

National Center on
Substance Abuse
and Child Welfare

Module 3:

Understanding Co-Occurring Substance Use Disorders,
Mental Health/Trauma, and Domestic Violence

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Introduction

The National Center on Substance Abuse and Child Welfare (NCSACW) developed the Child Welfare Training Toolkit to educate child welfare workers about substance use and co-occurring disorders among families involved in the child welfare system. The training is intended to provide foundational knowledge to help child welfare workers:

1. Understand substance use and co-occurring disorders.
2. Identify when substance use is a factor in a child welfare case.
3. Learn strategies for engaging parents and families in services.
4. Understand potential effects for the parent, children, and caregivers.
5. Learn the importance of collaboration within a system of care. Through a deeper understanding of these topics, child welfare workers can apply knowledge gained to their casework and improve their own practice.

The Training Toolkit consists of 10 modules—7 core and 3 special topics training modules:

Module 1: Understanding the Multiple Needs of Families Involved with the Child Welfare System

Module 2: Understanding Substance Use Disorders, Treatment, and Recovery

Module 3: Understanding Co-Occurring Substance Use Disorders, Mental Health/Trauma, and Domestic Violence

Module 4: Engagement and Intervention with Parents Affected by Substance Use Disorders and Mental Health/Trauma

Module 5: Case Planning, Family Strengthening, and Planning for Safety for Families with a Substance Use Disorder

Module 6: Understanding the Needs of Children of Parents with Substance Use or Co-Occurring Disorders

Module 7: Collaborating to Serve Parents with Substance Use Disorders

Special Topic: Considerations for Families in the Child Welfare System Affected by Methamphetamine

Special Topic: Considerations for Families in the Child Welfare System Affected by Opioids

Special Topic: Understanding Prenatal Substance Exposure and Child Welfare Implications

The entire Training Toolkit can be delivered in a series, or each module can be delivered individually as a stand-alone training. Each module is approximately 2 hours in length and contains a range of materials that can be adapted to meet the needs of child welfare trainers for in-person workshops or more formal training sessions. This flexibility allows the facilitator to determine the best format and timing for the training, according to the needs of the agency and staff. The special topics, in particular, lend themselves to brown-bag or lunchtime trainings.

Each module includes a Facilitator's Guide with training goals and learning objectives, a PowerPoint presentation, resources, and references. The PowerPoint presentation contains talking points and key details in the notes section of the slides. These talking points are not intended to serve as a script to read aloud to attendees, but rather as key points to highlight while presenting. Facilitators are encouraged to infuse their own content knowledge, expertise, and real-world experience to bring the training to life. NCSACW integrated discussion questions and experiential activities throughout the training sessions.

The Facilitator's Guide includes a list of resources where facilitators and participants can find additional information on related topics. Facilitators can customize content to include state or local child welfare practice information and terminology where appropriate.

NCSACW provides a free online tutorial, [*Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals*](#), which is a self-guided online training that complements the content of this Training Toolkit. Toolkit facilitators may encourage the training participants to complete the online tutorial to augment their knowledge. The online tutorial is approved for 4.5 Continuing Education Units.

Intended Audience

The Training Toolkit contains information considered foundational for child welfare practice. The content is general enough for all child welfare workers, but it should be tailored to the audience's experience and role in child welfare practice (such as investigations, in-home services, or ongoing case management) to enrich the learning opportunity.

Facilitator Qualifications

Facilitators should be knowledgeable about substance use disorders, mental health, and child welfare systems. They should be familiar with the laws and policies that affect child welfare agency decision-making to ensure that the information is presented in the proper context. If the facilitator does not have specific knowledge in substance use disorders or mental health, he or she should partner with local substance use and mental health treatment agencies for support.

Terminology

Field-specific terms are used during the course of this training. To understand the purpose and intended meanings of these terms, please review the Trainer Glossary at <https://ncsacw.samhsa.gov/training/toolkit>. This glossary is also a useful resource for training participants.

Module 3 Description and Objectives

The goal of Training Module 3 is to provide in-depth information and learning opportunities to support child welfare workers in working with diverse families affected by mental health disorders, co-occurring disorders, trauma, and domestic violence. It presents signs and symptoms of co-occurring and mental health disorders and includes domestic violence terminology. The module also includes an overview of treatment modalities within a culturally competent, family-centered framework.

After completing this training, child welfare workers will:

- Identify the spectrum and types of mental health disorders.
- Recognize signs and symptoms of co-occurring and mental health disorders.
- Explain the effect of trauma on co-occurring disorders.
- Recognize domestic violence in the child welfare population.
- Recognize the effects of co-occurring and mental health disorders on interpersonal relationships and parenting.
- Engage with families to identify co-occurring and mental health disorders.
- Understand treatment effectiveness and recovery from co-occurring disorders.

Training Tips

- ✓ Use the *** **bolded** discussion questions integrated in the module talking points to enrich the training.
- ✓ Partner with a local mental health and domestic violence service provider to co-facilitate the training.
- ✓ Share or incorporate agency policy and procedures.
- ✓ Provide a list of local resources.
- ✓ Highlight child welfare programs with expertise in serving families affected by mental health disorders and domestic violence, or programs that provide family-centered treatment.
- ✓ Contact the National Center on Substance Abuse and Child Welfare for more information about using the Collaborative Values Inventory in your community.

Materials

- ✓ Computer and projector
- ✓ Speakers
- ✓ Internet access
- ✓ PowerPoint slides
- ✓ Facilitator's Guide
- ✓ Flip chart paper or white board (for use as a visual aid during discussion)

PowerPoint Presentation and Talking Points

Slide 1

Module 3: Understanding Co-Occurring Substance Use Disorders, Mental Health/Trauma, and Domestic Violence


Child Welfare Training Toolkit



National Center on
Substance Abuse
and Child Welfare



Slide 2

Acknowledgment



**National Center on
Substance Abuse
and Child Welfare**

*A program of the Substance Abuse and Mental Health Services Administration (SAMHSA)
and the Administration for Children and Families (ACF), Children's Bureau*



www.ncsacw.samhsa.gov | ncsacw@cffutures.org

This toolkit was developed by the National Center on Substance Abuse and Child Welfare (NCSACW), an initiative of the U.S. Department of Health and Human Services jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families (ACYF), Children's Bureau's Office on Child Abuse and Neglect (OCAN).

Slide 3

Learning Objectives


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- Engage with families to identify co-occurring and mental health disorders
- Understand treatment effectiveness and recovery from co-occurring disorders

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Slide 4

Collaborative Values Inventory



- A parent with co-occurring mental health issues must first receive mental health treatment before substance use disorder treatment can work
- Parents with substance use disorders often fail to complete treatment because they face real barriers such as poverty, mental illness, family violence, or transportation challenges
- The stigma associated with addiction prevents parents from seeking treatment

(Children and Family Futures, 2017)

Differences in values among participants are important to recognize because they may come up in the training and with the families participants are working with. These questions can be asked at the beginning of this training to help understand the different values and perspectives participants bring to the training. Have a brief discussion with participants on how their individual values can affect their work with families.

