Unit 7, Section 1

TOC	S#	New Slides (Published 03/17/2025)
Title	1	Unit 7 Section 1 Substance Use Disorders (SUDs)
Welcome	2	This training is a prerequisite to all concentrations. Many of the families that DCFS serves will have substance use disorders, mental health issues, and/or intimate partner violence co-occurring with child maltreatment. Protecting children in families affected by these problems presents major challenges for child welfare professionals.
History	3	In addition to the usual challenges DCFS workers face with families, there is another complication. The likelihood is high that some of you grew up in homes where substance use or domestic violence affected you.
Journal	4	Before you go further in the training, get out your learning journal. Jot down: Your thoughts and beliefs about how your personal history with drugs, alcohol, mental illness, and/or intimate partner violence affects your attitudes and beliefs. Any biases or pre-conceived notions you have about addiction and the effectiveness of treatment. How your personal history affects the work you do with families.
Journal	5	Remember, you do not have to share your journal entries with anyone. However, as you reflect on the issues in this training, you may want to consider discussing some of these thoughts and ideas with your field trainer and with your supervisor. They are here to support you, and they may have valuable information on how to navigate complex feelings about substance use and its effect on families.
Looking Back - ACE	6	Let's look backwards for a minute at content you covered in earlier training. Remember the ACE (Adverse Childhood Experiences) studies?
Maltreatment Types	7	Do you remember the 10 ACEs? 1. physical abuse 2. sexual abuse 3. emotional abuse 4. physical neglect 5. emotional neglect 6. mental illness 7. incarcerated relative 8. mother treated violently 9. substance use 10. divorce
ACEs	8	And the subjects of todays training account for three more adverse childhood experiences: 1. Substance abuse 2.Mental illness 3. Mother treated violently

ACEs	9	Your work involves: Children who have experienced trauma (both from their caregivers and also from the "helping process"). Adults who have experiences childhood trauma (and who may experienced new, continued trauma in their lives, partly because of DFS' intervention).
ACEs	10	Something to keep in mind is that often these problems and behaviors begin to manifest during childhood or adolescence. As a result, we deal with children and youth who engage in high-risk behaviors (such as substance abuse) and have physical/emotional health problems due in part to the maltreatment they experienced.
ACEs	11	ACE=5+ 8 times greater risk of becoming an alcoholic
Intergenerational Trauma	12	Remember, the toxic levels of stress cause changes in the brain. Substance use causes physical changes in the brain, too. This means children, youth, and parents in these households are often in a complex intergenerational relationship with abuse and/ or neglect.
Moving Forward-SOP	13	*There is a lot of research that focuses on problems ….* But as we move through this training, let's not forget what we have learned from Safety Organized Practice (SOP): It is important to keep in mind what is **working well** with each family we encounter. The children or caregivers may have had multiple ACEs but that does not mean they cannot thrive going forward.
Resilience	14	Do you remember the film Resilience from Unit 1? "It's not about what's wrong with you. It's about what happened to you." While survivors of abuse and neglect may be deeply impacted by their traumatic experiences, there is **<u>always</u>** more to their story (and their future) than these events. **"ACEs does not = destiny."** Hold on to these thoughts as we discuss adverse childhood experiences in more detail and explore ways to keep children safe when substance abuse, mental illness, and/ or intimate partner violence is a way of life in their homes.
Co-occurrence	15	Which came first, the chicken or the egg? Which came first, substance abuse problems or mental health problems? Substance abuse disorders or intimate partner violence? In the training, we look at each topic separately, but in reality, they often co-occur. Keep this in mind as we move forward.
Resource	16	In this section we will cover Substance Abuse Disorders, but what exactly does that mean? Substance Use Disorders cover both substance abuse and dependency (addition) Click the link below to open/download the resource "Protecting Children in Families Affected by Substance Use Disorders." https://www.childwelfare.gov/pubs/usermanuals/substanceuse/ Read the information in chapter 2 to answer the upcoming questions.

Knowledge Check	17	Match the term to the definition A pattern of substance use that leads to significant impairment or distress, reflected in one or more of the following: Failure to fulfill major role obligations at work, school, or home. Continued use in spite of physical hazards. Trouble with the law. Interpersonal or social problems. Substance Use - Substance Abuse - Substance Dependence or Addiction
Knowledge Check	18	Match the term to the definition The progressive need for the substance characterized by: The continued use of a substance despite negative consequences. An increase in tolerance. Withdrawal symptoms. Behavioral changes such as using more than intended and spending excessive time obtaining, using, or withdrawing from use. Substance Use - Substance Abuse - **Substance Dependence or Addiction**
Knowledge Check	19	Match the term to the definition The consumption of low or infrequent doses of the substance with damaging consequences being rare or minor. **Substance Use** - Substance Abuse - Substance Dependence or Addiction
Knowledge Check	20	Substance dependence/ addiction is a chronic disease. **A.) True** B.) False
Knowledge Check	21	As long as a person has a prescription, there is no need to assess for substance abuse or dependence. A. True **B.) False**
Did You Know?	22	Did you know that more people abuse or are dependent on both alcohol and illicit drugs than abuse or are dependent on both alcohol and illicit drugs than abuse or are dependent only on alcohol? Also, did you know that parental substance use disorders contribute up to approximately 2/3 children involved with CPS?
SUD & Parents	23	So, what is the impact of living with a parent with SUD? Listen here to a couple of stories. “A Daughter's Struggle: how drug abuse hurts families and relationships and The Ripple Effect of Substance Abuse.” Write down one or two things you learned from this video about the impact of the parents’ substance abuse/dependence on their children.
VIDEO	24	VIDEO
Safety Threat	25	8.The caregiver’s substance abuse seriously impairs their ability to supervise, protect, or care for the child. Parental substance abuse or dependence can have a significant impact on parenting. DCFS recognizes it as significant enough that it is listed as one of 14 safety threats to assess on all contacts with the family.

		Note that it is not the substance use itself that is the safety threat; it is that the caretaker has abused the substance to the extent that they are or likely will be unable to care for the child (and may even harm them).
Trauma & Development	26	Think back to the lesson on normal development and the impact of trauma on development. Pair that with parental substance abuse or dependency. Think about substance use disorders in a developmental context. Maternal drug and alcohol use during pregnancy have been associated with premature birth, low birth weight, slowed growth, and a variety of physical, emotional, behavioral, and cognitive problems. (3)
Fetal Alcohol Spectrum	27	Alcohol consumption during pregnancy may, but not always, result in children born with fetal alcohol syndrome or who fall somewhere on the fetal alcohol spectrum. Look here for a description of disorders on the spectrum and the severity of each. https://depts.washington.edu/fasdpn/htmls/fasd-fas.htm
CDC	28	Now, check this site for a better understanding of how Alcohol effects your health. https://www.cdc.gov/alcohol/about-alcohol-use/?CDC_AAref_Val=https://www.cdc.gov/alcohol/faqs.htm
Knowledge Check	29	Which of the following is defined as moderate alcohol consumption? A) Up to two drinks a day for women and three drinks a day for men. **B) Up to one drink per day for women and two drinks per day for men.** C) Up to three drinks per day for women and four drinks per day for men.
Procedure II-J3	30	Let's stop for a minute and look at policy requirements as they relate to Fetal Alcohol Spectrum Disorders. Look at Procedure II-J3 Consider the following situation: You have a three-month-old child on your In-Home service caseload whose mother drank heavily during the first trimester of her pregnancy. Once she learned she was pregnant, she made every attempt to stop drinking, although she told you she "lapsed a couple of times." You think the child's head looks small, and he doesn't seem to follow or track objects with his eyes. The child has not had any well-child medical follow-up since his discharge from the hospital after his birth.
Knowledge Check	31	In addition to ensuring this child has a medical exam, what else do you need to do for the child? Drag all responses that apply to the bulletin board. Petition the court to compel the mother to seek treatment Get a good history of mother's alcohol use during pregnancy, including exploring her 'lapses' and when those happened during her pregnancy Arrange for any services identified during the screening Complete and submit CFS-099

