MODULE 3

Understanding Co-Occurring Disorders, Intimate Partner Violence & Trauma









National Center on Substance Abuse and Child Welfare

Contents

Introduction

The National Center on Substance Abuse and Child Welfare (NCSACW) developed the Child Welfare Training Toolkit to enhance child welfare workers knowledge and understanding about substance use and co-occurring disorders among families involved in the child welfare system. The toolkit is designed to provide foundational knowledge and skills to help advance child welfare casework practice.

The toolkit consists of ten modules—seven foundational and three special topics:

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

Module 2: Understanding Substance Use Disorders, Treatment & Recovery

Module 3: Understanding Co-Occurring Disorders, Intimate Partner Violence & Trauma

Module 4: Engagement and Intervention of Co-Occurring Substance Use, Mental Disorders & Trauma

Module 5: Case Planning Considerations for Families Affected by Parental Substance Use & Co-Occurring Disorders

Module 6: Understanding the Needs of Children and Adolescents Affected by Parental Substance Use & Co-Occurring Disorders

Module 7: A Coordinated Multi-System Approach to Better Serve Children and Families Affected by Substance Use & Co-Occurring Disorders

Module 8: Special Topic: Considerations for Children and Families Affected by Methamphetamine Use

Module 9: Special Topic: Considerations for Children and Families Affected by Opioid Use

Module 10: Special Topic: Care Coordination Considerations for Children and Families Affected by Prenatal Substance Exposure

In addition, the Child Welfare Training Toolkit is designed to offer states and local jurisdictions flexibility with delivery methods—the 10 modules can be delivered as a series or as standalone in-person or virtual trainings. Note, each module is equivalent to a half day or 3-hour training which should also account for one 15-minute break for learners during instruction.

Each module contains a detailed facilitator's guide outlining identified learning objectives, a presentation slide deck, a comprehensive reference list, and supplemental resources. To better support state and local training capacity, detailed talking points for each slide's content have been included which can be used as a script or a starting point to help acclimate and support facilitator readiness. As with all training curricula, facilitators are also encouraged to infuse their own subject matter expertise, practice-level experience, and knowledge of state or local policy or practice to help reinforce the toolkit's contents and learning objectives.

Lastly and more importantly, the toolkit is designed with careful attention to adult learning theory and principles to maximize child welfare workers learning experience. Each module considers the diverse learning styles and needs including auditory, visual, kinesthetic techniques, as well as individual, small, or large group transfer of learning activities or exercises.

Note, the NCSACW provides a free online tutorial titled, *Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals*. This self-guided online tutorial complements the contents of the Child Welfare Training Toolkit. State and local jurisdictions may encourage their workforce to take the online tutorial to further supplement their knowledge; learners who successfully complete the online tutorial will be eligible for continuing education credits.

Intended Audience

The contents of this training toolkit can be applied across the full child welfare services continuum, enriching the practice of alternative (differential) response, investigations, in-home, out-of-home, and ongoing units. State and local jurisdictions may use the toolkit to supplement their current onboarding (pre-service) or ongoing (in-service) workforce learning opportunities. Use of the training toolkit is also highly encouraged for all cross-training needs—promoting collaboration and system-level change within and between child welfare agencies, substance use and mental health treatment providers, the judicial system, and all other family-serving entities.

Facilitator Qualifications

Facilitators should be knowledgeable about substance use disorders, mental health, and child welfare practice. They should also 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 a facilitator does not hold knowledge in one of these identified areas, then partnering with a respective community agency is recommended to augment co-facilitation and/or subject matter expertise. All additional facilitator inquiries can be addressed to ncsacw@cffutures.org.

Language & Terminology

Discipline-specific language and terminology are used throughout this 10-module toolkit. A trainer glossary has been incorporated as part of the toolkit to better support knowledge and understanding of the purpose and intended meanings of commonly referenced terms and recommended use of person-first and non-stigmatizing language.

Materials Needed

In-Person Training Delivery

- Laptop Computer
- A/V Projector or Smart Board
- External Speakers (if needed)
- Internet or Wi-Fi Access
- Presentation Slide Deck
- Facilitator's Guide
- Flip Chart Paper
- Pens and Markers
- Training Fidgets

Virtual Training Delivery

- Laptop Computer
- Internet or Wi-Fi Access
- Virtual Meeting Platform (e.g., Zoom)
- Access to Free Online Word Cloud Generator (e.g., Mentimeter)
- Presentation Slide Deck
- Facilitator's Guide

Module 3 Description and Objectives

The goal of module 3 is to provide in-depth knowledge and understanding of co-occurring disorders, intimate partner violence, and trauma. Child welfare workers will acquire knowledge specific to mental health inclusivity including strategies to prevent or reduce stigma; identify the prevalence and common types of co-occurring disorders including associated symptoms; recognize the three models of care management for co-occurring substance use and mental disorders; acquire knowledge about intimate partner violence and the intersections of co-occurring disorders including prevalence, power and control dynamics, interagency response efforts, and best practice screening tools; differentiate between intimate partner violence and the co-occurrence of child maltreatment including key considerations when assessing safety and risk; acquire knowledge and strategies for increasing safety and protective capacities for families experiencing violence; and finally, awareness of the cumulative effects of trauma and the importance of providing trauma-informed care.

After completing this training, child welfare workers will:

- Discuss mental health as a spectrum with key language paradigm shifts to further reduce stigma
- Identify the prevalence and common types of co-occurring disorders along with associated symptoms
- Recognize the three models of care management for co-occurring substance use and mental disorders
- Acquire knowledge about intimate partner violence and the intersections of co-occurring disorders including prevalence, power and control dynamics, interagency response efforts, and best practice screening tools
- Differentiate between intimate partner violence and the co-occurrence of intimate partner violence and child maltreatment, including key considerations when assessing safety and risk
- Acquire knowledge and strategies for increasing safety and protective capacities for families experiencing violence
- Understand the cumulative effects of trauma and the importance of providing trauma-informed care

Presentation Slide Deck and Talking Points

This next section of the facilitator guide provides detailed information about the contents of each slide and is organized uniformly throughout the deck to help with your training preparation. These sections include:

- Facilitator Script: ready to use talking points that can be used in its current form or modified based on a facilitator's training capacity and subject matter expertise.

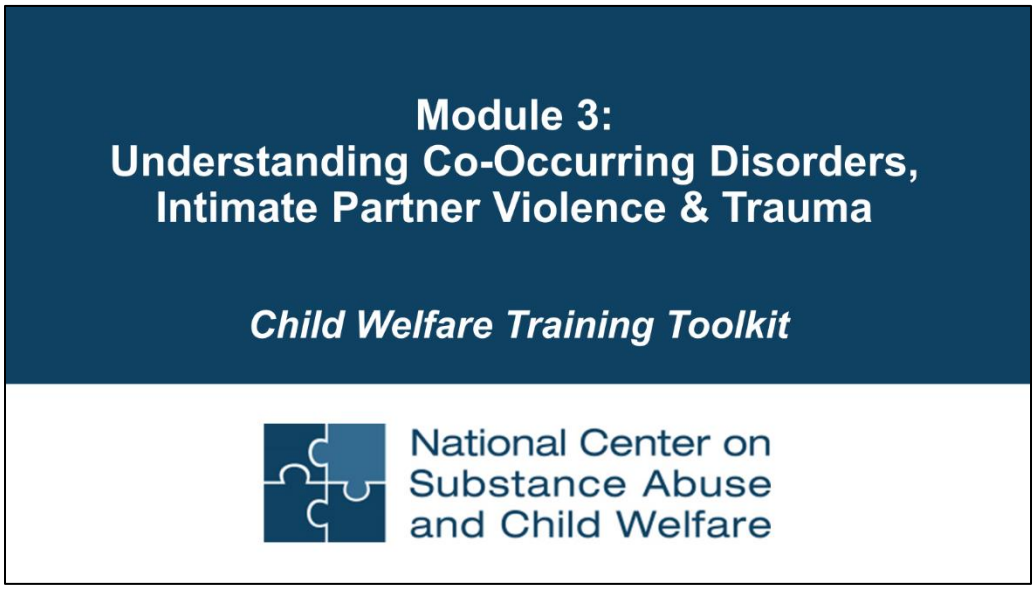
- Facilitative Prompts for Participants: content-specific inquiries developed to engage learners in further discussion and application of knowledge and skills (**bolded for easy reference**).

- Additional Facilitator Notes: contextual information to support the facilitator's knowledge and readiness, or specific mention of supplemental resources available to the learners hyperlinked within the resource section at the end of the presentation slide deck (*italicized for easy reference*).

- Underlined Content: a tool used to draw attention or emphasize specific content within the facilitator script.

Slide 1

Module 3: Understanding Co-Occurring Disorders, Intimate Partner Violence & Trauma



Facilitator Script:

Hello and welcome! Thank you for creating time in your schedule for today's training discussion. The next three hours were carefully designed to be a robust learning experience. Your active participation in the various adult learning exercises is encouraged, leading to a more in-depth understanding about co-occurring disorders, intimate partner violence, and trauma.

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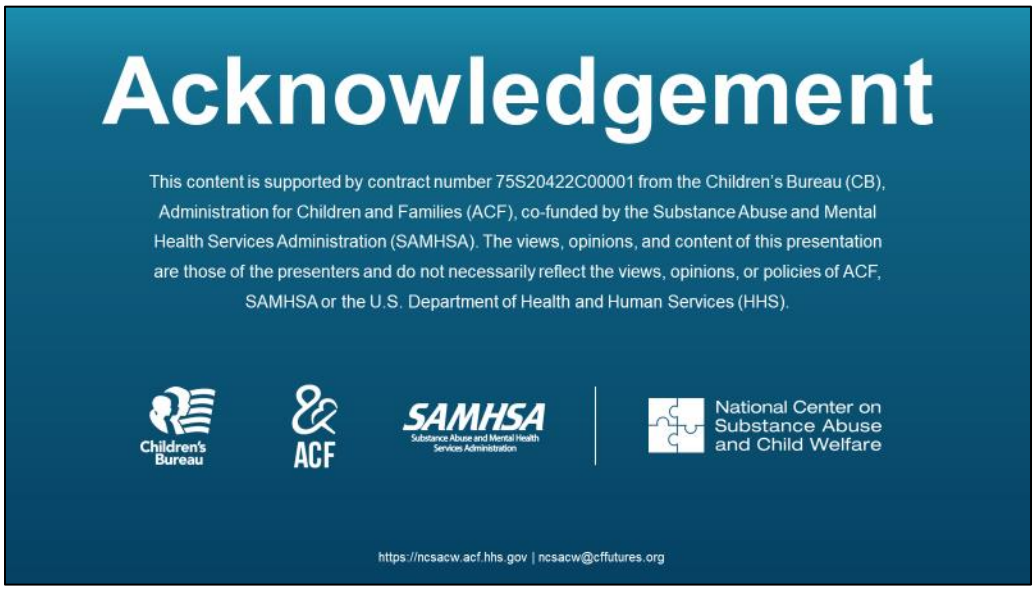
Slide 2

Acknowledgement

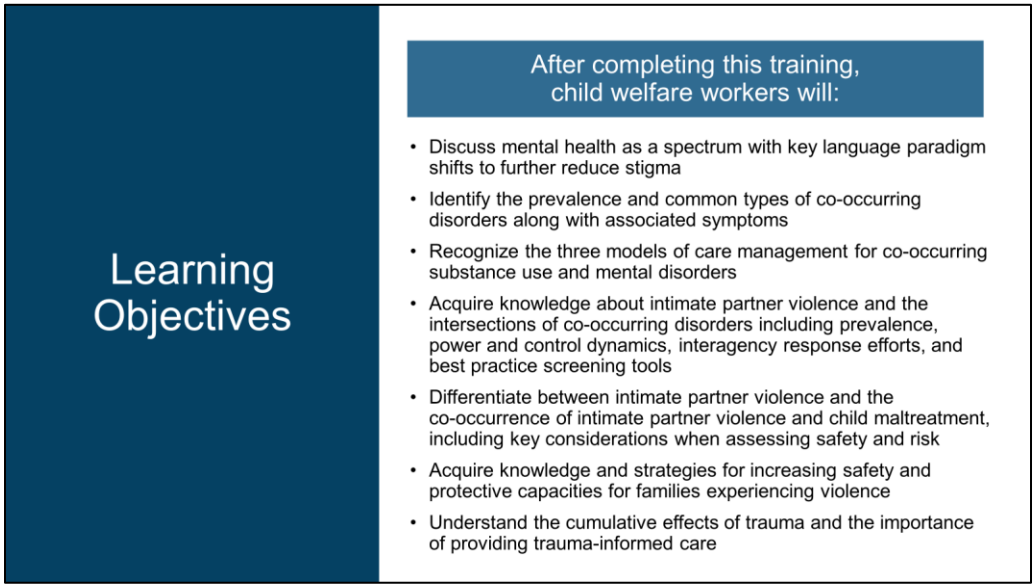


Facilitator Script:

Before we begin, I'd like to acknowledge that this training module was developed by the National Center on Substance Abuse and Child Welfare an initiative of the U.S. Department of Health and Human Services and is co-funded by the Children's Bureau, Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration.