*****Review the slide questions from the *Collaborative Values Inventory (CVI)*, a validated tool that assesses how much a group shares beliefs and values that underlie its work. Participants can share their experiences or keep their answers private. Discussion should be limited to understanding value clarification, instead of debating individual answers to questions. Participants will fall along a continuum. How might personal values and beliefs affect working with families affected by a co-occurring or mental health disorder?**

Slide 5



Mental Health
Disorders

Slide 6

Mental Health

- Many terms may be used, such as "mental illness," "mental health problems," or "behavioral disorders"
- Each disorder is different in each person
- There is no "have it" or "don't have it"
- Mental health is a continuum or spectrum
- Mental health disorders vary from person to person and from time to time

We know that many of the families involved in child welfare are affected by mental health disorders. The information in this module will enable you to help families with these conditions succeed in treatment. The module covers basic information about the spectrum and types of mental health disorders, their co-occurrence with substance use disorders, and the effects of trauma in adults.

In this training module, we use the term "mental health disorder" to describe a variety of mental and emotional difficulties. You may hear other terms, such as "mental illness," "mental health problems," or "behavioral health disorders." These terms refer to the same types of difficulties.

Mental health disorders take many forms, and the same disorder can express itself differently in different individuals. Mental health disorders are not something people "have" or "don't have"—mental health is a continuum, with mental health disorders at one end. It's better if we think of mental health disorders as existing on a spectrum or along a range: some disorders are more debilitating than others, and disorders can be more debilitating at certain times. Many people with substance use disorders also have co-occurring mental health disorders, and vice versa.

Effects of Mental Health Disorders

- Thought processes, moods, and emotions are affected by mental health disorders
- Mental health disorders are biologically based
- Effects on an individual's life are important to consider
- Disorders can vary in severity, and their severity may change over time
- Cause is less important than current severity
- Violence is not associated with all disorders

(National Institutes of Health, 2007)

There are many different mental health disorders that can affect adults and their ability to be good parents to their children. The most common element among many mental health disorders is that the thought processes, moods, or emotions are different in persons with mental health disorders compared to many other people—sometimes extremely different.

In the past 25 years, the field of brain science has learned that almost all mental health disorders have a significant biological basis, with marked differences in how the brain and the entire central nervous system function. In particular, specific neurotransmitters—which are the chemicals that carry messages from one brain or nerve cell to another—get out of balance and cause changes in thought, mood, and/or emotion. Because substance use disorders also involve the brain, co-occurring mental health and substance use disorders can be challenging to experience, respond to, diagnose, and treat.

Generally, persons with an emerging mental health disorder become less effective in living their lives (often described as "less functional"), but that lack of effectiveness can be different for different people and might show up as employment problems, health concerns, failed or fractured relationships, or poor emotional self-regulation (e.g., outbursts, unpredictable reactions, explosive anger, or even a totally flat affect in situations meriting a reaction). Any disorder may vary in severity, and within one individual the severity may change over time.

The important thing to remember is that the cause of a disorder (which could be biological inheritance, early trauma, or just learned behaviors) is less relevant than the current effect of the disorder on people's ability to live their lives, or to function. If minor children depend on adults with a mental health disorder to take care of them, the children may or may not experience inconsistency and difficulty.

Many people in our society hold fear about the potential for violence from persons with mental health disorders. When you watch the news and witness visible, violent acts, you might later learn that the perpetrator of those acts had a mental health disorder. The entertainment industry perpetuates the idea that people are dangerous because they have a mental health disorder. Violent acts are possible, but most persons with mental health disorders do not present a greater-than-normal risk of violence. That being said, child welfare workers should always take safety into consideration, just as when visiting any family home.

Types of Mental Health Disorders

- Schizophrenia spectrum and other psychotic disorders
- Bipolar disorder and related disorders
- Depressive disorders
- Anxiety disorders
- Obsessive-compulsive and related disorders
- Trauma- and stressor-related disorders
- Dissociative disorders
- Somatic symptom and related disorders

(American Psychiatric Association, 2013)

This slide covers some of the most common mental health disorders for adults. For further information on other mental health disorders, please reference the DSM-5.

Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

Bipolar and related disorders are separated from the depressive disorders in DSM-5 and placed between the chapters on schizophrenia spectrum and other psychotic disorders and depressive disorders in recognition of their place as a bridge between the two diagnostic classes in terms of symptomatology, family history, and genetics. A person with a bipolar disorder may experience challenges with their mood (mood swings, sadness, elevated mood, anxiety, anger), behavior (irritability, risk taking behaviors, agitation, crying), cognition (unwanted thoughts, delusion, lack of concentration, racing thoughts), psychological (depression, manic episode), and sleep (difficulties falling asleep or excess sleepiness).

Depressive disorders include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. The common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. What differs among them are issues of duration, timing, or presumed etiology.

Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. *Fear* is the emotional response to real or perceived imminent threat, whereas *anxiety* is anticipation of future threat. *Panic attacks* feature prominently within the anxiety disorders as a particular type of fear response. Panic attacks are not limited to anxiety disorders but rather can be seen in other mental health disorders as well.

Obsessive-compulsive and related disorders include obsessive-compulsive disorder (OCD), body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related

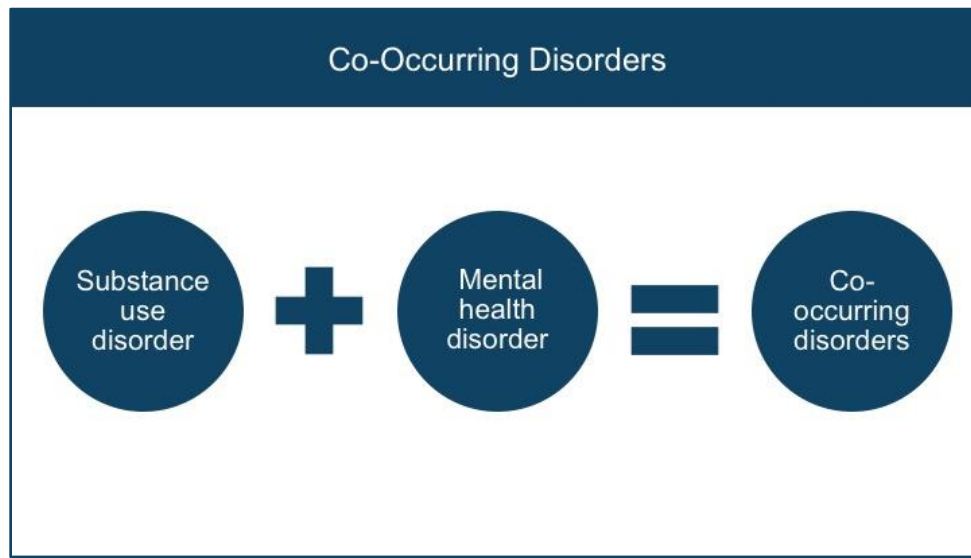
disorder, obsessive-compulsive and related disorder due to another medical condition, and other specified obsessive-compulsive and related disorder and unspecified obsessive-compulsive and related disorder (e.g., body-focused repetitive behavior disorder, obsessional jealousy).

Trauma- and stressor-related disorders include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. These include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders.

Dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior. Dissociative symptoms can potentially disrupt every area of psychological functioning. These disorders include dissociative identity disorder, dissociative amnesia, depersonalization/derealization disorder, other specified dissociative disorder, and unspecified dissociative disorder.

Somatic symptom disorder and other disorders with prominent somatic symptoms constitute a new category in DSM-5 called *somatic symptom and related disorders*. All of these disorders share a common feature: the prominence of somatic symptoms associated with significant distress and impairment. Individuals with disorders with prominent somatic symptoms are commonly encountered in primary care and other medical settings but are less commonly encountered in psychiatric and other mental health disorder treatment settings.