Alcohol	32	We took the time here to address the impact of alcohol because people do not always think of that when they hear the term substance use disorder. Even though it is legal, it can be a factor in many child welfare issues. In previous lessons, we addressed the issue of newborns exposed to an illegal substance, known as Garrett's Law babies.
Child Development	33	The effects of parental substance use disorder on normal development are not limited to prenatal and infants. An article on the Child Information Gateway (4) succinctly summarizes the possible impacts and effects on parenting older children and adolescents. These include but are not limited to: Physical or mental impairments caused by alcohol or other drugs. Reduced capacity to respond to a child's cues and needs. Difficulties regulating emotions and controlling anger and impulsivity. Disruptions in healthy parent-child attachment. Spending limited funds on alcohol and drugs rather than food or other household needs. Spending time seeking out, manufacturing, or using alcohol or other drugs. Incarceration, which can result in inadequate or inappropriate supervision for children. Estrangement from family and other social supports. This resource is included in your Information and Resource Folder.
Knowledge Check	34	DCFS has policies that address referrals for Early Intervention Services for children of families with open cases when there is concern that the child was exposed parentally to alcohol and potentially suffers from a disorder on the Fetal Alcohol Spectrum. **A) True** B) False Procedure II-J3: FASD Referrals and Services
Knowledge Check	35	Children who have been abused or neglected and are exposed to parental substance abuse or dependence would have an ACE score of at least A.) 1 (one) B.) **2 (two)** C.) 3 (three)
Parenting	36	It is clear that substance use disorders have the potential to significantly affect the quality of parenting. It is a pervasive enough problem that all DCFS workers need to recognize signs of substance use and then be able to do a quick screen to determine whether further action is needed. And when basing any decisions about child safety on a parent's substance use, workers must articulate how the substance use is adversely affecting the children and youth in the home.
Environmental Cues	37	A challenge for FSWs is to determine whether substance use disorders are present. This part of the training focuses on environmental cues that indicate the use of substances. All DCFS workers, including resource workers and adoption specialists, should be alert to the presence of drug paraphernalia in the home. If you grew up in a home where substance use disorders were not a problem, you may not recognize drug paraphernalia when you see it. So, let's look at a few indicators.
Environmental Cues	38	What illegal substances may be involved in these photos?
Homemade Lab	39	Common household items that might be involved in a homemade lab. Tubing and duct tape. Funnel. Plastic bottles (in this case Clorox but it could also be soda bottles). Glass container — here a beer bottle. Gas cylinders.

Meth Manufacturing	40	The pictures in the previous slides are overt labs. But meth can also be manufactured in a One-Pot or Shake n' Bake manner using only one sealed container. Located below are common household items used in manufacturing illegal substance. 2 32 oz. Gatorade bottles 2 Mason jars 3-4 ft. of aquarium tubing aquarium air pump (optional) fine coffee filters a funnel 75g 100% lye 130g 15-0-15 fertilizer (no weed killers) 2 96 ct. Pseudoephedrine (crushed into fine powder) Coleman lantern fuel 1.5g Ice 2 AA lithium batteries Iodized Salt Liquid Lightning (drain cleaner) Pipe cutter Needle nose pliers Xacto knife/Scissors If you see a cluster of these objects it might be a clue that methamphetamine is manufactured at that site..
Methamphetamine Lab	41	Review the "Safety Issues When Encountering a Suspected Methamphetamine Lab" on page 29 in the resource below. Protecting Children in Families Affected by Substance Use Disorders [https://www.childwelfare.gov/pubs/usermanuals/substanceuse/]
Knowledge Check	42	If you find yourself in a situation where you suspect meth production, the first thing you should do is: **A) Leave and call the police** B) Discuss with the adults present about how bad this is for children. C) Immediately remove any children and then call your supervisor.
Appendix 5	43	Appendix 5 in your policy manual has a protocol for responding to meth exposed children and meth lab situations. In addition to the steps outlined in the policy protocol, you should: 1.Confer with your supervisor. 2.Find out if your county or area has protocols with first responders and medical facilities. 3.Talk with your field trainer and together explore resources available in your community, especially medical facilities who can treat children who may have been exposed to/contaminated by meth production chemicals or residue.
Methamphetamine	44	Methamphetamine falls into the stimulant class of drugs. Another illicit stimulant is cocaine. In this picture, you see a snuff bullet. Other paraphernalia associated with cocaine use include rolled dollar bills, hollow pens, small mirrors, baggies and bindles (a folded paper container for the drug), and razor blades.
Heroin	45	Heroin is an illicit opioid.

		Thid is a picture of some of the paraphernalia associated with heroin when the person is injecting the substance. The lighter used to melt the drug in the spoon into an injectable liquid. There also may be a tie-off. This could be anything that can be tied around the limb to make the veins pop.
Heroin	46	We also have a cultural myth about heroin users. Watch this short video to see the faces of today's heroin addicts. They may not look like what we think of as heroin addicts. (VIDEO)
VIDEO	47	VIDEO
Cannabis	48	Cannabis (also known as marijuana, weed, and/or pot) is a depressant. Cannabis paraphernalia may vary as this drug can be smoked or eaten. So, technically, a brownie pan could be cannabis paraphernalia. But indications you might find in the home are bongs, bowls, hookahs, rolling papers, blunts (look for pieces of a cigar that has been stripped of tobacco and repacked with cannabis), and clips to hold the end of a joint so it can be smoked down further without burning the smoker.
Drug Abuse	49	Prescription drug abuse or dependency may not have the overt environmental cues of drug paraphernalia. Prescription drug abuse is the use of medication without a prescription, in a manner other than as prescribed, or for the experience or feelings elicited. (5)
Commonly Abused	50	The classes of prescription drugs most commonly abused are: Opioid pain relievers, such as Vicodin or Oxycontin. Stimulants for treating Attention Deficit Hyperactivity Disorder (ADHD), such as Adderall, Concerta, or Ritalin. Central nervous system (CNS) depressants for relieving anxiety, such as Valium or Xanax.(5) These are the same classes of drugs as the illicit drugs set out above. They just may not have the obvious environmental cues. This takes us to the next part of our assessment of substance abuse: behavioral indicators.
Behavioral Indicators	51	Behavioral Indicators: In addition to environmental indicators of substance use, behaviors can give clues that a person may be under the influence. Review the behaviors that can indicate the use of methamphetamine on page 28 in Protecting Children in Families Affected by Substance Use Disorders. [https://www.childwelfare.gov/pubs/usermanuals/substanceuse/] Note: Many of these behaviors can also be indicators of mental health disorders.
Resources	52	Another good resource that addresses not only behaviors but the effects that substance use disorders have on parenting is a chart titled