Slide 3

Learning Objectives

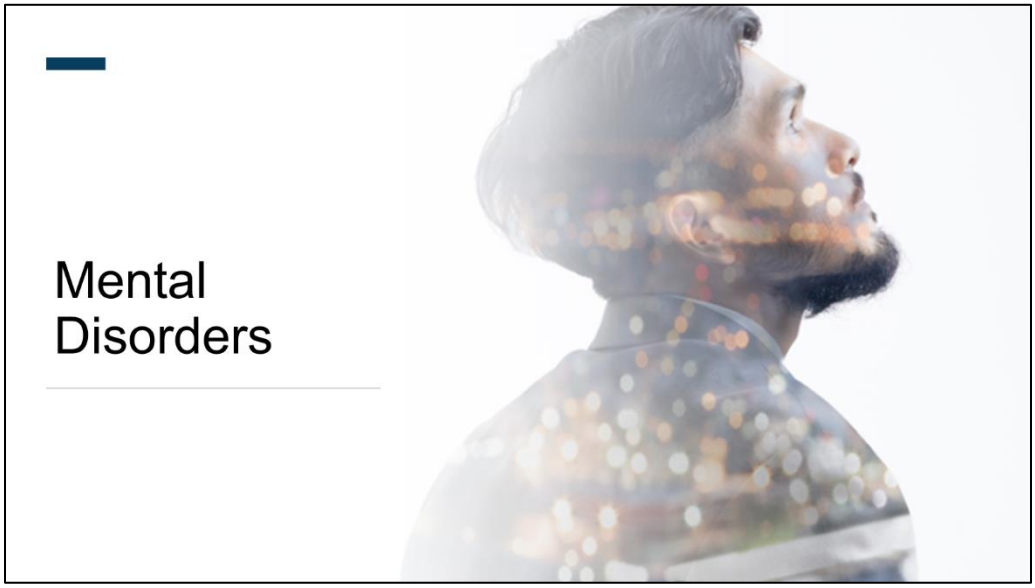


Facilitator Script:

The goal of module 3 is to provide in-depth knowledge and understanding of co-occurring disorders, intimate partner violence, and trauma. Child welfare workers will acquire knowledge specific to mental health inclusivity including strategies to prevent or reduce stigma; identify the prevalence and common types of co-occurring disorders including associated symptoms; recognize the three models of care management for co-occurring substance use and mental disorders; acquire knowledge about intimate partner violence and the intersections of co-occurring disorders including prevalence, power and control dynamics, interagency response efforts, and best practice screening tools; differentiate between intimate partner violence and the co-occurrence of child maltreatment including key considerations when assessing safety and risk; acquire knowledge and strategies for increasing safety and protective capacities for families experiencing violence; and finally, awareness of the cumulative effects of trauma and the importance of providing trauma-informed care.

Slide 4

Mental Disorders

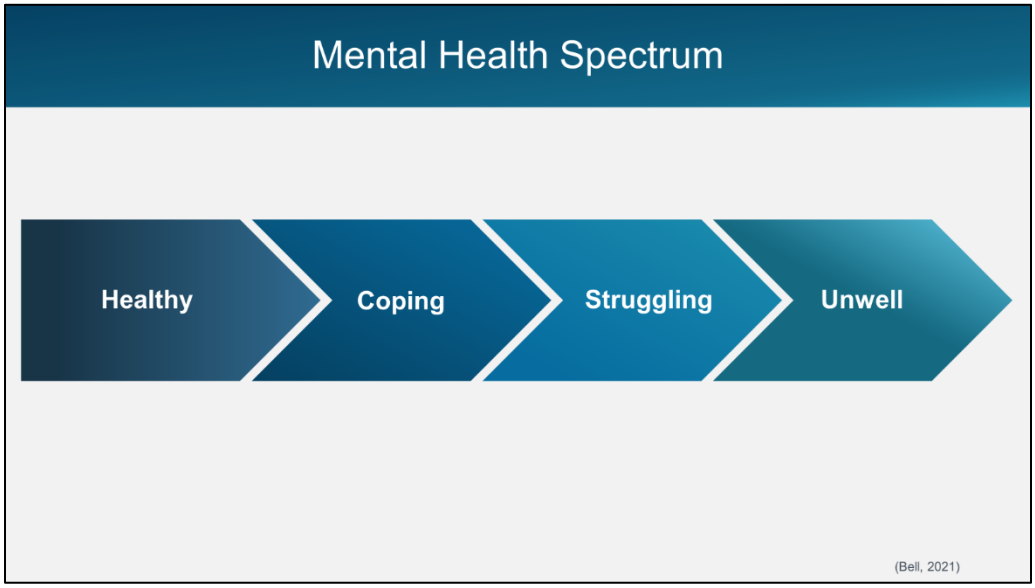


Facilitator Script:

Mental Health is HEALTH—and includes our emotional, psychological, and social well-being. It affects how we feel, how we think, how we show up in life, including how we handle stress and make decisions. Before we jump into today's training, let's take a moment to check in with ourselves and our neighbors—how are we feeling today? Take a moment to honor what you need in order to be more fully present in today's discussion.

Slide 5

Mental Health Spectrum



Facilitator Script:

Reimagining mental health as a continuum or spectrum allows us to shift the narrative around our mental and emotional well-being. This now becomes a conversation that is inclusive to everyone as we all would fall somewhere along the spectrum (with our positioning often fluctuating in response to a host of situational factors). Imagine what our conversations both personally and professionally could be like if we began to frame our mental and emotional well-being questions as, "How are you doing? How has your mental health been lately? Where would you fall on the continuum today? Has there been times when it was better? If so, what was different then?"

Notice how we've moved away from the often-stigmatizing questions like, "Do you have a mental health illness?" or "What's your diagnosis?" This can also look like when people place an over emphasis or generalization on the mental health diagnosis or label itself, "She seems off, she must be depressed!" or "He's acting bipolar today!"

Prompt for Participants:

What are some other examples of stigmatizing or generalizing language around mental health?

Facilitator Note: there are many variations of mental health spectrum or continuums using different types of scaling language. This one from the Centre for Mental Health was solely selected for its simplicity and applicability across audiences.

Source: (Bell, 2021)

Slide 6

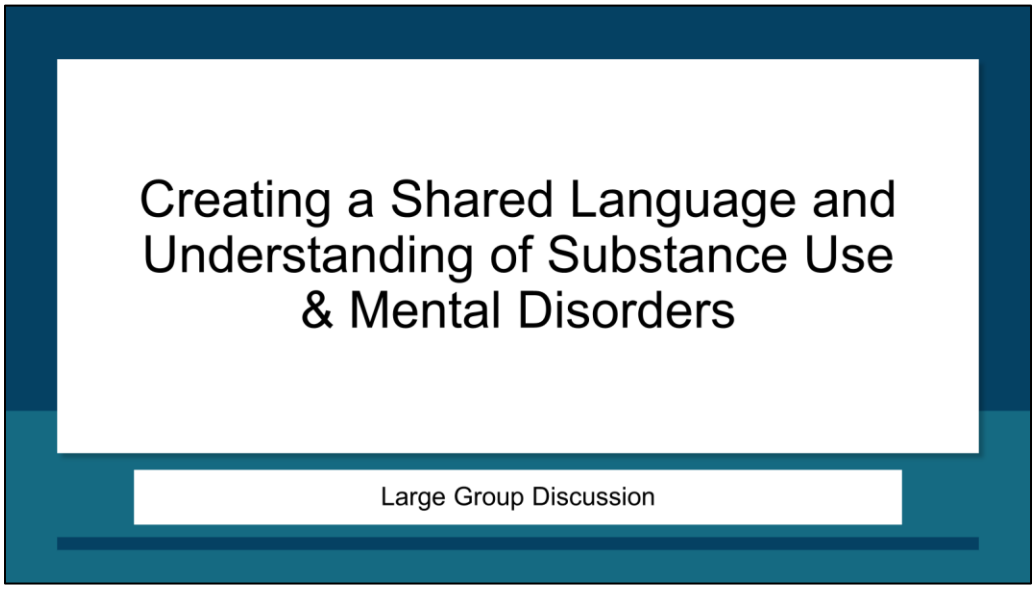
Which Term Should I Use?

Facilitator Script:

We know that many families involved with child welfare are affected by substance use and co-occurring disorders—and you may notice these mental health terms being used interchangeably and/or work within systems that have preferred terminology. In this training module, we will be using the term 'mental disorder' and in the same way that mental health is a continuum, so is the term 'disorder.' It's important to remember that the language we use to describe and talk about mental health is often shaped by our own personal, social, and cultural experiences. The term 'disorder' shouldn't be conflated with qualifiers such as 'serious' or 'debilitating;' rather, it is helpful to think of disorders with respect to their diagnostic specifiers of mild, moderate, or severe which was covered in module two of the toolkit.

Slide 7

Creating a Shared Language and Understanding of Substance Use & Mental Disorders



Facilitator Script:

Facilitator Note: Engage learners for a large group discussion on creating a shared language and understanding of substance use and mental disorders.

Prompts for Participants:

- **Did anybody notice what common mental health term wasn't listed on the previous slide?** *(Give learners an opportunity to answer by going back to the slide briefly)*; Answer: Mental Illness.

This helps us segue nicely to my next question for you all…

- **Why is the language we use in our work with families so important?**
- **How does the language we use to discuss substance use and mental disorders affect the children and families we serve?**

Slide 8

The Negative Effects of Stigma on Treatment & Recovery Outcomes

Facilitator Script:

Stigma is defined as the relationship between an attribute and a stereotype that assigns undesirable labels, qualities, and behaviors to a person exhibiting the attribute. Let's take parents affected by substance use and co-occurring mental disorders involved with the child welfare system as an example.

At the institutional level, stigma around parental substance use has and continues to shape policies and practices that can greatly influence family unification and reunification, respectively. This is in part due to the level of public stigma (driven by attitudes, beliefs, emotions, and behaviors) assigned to parents with substance use and co-occurring mental disorders—this includes stereotypes or misconceptions about parents choosing drugs or alcohol over their children, not being able to safely parent while in recovery, or beliefs that parents on medication for opioid use disorder are merely just replacing one drug for another.

The combined effects of institutional and public stigma then perpetuate a level of self-stigma or shame that is carried and internalized, often becoming the very thing standing between a parent seeking treatment and other supportive services.

Prompts for Participants:

What are some other ways stigma affects child welfare-involved families?

Facilitator Note: Encourage open large group discussion and then follow-up with next question…

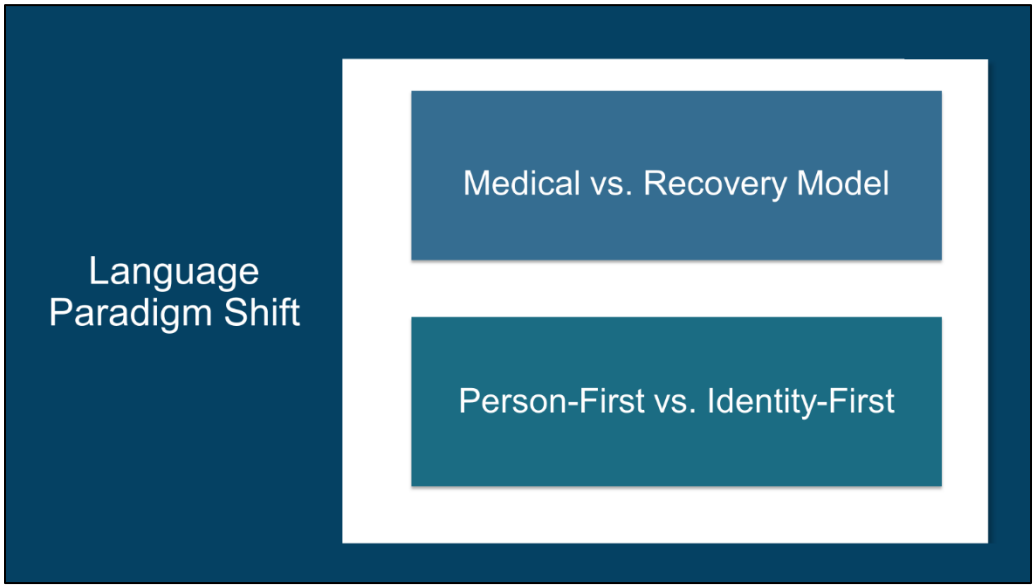
Have there been any active strategies to reduce stigma in your agencies?

Possible answers include training on the importance of person-first language (e.g., parent affected by substance use disorder versus addict or drug user); integrating peer recovery specialists into service delivery models; using public awareness campaigns to dispel common myths or misconceptions at the agency and community level.

Source: (National Center on Substance Abuse and Child Welfare, 2022)

Slide 9

Language Paradigm Shift



Facilitator Script:

The medical versus recovery model is the difference between focusing on the illness versus the person affected by the illness. It is the difference in how we ask, "what is wrong with you?" versus "what has happened to you." While once dominated by the medical model, our field has been undergoing a language paradigm shift with active efforts toward prioritizing healing and well-being, valuing the lived experience of our parents, viewing them as an expert on themselves, and engaging them in shared decision-making.

Another example of this paradigm shift is the emphasis being placed on language inclusivity in our field—more specifically, efforts at raising awareness around the importance of person-first language in place of the long-standing identity-first language used. Person-first language places emphasis on the person before the disability (diagnosis, condition, ailment, etc.). This shift is not specific to child welfare and SUD treatment—as we are witnessing public awareness and workforce development efforts across all disciplines.

Prompts for Participants:

- **Has your agency implemented any efforts toward language inclusivity and awareness? If so, what has this looked like?**
- **While many would agree that person-first language is a current best practice standard, can anyone think of any exceptions where identity-first language might be preferred and why?**

[One possibility is members in the recovery community—often within the secular/self-help groups terms and language like 'addict, alcoholic, etc.' are still used and within the norm for those settings].

Wrap up the discussion and close with:

This has been a good discussion. One final thought is that it's important to remember that person-first and identity-first language is never as simple as always right or always wrong—rather, affirming the preferences by asking what others prefer should always be the rule of thumb.

