

## OVERVIEW

Goal—The goal of Module 3 is to educate child welfare professionals about mental disorders and treatment. It provides in-depth information and learning opportunities designed to support child welfare professionals in working with diverse families affected by mental disorders. The module will inform child welfare professionals about the range of mental illnesses; address some of the differences between mental illness in adults and in children; explain signs and symptoms that can indicate the need for a comprehensive assessment of parents; inform child welfare professionals of potential screening tools that can be used by child welfare workers to determine if a comprehensive assessment is needed; provide an understanding of the different models of treatment, cultural competency in treatment, and management of mental illness; and discuss specifics of how mental illness can affect the interpersonal relationships and family dynamics of the families with whom they work.

Methods: PowerPoint presentations (or overhead/transparencies); large group and small group discussions, with Vignette discussion.

Training Aids: Projector and computer, disk with PowerPoint file (or overhead and transparencies); flip chart with markers; participant notebook.

Time: 3 hours

Learning Objectives—After completing Module 3, child welfare professionals will have an understanding of the following topics:

- Spectrum/types of mental disorders
- Signs and symptoms of potential mental disorders
- Culturally appropriate screening tools for determining if a further comprehensive assessment by mental health professional is needed
- Impact of trauma (early childhood and other) on mental health of parents
- Impact of stressful life events on mental health of parents
- Link between mental disorders and suicide and other violent behavior
- Models of treatment, cultural competency in treatment and management of mental disorders
- Effects of mental disorders on interpersonal relationships and family dynamics, care of children, etc.
  - Isolation
  - Negative social network
  - Poor parenting skills
  - Endangering behaviors
- Recovery from mental disorders

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

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

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

***[Slide III-1] Trainer introduces him- or herself and invites participants to briefly introduce themselves (name, unit, office location, years in the system, etc.). If this same group has been together for other modules in this series, you can substitute by asking them how they used information learned in previous sessions in place of introductions. If group is smaller than 12-15 people, trainer could invite them also to briefly describe their interest in this training. If group is larger than 40-50 people, individual introductions are likely to take too much time.***

***Describe the purpose of Module 3. Language for describing the purpose and overview follows this paragraph. Emphasize that child welfare professionals often work with families where one or more adults are experiencing mental disorders and this training is intended to prepare them to better help such adults recover from the effects of their disorder and function appropriately as parent or caregiver. The bottom line goal is safe care of children. The language provided also describes four simple ground rules for the training session. After presenting them, the trainer may ask the group if there are any other ground rules important to them.***

Good morning! (afternoon; evening) Thank you for coming today. I want to welcome you to this training, which has been designed specifically for child welfare professionals, with information and opportunities to practice skills useful to your work. In particular, this Module is designed to educate you about parents or primary caregivers with mental disorders: how to recognize the possibility of such disorders; how to seek assistance for parents; and how to understand the disorders and the treatment.

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

**15 – 35 minutes      Facilitated Group Discussion      20 min.**

***Overview: It is desirable to have participants share their attitudes about persons with disorders because some may discover and begin to question negative attitudes about persons with mental disorders, making them better able to work with and support parents in recovery for a mental disorder. The discussion may or may not center around stigma associated with mental disorders and their diagnoses. Try not to let one participant dominate the discussion; draw in others to the discussion.***

***Explain that the GOAL of this discussion is to help participants personalize the realities of mental disorders and their impact on each of us. Explain that in this discussion, the person must be discussed separately from the disorder (i.e. "a person diagnosed with bipolar disorder" rather than "a bipolar").***

**Begin this discussion with the whole group, asking them to share their experiences specifically with persons with mental disorders. Begin by asking:**

***What personal or professional experiences have you had with persons experiencing symptoms of mental disorders? What is (or was) that person's relationship to you, and how did their symptoms affect you? What symptoms did you notice when they are (or were) experiencing difficulties with mental disorders?***

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

- ***Beyond any child safety issues, how did the symptoms impact you?***
- ***What are your feelings about the label—or stigma—associated with the mental disorder?***
- ***Do those feelings have any impact on your professional work?***
- ***If so, what is the impact?***
- ***How do you think these feelings impact your professional work with clients who also may experience symptoms of a mental disorder?***