Slide 9



When a person has an existing substance use disorder and mental health disorder, it is called a co-occurring disorder (sometimes referred to as dual diagnosis).

Slide 10



Many individuals with mental health disorders and co-occurring disorders have also experienced trauma. Understanding the role of trauma in families' lives can help families receive appropriate treatment and recovery services.

Effect of Trauma

- Adverse Childhood Experiences (ACE) score
- Trauma increases risk for mental health and substance use disorders
- Parents learn to parent from their parents
- Childhood trauma affects parenting
- Child abuse sometimes crosses generations

(Center for Substance Abuse Treatment, 2000)

There are a number of things you need to consider when you are working with parents involved with the child welfare system. One thing to keep in mind is that adults who experienced physical, sexual, or emotional abuse, or fear of abuse through childhood, are at increased risk for experiencing mental health and substance use disorders. While these disorders do not define who they are, they may substantially influence who they are.

When a person grows up with exposure to traumatic events (for example, as a victim of child abuse or child maltreatment), their life and future parenting skills are likely to be affected in some way. A parent who has been abused by their own parents sometimes grows up to treat their own children the same way they were treated. In fact, child abuse is often cyclical, repeating itself through family generations. On the other hand, although people raised with abuse may continue that abuse in their own parenting, growing up with abuse does not automatically mean that a person will abuse their children. Part of our work is to help parents heal from their own trauma so they can break the cycle of abuse. Building individual resilience is an ongoing process.

To learn more, read *Chapter 3—Comprehensive Treatment for Adult Survivors of Child Abuse and Neglect* from the Center for Substance Abuse Treatment (From: *Substance abuse treatment for persons with child abuse and neglect issues*, Treatment Improvement Protocol [TIP] Series, No. 36. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000.) The link is provided on your resource list for this module.

Trauma and Families


- Parents with substance use disorders often have a history of trauma, with 60% to 90% of treatment participants having experienced one or more traumatic events
- Early traumatic events, such as exposure to family violence and physical abuse, can lead to a greater risk of developing posttraumatic stress disorder, which has been shown to significantly increase the likelihood of a substance use disorder among older youth in foster care
- Families affected by substance use disorders who are involved in the child welfare system need a system of care that recognizes the effect of trauma on their functioning and recovery
- Evidence-based trauma services should be provided within the context of an organizational culture that avoids triggering or unintentionally re-traumatizing both parents and children
- In a trauma-informed organization, every part of the organization—from management to service delivery—has an understanding of how trauma affects the life of an individual seeking services

(Center for Substance Abuse Treatment, 2000; Dube et al., 2002; Felitti et al., 1998; Greeson et al., 2011)

Failure to understand and address trauma may lead to a lack of engagement in services, increase in symptoms, re-traumatization, increase in relapse, withdrawal from the service relationship, and poor treatment outcomes for families. Growing up in a home with exposure to adverse, traumatic childhood experiences is associated with lifelong physical, emotional, psychological, and social challenges.

Effects of Trauma

- Attachment and relationships
- Physical health: body and brain
- Emotional responses
- Dissociation
- Behavior
- Cognition: thinking and learning
- Self-concept and future orientation
- Economic impact



(Levenson, 2017; Substance Abuse and Mental Health Services Administration, 2014)

Trauma can affect all aspects of a person, from their own behavior and responses to the relationships they have with others.


SAMHSA has its own concept of trauma: "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, and thinking; to regulate behavior; or to control the expression of emotions. Individuals may not make the connection between their thoughts and behaviors and their trauma.

Importance of Trauma-Informed Care

Failure to identify and address trauma may lead to:

- Withdrawal from services
- Inadequate or inappropriate services
- Re-traumatization
- Increase in relapse events
- Increase in management problems
- Poor treatment outcomes



Before assuming a client is being "non-compliant," think trauma first

(Levenson, 2017)

When families are not being "compliant" with our services, we need to think about trauma and how that is being addressed.

Does your agency use providers who are trauma-informed?

Slide 15

Importance of Trauma-Informed Care

- High prevalence of trauma, substance use, and mental health disorders in families involved with child welfare
- Traumatic events shatter trust; the experiences that a client has from the moment he or she arrives will affect his or her ability to engage in the healing process
- Need to maximize safety and reduce possible re-traumatization of clients
- Trauma-informed services improve retention in services and improve outcomes

(Levenson, 2017)

Trauma-informed care is critical for successful outcomes.

Six Principles of Trauma-Informed Care

- 1. Safety**—Ensure the physical and emotional safety of clients and staff
- 2. Trustworthiness and Transparency**—Provide clear information about what the client may expect in the program; ensure consistency in practice and maintain boundaries
- 3. Peer Support**—Provide peer support from people with lived experiences of trauma to establish safety and hope and build trust
- 4. Collaboration and Mutuality**—Maximize collaboration and sharing of power with consumers to level power differences between staff and clients
- 5. Empowerment, Voice, and Control**—Empower clients and staff to have a voice and share in decision-making and goal setting to cultivate self-advocacy
- 6. Cultural, Historical, and Gender Issues**—As an organization, move past cultural stereotypes and biases, offer gender and culturally responsive services, and recognize and address historical trauma

(Substance Abuse and Mental Health Services Administration, 2014)

These are the six principles of trauma-informed care developed by SAMHSA. Determine if your local treatment providers and programs use a trauma-informed care approach. It is also important to keep these principles in mind as child welfare workers.

Think about safety when gathering information from families. A parent may not have shared the details of their trauma and may not be comfortable sharing specific details. What information do you need to do your work and make an appropriate referral?

Work to develop a trusting relationship with the families you work with. Be clear on your role and the next steps. Does your agency use peer supports? Are there community resources you can refer families to for peer support?

It is important to collaborate with families and community providers. Families are their own experts and can be instrumental in establishing their next steps. Families need to be part of the solutions. Help families find their voice in the process. Be culturally and gender responsive to meet the needs of families for long-term success.

Slide 17



Domestic violence can often be present in families who are affected by parental substance use and mental health disorders. **The next few slides provide a brief overview of domestic violence and are not intended to be a complete training on domestic violence and child welfare.** Further training should be provided to participants in future trainings on risk and protective factors, safety planning, and local resources.

For further information, visit the following resources:

<http://www.nationalcenterdvtraumamh.org>

<https://nrcdv.org/dvrn>

<https://nrcdv.org>

<http://promising.futureswithoutviolence.org>

<https://www.childwelfare.gov/pubPDFs/domesticviolence2018.pdf>

Prevalence of Domestic Violence

- More than **1 in 3 women** and **1 in 4 men** have experienced at least one form of violence (sexual violence, physical violence, or stalking) by an intimate partner in their lifetime
- Approximately **1 in 4 women** and **1 in 7 men** have experienced severe physical violence by an intimate partner
- Nearly **1 in 10 women** have been raped by an intimate partner in their lifetime
- Nearly **half of all men and women** reported psychological abuse by an intimate partner
- The prevalence of domestic violence among individuals who identified as gay and lesbian was similar to and **higher than**, respectively, the prevalence of domestic violence among individuals who identified as heterosexual
- The prevalence of domestic violence among individuals who identified as bisexual was **higher than** that of gay, lesbian, and heterosexual identifying individuals
- Nearly one-quarter of survivors first experienced domestic violence **before age 25**

(Thomas et al., 2017; National Institute of Mental Health, 2017; Smith et al., 2018)

In order to understand the scope and prevalence of domestic violence, you need to be familiar with some basic research terms so that you can be a critical consumer when you read statistics about domestic violence.