		The Effects of Specific Substances on Parenting [http://www.midsouth.ualr.edu/NewFSWTrainingResources/Unit6_section1_Effects_specific_substance_on_parenting.pdf] The Jordan Institute for Families, UNC-CH, School of Social Work developed this resource. Review the effects on parenting and answer the questions in the next slide.
Supervised Time	53	A father comes to the office for supervised family time with his children. When he arrives, he appears to be on top of the world, greeting his children effusively and talking excitedly about his plans to seek employment tomorrow. Initially, he is very attentive to his children. As the family time session progresses, he appears to get sleepy. Near the end of the session, he nods off on the couch in the visiting room despite his 7-year-old's attempt to interest him in a toy.
Knowledge Check	54	Based only on the behavior described, you might be concerned that the father abuses: **A) An opioid such as OxyContin or heroin** B) An amphetamine or other stimulant C) Alcohol
Disclosures	55	Behaviors by others can also give you clues to a parental substance use disorder. These include disclosure of maltreatment by reporters or collaterals on cases of concerns about substance use. They also include reports by the children that parents are using.
Assessment Training	56	Many FSWs do not have the training to do formal assessments of the degree of substance use and when it has crossed over into either substance abuse or substance dependency. While you might have valuable information to share, the formal assessment needs to be done by a professional with the proper training.
Knowledge Check	57	What are two behaviors that might indicate that a person is using a stimulant? Check all that apply. **A) Increased alertness, attention, and energy** **B) May feel energetic with very little sleep** C) None of these
Additional Substance Use Training	58	Additional web-based training is available from the University of Arkansas Criminal Justice Institute to aid in further understanding the impact of substance use and identifying the most commonly used substances and paraphernalia. Drug Identification Online is a 2- hour self-paced training that is used by Law Enforcement. Click to access this optional training: https://www.cji.edu/course-dates/drug-identification-online-57/
Naloxone	59	Naloxone is a medication that rapidly reverses an opioid overdose. Other names for Naloxone are Narcan and Evzio. The MidSOUTH website offers additional training entitled "Prevention AR Naloxone Training." This training details how to administer the dose correctly.
Good Samaritan Law	60	In 2015, Arkansas passed the Joshua Ashley Pauley Act, which provides protection from arrest, charges, or prosecution for possession of an illicit substance for an individual or someone the individual knows when seeking medical help during a drug overdose.

CANS & FAST	61	By now, you have had exposure to the CANS and FAST assessment tools. The FAST has a question about Caregiver's Alcohol and/or Drug Use. The CANS 0-4 has a question on Caregiver Substance Use. The CANS 5+ has a question on the child's substance use and the caregiver's substance use. A score of 1, 2, or 3 on the CANS triggers a specific substance abuse module designed to elicit additional detail about substance use. While the last thing anyone wants is another form, some simple, evidence-informed screening tools can help you assess whether to consider referring the family for further evaluation for substance use disorders.
Ms. Jones	62	Let's look at an example: Ms. Jones' 3-year-old, Martin, was found wandering down the street at 10:45 pm wearing only a diaper and a T-shirt. There was a case on the family when the child was a newborn. At that time, the baby and mother tested positive for THC. Ms. Jones went to treatment. Observation of her parenting skills showed a mother who was attentive and responsive to her infant. Ms. Jones maintained she was only a recreational user and that she had smoked weed (cannabis) because it helped lessen the nausea she experienced throughout her pregnancy. Nonetheless, she entered treatment. After Ms. Jones accomplished six months of clean drug screens and was observed to have good parenting skills, the case was closed.
Ms. Jones	63	You are interviewing Ms. Jones about her possible substance use. "Ms. Jones, please tell me about your use of alcohol or any other drugs." "Well, I do drink sometimes. Come on, everyone does. And I might as well tell you I do smoke weed. Only on the weekends. I'm telling you because I know you people, and you'll probably drug screen me. And I know that stuff stays in my system forever.
Ms. Jones	64	"I see. Have you continued to use alcohol or weed longer than you intended?" "I don't know. I don't think it's bad to drink every once in a while. But I mainly just tried smoking to help with the nausea while I was pregnant with Martin. I guess I have used it a little longer than I meant to."
Ms. Jones	65	"Have you ever neglected some of your usual responsibilities because of alcohol or drug use?" "No, I don't let it mess me up like that. I only drink or smoke to take the edge off when it's just too much."
Ms. Jones	66	"Have you ever wanted to cut down or stop drinking or smoking but couldn't?" "Not really. I don't think I'm out of control or anything."
Ms. Jones	67	"Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?" "Uh, yeah. And it really gets under my skin. Especially if it's my friends. I mean, like when did they get to be mother of the year?"
Ms. Jones	68	"Have you ever found yourself preoccupied with wanting to drink or smoke?"

		"Maybe sometimes. When something goes wrong or I get real stressed out, sometimes I think it'll be okay if I can just have a little drink. Like I said, it takes the edge off."
Ms. Jones	69	"Have you ever used alcohol or drugs to relieve emotional discomforts, such as sadness, anger, or boredom?" "Well……uh, yeah, sometimes I need that joint just to face the day. Being a single mom is hard. And my job sucks. So, yeah, sometimes I do. Doesn't everyone?"
UNCOPE	70	Use Neglected Cut down Objected Preoccupied Emotional Have you continued to use alcohol or drugs longer than you intended? Have you ever neglected some of your usual responsibilities because of your alcohol or drug use? Have you ever wanted to cut down or stop using alcohol or drugs but could not? Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use? Have you ever found yourself preoccupied with wanting to use alcohol or drugs? Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom? Congratulations! You just did an UNCOPE screen. It's quick and it can help inform your ranking on the CANS or FAST. Two or more positive responses indicate possible abuse or dependence and need for further assessment. So, in the case of our example, Ms. Jones' responses indicate that she may need further assessment as well.
UNCOPE	71	Consider writing UNCOPE on a small card you can take with you when doing a family assessment or a child maltreatment investigation. Because these are yes/no questions, you will also follow up to get more details, such as the questions on the substance use module of the CANS. How long she's been using Whether she uses with friends Whether these are the same friends she was involved with back when Martin was born How frequently she uses How much she uses Using longer than intended Neglecting responsibilities Can't cut down/stop using Objections from loved ones Preoccupied with wanting to use Emotional discomfort relief
The Cycle of Abuse in Intimate Partner Violence	72	The Cycle of Abuse in Intimate Partner Violence
3 Stages	73	Intimate Partner Violence: 3 Stages

		Honeymoon Tension Explosion
Stage 1	74	Stage 1: Honeymoon
Honeymoon	75	In this stage, the abuser may: • Apologize for the abuse • Promise it will never happen again • Blame the victim for causing the abuse (gaslighting) • Minimize severity or deny the abuse took place • Give gifts to the victim (love bombing) • Physical abuse may not be taking place Promises made during “making up” may be met, and the victim hopes the abuse is over.
Stage 2	76	Stage 2: Tension
Tension	77	In this stage, the abuser may: • Starts to get angry • Abuser may begin • Communication breaks down • Tension becomes too much Victim the need to keep calm and feels like they are “ walking on eggshells”
Stage 3	78	Stage 3: Explosion
Explosion	79	In this stage, the abuser may: Any type of abuse can occur during this phase • Physical • Sexual • Verbal • Emotional
Statistics	80	• Every 9 seconds in the US, a woman is assaulted or beaten • Around the world, at least 1 in 3 women have been beaten, coerced into sex or otherwise abused during her lifetime, often by a family member • Intimate partner violence is the leading cause of injury to women-more than car accidents, muggings, and rapes combined • Studies suggest that up to 10 million children witness some form of intimate partner violence annually • In the US, 3+ women are murdered by their husbands or boyfriends EVERY day Source (used in part): https://domesticviolencestatistics.org/domestic-violence-statistics/
Statistics	81	What is the impact? • Intimate partner violence victims lose 8 million days of paid leave annually, which is the equivalent of 32,000full-time jobs. • Based on reports from 10 countries, between 55% and 95% of women who had been physically abused by their partners had never contacted non-governmental organizations, shelters, or the police for help. • The cost of intimate partner violence in the US alone exceed $5.8 billion per year: $4.1 billion are for direct medical and health care services while productivity losses account for nearly $1.8 billion.