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

## PRESENTATION 8

**35 – 45 minutes      *Presentation 8: Mental Disorders: What are they?* 10 min.**

***Deliver scripted Presentation 8 describing parental mental disorders. Slides III-1–III-5. At the conclusion of the presentation, ask if there are any brief questions that can be answered before moving on to the following discussion. Keep your answers brief. Only answer questions to which you know the answer.***

**[Slide III-1] Module 3: Understanding Mental Disorders, Treatment, and Recovery: Spectrum and Types of Mental Disorders in Adults**

We all know that many of the families whose children come into state custody are experiencing some effects from mental disorders. This presentation will give you information that can help you better help them succeed in treatment for these disorders. This is going to be basic information about the spectrum and types of mental disorders in adults, which should improve your ability to recognize and respond to disorders like these in the parents and caregivers of the children you serve.

**[Slide III-2] Mental Disorders -1**

To set the stage, let's talk generally about mental disorders. In this curriculum, we use the term "mental disorder" to describe a whole variety of mental and emotional difficulties people experience. You may hear other terms, such as "mental illness," "mental health problems," or "behavioral health disorders"--and they refer to these same types of difficulties.

Mental disorders take many forms, and the same disorder can express itself differently in different individuals. Mental disorders are not something people “have” or “don’t have” – mental health is a continuum, with mental disorders at one end. It’s better if we think of mental health disorders as “spectrums” or “ranges,” some more debilitating than others, and at some times more debilitating than at other times.

### **[Slide III-3] Mental Disorders - 2**

Myths about mental disorders have been around a long time. You can work to get rid of these myths by understanding the facts about the treatment of mental disorders. For example,

- Most persons with a mental disorder respond positively to appropriate treatments, such as education, medication, self-help, therapies, and other interventions.
- A person cannot “catch” mental disorders from another person, but there are some disorders, such as schizophrenia or depression, in which a predisposition appears to be inherited from one or both parents. Certain life experiences (such as abuse or neglect) can trigger the appearance and development of a mental disorder in their children.
- Most of the time, parents with or without mental illness do not “cause” mental illnesses in their children, although growing up with a parent with mental illness can be challenging. If abuse or neglect is added into the child’s experience, the child can be at greater risk of developing their own mental disorders. But many mental disorders expressed by children occur in families with skilled, caring parents, so a causal link should never be automatically assumed.

### **[Slide III-4] Impact of Mental Disorders**

There are many different mental disorders that can affect adults and their ability to be good parents to their children. The most common element in the many different mental disorders is that *thought processes* or *moods* or *emotion* are different in persons with mental disorders than in many other people (people that we call “normal”)--sometimes extremely different. And you may not know this, but, in the past 15 years the field of brain science has learned that almost all mental disorders have a significant biological basis with marked differences in how the brain and the entire central nervous system function. In particular, specific neurotransmitters – which are the chemicals that carry messages from one brain or nerve cell to another – get out of balance and cause changes in thought, mood and/or emotion.

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

The important thing to remember is that the *cause of a disorder* (which could be biological inheritance, early trauma, or just learned behaviors) *is less relevant than the current impact of the disorder* on their ability to live their lives, or to function. If minor children depend on adults with such a disorder, those children may or may not experience inconsistency and difficulty.

Another interesting fact that is often missed is that while symptoms of mental health disorders may not be adaptive in some situations, they can actually be very helpful in other situations.

People in jobs that require very high energy functioning on an erratic basis, for example, may find that while symptoms of mania are problematic in their personal lives, they may be professionally helpful.

Many people in our society hold fears about the potential for violence from persons with mental disorders. When you watch the news and witness visible, violent acts you might later learn that the perpetrator of those acts had a mental disorder. In the entertainment industry, various products rely for their effect on the idea that people are dangerous because they have a mental health disorder. However—and this is interesting—statistics show that persons with chronic or episodic mental illnesses commit violent acts at a slightly lower rate than persons in the general public (U.S. Surgeon General’s Report on Mental Health, 1999a). Violent acts are possible, but most persons with mental disorders do not present a greater-than-normal risk of violence. This said, child welfare professionals should always take safety into consideration, just as when visiting any family home.