Prevalence “is the proportion of a population who have (or had) a specific characteristic in a given time period.” It is determined by “randomly selecting a sample (smaller group) from the entire population, with the goal being for the sample to be representative of the population.” (www.nimh.nih.gov/health/statistics/prevalence/index.shtml).

Prevalence estimates can be difficult to attain because they require considerable resources. In addition, people’s willingness to report honestly (or at all) about their experience of domestic violence may be hindered by safety concerns and stigma.

One of the best sources for statistics on intimate partner violence is the Centers for Disease Control and Prevention (CDC). In 2010, CDC conducted the National Intimate Partner and Sexual Violence Survey (NISVS) with a nationally representative sample of 6,879 women and 5,848 men from the United States.

Children's Exposure to Domestic Violence

- At least 10% to 20% of children are exposed to domestic violence annually, a disproportionate number of whom are under the age of 6
- Exposure to domestic violence can include hearing, witnessing, and intervening during an incident as well as witnessing the impact on the mother after the incident
- Children may also become targets of violence during a domestic violence incident or may experience ongoing abuse themselves

(Thomas et al., 2017)

Review the prevalence of children exposed to domestic violence.

Children can experience domestic violence without physically witnessing the event. Children can often overhear the incident and can witness the impact of the incident on the mother.

At times, children may try to intervene, or they may become the targets of the violence themselves.

Domestic Violence Terminology

1. Domestic violence
2. Survivor
3. Safer
4. Person who uses abusive behaviors
5. Intimate partner
6. Intimate partner violence

(Thomas et al., 2017)

Domestic Violence:

Defining domestic violence is much harder than it seems. The term "intimate partner violence" has become more popular in recent years, especially in the research community, partly because of misconceptions that domestic violence applies only to people who live together.

Sometimes people use the same term but mean different things. For example, some people argue that the term domestic violence applies only to violence in the context of an intimate relationship; others argue that it refers to any violence that occurs among family members or cohabiting people.

There are multiple forms of domestic violence, including physical, sexual, emotional/psychological, economic, and social abuse, as well as stalking.

Survivor:

When referring to people who have experienced direct domestic violence victimization, we use "survivor" rather than "victim," because it focuses on people's inherent resilience, rather than their experience of trauma.

Safer:

Davies and Lyon (2014) assert that safety "requires more than the absence of physical violence"; instead, it means "there is no violence, their basic human needs are met, and they experience social and emotional well-being" (p. 6). Thus, absolute safety is an unrealistic goal when working with some survivors. A focus on "safer" or "increased safety" is generally the more realistic goal.

Person who uses abusive behaviors:

When referring to people who use domestic violence, we use the phrase "person who uses abusive behaviors," rather than terms such as "perpetrator," "batterer," or "abuser." Doing so separates people's identity from their violent actions, which is essential when working with people in the full context of their lives and helping them to adopt non-violent behaviors.

According to the CDC, an "intimate partner" is:

"A person with whom one has a close personal relationship that may be characterized by the partners' emotional connectedness, regular contact, ongoing physical contact and sexual

behavior, identity as a couple, and familiarity and knowledge about each other's lives. The relationship need not involve all of these dimensions."

And, "intimate partner violence" is:

"Intimate partner violence includes physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)."

Guidelines for Working with Families Affected by Domestic Violence

- Be aware of your own cultural and personal assumptions about domestic violence and how that might affect your interactions with the people with whom you work
- Be aware of how your gender, race, culture, and role may affect the experience of the people with whom you work
- Be aware that violence rarely presents itself in people's lives independent from other problems
- Provide a safe place for people to seek support, recognizing that people may feel "safe" in different types of places and contexts
- Advocate for people's needs within and outside your agency
- Act as an ally to survivors with whom you work
- Practice self-care
- Provide appropriate information and referrals

(Thomas et al., 2017)

When working with families affected by domestic violence, careful consideration should be given to your approach. Be aware of your own assumptions about domestic violence and how they may influence the work.

Your role as a child welfare worker also influences your interactions with families. A survivor may be concerned that sharing information about domestic violence will mean the removal of the children. Be upfront about your role and sensitive to the power differential that exists in your relationship with the family.

Domestic violence is often only one of many other challenges that exist in families. That is why universal screening of substance use, mental health disorders, trauma, and domestic violence is important for all families involved in the child welfare system. Create a safe environment for families and advocate for services and supports for survivors.

Take care of yourself! The work we do in child welfare is difficult, and self-care is important.

Screening for Domestic Violence

- Safety needs to be considered before engagement
- Each person should be interviewed alone
- Don't make false assumptions
- Consider what information you have and what you need to know
- Build rapport through general questions and building on strengths
- Use follow-up questions and remember to listen

(Thomas et al., 2017)

Screening for domestic violence is important in all child welfare cases. How one approaches screening is critical. **A person's safety, as well as their children's safety, must be considered prior to screening.** Determine safety before screening for domestic violence.

*****Discuss your agency's screening protocol.**

For a person to feel safe, they must be able to talk freely. People should be interviewed alone—this includes parents with children. When asking about domestic violence, children should not be present if possible. If children need to be present, you should carefully consider what questions to ask. Don't assume children don't understand or aren't paying attention.

Don't assume that because a family situation may look "happy" that you don't need to ask about domestic violence.

If you have information on the family, try to summarize for the survivor and determine what else you need. Make sure to give the survivor an opportunity to correct information if necessary.

Build rapport with the family before asking questions. Ask general questions, such as "How are you?" Build on the family's strengths.

Use follow-up questions to gather additional information. Listening to a family's story creates a greater understanding of the family.

Domestic Violence and Child Welfare

- Assess protective factors
- Assess risk factors
- Use a trauma-informed approach
- Conduct safety planning

(Thomas et al., 2017)

Many child welfare agencies assess protective and risk factors.

A protective factor is something that helps a person manage a negative event. These factors help "protect" a person or family from difficult or traumatic situations. For a family experiencing domestic violence, protective factors may include family supports, available community resources, or past acts of protection.

A risk factor is something that exacerbates the negative consequences of an event. Risk factors related to domestic violence may include limited resources, a mental health disorder, or a substance use disorder.

*****Ask the group to come up with additional protective and risk factors for families who may be experiencing domestic violence. What do we want to look for through a child welfare lens to understand the strengths and challenges a family faces?**

When working with families affected by domestic violence, use a trauma-informed approach, as highlighted earlier in this training. Many domestic violence survivors have experienced multiple traumas, and understanding the trauma can help inform your response.

Safety planning is an ongoing process when working with a family where domestic violence is occurring. A safety plan is based on an individual's needs, circumstances, and choices. A safety plan must be responsive to the ever-changing needs of the family. Safety planning with a family around domestic violence is critical, and workers need to have supervision and training on safety planning. Please see *Advocacy Beyond Leaving: Helping Battered Women in Contact With Current or Former Partners* on your resource list for more information on safety planning.

*****Additional direction should be given to participants on your agency's training and policy around domestic violence responses.**

Children's Experiences of Domestic Violence

Children can experience domestic violence in multiple ways. Some of the ways they can experience domestic violence include:

- Being in the home (or nearby) and hearing the abusive incident occurring
- Witnessing the direct aftermath of an incident
- Sensing the fear and anxiety of the abused parent (or caretaker)
- Feeling generally unsafe in the home
- Being used as a tool to control the survivor
- Being used indirectly as a tool to manipulate and control a survivor
- Being the indirect or direct targets of physical violence

(Thomas et al., 2017)

Children can experience domestic violence in multiple ways.