		• Male children who witness parental intimate partner violence are twice as likely to abuse their partner than sons of non-violent parents.
Cycle of Power & Control	82	ECONOMIC ABUSE Preventing them from getting or keeping a job, making them ask for money (giving an allowance) not letting them know or have access to family income MALE PRIVILEGE Treating them like a servant, making all the decisions, acting like the "Master of the Castle", being the one to define gender roles BAITING WITH CHILDREN Making them feel guilty about the children, using children to relay messages, using visitation to harass them, threatening to take children away MINIMIZING, DENYING & BLAMING Making light of the abuse, saying the abuse didn't happen, shifting responsibility for abusive behavior, gaslighting ISOLATION Controlling what a person does, who they sees or talks to , what they reads, where they go, limiting outside involvement, or using jealousy to justify actions INTIMIDATION Causing fear through looks, actions, gestures, (smashing things) destroying property, abusing pets, and displaying weapons COERCION & THREATS Making/carrying out threats to hurt, leave, commit suicide, report to DCFS, forcing illegal acts, or forcing to drop charges
Providers	83	In your concentrations training, you will practice incorporating substance use disorders into your assessment and planning. Before we end this training, though, we need to briefly address working with providers of SUD assessment and treatment.
Referral	84	If you make a referral, you need to know the outcome of the referral. If the person enters treatment, you need to know if they are making the changes needed to enable them to provide a safe, stable home for their children. But substance abuse providers are governed by strict federal laws about what information can and cannot be released. And you are limited in what you can share about families, too. So, how do you get around this potential barrier?
Consent	85	First, you can share information you gained through a screening (such as UNCOPE) since it was for the purpose of referring for an assessment. However, the best way to work together is to get the family member's written consent for DCFS to release information to the SUD Assessment and treatment provider and for the assessment and treatment provider to release information to DCFS. If proper consent is not obtained, a SUD treatment provider can only release information with a court order requiring them to do so.

		Ideally, this adversarial relationship is best avoided when another means (signed consents) exists to share information.
DHS-4000	86	Although it is not explicitly identified in the policy, the DHS-4000 Authorization to Release Health Information is the best consent form for substance use disorder treatment. It conforms with the federal laws that specify the conditions that permit sharing of treatment information, as it has all the following required elements: The name and general description of the program(s) making the disclosure. The name of the individual or organization that will receive the information. The name of the patient or client who is the subject of the disclosure. The purpose or need for the disclosure.
DHS-4000	87	Additional elements included in the DHS-4000: How much and what kind of information will be disclosed. A statement regarding revocation of consent. The date, event, or condition upon which the consent will expire. The signature of the patient. The date on which the consent is signed.
References	88	"The ACE Pyramid". Atlanta, Georgia: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. May 2014. Archived from the original on 16 January 2016. Quarterly Performance Report 1st Quarter SFY 2015, retrieved from humanservices.arkansas.gov/dcfs/.../1st%20Qtr%20SFY%202015%20FINAL.pdf National Institute on Drug Abuse. (2011). Prenatal exposure to drugs of abuse. Retrieved from http:// www.drugabuse.gov/sites/default/files/prenatal.pdf Parental Substance Use and the Child Welfare System. Retrieved from https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services. Child welfare and prescription drug abuse. Retrieved from http://www.trainingmatters-nc.org/tm_v13n1/4-19-11.pdf Hoffman, N.G. UNCOPE. Smithfield, RI: Evince Clinical Assessments. Retrieved July 28, 2006 from http://www.evinceassessment.com/UNCOPE_for_web.pdf
Congratulations	89	You have completed Unit 7 Section 1.

Unit 7, Section 2

TOC	S#	New Slides (Published 08/08/2023)
Title	**1**	Unit 7 Section 2 - Introduction to Domestic Violence
Welcome	**2**	Many of the families that DCFS serves will have substance use disorders, mental health issues, and/or intimate partner violence co-occurring with child maltreatment. Protecting children in families affected by these problems presents a major challenge for child welfare professionals.
ACE	**3**	Adverse Childhood Experiences Physical Abuse Sexual Abuse Emotional Abuse Physical Neglect Emotional Neglect Substance Abuse Mother Treated Violently In Unit 7.1 (Substance Use Disorders), we looked back to the ACE study. Child maltreatment of one type or another accounted for five of the adverse childhood experiences studied. Substance abuse accounted for a sixth adverse childhood experience. This lesson addresses yet another adverse childhood experience: mother treated violently.
Domestic Violence	**4**	Arkansas specifically identifies domestic violence as one of the 14 safety threats. It is threat 9, in which “domestic violence exists, and offender behavior poses an imminent danger of serious physical and/or emotional harm to the child.” 9. Domestic violence exists, and offender behavior poses an imminent danger of serious physical and/or emotional harm to the child.
CANS & FAST	**5**	Additionally, both the CANS and the FAST assessment instruments address the topic of violence within the family/household and its impact on children. Take a minute to look at the items on the FAST. Several of these assess the presence or potential for domestic violence. These include: Family conflict (family together scale). Partner relationship (caregiver A and caregiver B scales). Family safety (family together scale). Other areas of assessment that might give clues to domestic violence are: Disparities in income. PTSD symptoms. Safety (caregiver A and caregiver B scales). Substance abuse and mental health issues may also come into play.
Trauma Scale	**6**	Similarly, on the CANS, the child trauma scale directly addresses witnessing family violence. The adult scale specifically directs you to assess marital/partner violence. Just like in the FAST, PTSD symptoms may indicate domestic violence, as may substance abuse, mental health problems, or disparities in access to income or lack of

		equality in the relationship. However ... just because someone experienced a traumatic event or has PTSD does not mean that they will exhibit violent behavior. Evidence of trauma does not prove domestic violence, but it is important to note.
Resources	**7**	The Children's Bureau maintains a very useful website, the Child Welfare Information Gateway at www.childwelfare.gov/. One of the series of user manuals for child welfare workers and supervisors is Child Protection in Families Experiencing Domestic Violence. (1) It is one of the sources used in this lesson and is available to you in your Information and Resources online.
Domestic Violence	**8**	Let's start this lesson a little differently and begin with you telling us what you already know about domestic violence. While this might look like a test, don't worry. Your scores on this part of the lesson just set a baseline. They are not reported to your supervisor.
Knowledge Check	**9**	People who stay in an abusive relationship are passive and dependent. A) True **B) False**
Knowledge Check	**10**	The event that triggers an explosion may be relatively minor. **A) True** B) False
Knowledge Check	**11**	Which statement is most accurate? **A) Domestic violence is an issue of power and control** B) Domestic violence is a problem of anger management
Knowledge Check	**12**	There is no good reason for a victim to stay in an abusive situation. A) True **B) False**
Handout 7.2.1	**13**	Let's watch a short presentation on the cycle of Violence. Note: The presentation is hosted on Prezi. Press the next arrow to keep the slides going. Print Handout 7.2.1 to take notes on, or use any other media for notes that you choose.
Knowledge Check	**14**	Now, let's do a quick review. Use the note sheet that you made during the presentation. One of the three phases in the cycle of violence is:
Knowledge Check	**15**	One of the three phases in the cycle of violence is:
Knowledge Check	**16**	One of the three phases in the cycle of violence is:
Cycles of Violence	**17**	Answers (in any order): Honeymoon Tension Explosion
Knowledge Check	**18**	Match the behavior to the strategy of gaining power and control.
	19	An important fact to remember when looking at the Wheel of Power and Control is that more often than not these behaviors begin slowly. In the beginning, the abuser charms or seduces the intended victim. If there are signs of what's to come, they may be subtle. We are culturally conditioned to think of jealousy as an indication of love. So, if a partner is jealous during dating and relationship building, well, doesn't that prove that they love us?
	20	We are also culturally conditioned to think it is our responsibility and duty to help our spouse or intimate partner if they are a deeply troubled person. Again, is that not one way we demonstrate our love?