### **[Slide III-5] The Recovery Model**

The adult mental health care system continues to develop new approaches that reflect what is called a “recovery” model of care. “Recovery” is based on the belief that a person does not have to remain seriously and negatively impacted by their mental disorder, and with appropriate treatment, education and supports, most people can “recover” from mental disorders and lead normal, productive, hopeful lives. Similar to adaptations people make to physically challenging conditions, people living with mental disorders learn to adapt their lifestyles in such a way that they can maintain this state of recovery, sometimes for years. This approach challenges stigma about persons with mental disorders and their chances for life success. This model also challenges some of the traditional mental health treatment approaches and the roles played by treatment professionals.

So, how does the Recovery Model work? First, any social worker may be the community helper that identifies a need for additional assessment of possible mental health needs in an adult who is caring for a minor child. In some families, the effective treatment of a parent’s mental disorder may be the key to effective child protection interventions, and referral may be one of your best actions (with safety always the highest priority). In such a family, your most meaningful contribution to the health and well being of the child may be connecting their parent to an appropriate treatment professional to assess whether they suffer from a mental disorder, and then to point them towards appropriate treatment.

I’d like to stop now for a few questions and then let’s move to a short discussion about your understanding about people with mental disorders.

**45 – 65 minutes      *Facilitated Group Discussion*      20 min.**

***Once any immediate questions have been addressed, move the whole group into a discussion about their beliefs about persons with mental disorders. Begin by asking,***

***What beliefs have you been exposed to about persons with mental disorders—and how do you distinguish between myths and facts?***

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

- ***What kind of myths have you heard about mental disorders?***

- **What are the truths each of you has learned about mental disorders?**
- **What resources can you use to distinguish between myth and reality?**

**The GOAL of this discussion is to help participants recognize that we have all been taught some things about persons with mental illness that are not true, at least not for every person with a mental disorder. Hearing other participants acknowledge myths will help each participant better understand the truth of disorders. Try not to let one participant dominate the discussion; draw in others to the discussion.**

**To bring final closure to this discussion, emphasize that each individual with a mental disorder is unique, has strengths and abilities, and can recover from the impact of the disorder with appropriate help.**

<b>PRESENTATION 9</b>
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**65 – 90 minutes      *Presentation 9: Signs and symptoms of mental disorders in adults; screening for referral for further assessment*      25 min.**

***Deliver scripted Presentation 9 on signs and symptoms of mental disorders in adults and screening for referral. Slides III-6 through III-11. This presentation briefly describes many different mental disorders and then describes a tool that can be used to help screen adults to identify a need for further assessment. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on. Keep answers brief. Answer only questions to which you know the answer.***

**[Slide III-6] Module 3: Understanding Mental Disorders, Treatment, and Recovery: Signs and Symptoms of Mental Disorders in Adults**

We're going to talk now about some specific signs and symptoms of possible mental disorders in adults, hoping to help you better recognize these disorders and understand the possibilities for treatment and recovery. We'll also talk about how these signs may differ from those you'd see in children and adolescents.

There is one caveat. By presenting this information, we do not expect to prepare you, as a child welfare professional, to diagnose mental disorders. Rather, we hope to help you recognize when a referral for further assessment by a qualified professional is appropriate. Likewise, if a parent is diagnosed in the assessment, this information will help you better understand some of the dynamics of the disorder.

**[Slide III-7] Types of Mental Disorders - 1**

More common adult mental disorders may include any of the following (American Psychiatric Association [APA], 2000) and can be categorized broadly as affective disorders, psychotic disorders, personality disorders and obsessive disorders:

Affective Disorders are disorders that affect a person's mood. Here are some of the most common affective disorders:

- *Anxiety disorders* – This is when a person experiences an anxiety so powerful that functioning may become difficult. It can be accompanied by powerful physical symptoms like shaking or the heart racing. The person may or may not identify a cause for the anxiety, but others are not likely to see the identified cause as real or powerful. Sleeping, eating, work and relationships may all be impacted by the anxiety, which may be constant or episodic.
- *Manic episodes* – Manic episodes occur when a person is unusually excited, happy, or active and are often accompanied by long sleepless periods, often followed by a “crash” that can be physical or emotional or both. Manic episodes may be, but are not always, episodic and can follow solar, body, or other rhythms. The person with mania will often have a sense of increased power or creativity or intelligence during an episode, and they often have a feeling of invulnerability.
- *Depressive disorders* – A depressive disorder is a serious manifestation of depressed mood, sometimes combined with elation, both beyond the normal ups and downs of life. Some of these disorders are cyclical, bouncing back and forth between depression and mania; others alternate between seeming “normalcy” and depressive symptoms, following inner physical rhythms. It is important to distinguish between feeling sad (or “down” or “blue”) due to life events and clinical depression, which lasts longer and can include thoughts of death or a slowing of activities, speech, reaction time, etc.
- *Panic disorders* – When a person has a panic disorder, fears (real or imagined) or more general stressors lead to an intense “fight or flight” reaction in the body, a reaction that is very real and tends to reinforce or heighten fears already in place. The fear or experience of such a physical reaction may cause a person to alter their behaviors to avoid the situations or circumstances that bring about the panic response.
- *Phobias* – Fears that keep a person from living a full, involved life are called “phobias.” These fears can be small and limit very little in that person’s life, or they may be multiple or large and severely limit life activities. Phobias may occur in response to traumatic life events (e.g., confronting a large snake) or for unexplainable reasons. Their impact on the person’s behavior is just as real in either case.
- *Post-traumatic stress disorder (PTSD)* – Life disruptions caused by a single traumatic experience (e.g., war or natural catastrophe) or a pattern of traumatic or fearful experiences (e.g., a child growing up in constant fear of abuse, a victim of domestic violence). Many different symptoms may reflect PTSD, including any combination of sleep disruptions, night terrors, recurring nightmares, eating disruptions, paranoia, lethargy, disrupted relationships, phobias, and others.

### **[Slide III-8] Types of Mental Disorders – 2**

These are some other types of mental disorders:

- *Eating disorders* – Holding a self-perception that leads to distortions in body image and consequential eating behaviors (e.g., needing to eat but then purging so that weight won’t be gained; avoiding eating for fear of gaining weight; fits of heavy, or binge, eating; all of the above). The person may not understand why they behave in these ways and hide the behaviors from others.

- *Obsessive-compulsive disorders* – An intense and often debilitating focus on certain thoughts, images, sounds or behaviors (obsession – e.g., unable to stop thinking about...), and/or continuing behaviors that have no inherent meaning but are repeated nonetheless (compulsion – e.g., repetitive hand-washing, checking the door locks over and over before going to sleep). A person with this disorder may be unable to maintain relationships or perform necessary functions as a consequence of the focus on certain thoughts or specific behaviors. An individual may be able to manage the disorder within their own environment (e.g., their home or office) but show functional impairment in other environments, especially in unfamiliar or stressful environments.
- *Personality disorders* – A range of difficulties, manifesting in many different ways that place a person “at odds” with life around them. Withdrawal from contact with others may result, and so may illegal behaviors, behaviors that bring self-harm, or aggression that threatens harm to others. Many persons with personality disorders are unable to recognize the differences or challenges presented by their disorder. Personality disorders are recognizable when a pattern of interaction or relationship recurs in a person’s life over and over again regardless of the individuals involved.
- *Delusional disorders* – An experience of perceptions that others do not share. Such delusions seem very real to the person experiencing them but often put their behavior at odds with others around them who are not experiencing them. Not all delusions are psychotic, but in the most extreme form persons may experience hallucinations, such as seeing people not there, hearing voices no one else hears, being convinced “they’re out to get me”, using aluminum foil to shield the brain from intruding thoughts, etc. Such experiences must be assumed to be serious, possible indicators of psychosis (below).
- *Psychoses* – Serious disruptions in thought and/or mood (e.g., schizophrenia). Such disruptions may be obvious, especially to persons close to an individual with the disorder, but they also may not be so obvious. Generally, disruptions involve perceptions, thoughts, and/or moods that are out-of-line with the person’s experience as observed by anyone else. This may include hearing voices, seeing visions unseen by others, or focusing on thoughts that are held exclusively by that person and not supported by reasonable evidence. The disorder, when active, makes it hard for the affected individual to see the consequences of the disorder.
- *Sexual and gender identity disorders* – Internal mental and/or emotional confusion about one’s identity or role, in conflict with societal expectations or roles, which may lead to behaviors that lie outside normal expectations or boundaries. A person may feel that they have ambiguous sexual organs or experience attractions that are outside traditional gender identities in our culture. For some, this is a serious and debilitating disorder. A person who is gay, lesbian, bi-sexual or transgender does not necessarily have a disorder – they must be experiencing a compromise in their social, occupational, or other important areas of functioning for this diagnosis.