Let’s now shift our discussion to co-occurring disorders…

Slide 10

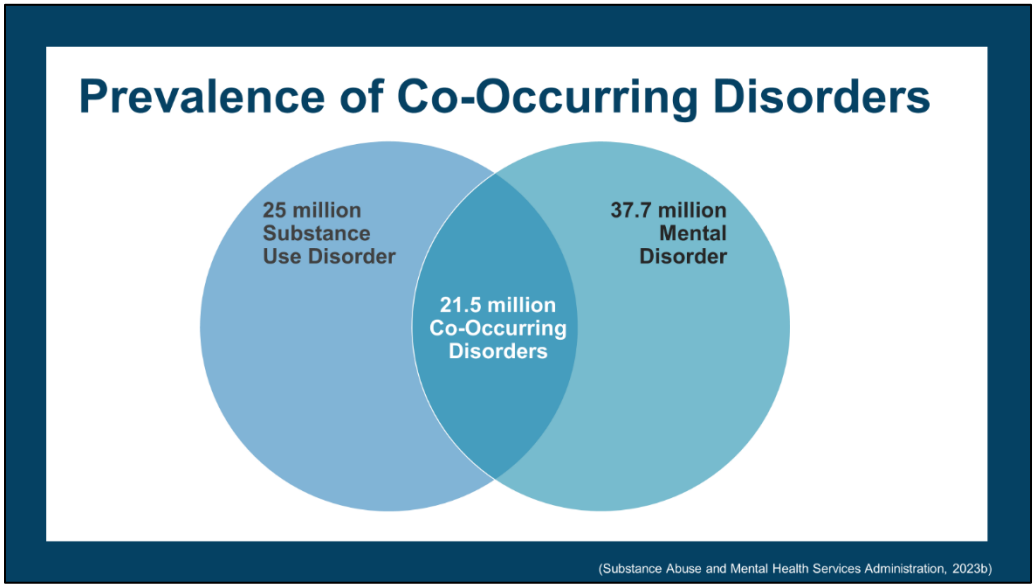
Co-Occurring Substance Use & Mental Disorders

Facilitator Script:

Now let's shift our attention to the topic of co-occurring substance use and mental disorders…

Slide 11

Prevalence of Co-Occurring Disorders



Facilitator Script:

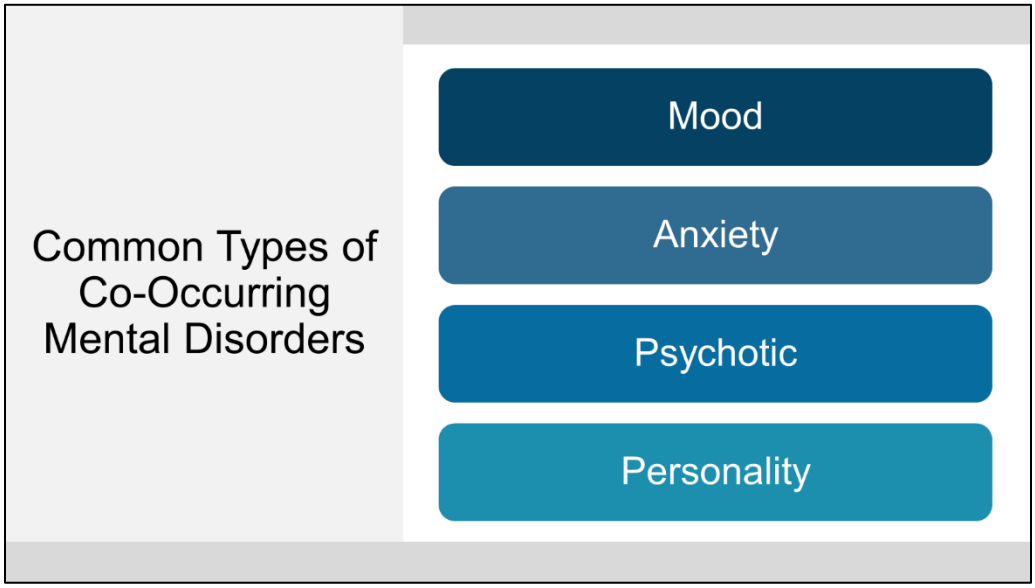
As an important recap to module one, co-occurring disorders are increasingly common. According to SAMHSA's 2022 National Survey on Drug Use and Health, over 21.5 million adults met this diagnostic criterion which, if you recall, just means being affected by both a substance use and mental disorder at the same time. This may present as a substance use disorder in combination with a mood disorder such as depression or bipolar disorder; or an anxiety disorder such as post-traumatic stress disorder (PTSD); or for some individuals a psychotic disorder like schizophrenia (among many other different types). Regardless of the specific type, it's important to remember that the severity of the co-occurring disorder can vary from mild, moderate, or severe. Sometimes one disorder can mask or complicate the symptoms of the other, making it difficult to differentiate for diagnostic and treatment planning purposes.

Now, that we have covered the latest data on prevalence, let's spend some time going over the most common types of co-occurring mental disorders…

Source: (Substance Abuse and Mental Health Services Administration, 2023b)

Slide 12

Common Types of Co-Occurring Mental Disorders



Facilitator Script:

So, the most common types of co-occurring mental disorders generally fall into these four categories: mood, anxiety, psychotic, and personality.

Mood disorders are a classification of mental health diagnoses that are marked by impairments to a person's emotional state of well-being—particularly how we think and feel, and these changes begin to interfere with our ability to function in our everyday lives. Common symptoms of mood disorders include excessive sadness, withdrawal, isolation, fatigue, irritability, poor concentration, sleep disturbances, changes in appetite, and at times suicidal thoughts and behaviors. Like all mental health diagnoses, mood disorders range in severity from mild, moderate, to severe with some causing short-term temporary challenges while others are considered lifelong conditions.

Anxiety disorders (on the other hand) are a group of related mental health diagnoses that share one commonality which is a level of persistent, excessive fear or worry that manifests both physically and emotionally. Common symptoms include apprehension, dread, restlessness, hypervigilance, racing heart, shortness of breath, sweating, upset stomach, headaches, fatigue, or insomnia. Like mood disorders, anxiety disorders are marked by their level of interference with our normal daily functioning and are the most common of all mental health conditions.

There are also psychotic disorders, which are a group of severe mental disorders characterized by their disconnection from reality. The two telltale symptoms of these disorders include delusions (or false beliefs) and hallucinations (false perceptions), but other common symptoms include disorganized thinking, incoherent speech, unusual behavior, and poor hygiene. Onset of psychotic disorders typically appear in late adolescence into early adulthood, affecting both males and females equally.

Lastly, we have personality disorders which are a group of mental disorders marked by rigid and unhealthy patterns of thinking and relating thereby causing significant challenges related to school, work, friendships, and relationships. Personality disorders are organized into three clusters based on common characteristics and symptoms:

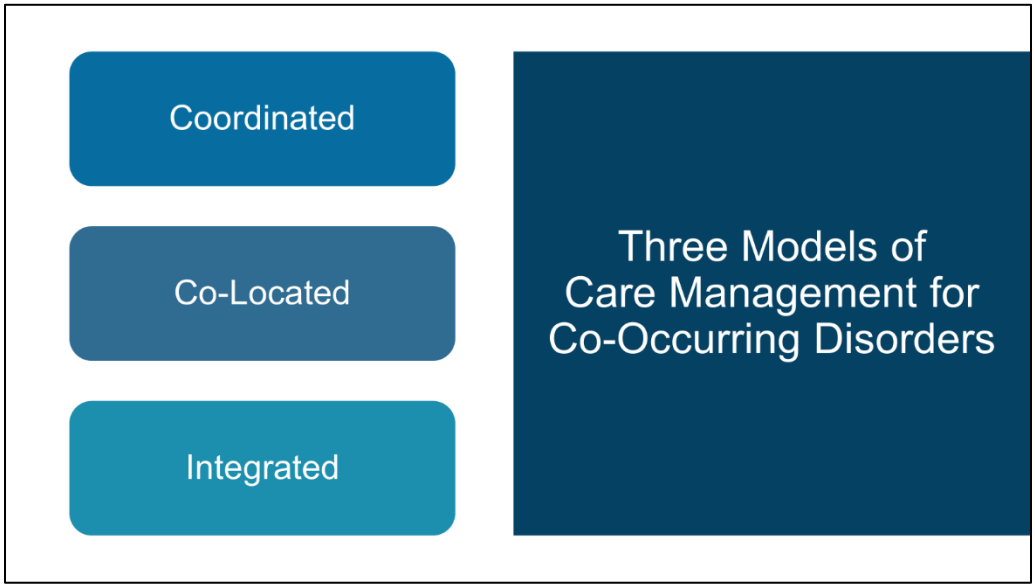
- Cluster A is marked by odd or eccentric thinking and behavior;
- Cluster B is marked by overly dramatic, emotional or unpredictable thinking and behavior;
- While Cluster C is marked by anxious or fearful thinking and behavior.

These groups of disorders cause significant disruption to not only the lives of those affected but also to those closest to them. Onset of personality disorders also typically occur in late adolescence into early adulthood.

Source: (Substance Abuse and Mental Health Services Administration, 2023a)

Slide 13

Three Models of Care Management for Co-Occurring Disorders



Facilitator Script:

And finally, SAMHSA recognizes three specific models of care management for co-occurring disorders: coordinated, co-located, and integrated.

Coordinated care models refer to when an individual receives care from two separate practitioners—one who is qualified to treat the substance use disorder and one who is qualified to treat the mental disorder. The two practitioners then ideally coordinate treatment to support their client's recovery and well-being. For decades this was the standard of care in the field largely due to not having the scientific advancements, resources, and trained professionals to offer anything beyond this.

Co-located care models improved upon the well documented challenges of coordinated care models by housing both substance use and mental health treatment providers together in one office setting. While this model does not solve the issue of having two separate practitioners it does help considerably in reducing communication and other logistical challenges thereby improving the level of collaborative partnership which directly benefits the consumer (or in our case, court-involved families).

Ideally though, all individuals affected by co-occurring disorders would have access to integrated care models. Like the name implies integrated care models screen for both substance use and mental disorders at the same time and follow this up with developing an integrated treatment plan. In this model, treatment is also provided by one practitioner (or a team of practitioners) who are trained and qualified to treat both conditions offering consumers a more robust recovery experience and in turn improved outcomes such as reduced or discontinued use of substances, improvements to mental health symptoms including decreased hospitalizations and reduced medication interactions, and an overall improved quality of life.

Prompts for Participants:

Now a question for the large group…

On average, which care management model are child welfare-involved families receiving in your state and local communities—coordinated, co-located, or integrated? And if not integrated, what have been the challenges to implementation?

Facilitator Note: Additional resources are available for more information on this topic: Supporting Recovery in Parents with Co-Occurring Disorders in Child Welfare. No. 26 and *Treatment Improvement Protocol (TIP) 42: Substance Use Treatment for Persons With Co-Occurring Disorders*.

Sources: (Substance Abuse and Mental Health Services Administration, 2009; Substance Abuse and Mental Health Services Administration, 2022)

Slide 14

Mental Scategories

Facilitator Script:

Now that we have some foundational knowledge under our belts—how about we put it to the test?! Let's convene in small groups of (X) number at your tables. For this activity, each group will receive a large piece of easel paper with the four common types of co-occurring mental disorders listed. You'll receive an envelope with 20 various mental diagnoses listed on little post-it notes. You and your group members will have (x) amount of time to properly 'scategorize.' First group to complete the task will walk us through their answers in a large group setting and the group with the most correct answers wins…bragging rights!!

Materials Needed:

- *Large Easel Paper (Pre-filled with sections for Mood, Anxiety, Psychotic & Personality)*
- *Envelopes containing 20 pre-filled small post-it notes containing one mental diagnosis (one per small group—prep based on size of each training)*

Specific diagnoses for the 20 pre-filled post-it notes:

Mood:

- Major Depression
- Bipolar I
- Cyclothymia
- Seasonal Affective
- Postpartum Depression

Anxiety:

- Obsessive-Compulsive
- Agoraphobia
- Post-Traumatic Stress
- Social Phobia
- Body Dysmorphia

Psychotic:

- Shared Psychosis
- Substance-Induced Psychosis
- Schizophrenia
- Schizoaffective
- Schizophreniform

Personality:

- Histrionic
- Narcissistic
- Schizoid
- Paranoid
- Antisocial

**Alternative Instructions for Virtual Training*

Use breakout rooms feature on your respective virtual platform to allow for small group activity. Once groups are assigned to breakout rooms provide them access to a de-categorized list of the 20 specific mental health diagnoses listed below by adding to the group chat. Use the same talking points to set up the virtual small group activity…

You and your group members will have (x) amount of time to properly 'scategorize.' First group to complete the task will walk us through their answers in a large group setting and the group with the most correct answers wins…bragging rights!!

Materials Needed:

**Be sure to de-categorize the list below before adding it to the chat box.*

Mood:

- Major Depression
- Bipolar I
- Cyclothymia
- Seasonal Affective
- Postpartum Depression

Anxiety:

- Obsessive-Compulsive
- Agoraphobia
- Post-Traumatic Stress
- Social Phobia
- Body Dysmorphia

Psychotic:

- Shared Psychosis
- Substance-Induced Psychosis
- Schizophrenia
- Schizoaffective
- Schizophreniform

Personality:

- Histrionic
- Narcissistic
- Schizoid
- Paranoid
- Antisocial

Slide 15

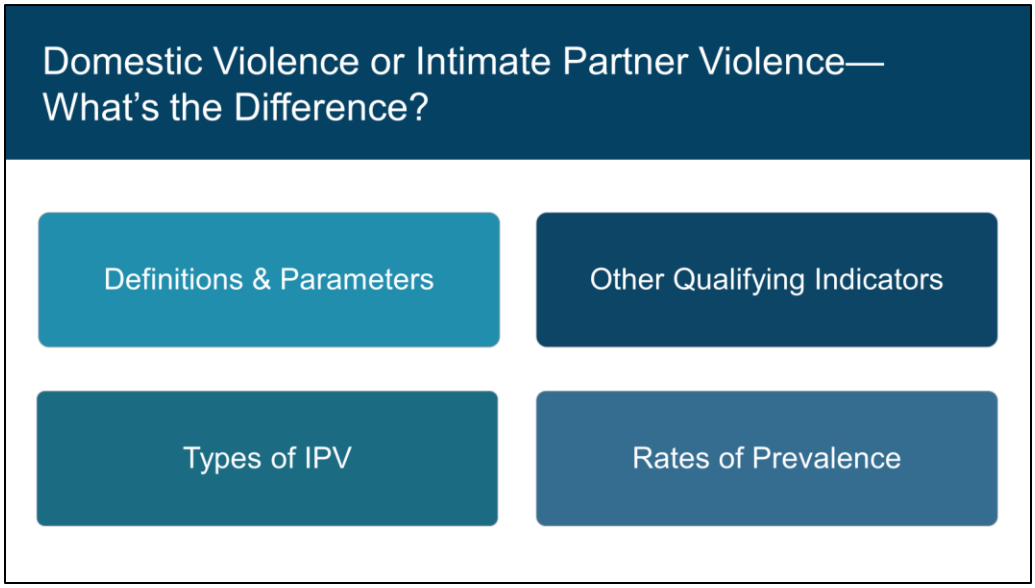
Intimate Partner Violence & the Intersection with Co-Occurring Disorders

Facilitator Script:

Let's now keep all that information about co-occurring disorders in mind as we move into a discussion around the intersection of intimate partner violence.

Slide 16

Domestic Violence or Intimate Partner Violence—What's the Difference?