They may physically witness or overhear the incident.

A child may be exposed to the aftermath of an incident.

Children may feel unsafe in the home or they may be used as a tool against the survivor.

Children may be the indirect or direct target of the violence.

Women's Experiences of Co-Occurring Disorders, Trauma, and Domestic Violence

Domestic Violence

- Women using substances are more likely to become victims of domestic violence
- Victims of domestic violence are more likely to become dependent on tranquilizers, sedatives, stimulants, and painkillers, and are more likely to misuse alcohol

Co-Occurring Disorders

- Childhood abuse and neglect may contribute to anxiety, depression, PTSD, dissociative disorders, personality disorders, self-mutilation, and self-harming in adults
- Among individuals with substance use problems, more women than men have a second diagnosis of a mental health disorder

(Center for Substance Abuse Treatment, 2014; Mason & O'Rinn, 2014)

Domestic Violence

How many domestic violence cases does your child welfare agency currently have open (referrals and cases)?

Women who use substances are more likely to become victims of domestic violence. Victims of domestic violence are also more likely to become dependent on tranquilizers, sedatives, stimulants, and painkillers and are more likely to misuse alcohol.

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

How many referrals/cases open do you think child welfare has? The number will be high because a majority of families with whom child welfare works present dual diagnosis. This information can be found in your county's safety/risk assessments data.

Mental health disorders 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. We will cover these disorders in an upcoming training module. Among individuals with substance use problems, more women than men have a second diagnosis of a mental health disorder. Women may experience any one of these disorders, or a combination of several.



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Case Vignette

Mother's name: Ginny

Stepfather's name: Harold

Children's names: Charles (13), Gina (9), Lenny (6)

Family ethnicity: Caucasian

Ginny (35) is recently married to Harold (42). She has three children from two previous relationships, including a relationship with a man who was jailed for violence against her and her children. Charles has been in a residential facility after his behavior was found to be too disruptive for school. Gina is very quiet, staying close to her mother. Lenny has boundless energy and rarely sits down. Ginny has a past diagnosis of depression and posttraumatic stress disorder. She smokes marijuana, because she says it helps her stay calm. Lenny is starting to show disruptive behaviors at school, similar to Charles' past behaviors. The school has filed a report because Ginny has not come to several meetings set up by the school.

*****Read the case vignette. Break the group into smaller groups for this activity.**

Case Activity

- What are your concerns?
- What information do you want to gather?
- How would you use a trauma-informed approach to meet with Ginny's family?

*****Ask the small groups to discuss their concerns, particularly in the areas of substance use, mental health, trauma, and domestic violence.**

- What additional information do participants want to gather from the family?
- How can child welfare workers be trauma-informed when they meet with Ginny's family? Safety is important. How would they create safety during their home visit?
- Have the groups answer the questions and then report back to the larger group.
- What were common themes? What approaches can you identify?



Effects of Trauma and Mental Health Disorders on Children

Much research has been conducted on the singular effects of maternal depression, anxiety, and substance use on children. In contrast, considerably less research has been directed to the effects of parental co-occurring disorders on children. There are some things we do know, however, about the heightened risks these children face.

Risk Factors for Children

- Exposure to violence and trauma
- Poverty
- Neglect
- Housing and custodial instability
- Mental health and substance use disorders
- Developmental delays
- Stigma and isolation
- “Parentification”

(National Abandoned Infants Assistance Resource Center, 2012)

It is well-documented in the literature that children growing up in homes headed by a parent with co-occurring mental health and substance use disorders are at an increased risk for a multitude of psychosocial complications.

Exposure to Violence and Trauma

Individuals with co-occurring disorders are more likely to have been exposed to violence than are individuals with either a mental health or substance use disorder. Children often witness violence or illegal activity in the home. Parental mental health disorders, substance use disorders, and domestic violence brings with it an increased risk of being exposed to violence and experiencing trauma.

Poverty

Childhood poverty has also been found to be a risk factor for children.

Neglect

Neglect is a serious concern for children of parents with co-occurring disorders. Children may be left alone or not have appropriate parental supervision. Parental drug-seeking behaviors may result in inadequate or inappropriate care of the child.

Housing and Custodial Instability

An unstable living environment is common for children living in households affected by parental co-occurring disorders.

Mental Health and Substance Use Disorders

There is consensus that children living in households with a parent with a co-occurring disorder are at-risk on both fronts. They may be born with a genetic predisposition for substance use disorders and mental health disorders, and they may experience daily exposure to an environment that may breed such disorders.

Developmental Delays

These children are at higher risk for developmental delays due to potential in-utero substance exposure, poor or inconsistent parenting, lack of resources, etc.

Stigma and Isolation

Isolation and stigma are also common for children affected by parental substance use or mental health disorders. This isolation can lead to a lack of informal and formal supports in the home, and the child feeling as if they need to care for the parent independently.

Parentification

Due to the parent's incapacity at times, many children in these homes are expected to perform household tasks that are not age-appropriate, such as caring for a younger sibling, making meals, doing laundry, and buying groceries.

Effect of Parental Substance Use and Co-Occurring Disorders on Children


- **Delayed development:** Understand how the environment disrupts physical, emotional, social, or educational development
- **Child's needs:** Work with substance use disorder and mental health treatment professionals
- **Educate:** Help children understand substance use and mental health disorders in nonjudgmental and supportive terms (define the disorder, not the person)

(National Abandoned Infants Assistance Resource Center, 2012)

It is important to keep the following considerations in mind when working with families affected by substance use and/or co-occurring disorders:

- The potential for *delayed child development*. Each child is on an individual development path. But children of parents with substance use and/or mental health disorders may not progress through normal child developmental milestones. Their family experiences can interfere with typical physical, emotional, and educational development.
- Understanding *the child's needs* while a parent is in treatment. Child welfare workers understand the importance of providing assistance and support to children and youth. You know to address children's developmental needs in the context of potential separation and loss of parents, abuse or neglect, and potential experiences with trauma.
- *Educating children* about substance use and mental health disorders. Child welfare workers must help children develop a foundational understanding about substance use and mental health disorders in terms that are nonjudgmental and supportive. Information must be conveyed in a way that defines the disorder, not the person, and that leads to the child's hopefulness about the possibility of recovery.

Effects of Trauma on the Child



- Executive functioning problems, inability to self-regulate and to generalize across situations
- Gross and fine motor delays
- Attention problems
- Memory difficulties
- Attachment disorders

Children of parents with substance use disorders are at an increased risk of developing their own substance use and mental health disorders

(Calhoun et al., 2015)

Many of these problems may not show up until later on, when a child starts school. A lack of attention to the parent's substance use may mean that the child's needs are not identified early on. Without parental history, these problems are often misdiagnosed, showing up later and not just as learning problems, but more often as behavior, social/emotional problems, and high rates of aggressive behavior in young children.

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Engage families in the screening and assessment process to understand the effects of substance use, mental health, co-occurring disorders, and domestic violence. This engagement must be done in a way to understand risk and safety for children and all family members.