		So, many who become victims do not recognize the signs as the relationship moves into a different level. Many abusers begin with the threat of violence (not actual physical or sexual violence) to see how their partner reacts. As the relationship develops, the threats may increase in frequency and severity and the actual physical or sexual abuse begins.
Knowledge Check	**21**	Which statement is most accurate? A) Domestic violence is an issue of power and control B) Domestic violence is a problem of anger management
Knowledge Check	**22**	Abusers rarely apologize for the abuse. A) True **B) False**
Knowledge Check	**23**	Which statement about the number of women who die at the hands of their husbands or intimate partners is most accurate? A) One woman will die every month in the US from domestic violence. B) Two women will die every week in the US from domestic violence. **C) Three or more women will die every day in the US from domestic violence.**
Risks of Leaving	**24**	The numbers of fatalities due to domestic violence are significant because women are most likely to be killed or seriously injured when they leave or are actively attempting to leave the abuser. Women are five times more likely to be killed during or after the separation. 2 It is critical as a child welfare professional that you understand this when you and a family are planning ways to keep the children safe.
Domestic Abuse Infographic	**25**	[image of children's domestic abuse wheel]
Domestic Violence	**26**	This wheel applies to all children who are exposed to domestic violence. Think how much more intense it is when the child is also being neglected and/or physically/sexually abused. The same power and control issues that keep children from telling about abuse apply to keeping the secret of domestic violence.
Cycle of Violence	**27**	When discussing the cycle of violence and the power ——————————and control wheel, it is important to remember that each family's experiences are unique. While many abusers and victims cycle through the phases of tension, explosive incident(s), and then making up in a honeymoon type atmosphere, not all will. What does tend to stay consistent in domestic violence are those issues of power and control. While the mechanisms might differ from family to family, the dynamic remains the same.
Barriers to Leaving	**28**	When you look at the dynamics of power and control, you begin to see why victims stay in abusive relationships. Very real barriers to leaving exist. These include: Fear for their lives or their children's lives. Inability to provide for themselves. No support from friends or family. Systematic isolation. Shame or guilt for being a victim.

		Religious and/or family beliefs and pressures. Past failures of the “helping systems” to actually protect them.3
Other Facts	**29**	Here are a few more facts about domestic violence that we haven’t touched on yet. While men can be victims, 95 percent of all spousal assaults are committed by men against women. DV occurs across all socio-economic classes and across all racial and ethnic groups. Women and children in the same family are often both victims of the abuser. Children who live in homes where domestic violence occurs are abused at a rate that is 150% higher than the national average.
Adult Victims	**30**	There is another, darker fact about adult victimization... Adult victims of domestic violence are much more likely to abuse their children than non-victimized parents. It stands to reason that if an abuser is victimizing their intimate partner, they would be a high risk to abuse the children as well. What’s hard to wrap your head around is that victims may react in a violent way toward their children when frustrated or afraid.
Co-occurrence	**31**	This co-occurrence of being the victim and at the same time being an abuser can be a tension point between child welfare professionals and domestic violence service providers.
Tanesha & Gerald	**32**	Read this situation and respond to the questions. Tanesha lives in the local domestic violence shelter with her two children Michael, age eight, and Tanya, age four. Tanesha came to the center after an extremely violent abusive episode where her husband, Gerald, beat her with his fists and with the butt of a pistol, broke her nose, blacked both eyes, fractured her cheekbone, and knocked out a tooth. He then held the gun to her head and threatened to kill her. After he cooled down, Gerald was very remorseful. He took Tanesha to the Emergency Room for treatment. They both told medical staff that she had fallen down two flights of stairs. When the hospital staff were able to talk to her alone, Tanesha tearfully admitted what her husband had done.
Tanesha & Gerald	**33**	She begged for help getting her children and herself out of the situation. The hospital arranged the DV Shelter placement and local law enforcement got the children from the neighbor who was watching them and brought them to the shelter. With the shelter staff’s assistance, Tanesha got an order of protection. At the shelter, she benefits from counseling, receives assistance with applications for SNAP and other government benefits, and receives job placement services. Tanesha is actively involved and utilizing all the services. She and the children have been there almost two months.
Tanesha & Gerald	**34**	Although the court issued an order of protection, it did not prohibit Gerald from attending family time sessions with his children because no one presented any evidence that he was a danger to them. These sessions take place at the family’s church. A shelter volunteer transports the children to and from the church.
Tanesha & Gerald	**35**	Today, Michael returned from a visit and questioned his mother about why she was “so mean to Daddy.” Michael loves his father even though he is terrified during abusive incidents. He said, “Daddy is sorry and we need to come home.” Tanesha told him several times that they were not going home right now. Each time, Michael got louder and louder in his demands and she got louder in response.

		——————————————————————————————Finally, in pure frustration, she grabbed her son, shook him very hard, and shoved him backwards. Michael hit his head on the floor hard enough to knock him out. Because he was unconscious for several minutes, the shelter staff took Tanesha and Michael to the hospital. As mandated reporters, they called the Hotline.
Knowledge Check	**36**	As the child welfare professional, what is your primary responsibility in this scenario? **A) Ensuring the safety of Michael and Tanya** B) Ensuring that the father is involved in safety decisions C) Ensuring the safety of Tanesha and her children
DCFS Involvement	**37**	There are many fears and misconceptions about DCFS involvement with a family. ——————————————————The shelter professionals may fear that DCFS will automatically remove the children from the mother. And, they may fear that DCFS will place the children with their father as there is currently no report alleging he abuses the children. They worry about how DCFS involvement will affect the mother's progress towards getting herself in a safe situation.
Worker Worries	**38**	You may worry that the shelter professionals will minimize the mother's behavior because she is "a victim." ——————————————————————————————You may struggle with your requirements to locate and involve the children's father in planning. You may also worry about your own safety when you meet with the father, based on the violence of his last attack on the mother.
Safety	**39**	You can see how the difference in roles between DCFS and domestic violence service providers/advocates, plus fears and misconceptions, might lead to tension and conflict if you do not take active steps to learn how to work together as professionals. Luckily, there is now recognition of the critical need for collaborative partnerships to assure the safety of both the children and the adult victim.
Resource Manual	**40**	Coalition building is beyond the scope of this lesson. ——————————————————However, there is an entire chapter in your resource manual, "Child Protection in Families Experiencing Domestic Violence." It is worth the time for you to read Chapter 6.
Dynamics of Violence	**41**	Before we move on, remember, we have looked at a broad overview of domestic violence. The reality is that there is tons of information available online about the dynamics of domestic violence and its effects on children. There is also a lot of information on the "characteristics" of abusers, adult victims, and children exposed to domestic violence. By definition, you are involved with these families because child abuse occurred or an investigation is underway to determine if child abuse or neglect occurred. When you encounter domestic violence in your practice, we encourage you to read and educate yourself. Use the manual in your Information and Resources.
Handout 7.2.2	**42**	We will now look at a few specific issues you will grapple with as a child welfare professional. These issues do not necessarily have a right or wrong answer. As you attempt to resolve them, however, you need to do so in an informed manner that anticipates possible outcomes in response to actions taken by child welfare professionals. Take a moment to think back on Tanesha's situation.
Handout 7.2.3	**43**	Let's consider some additional information that you got from the hospital social worker about Tanesha's situation.