Facilitator Script:

Another example of a language paradigm shift our field has witnessed is the move from using domestic violence terminology in favor of intimate partner violence instead. While these terms are often believed to be synonymous with each other, they do hold slightly different meanings and parameters with respect to the law. By definition, domestic violence is any act of violence that occurs within a household between any two individuals residing together—this could mean violence between a couple, a parent and child, two roommates, etc. —again the emphasis on any two individuals residing in the same home together. Intimate partner violence (as the name implies) focuses more narrowly on the nature of the intimate partnership (with acknowledgment to both current or former relationships) and any behavior that one partner uses to establish control over the other—with no bearing on whether the two partners reside together or not.

Power and control between intimate partners may appear vastly differently from one to the next in addition to the telltale forms of physical or sexual violence, we should also understand how other forms manifest in relationships which may include attempts to exert power and control through emotional, psychological, financial, cultural, spiritual, reproductive, and other means.

Other important qualifying indicators of IPV include type of partnership—IPV is inclusive to all forms of relationships including current or former spouses, domestic or same sex partners, boyfriends and girlfriends, dating partners including casual sex partners. In addition to type of partnership, information related to type of violence or coercion, level of connection, and the degree or amount of contact is critical for assessment and service planning.

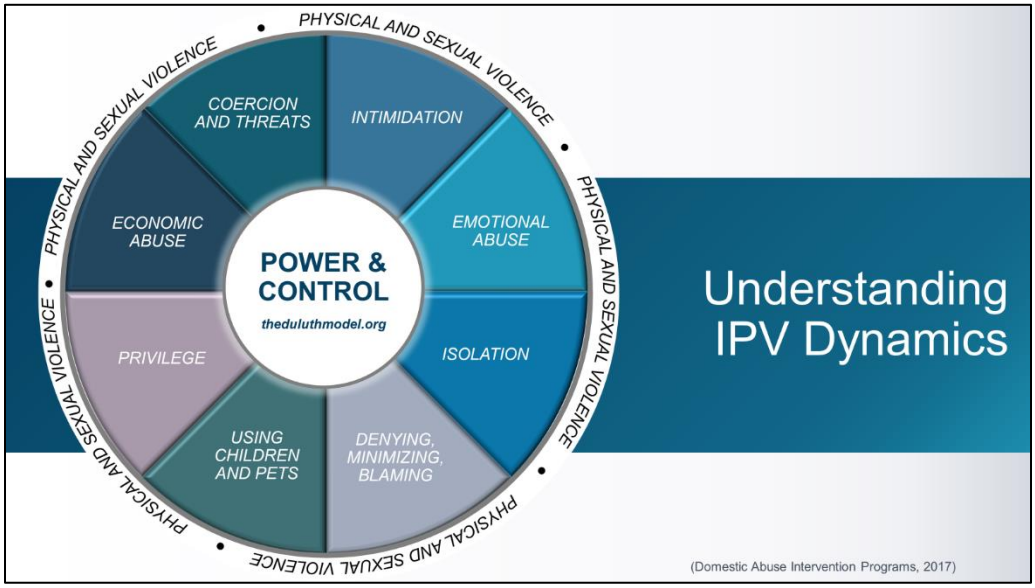
So just how common is IPV? According to data from the CDC's National Intimate Partner and Sexual Violence Survey roughly 41% of women and 26% of men have experienced intimate partner violence during their lifetime. This survey was limited to sexual and physical acts of violence (including stalking) and therefore does not account for all the other various forms of

power and control experienced within intimate partnerships. A separate figure from the CDC quantified that over 61 million women and 53 million men have experienced emotional or psychological aggression during their lifetime which might be a more accurate figure capturing the depth of this public health issue.

Source: (Centers for Disease Control and Prevention, 2022)

Slide 17

Understanding IPV Dynamics



Facilitator Script:

So now that we have covered an introduction to intimate partner violence including definitions, types, qualifying indicators, and its prevalence—let's now move into a discussion about understanding IPV dynamics. This is a de-identified version of the Duluth Model's Power and Control Wheel. This adapted version only lists out the broader level tactics used to exert power and control within intimate partnerships which is different from the original, gender-specific version informed by focus groups held with female survivors during the mid-to-late 80's.

As we move into an experiential exercise, it's important to note that while these broader level tactics apply to both hetero and same-sex partnerships, details in how they manifest may present differently due to factors beyond gender-based stereotypes or assumptions about IPV.

Prompt for Participants:

Does anyone have any thoughts or insights into other factors that may be influencing IPV in same-sex partnerships?

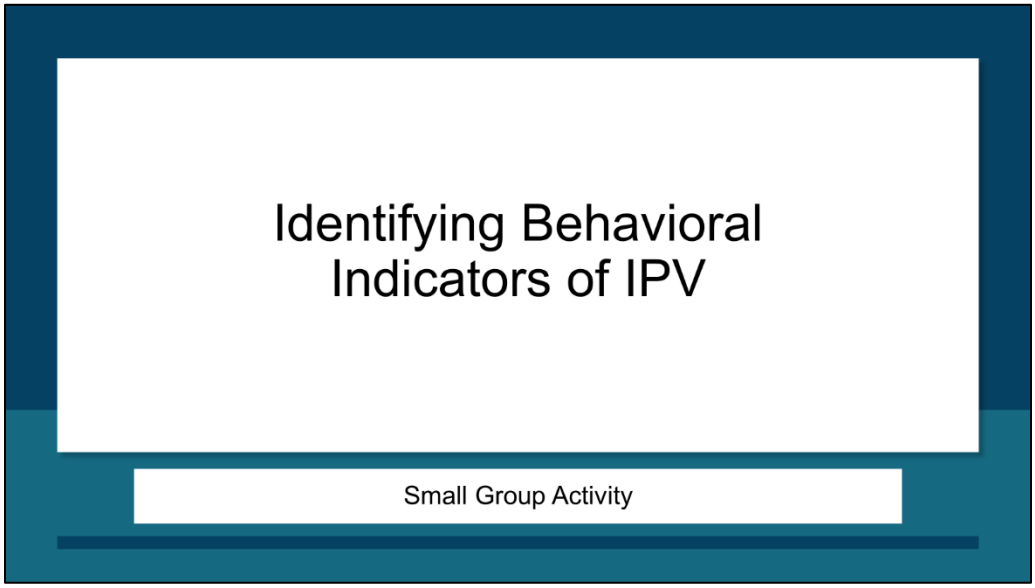
[Possible answers include systemic and cultural stressors specific to the LGBTQIA2S+ community—whether same-sex couples can be safely out in their communities, whether they have access to legal rights and supportive services, including if their state or local jurisdiction recognizes same-sex couples in order of protections.]

Facilitator Note: For more information on this topic, visit the additional resources: The Duluth Model Wheel Library from the Domestic Abuse Intervention Programs, the National Domestic Violence Hotline, and the Strong Hearts Native Helpline.

Sources: (Baker et al., 2013; Domestic Abuse Intervention Programs, 2017)

Slide 18

Identifying Behavioral Indicators of IPV



Facilitator Script:

Let's now reconvene in our small groups for an activity on identifying behavioral indicators for each category of the power and control wheel with consideration to both hetero and same-sex relationships. Let's plan to meet in our small groups for (x amount of time) before reconvening for a large group report out and discussion.

Here's an example to get you started in your small groups:

Isolation:

An example of isolation as a power and control tactic would be when a person doesn't allow their partner to have any meaningful social connections such as not allowing them to work, or maintain relationships with family, friends, or neighbors.

Now it's your turn, let's plan to reconvene as a large group in [x] minutes!

Materials Needed:

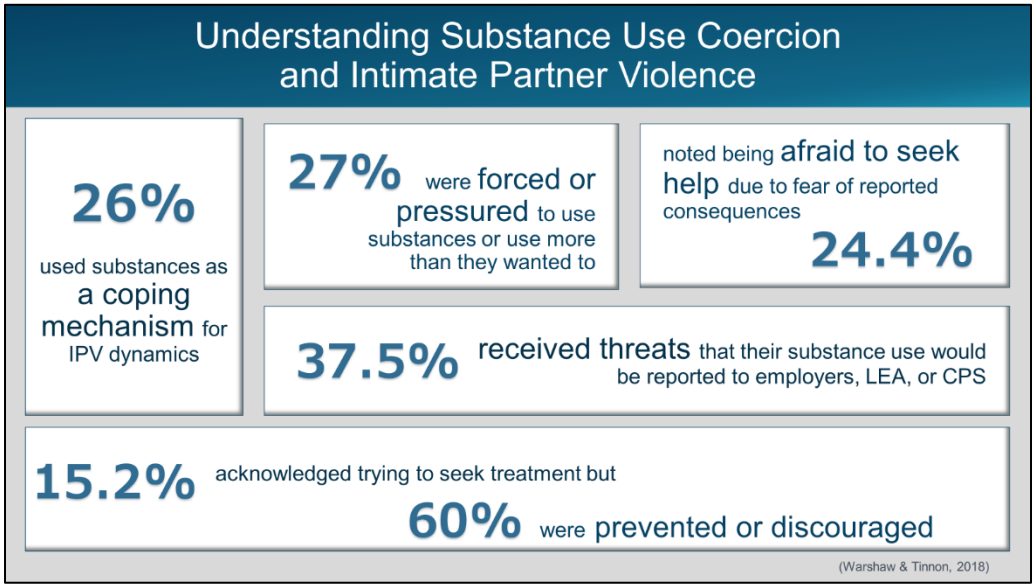
- *Large Easel Paper*
- *Markers*

**Alternative Instructions for Virtual Training*

Use breakout rooms feature on your respective virtual platform to allow for small group activity or proceed with an individual activity followed by large group discussion.

Slide 19

Understanding Substance Use Coercion and Intimate Partner Violence



Facilitator Script:

Now let's focus on the intersection of substance use and intimate partner violence. Substance use may play a facilitative role in intimate partner violence—meaning it might either precipitate or exacerbate the level of violence between partners. A form of intimate partner violence that we haven't already discussed in this toolkit involves substance use coercion—or tactics used by the partner using violence to control and/or manipulate their partner's use of substances, access to treatment, and other sources of protection. The National Domestic Violence Hotline in collaboration with the National Center on Domestic Violence, Trauma & Mental Health administered a first of its kind survey to hotline callers who were not in immediate crisis over a six-week period. A total of 3,248 respondents agreed to participate in the survey and this is what the results found:

- 26% acknowledged using substances as a coping mechanism in response to IPV incidents
- 27% reported being forced or pressured to use substances and/or use more than they wanted by their offending partner
- 24.4% noted being afraid to seek out help or sources of protection because their offending partner said they would face consequences for being under the influences of substances (e.g., being arrested or having children being taken away)
- 37.5% stated that their offending partner threatened to report their substance use to employers, law enforcement agency (LEA), or child protective services (CPS) to exert power and control
- 15.2% acknowledged trying to seek treatment for their substance use in the last few years but also that 60% of those same respondents had offending partners who prevented or discouraged them from participating

Overall, 43% of survey respondents experienced at least one type of substance use coercion.

Facilitator Note: The National Center on Domestic Violence, Trauma, & Mental Health Website is included in this guide as an additional resource on this topic.

Source: (Warshaw & Tinnon, 2018)

Slide 20

Child Welfare Involvement as a Power and Control Tactic

Facilitator Script:

As the hotline survey results indicated, a person using violence may use child welfare involvement to further assert power and control in their partnership. This will be different for all families experiencing violence but may include threats or retaliations such as:

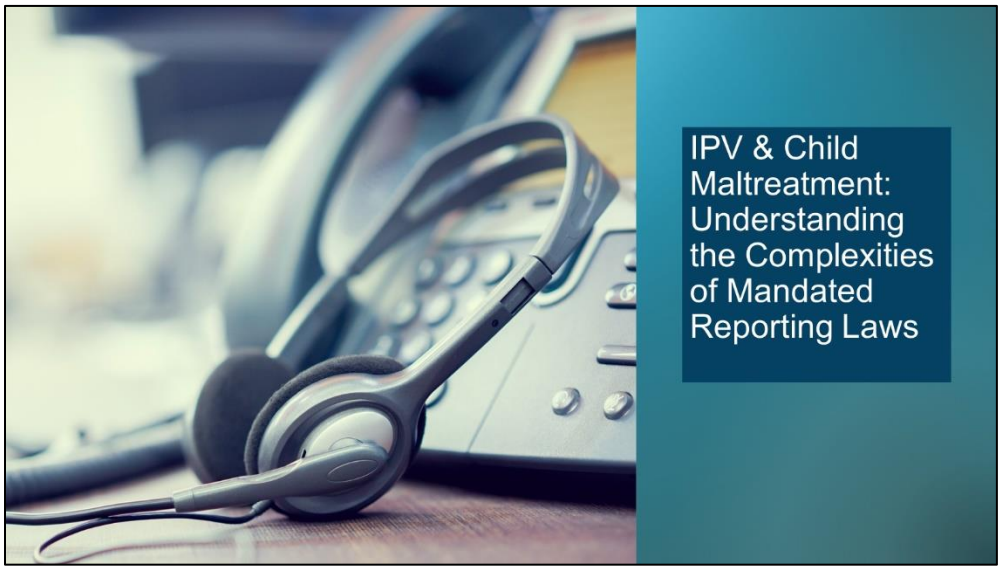
- Escalating violence and coercive behavior
- Withholding finances or jeopardizing employment status
- Threatening deportation or interfering with immigration status
- Making false reports to child abuse hotlines
- Filing false police reports or restraining orders

Let's keep all this information in mind as we transition into a discussion about differentiating between IPV and child maltreatment and the complexities that mandated reporting laws present…

Sources: (National Domestic Violence Hotline, n.d.; HeadStart ECLKC, 2024)

Slide 21

IPV & Child Maltreatment: Understanding the Complexities of Mandated Reporting Laws



Facilitator Script:

As child welfare workers, a critical first step to promoting safety and healing for children, parents, and families experiencing violence is to be able to differentiate between intimate partner violence from co-occurring intimate partner violence and child maltreatment. This can be a challenging task for many reasons, but let's begin by understanding how differences in state, local, and tribal laws influence mandated reporting practices across communities.

First, there are considerable differences in how mandated reporting laws define child abuse and neglect, including the intersection with IPV exposure. In some localities, the law mandates that a report be made for any known or suspected IPV exposure, while in others, the law allows for reporter discretion—such as consultation with child protective services and local law enforcement agencies, and then in some other instances, the law does not include any specific reference or guidance.

