needs. Risks to children can stem from both prenatal substance exposure and post-natal environments.

Assessment and intervention with children are addressed in Module 6; however, during initial screening processes in child welfare, some special situations for children need specific screening. Two specific issues discussed here are Fetal Alcohol Syndrome (FAS) and Alcohol-Related Neurodevelopmental Disorder (ARND).

[Slide IV-47] Fetal Alcohol Syndrome (FAS)

Fetal Alcohol Syndrome (FAS) is characterized by a pattern of neurological, behavioral, and cognitive deficits that affect growth, learning and socialization, across these four major components (Bertrand, Floyd, Weber, O'Connor, Riley, Johnson, Cohen, National Task Force on FAS/FAE, 2004):

- 1) A characteristic pattern of facial abnormalities, including small eye openings, indistinct or flat philtrum (which is the midline groove in the upper lip that runs from the top of the lip to the nose), and a thin upper lip;
- 2) Growth deficiencies, including low birth weight;
- 3) Brain damage, including a small skull at birth, structural defects, and neurological signs, such as impaired fine motor skills, poor eye-hand coordination, and tremors; and,
- 4) Maternal alcohol use during pregnancy.

[Slide IV-48] Fetal Alcohol Spectrum Disorder (FASD)

The term Fetal Alcohol Spectrum Disorder (FASD) is used to describe individuals with FAS as well as those with behavioral, cognitive, and other deficiencies who do not have the physical facial abnormalities of individuals with FAS (Bertrand et al, 2004).

FASD is not a clinical diagnostic term but refers to FAS, Alcohol-Related Birth Defects, and Alcohol-Related Neurodevelopmental Disorder (ARND).

[Slide IV-49] Alcohol-Related Neurodevelopmental Disorder (ARND)

Many of the deficiencies seen in individuals with ARND are similar to those seen in those who have been exposed to other substances, Studies have shown that prenatal substance exposure can have multiple consequences, including:

- Physical Health Consequences
- Lack of Secure Attachment
- Psychopathology
- Behavioral Problems
- Poor Social Relations/Skills
- Deficits in Motor Skills
- Cognition and Learning Disabilities

The deficits or delays exhibited by children who have been substance exposed may be noticed at different times in a child's development. For example many of the physical health issues are likely to be noticed in an infant, while cognitive and learning disabilities are more likely to become apparent in school-aged children.

There is no consensus on how short-term effects may translate into long-term consequences for those who have had this type of exposure. Because a child exhibits negative effects as a newborn does not predict that he or she will suffer long-term dysfunction. Outcomes for children will depend upon a variety of dynamics including the child's postnatal environment and continuing exposure to other risk factors.

[Note to Trainer: As an additional discussion, you can ask participants “Do you see any of these characteristics in Jackie’s daughters?”]

[Slide IV-50] Involvement of Fathers - 1

Fostering healthy relationships between parents and children can be so important to the recovery from addiction and to the development of parenting skills. Both parents—mothers and fathers—should be involved in the lives of their children, as long as the children remain safe and protected. Likewise, although the parent in treatment is most often the mother and there may be reluctance to involve the fathers because of perceived safety concerns, both parents should be involved with services provided through the child welfare and treatment systems.

In fact, child welfare professionals are usually directed by courts and attorneys to seek and involve absent parents, especially fathers. There has been a great deal of emphasis on this recently through the Child and Family Service Review. Inattention to the father's needs may disrupt progress that the mother may be making. Services for fathers need to include:

- Gender-specific services;
- Outreach strategies for fathers who do not initially respond to opportunities to participate in the lives of their children;
- Screening for substance use disorders and, when appropriate, referral for further assessment and treatment;

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, remind them of what comes next, and when.