		The hospital social worker obtained this history during the evaluation of Michael's injuries.
Tanesha & Gerald	**44**	Tanesha has a bachelor's degree in accounting. She and Gerald met at work. However, she has not worked for five years. She quit to stay home because Gerald thought she should be a full time Mom and he should be the only bread winner for the family. Gerald was also suspicious and jealous of her relationships with male co-workers. The first time Gerald hit Tanesha was when he accused her of flirting with her boss and she denied it. It was becoming difficult for Tanesha to hide the bruises and cuts from their fights from her friends and coworkers. She felt increasingly guilty that she could not "help him control his anger."
Tanesha & Gerald	**45**	Currently Gerald controls the family money. The checking account is in Gerald's name only. He gives Tanesha an allowance for household expenses and food. He pays all the other bills. Tanesha is actively looking for work but is concerned that she will not be able to get a job that pays enough for a separate household. She has thought about getting out of the situation before, but Gerald threatened to kill her if she tried it. ——————————————————————————The incident that finally motivated her to get out started out as just a "regular" fight because "I did some little thing wrong."
Tanesha & Gerald	**46**	Michael feared for his mother and tried to stop his father. Gerald "exploded" during one fight and came after Michael. Tanesha jumped between them. Gerald reacted by beating her with his fists and with the butt of a pistol that he keeps in the living room. Tanesha remembers screaming, "We're getting out of here right now," and that is when Gerald put the gun to her head and told her, "the only way you'll leave here is in a body bag." ——————————————————————————After that, she does not remember anything until she "came to with Gerald crying and saying he was sorry."
Tanesha & Gerald	**47**	When questioned about whether this was the first time that Gerald had come after the children, Tanesha said, "It was the worst. He has hit them before for crying if I start a fight, but this time I was terrified that he would really hurt Michael." She later clarified that the "hitting" she mentioned was with both an open hand and a closed fist. One time Tanya had gotten a bloody nose because she would not be quiet, and another time Michael had a black eye. Other than that, it was "just little scrapes or bruises."
Knowledge Check	**48**	In Tanesha's scenario, based on the information you have right now, do you think DCFS should make a True finding on the allegations of physical abuse with Tanesha as the named offender? **A) Yes** B) No
Tanesha & Gerald	**49**	Now let's look at a question that is more difficult. It appears from Tanesha's account that Gerald has physically injured the children in the past and she was, in fact, terrified that he would hurt Michael very badly during the last abusive incident. The question is, was there Failure to Protect because she didn't leave?

		The possibility of this particular finding is one that may actually be a disincentive for abuse victims to seek help.
Knowledge Check	**50**	Based on what you know about domestic violence, should there be a finding of Failure to Protect? **A) Yes** B) No
	51	Let's make it a little more complicated. What if Gerald finds out about DCFS involvement? In violation of the order of protection, he calls Tanesha. He tells her that he knew she was a crappy mother and this just proves it. If she does not agree to come home, he will file for full custody of the children.
Knowledge Check	**52**	If Tanesha decides to return, should there be a finding of Failure to Protect? **A) Yes** B) No
Knowledge Check	**53**	Here are a few things to consider. How real is the possibility that Gerald would be granted full custody of the children? 1 (Highly Unlikely) - 4 (Likely)
Tanesha & Gerald	**54**	This is actually a very real possibility. There is a substantiated maltreatment report naming Tanesha. She has no income and no permanent place to live. There are no substantiated maltreatment reports on Gerald, and while there are police reports in relation to domestic violence, there are no convictions.
Tanesha & Gerald	**55**	Tanesha must consider these very real concerns: Will she be able to support her children (housing, food, medical, and child-care)? Does she have friends or family who are pressuring her to return or do her personal values say that divorce is wrong and that children need their fathers? Can a realistic Safety Plan be put into place for her and the children if she decides to return?
Tanesha & Gerald	**56**	The reasons we have spent this much time on the issue of Failure to Protect are: 1) It is very easy to overuse this finding and further penalize the adult victim. As the investigator or the caseworker, you must give careful and thoughtful consideration to the victim's very real barriers to leaving and/or returning to the situation. And, you must give recognition to the ways the victim did try to protect the children. 2) Fear of this finding (or its equivalent) and fear of the children being removed by the state may have been one reason that the victim did not leave or may have been a threat by the abuser to force the adult victim to stay in the situation.
Failure to Protect	**57**	The intent of this section of training is to highlight the complexity of situations where both child abuse and domestic abuse occur in the same family. This section does not provide a definitive answer, other than to be leery of just routinely using Failure to Protect.
Safety Plans	**58**	Another skill you will need for addressing domestic violence and child abuse situations is the ability to work with the adult victim to develop a Safety Plan. By now, you have probably realized that the plan can't just simply be, "You have to leave."
Safety Plans	**59**	So, let's quickly look at what needs to be in a Safety Plan (and, realistically, this will also be in your Immediate Safety Plan if the children remain in the home). Look at the sample Safety Plan (also located in Appendix H in your resource manual "Child Protection in Families Experiencing Domestic Violence").

Safety Planning Resource	**60**	Look at this resource to see how your answers compare with those given by professionals in the domestic violence field. This link is best viewed in the CHROME browser. www.thehotline.org/2013/04/safety-planning-with-children/
Tips	**61**	Here are some tips when you know you are interacting with an adult who perpetrates domestic violence. Review the record for mention of domestic violence. Talk with co-workers and your supervisor to see if they are aware of any domestic violence in the family on your caseload. Be attuned to the same behavioral indicators that the abusive partner uses with their partner, such as glaring at you, agitation, and veiled verbal threats.
Tips	**62**	Meet with the abusive caregiver at the agency or in a public place if possible. Have a code or cue that you need help if the meeting is in your office. Make sure co-workers and supervisors are aware that you are meeting with someone who has the potential for violent behavior. Be attuned to your surroundings both during the interview and when you are arriving at or leaving from the meeting (even if it took place at your office). Know where the doors are located. Notify supervisor and co-workers of the exact location and time of the interview, meeting, or family time visit if that interaction is to take place in the home of the abusive partner.
Tips	**63**	Attempt to avoid verbal confrontation. Use your de-escalation skills. Try to avoid showing fear. Always let the adult victim know if the partner's anger has escalated, as this may raise the risk to the victim and the children. Consult with your field trainer and your supervisor for more suggestions on managing difficult encounters such as these.
References	**64**	Child Welfare Information Gateway. (2003). Child protection in families experiencing domestic violence. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Domestic violence facts and FAQs. Retrieved from http://www.dcadv.org/domestic-violence-facts-and-faqs#faq-why-victims-stay Domestic violence facts and FAQs. Retrieved from http://www.dcadv.org/domestic-violence-facts-and-faqs#faq-why-victims-stay
Congratulations	**65**	You have completed Unit 7 Section 2. Click [Exit Activity] at the top of the page to exit the training.