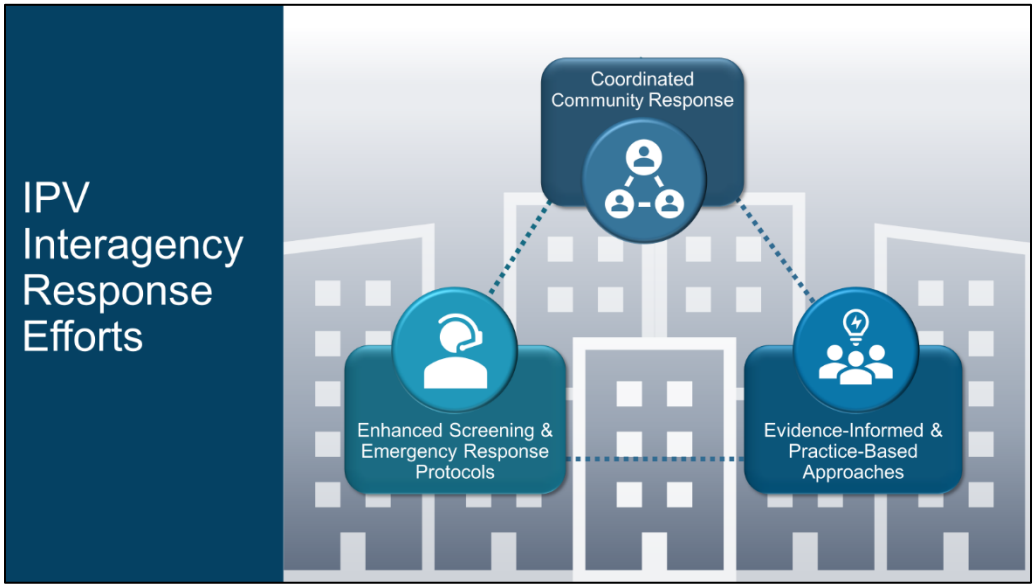
And while mandated reporting laws were designed with the intent of increasing child safety, we also know this practice has significantly contributed to the overrepresentation of families of color involved with the child welfare system. As child welfare workers, it's important that we understand how the disproportionate involvement of families of color begins with the initial reporting decision and continues with various decision-making points during the child welfare intervention period. Knowing how systemic and personal bias influences initial reporting decisions followed by screening and assessment practices is one step toward improving racial equity and rebuilding trust with mandated reporting and decision-making practices across all communities and for all families regardless of race, ethnicity, gender, or class.

Facilitator Note: An additional resource is available for more information on state specific laws: Child Welfare Information Gateway: State Statutes Search.

Sources: (Mandated Reporter Training, 2022; HeadStart ECLKC, 2024; Evident Change, 2023; UCLA Pritzker Center, 2021)

Slide 22

IPV Interagency Response Efforts



Facilitator Script:

As we've learned, intimate partner violence is a serious public health matter—one that requires multiagency collaboration to ensure proper identification and intervention for families experiencing violence. A coordinated community response to intimate partner violence brings together stakeholders from child welfare, family violence service providers including survivor advocates, substance use and mental health treatment providers, law enforcement agencies, and the judicial system with the goal of advancing interagency response efforts—more specifically opportunities for enhanced collaboration, cross-training, and trauma-informed service provision.

For child welfare jurisdictions, this includes opportunities for enhanced screening and emergency response protocols that 1) promote identification and accountability of the person causing harm through use of violence, 2) amplify the voice of the person experiencing violence related to defining safety and healing for themselves and their children, and 3) prioritize the physical, emotional, and psychological safety for all involved parties—children, parents, and families experiencing violence as well as the professionals charged with immediate intervention and ongoing service provision.

So, what are some actionable policy and practice improvements specific to child welfare intervention for families experiencing violence? An environmental scan highlights several evidenced-informed and practice-based approaches. These include 1) ensuring that allegations are filed or screened in under the name of the parent using violence and not the parent experiencing violence, 2) engaging the parent experiencing violence to identify family strengths and protective capacities and working together to enhance safety and prevent family separation whenever possible, and 3) partnering with community agencies for co-location of family violence prevention specialists or survivor advocates in child welfare settings to provide essential functions, including:

- Engaging and supporting children, parents, and families experiencing violence

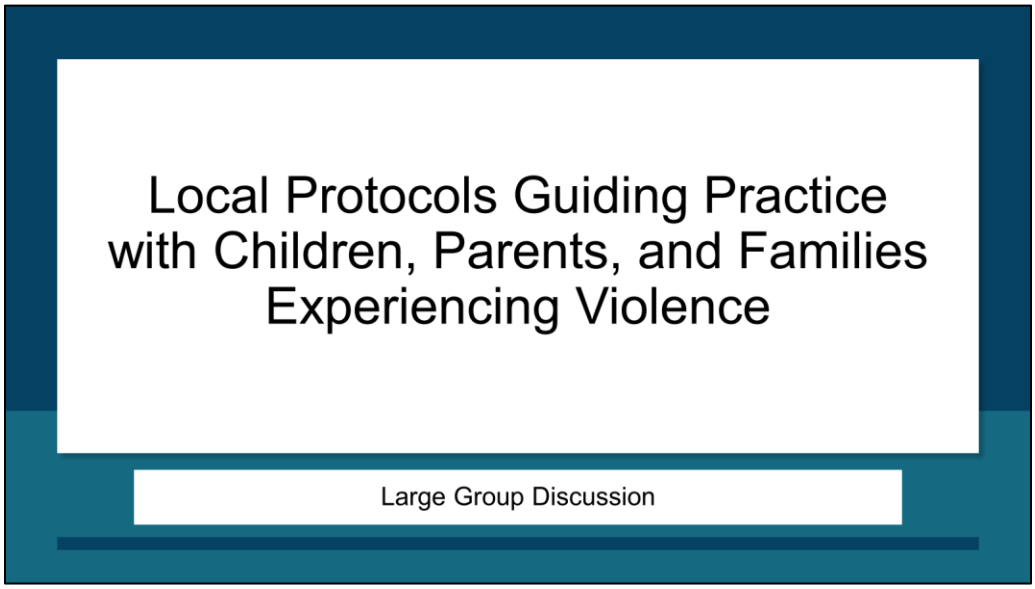
- Collaborating with child welfare workers for enhanced casework practice through consultation and service planning
- Improving interagency collaboration and coordinated community response efforts through subject matter expertise and cross-training learning opportunities

Facilitator Note: The additional resource Adult & Child Survivor-Centered Approach for Addressing Domestic Violence is available for more information.

Sources: (Hetzel-Riggin, 2022; Duane et al., 2021; UCLA Pritzker Center, 2021; Minnesota Department of Human Services, 2021)

Slide 23

Local Protocols Guiding Practice with Children, Parents, and Families Experiencing Violence



Facilitator Script:

So, while we've covered more general information on evidence-informed and practice-based approaches, let's now hear what is happening locally within our own communities.

Prompt for Large Group Discussion:

How are local protocols guiding our practice with children, parents, and families experiencing violence? Would anyone like to share about current screening, emergency response, or field safety protocols?

This was very informative, thank you all for sharing about your local protocols. Let's now transition to a discussion about IPV screening tools and how these can support proper identification and intervention for parents experiencing violence.

Slide 24

IPV Screening Tools

Facilitator Script:

Screening for IPV will also vary depending on type of care setting or service provision. The United States Preventative Services Task Force (USPSTF) and the Department of Health and Human Services recommend IPV screening and counseling as an integrated part of preventative health care services—specifically those of childbearing age or older, including vulnerable adults. This recommendation, also supported by the Affordable Care Act (ACA) has led to more efforts at promoting universal screening during routine annual healthcare visits—and the extension of this recommendation into child welfare settings is yet another example of an evidence-informed and practice-based approach to promoting a future without violence.

While an environmental scan produced numerous options for validated IPV screening tools, the tools highlighted here represent those that are accessible at no cost to service providers:

- The Abuse Assessment Screen (AAS) is a tool administered via provider and contains a total of five standardized questions, including a body map that marks the area of injury with a corresponding incident rating using a 1-6 scale.
- The Ongoing Violence Assessment Tool (OVAT) previously referred to as the Ongoing Abuse Screen (OAS) is an adaptation of the AAS allowing for screening of ongoing IPV. The tool is administered via self report and contains four standardized questions—three of which are yes or no, with the final question answered using a 5-point Likert scale.
- The Danger Assessment 5 (DA-5) is an adaptation of the full Danger Assessment and is administered via self report; it contains five standardized yes or no questions with a scoring key identifying next steps for the provider conducting the screening.

- The Humiliation, Afraid, Rape, and Kick (HARK) is a tool administered via self report and contains four standardized yes or no questions with one point given for every yes response.
- The Partner Violence Screen (PVS) is a provider-administered tool and contains three standardized questions designed to assess physical IPV in the last year, as well as current levels of safety.
- And finally, the Woman Abuse Screen Tool (WAST) is administered via self report and contains seven standardized questions designed to assess for physical and emotional violence.

Prompts for Participants:

Alright, now I'd like to hear from you all. Has your agency begun screening for IPV? And if so, which tools are you currently using?

Sources: (Stephan et al., 2021; Basile et al., 2007; de Boinville, 2013)

Slide 25

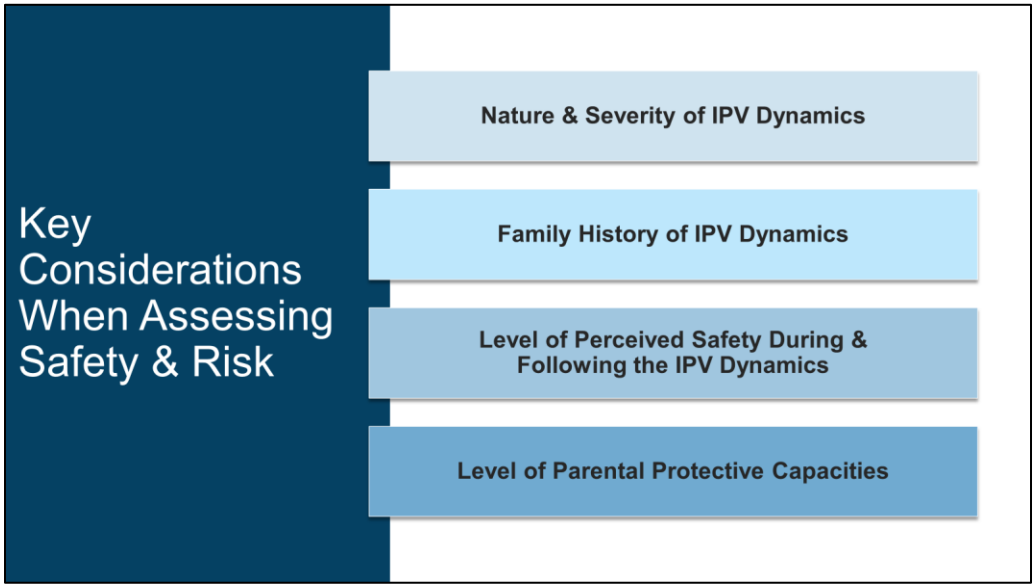
IPV Exposure & Child Welfare Intervention

Facilitator Script:

Let's now take what we have learned about family violence—both IPV and IPV exposure—and begin exploring key considerations for assessment of safety and risk.

Slide 26

Key Considerations When Assessing Safety & Risk



Facilitator Script:

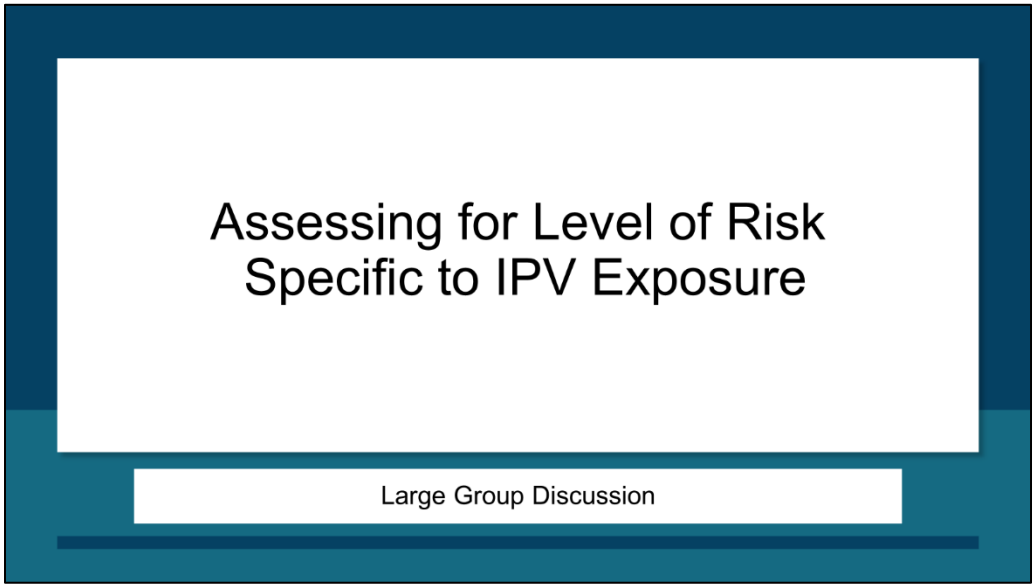
Proper identification and intervention with families experiencing violence can be challenging, but our focus as child welfare workers should always remain on understanding the level of risk to the child and increasing safety and protective capacities for the family—with services and supports directed at both the parent/caregiver using violence and the parent/caregiver experiencing the violence.

Let's first start by reviewing key considerations for when assessing the level of risk to a child. This will include information that can inform the nature, severity, and frequency of family violence. This includes details about the level of exposure to violent and/or coercive behavior, how long it has been going on for, level of perceived safety both during and following the occurrence of violent or coercive behavior, and the level of parental protective capacities to help mitigate risk and increase child and family safety.

Sources: (HeadStart ECLKC, 2024; Minnesota Department of Human Services, 2021)

Slide 27

Assessing for Level of Risk Specific to IPV Exposure



Facilitator Script:

Let's now spend some time together discussing as a large group the types of questions we should be asking when assessing for level of risk specific to IPV exposure.