Building Rapport

- Acknowledging the power differential
- Establishing a relationship
- Explaining the process
- Screening for substance use, mental health disorders, and domestic violence

(Storer et al., 2012)

When a child welfare worker is meeting with parents, parents are often fearful of becoming involved with the child welfare system and worried about losing their children. Acknowledging a parent's fear and concern about your role during the first meeting with a family can help establish a relationship. Be honest about your role, without making any promises.

When establishing a relationship with a family, it is important to create an environment that is open. A parent should feel respected during the process. Parents need to be able to share their perspective. At the same time, a child welfare worker should understand professional boundaries. A child welfare worker should not share personal experiences as a way to establish a relationship and join with the family. At the beginning of each visit, it is important to be clear about why you are there. If this is a response or assessment visit, explain the process. Let families know there will be a lot of questions that your agency asks all families.

All families in child welfare should be screened for the presence of substance use and mental health disorders and domestic violence.

Engaging Parents in Treatment: A Continuous Process

Child welfare workers:

- Screen parents for potential substance use or mental health disorders
- Motivate parents to engage in and remain in treatment
- Help parents to sustain recovery
- Do not wait for substance use treatment or mental health disorder treatment to begin before other interventions occur

(Wells et al., 2015)

Engaging parents and families in treatment is a continuous process for child welfare workers. It includes screening parents for potential substance use or mental health 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 use disorder treatment or mental health disorder 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 that 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 workers must remain involved with the parent throughout the treatment and recovery process, promoting reunification as long as reunification remains the appropriate goal.

Enhancing Parent Motivation

Encourage parents to **seek** treatment:

- Work with attorneys and courts

Encourage parents to **stay** in treatment:

- Respond appropriately to relapse
- Support sustained recovery
- Help parents understand dependency court requirements
- Assure parents that children are safe and in good care

(Geiger, 2017)

How can you motivate parents to become engaged in appropriate treatment? First, you can encourage parents to seek treatment. Once a screening suggests that a substance use and/or mental health 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. 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.

For more information on engaging families, please see *Module 4: Engagement and Intervention with Parents Affected by Substance Use Disorders and Mental Health/Trauma*

Engaging Parents in Treatment Models and Strategies

Using motivational enhancement strategies:

- Help parents and children identify their needs
- Develop rapport and build trust with parents
- Recognize and affirm positive behaviors
- Ensure frequent and safe visitation, as appropriate
 - This is vital for both children and parents
 - Do not use as a “reward” or “punishment”

(Randolph et al., 2009)

This strategy is based on sessions with parents to provide supportive feedback designed to strengthen their commitment to change.

How can child welfare workers 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 when parents are not compliant.

Engaging With Children Affected by Domestic Violence

- Respond to the child in a calm and supportive way
- Seek supervision or consultation
- Create a safety plan with family members and children when age appropriate
- Provide emotional support
- Provide social support

(Thomas et al., 2017)

When children are affected by domestic violence, it is important to respond in a safe and supportive manner.

Create a safe space for children.

Seek supervision or consultation to plan next steps. Planning is critical to avoid further safety issues for children and survivors.

Work with safe family members to be part of the safety planning process. When it is age and developmentally appropriate, create a safety plan with the children. Children under the age of 4 are not developmentally able to participate in the safety plan.

Here are some questions for older children when thinking about a safety plan:

- Who can you call?
- Is there a safe adult you can stay with?
- Do you know how to call 911?
- What have you been doing already to keep safe?

In your role as a child welfare worker, you need to provide emotional and social support to children affected by domestic violence. Children should never feel punished for sharing their story. Children may also feel loyal to and protective of the abusive parent. Respect their feelings. Work with community providers and supports to access appropriate services for children.

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Case Activity: Ginny and Harold

Very little is known about Harold. He doesn't answer questions and does not want to be involved with child welfare. Ginny has used domestic violence services in the past but never follows through for long. Ginny states that smoking marijuana is more effective than counseling for dealing with her depression. Ginny's mother lives down the street from the family and will pick the children up at school most days. Ginny attends all of the meetings at Charles' residential program and is excited that he is returning home. Ginny is working part-time as a receptionist at an insurance company.

This is more information on Ginny and Harold's family.

*****Break into groups again and answer the questions on the next slide.**

Case Activity: Next Steps

- List the protective and risk factors for the family.
- What engagement strategies would you use when working with Ginny?
- What services would you consider for Ginny, Harold, and the children?

***** Ask groups to answer the questions and then share them with the larger group. What were the common themes among the groups?**

Protective factors could include that Ginny attends school meetings, has used services in the past, or that her mother lives nearby.

Risk factors may be her coping method of smoking marijuana, Harold's lack of involvement, or her lack of follow-through with treatment.

Discuss ways to build rapport with the family.

What types of services would you consider?

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Assessment of Mental Health Disorders

Mental Health Disorder Assessment

- Conducted by qualified mental health professionals
- Based on the *Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5)—outlines criteria for each diagnosis
- Diagnosing mental health disorders is not exact
- Trauma and stressor-related disorders can be diagnosed and treated
- Some people receive multiple, appropriate diagnoses, and diagnoses change over time

(Thagard & Larocque, 2018)

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

A mental health disorder assessment, by a qualified mental health or co-occurring disorder 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 Statistical Manual of Mental Disorders, Fifth Edition*.

If the professional determines that an individual's mental, emotional, or behavioral processes match the criteria listed in the DSM-5, 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-5's organizational system, now also used extensively for billing processes. There is a whole category for trauma and stressor-related disorders, but sometimes people with trauma histories can have symptoms that meet the criteria for other mental health disorders, and they may also have substance use disorders.

It is very important to be aware that determining a mental health or substance use disorder diagnosis is not an exact science, and there continue to be variations in how different qualified professionals apply the criteria in the DSM-5. 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 behavior 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 health or substance use disorder, even though they may present risks 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 disorder 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 health disorders will also be asked, and the professional has been trained to interpret answers to those questions in the context of the diagnostic criteria.

Mental Health Disorder Assessment Outcomes

What you might expect to receive:

- A diagnosis
- Multiple diagnoses
- Treatment recommendations related to the diagnosis
- Recommendations for further assessment
- Recommendations for other service agencies

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

- A diagnostic label.
- Multiple diagnostic labels, suggesting that the person meets the criteria for more than one mental health and/or substance use disorder, which is very possible.
- Recommendations for treatment, based on the type of mental health disorder that has been identified and any other factors, such as trauma, that were identified during the assessment.
- Recommendations for further assessment. There are often questions about whether a biological basis for a mental health 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 determine a more effective course of treatment.
- Recommendations for other service agencies (such as child protection or the justice system) about how they can respond most effectively to the person's mental health disorder.

Co-Occurring Substance Use and Mental Health Disorders


- A co-occurring disorder is the co-existence of both a mental health and a substance use disorder
- People with mental health disorders are more likely to experience a substance use disorder
- Symptoms can be complex and hard to diagnose
- Symptoms of each disorder can vary in severity
- It is important to identify and treat both disorders through integrated treatment

(Padwa et al., 2015)

This slide examines what happens when a parent is suspected or found to have both a substance use and mental health disorder, called a "co-occurring" disorder. This term recognizes that some people have complex needs, including having mental health and substance use disorders at the same time.

Co-occurring disorders are fairly common. The severity of the disorders can vary from mild to severe. Sometimes one disorder can mask or complicate the symptoms of the other, making it difficult to differentiate and diagnose each disorder. People with co-occurring disorders are best served through integrated treatment, where both disorders are identified and treated simultaneously. Integrated treatment services are not always available in every state or community. When this is the case, parallel services may be the next best option. Parallel services are when the person receives services at the same time by different providers who coordinate their services and treatment plans.