Unit 7, Section 3

TOC	S#	New Slides (Published 08/08/2023)
Title	1	Unit 7 Section 3 Mental Health
Co-occurence	2	In Section 2, we addressed an 8th ACE factor — Household Mental Illness. Early on in Unit 7 we posed the question, "Which came first — the mental illness or the substance abuse?" In some ways, it doesn't matter. What's important to remember is that they can and frequently do occur together. For the families you encounter, the children have been abused or neglected, or the family is under investigation to determine whether a report of maltreatment is true.
ACE	3	Children growing up in homes where caregivers have SUDs experience multiple, repeated adverse childhood experiences: Domestic violence may occur and one or more caregivers may suffer from mental illness. This puts the children in these homes at high risk to develop problems as adults, which influences how they parent their own children.
Mental Health	4	Mental health, or its absence, is an item on both the FAST and the CANS caregiver scales. Caregiver mental instability and how it affects parenting functions is also one of the 14 safety threats to assess on each contact with the family. In other words, caregiver mental health assessment is a duty that goes across all DCFS job functions.
Overview	5	This section of training provides: A broad overview of adult mental illness ——————————and its impact on children.———————————— Simple screening instruments that help you determine whether someone should be referred for a formal evaluation by a mental health professional.———————— Some helpful resources to support your journey. There is no expectation that Family Service Workers make psychiatric diagnoses. In fact, labeling clients with diagnostic terms is problematic. However, being able to recognize signs and behaviors that indicate a person is suffering from mental illness will help you in responding appropriately.
Survey	6	Let's start with the scope of the problem. And let's also acknowledge that different sources will give slightly different numbers. If you had to guess the number of adults suffering from some form of mental illness in any given year, which figure would you choose?
Survey	7	If you had to guess, are people suffering from mental illness more or less likely to have substance use disorders?
Resources	8	The statistics vary, but it is estimated that around 1 in 5 U.S. adults suffer from a mental illness. Approximately 1 in 25 experience a serious mental illness that limits major life

		activities. And according to the National Survey on Drug Use and Health, 17 million U.S. adults experienced both mental illness and a substance use disorder in 2020. Reference: Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
Video	9	What does it look like to be a child growing up in home where one of the caregivers has a mental illness? Let's watch this child's experience. As you watch, jot down things that catch your attention.
Survey	10	For the next several slides, drag the person onto the statement that best reflects your personal belief.
Survey	11	People with mental illnesses are violent and unpredictable.
Survey	12	People who suffer from mental illness are usually developmentally disabled as well.
Survey	13	Mental illness is brought on by weakness of personality or character flaws.
Survey	14	People with mental illnesses cannot tolerate the stress of a job.
Survey	15	People with mental illnesses never recover.
Survey	16	Medical treatments (drugs) are more effective in treating mental illnesses than therapy.
Survey	17	Children do not have mental illnesses; only bad parenting.
Survey	18	Mental illness cannot be prevented; it is genetically determined.
Survey	19	People with mental illnesses should be isolated from the community.
Survey	20	We have progressed to the point where there is no stigma associated with mental illness.
Myths & Facts Link	21	We are all entitled to our opinions, but let's look at what the research says about the common myths and stereotypes we just looked at.
Myths & Facts	22	"People with mental illnesses are violent and unpredictable." The majority of people with mental illnesses are not dangerous. Only 3%-5% of violent acts can be attributed to a person living with a serious mental illness. In fact, people with mental illnesses are more likely to be the victims of violence.
Myths & Facts	23	"People who suffer from mental illness are usually developmentally disabled as well." These are different conditions. While some people with mental illness can have limited intellectual functioning, there is a wide range in the intellectual functioning of people who suffer mental illness, just as there is a wide range in the general population.
Myths & Facts	24	"Mental illness is brought on by weakness of personality or character flaws." This is potentially one of the most damaging myths about mental illness. It implies that people could just pull themselves out of it if they chose to do so. In reality, mental illness is a complex interaction between biological, psychological,

		environmental, and social factors. Beliefs that mental illness is a character flaw contribute to negative stereotyping.
Myths & Facts	25	"People with mental illnesses cannot tolerate the stress of a job." People with mental illnesses can be just as productive as other employees. We should not assume that the presence of a mental illness automatically prohibits a person from working and being able to support their children.
Myths & Facts	26	“People with mental illnesses should not be caregivers.” The key assessment point for child welfare professionals is the impact of the caregiver’s behavior on the children. There is no literature that would support removing children from a caregiver just because the caregiver has a mental illness.
Myths & Facts	27	"People with mental illnesses never recover." Research supports the assertion that most people with mental illnesses get better and that many recover completely. Recovery refers to the ability to live a fulfilling and productive life and/or the reduction or complete remission of symptoms.
Myths & Facts	28	"Medical treatments (drugs) are more effective in treating mental illnesses than therapy." Successful treatment depends on the nature of the illness and is usually a combination of therapy, medication, and support. Some illnesses may be treated primarily with medication while others may be treated with traditional therapy of some sort (since there are LOTS of therapies). The main point is, no one size fits all.
Myths & Facts	29	"Children do not have mental illnesses; only bad parenting." Half of mental health disorders show first signs before age 14 and ¾ of mental health disorders begin before age 24. Children in the child welfare system may be even more at risk because of the amount of trauma they have experienced from very young ages. For this reason there is a policy requirement that children entering out-of-home care receive mental health evaluation as part of a comprehensive health assessment.
Myths & Facts	30	"Mental illness cannot be prevented; it is genetically determined." Some people are genetically predisposed to mental illness. Schizophrenia is a good example, as are bipolar disorders. However, remember that it is a combination of genetics, social, environment, and other factors. That is why it is so important that child welfare professionals ensure children’s mental health needs are addressed.
Myths & Facts	31	"People with mental illnesses should be isolated from the community." Again, this is somewhat related to the myth that all people suffering from mental illness are violent and dangerous. There is no reason to segregate the majority of mentally ill people from the community.
Myths & Facts	32	"We have progressed to the point where there is no stigma associated with mental illness." Stigma is still a huge problem. Perhaps even more so than SUDs, the stigma associated with mental illness is a barrier to seeking treatment. Stigma is part of what makes it so difficult for children of caregivers with a mental illness. They know their caregiver is not like others and suffer from shame, guilt, and anger as they try to adapt to a situation they may be too young to understand.

Traumatic Experiences	33	When we look at the issues faced by children who are abused, children who are exposed to caregiver violence, children whose caregivers have substance use disorders, and now, children whose caregiver has a mental illness, they are remarkably the same. Or perhaps it is not remarkable. After all, these are all traumatic experiences.
Results	34	Here are some of the insidious and overt results of children exposed to caregiver's mental illness: Parentification. Problems forming attachments (especially if a caregiver has multiple and/or lengthy hospitalizations). Poor school performance. Anxiety and insecurity, in part due to anxiety; in part due to PTSD symptoms. Shame and guilt. Blaming self for their caregiver's problems. Poor social skills. Abused or neglected due to their caregiver's illness.
Brianne Article	35	Read this article for a firsthand account of growing up in a home where a caregiver has an undiagnosed mental illness.
Broad Look	36	The reality is that there is tons of information available to you on the internet these days if you need specific information on any type of mental illness or any particular diagnosis. So, let's take a broad look at some common categories of mental illness and then look at one in closer detail.
Major Categories	37	Mental illness diagnoses can be grouped under five major categories. These are: Anxiety disorders Mood disorders Schizophrenic/Psychotic disorders Dementias Eating disorders Let's take a brief look at three of these. We'll start with anxiety disorders.
Anxiety Disorders	38	"Occasional anxiety is a normal part of life. Many people worry about things such as health, money, or family problems. But anxiety disorders involve more than temporary worry or fear. For people with an anxiety disorder, the anxiety does not go away and can get worse over time. The symptoms can interfere with daily activities such as job performance, schoolwork, and relationships. There are several types of anxiety disorders, including generalized anxiety disorder, panic disorder, social anxiety disorder, and various phobia-related disorders."
Schizophrenic/ Psychotic Disorders	39	"Schizophrenia is a serious mental illness that affects how a person thinks, feels, and behaves. People with schizophrenia may seem like they have lost touch with reality, which can be distressing for them and for their family and friends. The symptoms of schizophrenia can make it difficult to participate in usual, everyday activities, but effective treatments are available. Many people who receive treatment can engage in school or work, achieve independence, and enjoy personal relationships."