Here's an example to get us started:

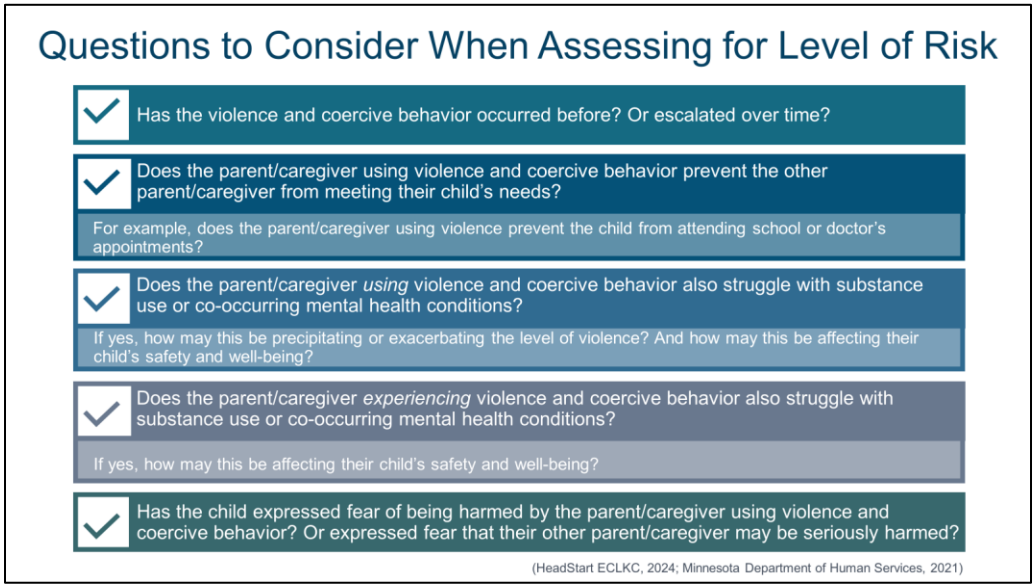
Has the violence and coercive behavior occurred before? Or escalated over time?

Prompt for Large Group Discussion:

What are some other examples from your experience working with families who have experienced violence?

Slide 28

Questions to Consider when Assessing for Level of Risk



Facilitator Script:

Facilitator Notes: As a follow up to the large group discussion, walk participants through the list of questions to consider when assessing for level of risk specific to IPV exposure.

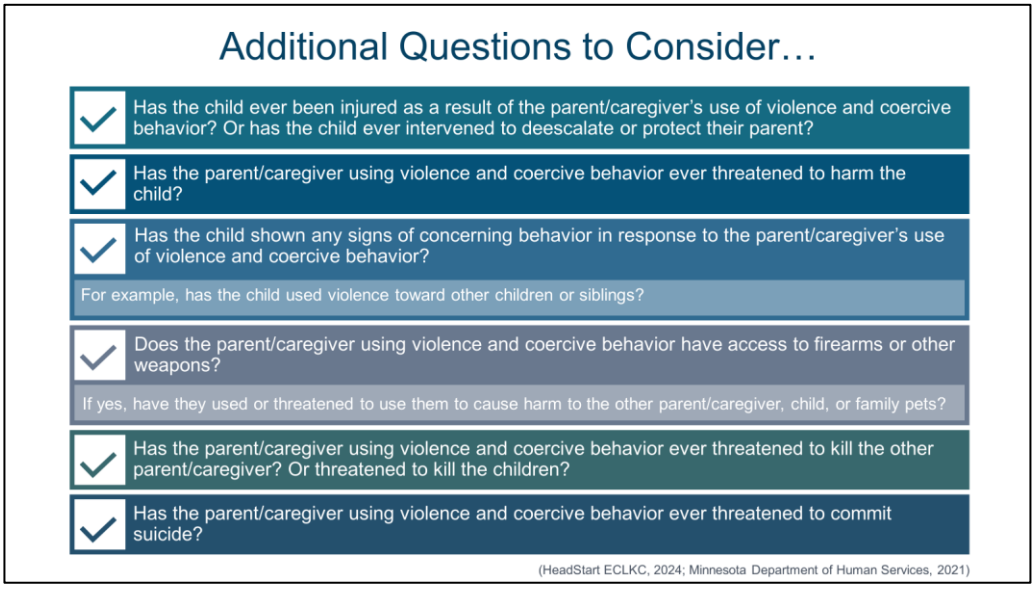
Alright, let's check out how we did! Questions to consider when assessing for level of risk specific to IPV exposure include:

- Has the violence and coercive behavior occurred before? Or escalated over time?
- Does the parent/caregiver using violence and coercive behavior prevent the other parent/caregiver from meeting their child's needs?
    - For example, does the parent/caregiver using violence prevent the child from attending school or doctor's appointments?
- Does the parent/caregiver using violence and coercive behavior also struggle with substance use or co-occurring mental health conditions? If yes, how may this be precipitating or exacerbating the level of violence? And how may this be affecting their child's safety and well-being?
- Does the parent/caregiver experiencing violence and coercive behavior also struggle with substance use or co-occurring mental health conditions? If yes, how may this be affecting their child's safety and well-being?
- Has the child expressed fear of being harmed by the parent/caregiver using violence and coercive behavior? Or expressed fear that their other parent/caregiver may be seriously harmed?

Sources: (HeadStart ECLKC, 2024; Minnesota Department of Human Services, 2021)

Slide 29

Additional Questions to Consider…



Facilitator Script:

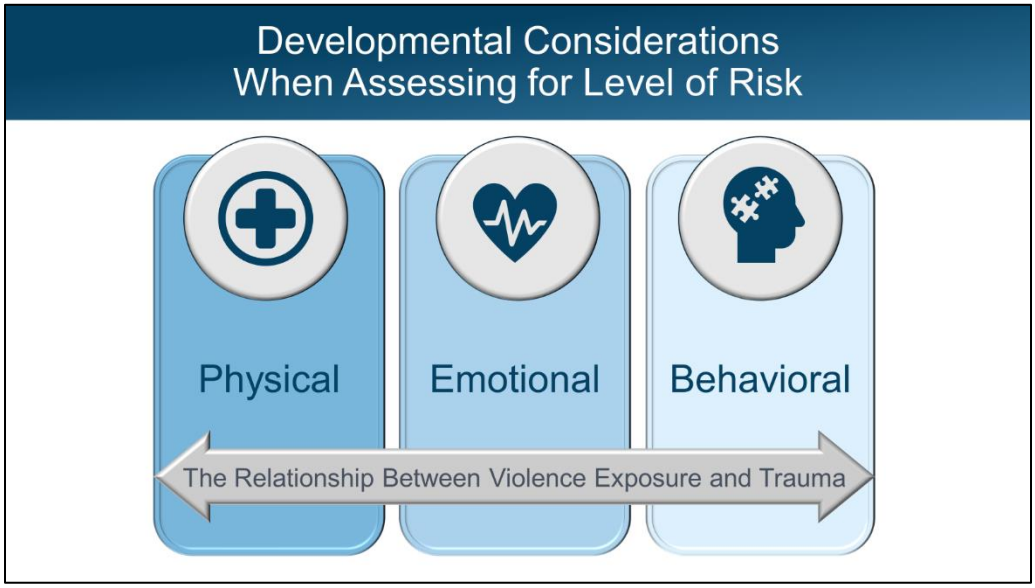
And some additional questions to consider:

- Has the child ever been injured as a result of the parent/caregiver's use of violence and coercive behavior? Or has the child ever intervened to deescalate their parent/caregiver's use of violence and coercive behavior? Or has the child ever intervened to protect their parent/caregiver experiencing violence or coercive behavior?
- Has the parent/caregiver using violence and coercive behavior ever threatened to harm the child?
- Has the child shown any signs of concerning behavior in response to the parent/caregiver's use of violence and coercive behavior?
    - For example, has the child used violence toward other children or siblings?
- Does the parent/caregiver using violence and coercive behavior have access to firearms or other weapons? If yes, have they used or threatened to use them to cause harm to the other parent/caregiver, child, or family pets?
- Has the parent/caregiver using violence and coercive behavior ever threatened to kill the other parent/caregiver? Or threatened to kill the children?
- Has the parent/caregiver using violence and coercive behavior ever threatened to commit suicide?

Sources: (HeadStart ECLKC, 2024; Minnesota Department of Human Services, 2021)

Slide 30

Developmental Considerations When Assessing for Level of Risk



Facilitator Script:

So, in addition to the types of questions we should be asking when assessing for level of risk, we also have some important developmental considerations to keep in mind as well. As we've learned from previous modules, adverse childhood experiences including exposure to intimate partner violence can cause traumatic stress for children and adolescents. Responses to traumatic stress will range depending on considerations such as age, developmental stage, along with other factors including nature and severity of violence exposure, and the presence of individual and familial strengths and protective capacities. Let's review some important developmental considerations when assessing level of risk…

For infants and toddlers, while they can't understand what is happening developmentally, they can indeed sense the violence through what they hear and what they feel from their caregivers and their environment. Traumatic stress at this stage of development will often present as increased dysregulation such as crying, fussiness, and challenges with soothing the infant or toddler.

Similarly, for preschool-aged children, they also rely heavily on their senses—what they see, hear, and feel. Traumatic stress at this stage of development will often present as regressive behavior such as thumb sucking, increased clinginess, nightmares, and bedwetting.

School-aged children begin to have a better understanding of the complexities of family violence. Traumatic stress at this stage of development will often present as somatic complaints such as headaches or stomachaches, difficulty concentrating in the classroom, withdrawn or reactive behavior including increased anger or irritability.

And finally, adolescents are more likely to demonstrate the long-term effects of violence exposure through their choices and behaviors. Traumatic stress at this stage of development will often present as engaging in high-risk behavior such as fighting, skipping school, experimenting with

alcohol and other drugs, and repeating patterns of abuse—both the person using violence and coercive behavior and the person experiencing violence and coercive behavior.

As we touched on in module one, when the cumulative effects of emotional stress or adverse childhood experiences are not dealt with timely or appropriately, the level of toxic stress can very much escalate to the point of clinical intervention and diagnosis with a host of serious, long-term health and well-being implications.

Facilitator Note: The additional resource, Domestic Violence and the Child Welfare Professional: General Practice Tips is available for more information.

Sources: (The National Child Traumatic Stress Network, n.d.-b; Capacity Building Center for States, 2017; Cunningham & Baker, 2007)

Slide 31

Increasing Safety and Protective Capacities for Families Experiencing Violence

Facilitator Script:

Now as we've learned, some families experiencing violence may present with safety considerations that will require child welfare intervention due to the co-occurrence of intimate partner violence and child maltreatment. For these families, optimal family outcomes will necessitate a coordinated community response to increase safety and protective capacities to prevent further harm while also facilitating the process of healing.

Beginning with the person using violence this will look like increasing accountability through creating pathways for personal responsibility and transformative change including reparations for the harm they have caused to their partner and children. For service planning, this will necessitate greater engagement and support to the person using violence including referral and linkage to abusive partner intervention programs or APIPs and individualized safety plans that reinforce accountability and insight into the effects of their use of violence and coercive behavior.

Increasing accountability for the person using violence will also require a change to policies and practices that have historically misdirected responsibility to the person experiencing the violence under the guise of statutory responses such as failure to protect and environmental circumstances statues. Instead, child welfare and family violence experts strongly advocate for collaborative engagement of the person experiencing violence to identify existing protective capacities while working to enhance family safety and stability, such as:

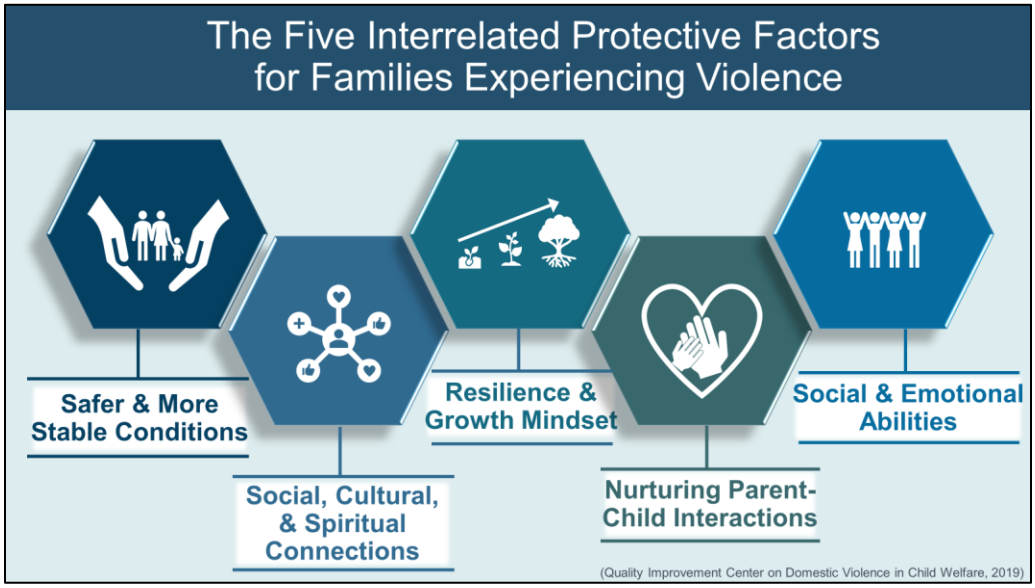
- Providing referral and linkage to family violence service providers and resources
- Facilitating access to concrete supports and services to ensure the family's basic needs are being met
- Engaging the parent experiencing violence to learn about steps they have already taken to protect their children from harm, including discussion of what has worked and what hasn't worked in the past

- Exploring the benefits and drawbacks of different sources of protection for the children and parent experiencing the violence and co-develop a family safety plan that is achievable and adaptable based on changes to the family's circumstances
- Identifying actionable steps detailing who to call, where to go, and what to do in response to increased violence and coercive behavior
- Developing a list of personal and familial items needed during an emergent situation requiring the family to leave and seek immediate safety. Such personal items may include birth certificates, immigration documents, list of contact information for family, friends, service providers, banking information, insurance cards, etc.

Sources: (Center for Court Innovation, 2022; Minnesota Department of Human Services, 2021)

Slide 32

The Five Interrelated Protective Factors for Families Experiencing Violence



Facilitator Script:

The Quality Improvement Center on Domestic Violence in Child Welfare or QIC-DVCW developed the Adult & Child Survivor-Centered Approach that includes a Risk and Protective Factors Framework. Protective factors in the context of family violence comprise of individual and relational attributes in addition to environmental and social conditions that help mitigate risk of harm while building individual and familial strengths, healthy development and nurturing relationships, and conditions that support the safety, healing, and well-being for families experiencing violence.