Assessment of Co-Occurring Disorders



Three possible paths:

1. One person assesses for both a substance use and mental health disorder
2. Assessment of substance use disorder leads to referral and assessment for a mental health disorder
3. Assessment of mental health disorder leads to referral and assessment for a substance use disorder

Some treatment professionals are cross-trained to conduct both assessments, actively looking for co-occurring disorders

(Darghouth et al., 2012)

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 health disorder by one professional who is qualified to make such assessments. Some systems are not organized in a way that provides assessment for both at the same time. In this case, you may have to make referrals for two assessments: one for mental health disorders and one for substance use disorders. 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 use disorder treatment professional, with a referral and subsequent assessment for a mental health disorder from a mental health professional. The third way is an assessment of a mental health disorder by a mental health professional, with a referral and subsequent assessment for a substance use disorder by a substance use disorder treatment professional. In these cases, substance use and mental health disorder treatment professionals would conduct their respective assessment process and provide the resulting information as discussed above.

Ask the treatment providers in your community how they are certified, and what their training and licensure enables them to do. Trust your clinical instincts. If you suspect a co-occurring disorder, you should advocate for appropriate assessments.

Co-Occurring Disorders and Case Planning

- Include diagnoses, level of care, and treatment plan(s)
- Address social, economic, motivational, or other issues
- Engage the Collaborative Team—treatment and child welfare workers and relevant family and friends
- Resolve conflicting treatment messages


(Darghouth et al., 2012)

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 use and mental health disorder treatment. As mentioned earlier, a child welfare worker'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 use 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 workers 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 a co-occurring disorder will address all diagnoses using a coordinated, consultative and/or integrated approach, depending on the severity of the co-occurring disorder. It is possible to recover from these challenging co-occurring disorders and become functional in ways that support the family and contributes to the community. This recovery will depend, in part, on support from the community. Ongoing supports may be needed on a recurring or continuous basis.

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Treatment and Supports for Co-Occurring Mental Health Disorders and Domestic Violence

This module has covered the kinds of co-occurring disorders that the parents you encounter might experience. It is also important that you have some understanding of the kind of treatment that might be available in response to the identification of mental health disorders, trauma, and domestic violence.

Co-Occurring Disorder Treatment

- **Integrated:** Both disorders are treated at the same time by the same treatment provider
- **Parallel:** Both disorders are treated at the same time but by different providers
- **Sequential:** One disorder is treated at a time

(Substance Abuse and Mental Health Services Administration, 2005)

The recognition of substance use and mental health disorders both occurring in the same person has been somewhat recent. Historically, substance use and mental health disorder treatment providers worked in silos and were not cross-trained to be able to identify and treat both types of disorders. More frequently now professionals receive cross-training and are sometimes dually-credentialed in both substance use and mental health disorder treatment. Some agencies have integrated their services for both disorders or at least have special programming for people with co-occurring disorders, since the co-occurrence can be complicated for the person with the disorders and their treatment providers.

There are several approaches to treating co-occurring disorders. Integrated and coordinated treatment has been found to be more effective than treating one disorder at a time (CSAT, 2013).

- Integrated treatment, sometimes called co-occurring capable treatment, is when both disorders are treated simultaneously by the same agency and the same treatment providers. The availability of cross-trained professionals and co-occurring competent treatment programs varies across states and regions. Some curricula for treating co-occurring disorders, including co-occurring substance use and trauma, have been developed, and their use is becoming more common.
- Parallel treatment is when both disorders are identified and the person receives treatment for both disorders but by separate professionals and possibly in separate agencies. Some downfalls to this approach include potentially misaligned treatment plans, communication barriers, and increased requirements for the person seeking treatment.
- Sequential treatment is when one disorder is treated first and then the other. This approach requires that the person receiving treatment stabilizes with one disorder before addressing the other, which can be a challenge for persons with co-occurring disorders.

For additional information, see <https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992>

For a video that can be shown to participants on this topic, go to <https://www.youtube.com/watch?v=DfwaLQRWBaQ>. This video, produced by the Substance Abuse and Mental Health Services Administration, is about the successful

implementation of integrated treatment, including the experiences of consumers, policy makers, and practitioners.

Interventions for Co-occurring Mental Health Disorders

- Medication
- Education for client and family
- Counseling
- Respite care
- Peer support
- Self-help groups
- Care or case management
- Day treatment
- Residential treatment
- Hospitalization

(Mueser et al., 2009; Subodhet et al., 2018)

Many different community-based mental health interventions, services, and supports are currently being used for adults and children, and these can be used in any combination:

- *Medication*—When the diagnosis is correct, an appropriate medication applied in appropriate dosages can counter the negative effects of many mental health disorders. Medication should be monitored regularly. Some medications require regular physical/blood tests to prevent or monitor potentially harmful side effects.
- *Education*—It is often effective to educate individuals about the nature and effects of mental health disorders they may have, giving them a chance to understand and take control of their own mental and physical health, using strategies that have been shown to be effective. It can help to educate their family members as well so that they can be supportive of their recovery plan.
- *Counseling or Therapy*—Some people are able to talk with others about their illnesses or symptoms in ways that help them gain insight and knowledge of how to manage their own disorders. Therapy may be provided to individuals, to entire family groups, or to treatment groups of people with similar mental health disorders.
- *Respite Care*—Many people with mental health disorders have someone in their life who cares about them and looks after them, to varying degrees. Those caregivers may become exhausted or overwhelmed by the care responsibilities and may need periodic relief. Respite services provide relief like this on a scheduled and/or emergency basis.
- *Peer Support*—In some states, it is possible to become certified as a Peer Support Specialist (PSS) in mental health, substance use disorders, or a combination. PSS, also called Recovery Coaches, use their personal experience of recovery from a mental health and/or substance use disorder to provide emotional support and recovery coaching to individuals seeking recovery. PSS might be employed or volunteer, and this service might be available in any number of settings, including hospitals, residential treatment, outpatient clinics, ACT teams, day treatment, or drop-in centers.
- *Self-Help*—Many consumer-led services and supports have emerged in the past decade and are effective for many people with mental health and substance use disorders, helping them manage their own disorder and remain functional in their community. A number of

self-help options exist in communities, with peer-to-peer relationships at the heart of successful support. One example is Double Trouble in Recovery, a 12-step based group for people with co-occurring substance use and serious mental health disorders. Peer-led drop-in centers are also available in some communities.

- *Care Management (also known as case management)*—Some people with complex or very serious mental health disorders respond well when a paraprofessional or professional staff person agrees to work with them to help manage the delivery of care through the community system. This role may be very simple or very involved. The field has used the term "case management" for many years, but consumers of this type of care are working to change the term to "care management" so that they are no longer thought of simply as "cases."
- *Day Treatment*—Many people with severe mental health and co-occurring substance use disorders manage their difficulties well when they have short-term or longer-term access to a structured program with therapy and/or opportunities to develop socialization and other life skills and access to necessary supports. These services may also be called intensive day treatment, intensive outpatient, partial hospitalization, or therapeutic rehabilitation. Some programs specialize in the treatment of co-occurring mental health and substance use disorders, and some focus on just one or the other. Many adults with mental health disorders have someone caring for them, and day treatment programming may allow the caregiver to fulfill job responsibilities or get respite from the challenges presented by day-to-day care.
- *Residential Treatment for Co-Occurring Mental Health and Substance Use Disorders*—This service, usually short-term, provides a combination of interventions in order to help the patient with both disorders. Sometimes these facilities can attend to withdrawal symptoms. The availability of residential treatment beds varies widely across states and communities.
- *Hospitalization or Crisis Stabilization*—This service is extremely important when it is needed briefly for stabilization, accurate diagnosis, detoxification from drugs and alcohol, or medication adjustment, but hospitalization is needed rarely and should be used as infrequently and as briefly as possible, unless it is the only environment in which the person is not a threat to themselves or others. Crisis Stabilization units are available in some communities to provide short-term stabilization services as an alternative to hospitalization. The availability of hospital and crisis stabilization beds varies widely across states and communities.