Mood Disorders	40	The most common types of mood disorders: Major depression. Having less interest in usual activities, feeling sad or hopeless, and other symptoms for at least 2 weeks may indicate depression. Dysthymia. This is a chronic, low-grade, depressed, or irritable mood that lasts for at least 2 years. Bipolar disorder. This is a condition in which a person has periods of depression alternating with periods of mania or elevated mood.
Mood Disorders	41	The most common types of mood disorders (continued): Mood disorder related to another health condition. Many medical illnesses (including cancer, injuries, infections, and chronic illnesses) can trigger symptoms of depression. Substance-induced mood disorder. Symptoms of depression that are due to the effects of medicine, drug abuse, alcoholism, exposure to toxins, or other forms of treatment.
Assessment	42	If you are involved with a family where a family member is schizophrenic or manic, you are likely to be able to tell by looking and listening that something is wrong and needs further assessment by a mental health and/or SUD professional.
Looking Back	43	Let's look back on one of the family situations you encountered in a previous training. Do you remember this situation? You responded to threat of harm report made to the Hotline by an anonymous caller. (This is a Priority 1 report for which DCFS has investigation responsibility.) The caller was concerned because she overheard her neighbor threaten to "burn the demon" out of her 8-year-old child. The neighbor had a gas can and a lighter. The caller was afraid to give her name because she thinks the mother is "crazy and just likely to burn my house down too."
Scenario	44	The child was out in the yard when the caller contacted the Hotline and the mother was on the front porch. The Hotline advised the caller to call the police and followed up with a call to them as well. The police called you when they arrived at the scene. When you arrive, you find an eight-year-old female child outside in the front yard. A woman the child identifies as "mama" is pacing rapidly back and forth on the front porch. She is holding a cigarette lighter in her hand and extending it out in front of her saying over and over, "Gonna burn you out Satan! Gonna burn you out! Don't you be getting on my house. Don't you be getting near me."
Scenario	45	"Don't show me them demon eyes. You keep them Demon eyes off me!" Despite the content of her words, her affect is somewhat flat. She is disheveled, her hair is tangled and her clothes are dirty. There is an empty gas can in the yard near the front porch and the child's clothes are soaked. When law enforcement attempts to talk to the mother, she screams and runs inside the house. You interview the child to initiate the investigation. During the interview, she makes it known that this type of behavior happens frequently. She is both afraid of her mother and afraid for her mother.

Knowledge Check	46	Based on the information you have so far, would you suspect that this mother suffers from mental illness? **A) Yes** B) No
Knowledge Check	47	Based on the information you have so far, would you suspect: - Anxiety disorder **- Schizophrenic disorder** - Mood disorder
Professional Input	48	You can see that the mother appears to have severe problems, and you will need to have input from a mental health professional as you go forward in planning for permanency for this child.
Depression	49	Let's look at one mood disorder, depression, a little closer. In many neglect cases you need to decide whether a caregiver's treatment of the children has an underlying mental health issue or whether it's an indication that they just don't care.
Depression	50	Depression is more than just sadness or unhappiness. It includes pervasive, debilitating feelings of sadness and hopelessness that interfere with the ability to carry out activities of daily living. It is characterized by: Persistent sad, anxious, or "empty" mood Feelings of hopelessness or pessimism Feelings of guilt, worthlessness, or helplessness Loss of interest or pleasure in hobbies or activities
Depression	51	Decreased energy, fatigue, or being "slowed down" Difficulty concentrating, remembering, or making decisions Difficulty sleeping or oversleeping Appetite and/or weight changes Thoughts of death or suicide or suicide attempts Restlessness or irritability Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment
CANS/FAST	52	You have resources available to you to help you screen for mental health issues. These resources have suggested questions you can ask to move into this area that people might be reluctant to discuss. The first of these is your CANS/FAST Guides (located on CHRIS/CHRISNet under the Resources tab). Just a reminder: While the suggested questions for the caregivers are listed under CANS, these conversation starters will also work on the FAST.
Handout 7.3.1	53	Read the following scenario. Approach this scenario as if you were the caseworker completing the initial assessment.
Survey	54	Would you be concerned that Ms Franklin is depressed? A) Yes B) No
Caregiver Guide	55	Hopefully you at least considered the possibility that she is depressed and that her depression is contributing to the family's difficulties caring for their children. There is one question on your "Caregiver Guide" related to mental health and that is the open ended directive: Tell me about your mental health. But early in the relationship that might be too threatening for Ms. Franklin.

Handout 7.3.2	56	Now, let's add some screening questions to your assessment toolbox. Handout 7.3.2 has the questions for you.
Two Questions	57	So, you can start by asking Ms. Franklin two questions. Over the past two weeks how often have you been bothered by any of the following problems? Little interest or pleasure in doing things. Feeling down, depressed, or hopeless. If she tells you that she has been bothered, you can move to the longer scale.
Diagnose	58	Again, you are not expected to diagnose Ms. Franklin. But as you talk, you may be able to determine if a referral is needed, and if so you can: Secure a release of information (DHS 4000). Share her responses and your concerns with the provider.
Assessment Skills	59	Assessment of the interrelationship between mental health disorders, substance use disorders, domestic violence, and child abuse is complicated. The first step in improving your assessment skills is recognizing that in families where child abuse or neglect occurred, these other problems may be present as well. This recognition will help you do a better job engaging the family in a discussion about how to keep their children safe from harm. Hopefully, it will also help you assess when children can be safe at home with an immediate safety plan and when there is no alternative to ensure safety other than removal.
Safety Plans	60	Substance use disorders, caregiver mental illness, and domestic violence in the home do not automatically require that you must remove children. But any Safety Plan or Immediate Safety Plan you implement must take these potential Safety Threats into consideration.
References	61	Mental health by the numbers. Retrieved from https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers SAMHSA: Co-occurring disorders. Retrieved from https://www.samhsa.gov/disorders/co-occurring In the eyes of a child. Retrieve from https://www.youtube.com/watch?v=8Bvm0lZ77ic Mental health myths and facts. Retrieved from https://www.mentalhealth.gov/basics/myths-facts/index.html Anxiety disorder. Retrieved from https://en.wikipedia.org/wiki/Anxiety_disorder Schizophrenia. Retrieved from https://en.wikipedia.org/wiki/Schizophrenia Mania. Retrieved from https://en.wikipedia.org/wiki/Mania Screening for depression. Retrieved from http://www.aafp.org/afp/2012/0115/p139.html
Congratulations	62	You have completed Unit 7 Section 3. Click [Exit Activity] at the top of the page to exit the training.