Safer & More Stable Conditions: For families experiencing violence, safer conditions refers to a reduced risk of physical, sexual, or emotional harm including power and control tactics such as threats, retaliations, intimidation, oppression, coercion, and isolation—for both physical and social environments and relationships. Just as each family experiences violence differently, safer conditions will also look different for each family. Similarly, more stable conditions refer to the presence of positive experiences such as the presence of consistent and predictable housing, employment, educational or vocational opportunities, childcare, and other sources of concrete supports and services.

Social, Cultural, & Spiritual Connections: For families experiencing violence, social, cultural, and spiritual connections refer to healthy and constructive relationships that foster connectedness and positive self-identity. This will also look different for each family but generally represents sustained relationships within their natural network such as family members or peers, as well as community, institutional, and faith-based supports. These connections are valuable resources as they increase trust, belonging, hope, and belief in oneself while also providing concrete, affiliative, emotional, informational, cultural, and spiritual supports to families experiencing violence.

Resilience & Growth Mindset: For families experiencing violence, resilience and growth mindset refers to an individual or family's ability to adapt and grow in response to adverse experiences. This includes an individual or family's ability to cope, problem solve, access and utilize resources that will support personal and familial growth. Resilient and growth mindset families view their adverse experiences as temporary conditions or challenges that can be positively influenced by their own choices or actions and commitment to change.

Nurturing Parent-Child Interactions: For families experiencing violence, nurturing parent-child interactions refers to the presence of at least one parent or caregiver who consistently responds to and meets the needs of the child demonstrating love, nurturance, patience, and attunement. This protective factor is considered the single most important resource for children's healthy development and for children exposed to family violence, this also extends to their healing, increased sense of safety, and well-being. Similarly, for parents experiencing violence, nurturing parent-child interactions also facilitate a greater sense of self-efficacy—or a belief in their ability to meet their child's needs in the context of the family violence while also maintaining or strengthening their emotional bond of trust, love, and affection.

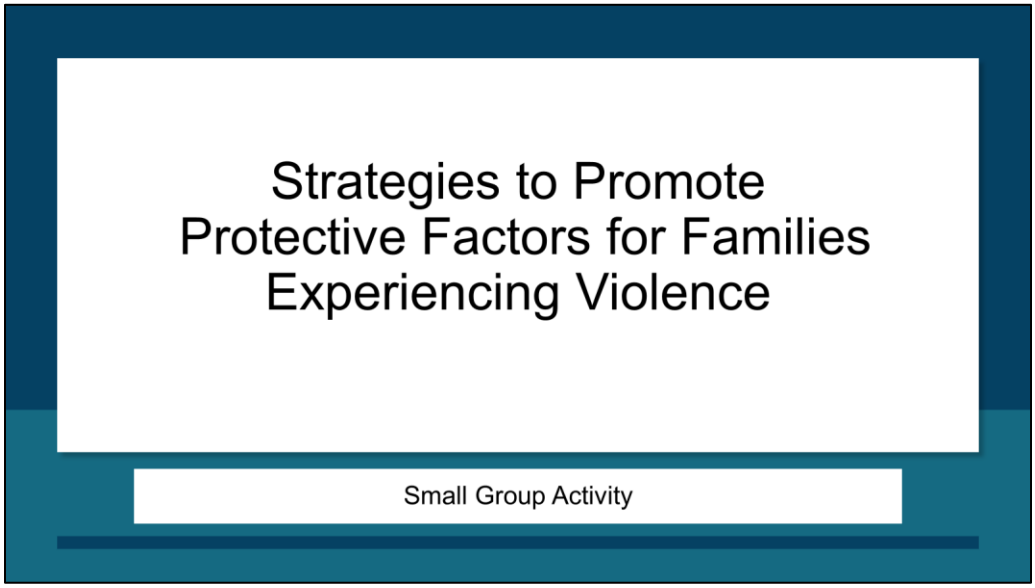
Social & Emotional Abilities: For families experiencing violence, social and emotional abilities refers to knowledge, attitudes, and abilities that lend to understanding and responding appropriately to emotions, feeling and demonstrating empathy for others, setting and achieving individual and familial goals, establishing and maintaining healthy and positive relationships, and making responsible decisions and choices. This protective factor helps families who experience violence develop a healthier self-concept; one of increased self-esteem and self-efficacy, enhanced communication and problem-solving skills, and equipped with the tools to manage stress and persevere through adverse challenges or circumstances.

Facilitator Note: An additional resource from the Quality Improvement Center on Domestic Violence in Child Welfare: Protective Factors for Survivors of Domestic Violence is available for more information.

Source: (Quality Improvement Center on Domestic Violence in Child Welfare, 2019)

Slide 33

Strategies to Promote Protective Factors for Families Experiencing Violence



Facilitator Script:

Let's now go ahead and reconvene in our small groups. For this activity, each group will receive a large piece of easel paper for you and your group members to record all the strategies you identify for each of the five interrelated protective factors. Let's plan to meet in our small groups for (x amount of time) before reconvening for a large group report out and discussion.

Here's an example to get everyone started…

Safer & More Stable Conditions:

Identifying significant life stressors and helping the parent experiencing the violence obtain or secure needed resources.

Materials Needed:

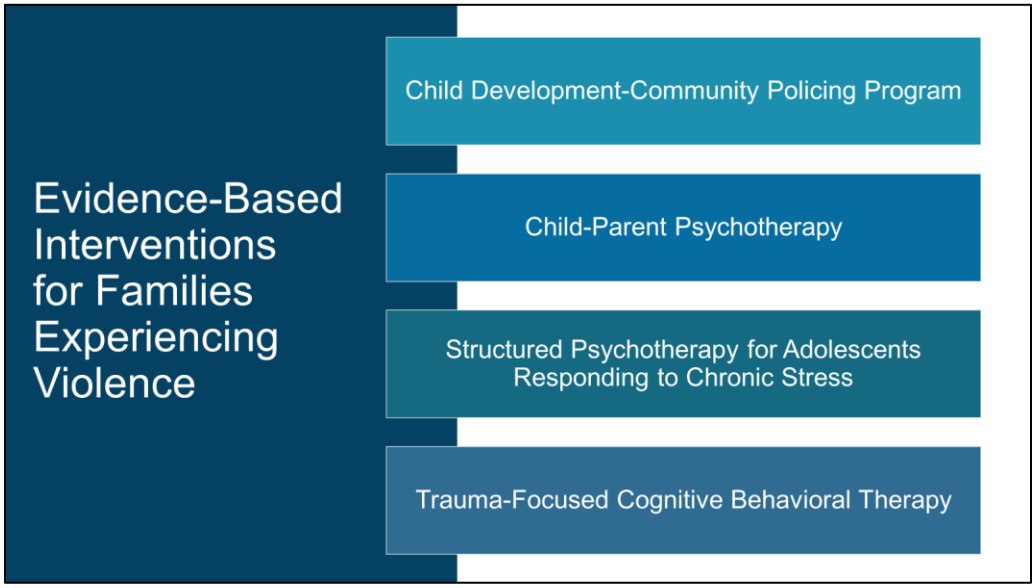
- *Large Easel Paper*
- *Markers*

**Alternative Instructions for Virtual Training*

Use breakout rooms feature on your respective virtual platform to allow for small group activity or proceed with an individual activity followed by large group discussion.

Slide 34

Evidence-Based Interventions for Families Experiencing Violence



Facilitator Script:

Before we wrap up this section, we also wanted to highlight some evidence-based interventions that also offer a path forward for families experiencing violence—through creating a safe place for healing and improved well-being.

The Child Development-Community Policing Program is a secondary prevention model offering crisis intervention and follow-up interventions for IPV-exposed children. The model is a collaborative partnership between child mental health professionals and law enforcement agencies and is designed to build parents' capacity to support their child's well-being following violence or coercive control dynamics. The model consists of two interventions—the Domestic Violence Home Visit Initiative and the Child and Family Traumatic Stress Initiative.

Child-Parent Psychotherapy, also referred to as CPP, is an intervention model targeting children 0-6 with exposure to at least one traumatic event and/or subsequent mental or behavioral challenges. CPP is rooted in attachment theory but also pulls in techniques from cognitive-behavioral, developmental, social, and trauma-informed modalities. Treatment sessions are held together with the goal of supporting and improving the parent-child relationship.

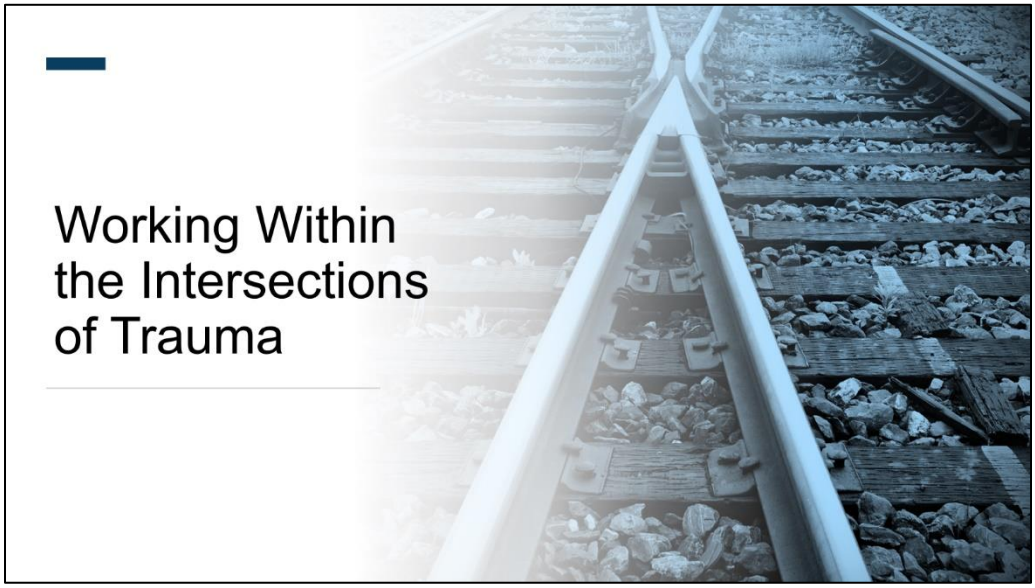
Structured Psychotherapy for Adolescents Responding to Chronic Stress is a group treatment modality guided by a curriculum manual. The model is designed for adolescents and young adults ages 12-21 with histories of chronic violence exposure and moderate to severe mental health symptoms such as affect dysregulation and impulsivity, low self-esteem, poor social functioning, dissociative and self-harm behaviors.

Trauma-Focused Cognitive Behavioral Therapy or TF-CBT is a components-based treatment model that combines trauma-sensitive intervention strategies with other cognitive-behavioral (including family and humanistic) modalities. TF-CBT has a strong evidence base with the 3-18 population but can serve young adults up to the age of 21 who have a diagnosis of PTSD or other mental health challenges related to family violence exposure.

Source: (The National Child Traumatic Stress Network, n.d.-a)

Slide 35

Working Within the Intersections of Trauma

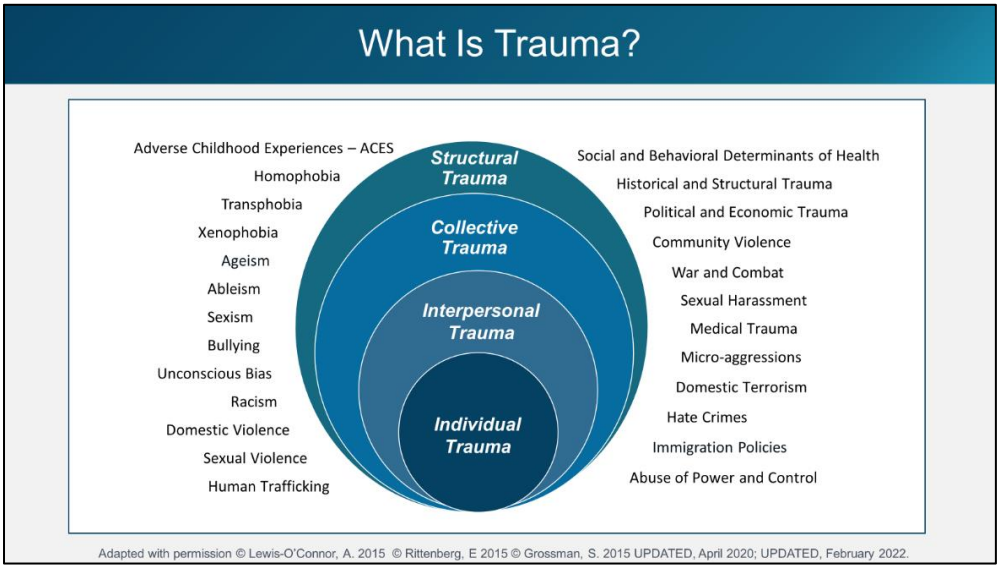


Facilitator Script:

Now as we move on from our discussion about IPV, it is important to remember that a large majority of individuals exposed to this form of violence, have not been screened or referred for trauma responsive services or formerly diagnosed with a trauma-related disorder—meaning our work on behalf of children, parents, and families often occurs within the intersections of underlying trauma...

Slide 36

What Is Trauma?



Facilitator Script:

Facilitator Note: Ask participants to review the diagram and with a show of hands ask the following…

Prompt for Participants:

How many of you in your professional capacity have supported children and families affected by at least 25% of these listed traumas? Show of hands for 50%? Show of hands for 75%? What about 100%?

Facilitator Script:

Our field of practice is tasked with engaging children and families who hold and carry within various forms of traumas. While you'll notice a variety of different language used to describe the different types or levels of trauma, they all do so with the same purpose of amplifying the message that trauma comes in many forms and experiences that often do not occur in isolation of the others—meaning trauma is dynamic and highly intersectional.

In this model referenced here, individual trauma simply represents a single or series of traumatic events experienced by an individual that has lasting effects on their physical safety and emotional well-being. In other models this might be labeled acute trauma which also represents a single traumatic event.

Interpersonal trauma (implied by its name) represents traumatic experiences that are relational in nature—things like child abuse and neglect, intimate partner violence, and other adverse childhood experiences would fall within this category. In childhood trauma models, this level of trauma is often referred to as chronic due to repeated and prolonged exposure and overlaps with complex due to the invasive and interpersonal nature of the traumatic experiences.