It is important to recognize that no practice or approach works for everyone—treatment or service approaches have to be uniquely planned and implemented for each individual and be responsive to their unique needs—and their strengths. Even evidence-based approaches and protocols work differently with people with different diagnoses, different circumstances, and in different groups.

*****Highlight other community treatment resources in your area.**

Domestic Violence Resources

- Domestic violence hotlines
- Domestic violence community-based and residential programs
 - Community-based services
 - Domestic violence residential services: shelters and transitional living programs
- Emergency homeless shelter system
 - Family shelters
 - Shelters for individuals (a.k.a. unaccompanied adults)
- Hospitals and health centers

(Thomas et al., 2017)

Domestic Violence Hotlines

- Hotlines are 24-hour numbers that are staffed by trained advocates. The counselors can provide emotional support, assistance with finding emergency shelter, safety planning, and information about legal options. Survivors can call anonymously or confidentially.
- Family and friends can also call hotlines for resources and information. They might also call because they need emotional support when someone they know is in an abusive relationship.

Domestic Violence Community-Based and Residential Programs

There are approximately 2,000 programs across the United States. The goal of a domestic violence program is to provide a free and safe place for survivors and their children to find emotional support and assistance with a range of needs. Some domestic violence programs provide housing in the form of emergency shelter (typically anywhere from 1 to 6 months) and/or transitional living (approximately 2 years). Not all programs provide housing; they are referred to here as community-based programs.

Emergency Homeless Shelter System

Hospitals and Health Centers

Many hospitals and health centers have domestic violence programs or dedicated domestic violence advocates.

For further information, visit the following resources:

<http://www.nationalcenterdvtraumamh.org>

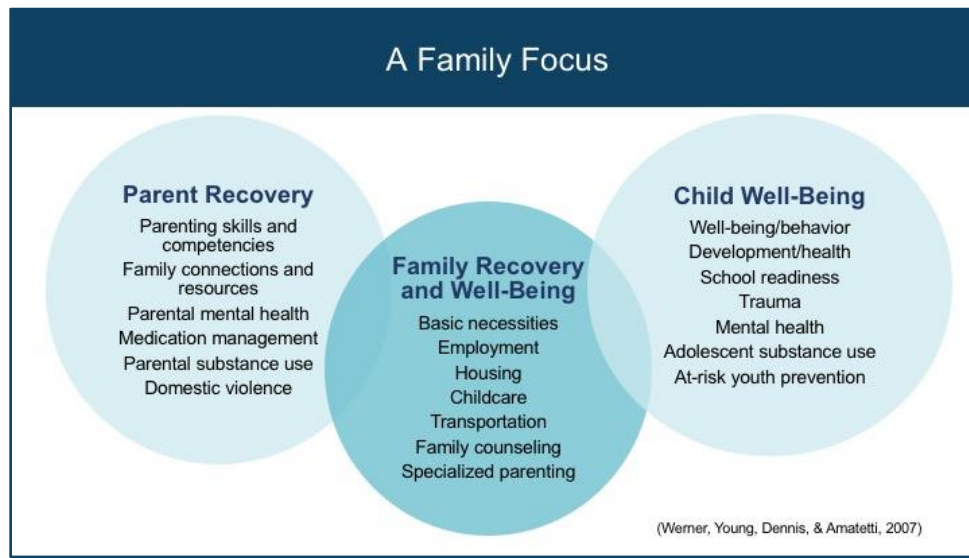
<https://nrcdv.org/dvrn>

<https://nrcdv.org>

<http://promising.futureswithoutviolence.org>

<https://www.childwelfare.gov/pubPDFs/domesticviolence2018.pdf>

*****Highlight any residential, shelter, or community-based domestic violence programs in your community.**

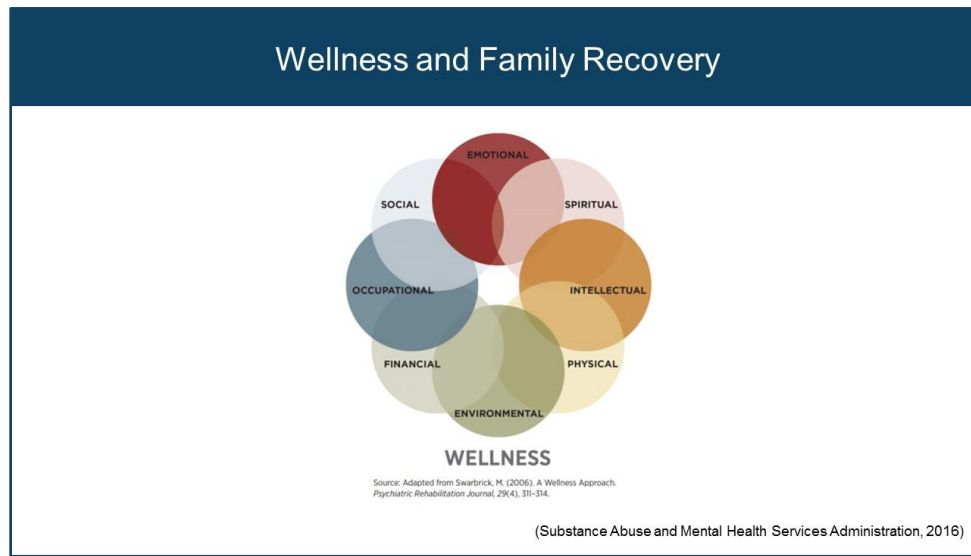


When serving a family holistically, the focus is on the parent's recovery, the child's well-being, and the family recovery and well-being as a whole.

- Services to support parents' recovery should address:
 - Parenting skills and competencies
 - Family connections and resources
 - Parental mental health
 - Medication management
 - Parental substance use
 - Domestic violence
- Services that support child well-being must address:
 - Well-being/behavior
 - Development/health
 - School readiness
 - Trauma
 - Mental health
 - Adolescent substance use
 - At-risk youth prevention
- Supporting the entire family's recovery and well-being means providing:
 - Basic necessities
 - Employment
 - Housing
 - Child care

- Transportation
- Family counseling
- Specialized parenting

Slide 52



Thinking about family recovery through a holistic approach helps promote overall wellness for the family. Each dimension of wellness can affect the overall quality of someone's life. Supporting families in recovery means looking beyond the individual symptoms and disorders and supporting families in all aspects of their life to achieve overall wellness.



National Center on Substance Abuse and Child Welfare

A Program of the

Substance Abuse and Mental Health Services
Administration

Center for Substance Abuse Treatment
and the

Administration on Children, Youth and Families
Children's Bureau
Office on Child Abuse and Neglect

www.ncsacw.samhsa.gov

ncsacw@cffutures.org

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