Collective trauma in this model represents the cumulative effects of cultural, historical, social, political, and structural inequities (also labeled here structural trauma) that have disproportionately impacted children and families from diverse racial and ethnic backgrounds. The term collective was chosen intentionally to redirect attention and efforts upstream—identifying the source and root causes of adverse experiences therein employing our collective responsibility to improve this public health matter. More on this in our next activity…

Source: (Grossman et al., 2021)

Slide 37

Trauma-Informed Care Elevator Speech

Facilitator Script:

As child welfare workers, we have a collective responsibility to understand trauma and transform the standard of care for our communities' most vulnerable children and families—which in this context are those affected by co-occurring SUDs, mental health, intimate partner violence, and trauma. We know from statistics that 60-90% of parents with substance use disorders report experiencing at least one traumatic event in their lifetime. We also know that when these same families come to the attention of child welfare, our system and other public serving entities represent the source of some these deeply painful inequities. As a system charged with supporting the safety and well-being of children and families, we also have a responsibility to not add to or compound trauma—which speaks to the importance of trauma-informed care. Before we dig in more, let's hear from each other on what exactly we mean by 'trauma-informed' child welfare services.

Facilitator Notes: Activity: Pair Share—ask participants to turn to a neighbor and share what 'trauma-informed care' in child welfare services would look like. Ask pairs to work together to craft an elevator speech describing trauma-informed care to someone not in our field of practice. Ask for volunteers to share their crafted elevator speeches to the larger group.

Use the example from NCTSN to help generate discussion (if needed): "Trauma-informed [care] infuses and sustains trauma awareness, knowledge, and skills into organizational practices and policies to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive."

Materials Needed:

- *Large Easel Paper*
- *Markers*

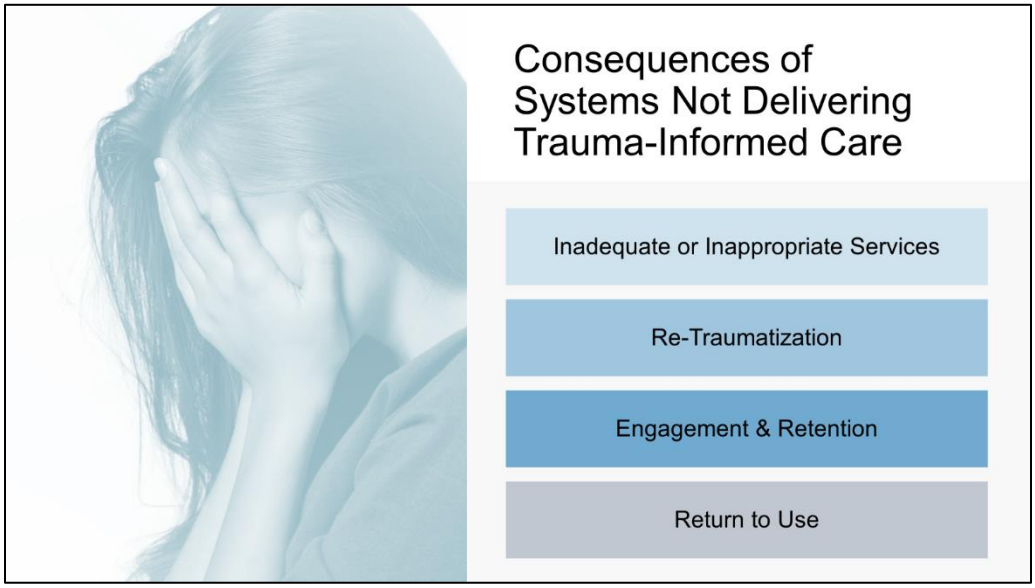
**Alternative Instructions for Virtual Training*

Use breakout rooms feature on your respective virtual platform to allow for activity. Recommend switching this from a pair share activity to a small group activity (max 4-5 learners per group) and proceed with the same instructions as noted above.

Source: (The National Child Traumatic Stress Network, n.d.-c)

Slide 38

Consequences of Systems Not Delivering Trauma-Informed Care



Facilitator Script:

So, why is this all important? The consequences of child welfare and other systems not delivering trauma-informed care are well documented.

First, when systems are not designed to screen families for trauma, there's an even greater likelihood of families being referred to any combination of inadequate or inappropriate services.

In the absence of trauma responsive services, systems' policies and practices can either intentionally or unintentionally trigger or re-traumatize both parents and children.

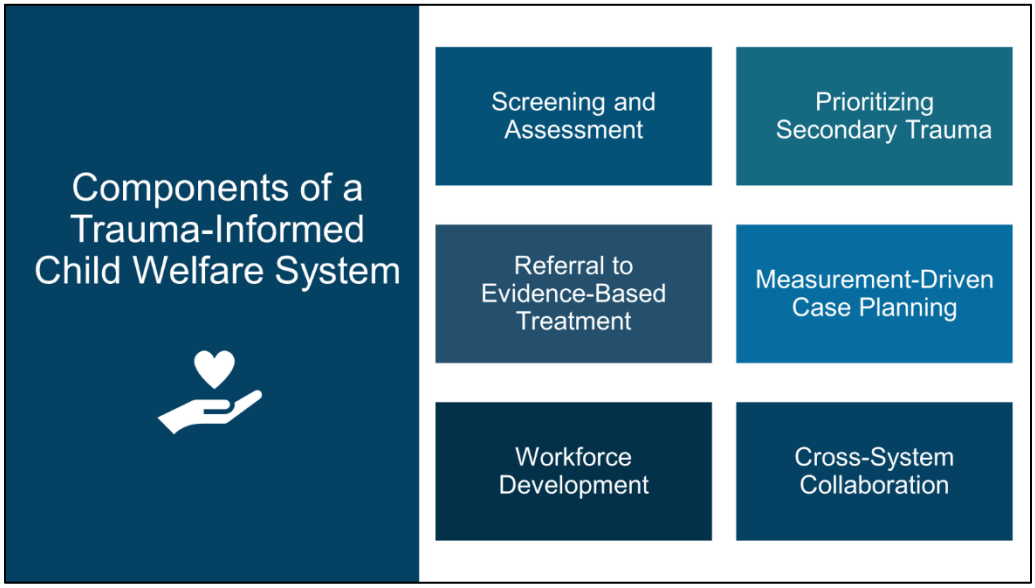
We also know that trauma fundamentally disrupts trust, and it can take just one negative experience to alter a family's willingness to engage or remain in services.

Which consequently may increase their risk for a return to use and/or further destabilization. Ultimately, leading to poor treatment outcomes.

Facilitator Note: The additional resource: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach is available for more information.

Slide 39

Components of a Trauma-Informed Child Welfare System



Facilitator Script:

So, what is trauma-informed care actually like in our everyday child welfare practice?

First, it starts with ensuring that all families are screened and assessed for trauma at time of initial service engagement. This practice will allow for upfront identification and appropriate service planning based on the individual child and family's needs. An example of a child-specific trauma screening is the Child Trauma Screen, formerly called the Connecticut Trauma Screen—a brief tool developed by Connecticut's Department of Children and Families, or DCF, in partnership with the Child Health and Development Institute, or CHDI, and Yale University. This free, 10-item tool is designed and tested for use on children ages 6-17, with a version for children 3-6 under development, and is used by DCF, multidisciplinary teams including child welfare workers, juvenile probation officers, pediatricians, and school personnel.

As we briefly touched on earlier in this module, child welfare agencies are now shifting their resources toward funding of evidence-based interventions under the Family First Prevention Services Act. The Prevention Services Clearinghouse is a resource to child welfare agencies seeking to expand or improve upon their service delivery options for families affected by co-occurring substance use, mental disorders, and trauma.

The transition to becoming a trauma-informed system will also require attention and resources directed at ongoing workforce development and organizational needs. This should include a re-examination of all foundational and ongoing workforce training to ensure that all staff are adequately trained to understand trauma and its effects on children and families including practice strategies to ensure their psychological safety and emotional well-being. Training alone will not suffice though, trauma-informed care requires a system's transformation from all aspects of the child welfare agency—from the front-end to the back-end of the continuum of services, as well as all administrative and policy-level functions. It requires a paradigm shift that will transcend the

perspective and goals of child welfare service provision with greater emphasis on interagency collaboration, early intervention, and family-centered treatment.

Trauma-informed child welfare systems are also designed to recognize and prioritize the health and well-being of its workforce. The effects of secondary trauma are well documented—lower productivity, increased leave of absences, and high staff turnover. Trauma-informed strategies to offset the impact of secondary trauma include things like secondary trauma groups, agency-sponsored wellness activities, and dedicated restorative space for decompression throughout the workday.

Measurement-driven case planning relies on agencies use of data to inform continuous quality improvement—a trauma-informed strategy that helps identify current strengths, needs, or gaps in child welfare service delivery (including the direct practice, system and cross-system levels).

Being trauma-informed will also require cross-system collaboration among the many service providers for child welfare-involved families. Strategies that promote collaboration and systems-level change should include consideration to cross-system training, system mapping, multidisciplinary staffings, and ways to maximize funding streams to better serve children and families affected by trauma.

Facilitator Note: The following additional resources are available in the Resources section of this guide for more information on this topic: Promising Futures Website, the Casey Family Programs' Supportive Communities-Issue Brief: Why Should Child Protection Agencies Become Trauma-Informed?, and the Title IV-E Prevention Services Clearinghouse Website.

Sources: (Child Health and Development Institute, 2023; Child Welfare Information Gateway, 2020)

Slide 40

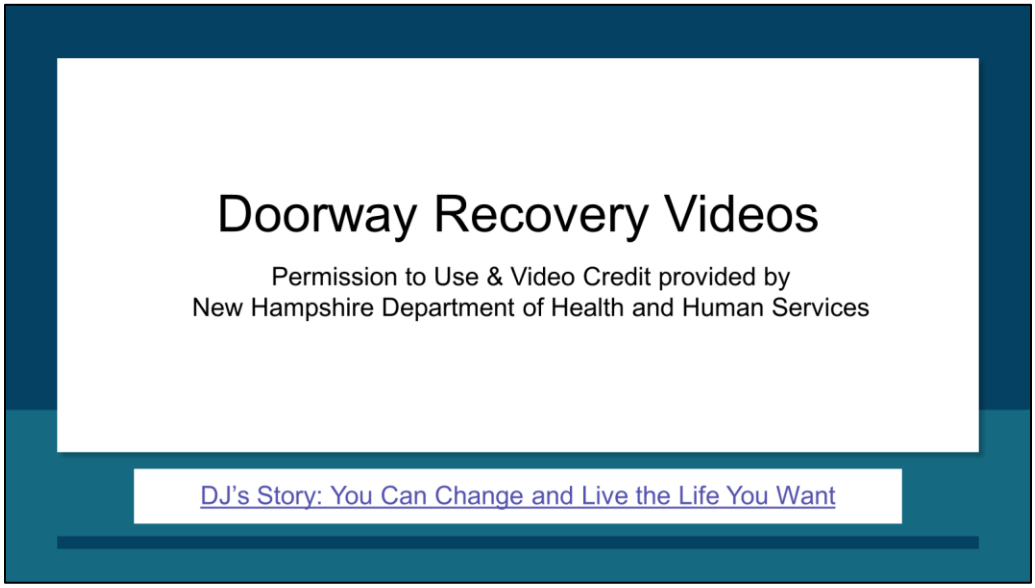
Recovery Is Possible

Facilitator Script:

Recovery from co-occurring disorders is not easy, but it is possible! As child welfare workers we play an important role in ensuring parents and families are first screened and assessed while also facilitating access to an integrated treatment plan that is meeting both their substance use and mental health needs; and when done within a trauma-informed approach this then becomes the foundation for hope and a pathway toward self-directed change and long-term recovery.

Slide 41

DJ's Story: You Can Change and Live the Life You Want



Facilitator Script:

Let's now pause and take a few minutes to watch a real-life recovery video made possible by Doorway Recovery and the New Hampshire Department of Health and Human Services.

Prompts for Participants to Close Out Today's Training Discussion:

- **What part of DJ's story resonated with you the most?**
- **DJ spoke openly about his substance use, but what else may have been contributing to his de-stabilization from a co-occurring standpoint?**

Yes, it is clear that DJ and his family suffered a significant trauma through the loss of his brother. Without knowing the exact details of this loss, we can infer from parts of his story that there may have been unprocessed grief, survivor's guilt, and unhealthy coping patterns that may have contributed to his substance use such as self-medicating through alcohol and drugs to ease the pain brought on by difficult and challenging emotions following the loss of his brother. Treatment of co-occurring disorders will take time to get at what may have come first (substance use or mental disorder) which is why it is so important that parent and families have access to quality integrated care and services. Remember, recovery is possible and let's be sure we are doing our part to set parents and families up for success.

Video Source: Doorway Recovery Videos and New Hampshire Department of Health and Human Services

Slide 42

Contact the NCSACW TTA Program

Facilitator Script:

Alright, this wraps up the instructional content for module three. If you have any follow up questions from today's training, feel free to reach out to the National Center on Substance Abuse and Child Welfare at ncsacw@cffutures.org or toll free at 1-866-493-2758. Thank you all for our rich discussion today and for your continued work on behalf of children, parents, and families affected by parental substance use and co-occurring disorders. Have a nice day, everyone!

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Resources

- Capacity Building Center for States: *Domestic Violence and the Child Welfare Professional: General Practice Tips* (2017)
- Casey Family Programs: *Supportive Communities: How Are Child Protection Agencies Implementing Trauma-Informed, Healing-Centered Policies and Practices?* (2023)
- Child Welfare Information Gateway: State Statutes Search (n.d.)
- Domestic Abuse Intervention Programs: *The Duluth Model Wheel Library* (2017)
- National Center on Domestic Violence, Trauma & Mental Health Website (2023)
- National Domestic Violence Hotline (n.d.)
- National Resource Center on Domestic Violence Website (2021)
- Promising Futures Website (2024)
- Quality Improvement Center on Domestic Violence in Child Welfare: *Adult & Child Survivor-Centered Approach for Addressing Domestic Violence* (2019)
- Quality Improvement Center on Domestic Violence in Child Welfare: *Protective Factors for Survivors of Domestic Violence* (2019)
- Strong Hearts Native Helpline (2024)
- Substance Abuse and Mental Health Services Administration: *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014)
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