For more information on anxiety disorders, refer to Handouts *Anxiety Disorders, Mood Disorders, Eating Disorders and Schizophrenia*.

***[Optional Discussion (Time Permitting): Ask the group: “Are any of you thinking about whether any of these labels apply to you” Remind them all mental health is a continuum***

**– these are behaviors common among us, where the extreme versions are mental disorders.]**

- To learn more, visit the websites of the Center for Mental Health Services, National Mental Health Association, American Psychological Association, and the American Psychiatric Association. These links are provided on your internet resources list.

Having described all of these disorders, I want to emphasize again two important aspects of mental disorders. First, virtually all of these disorders have a significant biological basis and do not always reflect the person's choices nor do they make them a "bad" person. Second, all mental disorders are treatable, making proper assessment and treatment planning essential to recovery.

I'd also like to mention that some children and adolescents experience these disorders as well [Refer to Module 6 for more information]--but disorders under the same name (like depression) tend to look different in children or adolescents. This is one reason why mental health professionals are often trained either for work with adults or for work with children and adolescents, although a few professionals have expertise across both populations. It is important to try to match professionals with the appropriate expertise to the person with needs.

### **[Slide III-9] Mental Health Screening Form-III**

Now, I'd like to turn our attention to a culturally appropriate screening tool for determining if a further comprehensive assessment by mental health professional is needed.

You, as child welfare professionals, may be able to recognize certain indicators of mental disorders in the parents and caregivers of the children you serve. This is important because the critical keys in limiting the negative impact of mental disorders are early identification, appropriate assessment, effective care planning, and appropriate treatment.

Professionals trained to assess mental disorders have a variety of tools they use to determine if a disorder exists and to design an appropriate course of treatment. But there are also simple screening tools that can help social workers determine whether or not to refer a parent on to a professional for further assessment. One of the best examples of such a screening tool is the Mental Health Screening Form III (MHSF-III; Carroll and McGinley, 2000). Please refer to the Mental Health Screening Form III (MHSF-III) Handout. This tool includes 18 "yes" or "no" questions, with the first four aimed at general mental health concepts and the remainder associated with a range of specific mental disorders.

Generally speaking, child welfare professionals can give this screening form to a parent to complete by themselves, or the questions can be asked during an interview and the answers noted on a form. If you have concerns about a parent's reading level, it may be best to use the screening form as the basis for an interview.

All the questions in this screening form are "yes" or "no" questions and they refer to the person's life experience, not just the immediate moment. If the answer to any question is "yes," it is appropriate to ask follow-up questions, particularly to determine if the "yes" answer applies to current or past circumstances. For example, if someone says "yes, but it happened a long time ago," and it is clear that they successfully resolved the problem and it has not recurred, they may not need further assessment. You might also ask, "When did this first develop?" or "How

long did it last?" Another useful follow up question might be, "What was happening in your life at that time?"

Generally, "yes" answers to any of these questions also suggest that it may be appropriate to refer the parent to a mental health professional for further assessment—especially the answers to questions 3-17. As you can see from the nature of the questions, this screening tool mostly contains one question each for a wide range of mental disorders. The answers to these questions are not nearly enough to form a diagnosis or a treatment plan – they are simply aimed at helping a social worker decide when to refer for further assessment.

### **[Slide III-10] MHSF-III – Questions – 1**

Let's look at the specific questions and I'll make some general remarks about them to help you use this tool. It references the same disorders we just talked about. Please refer to Handout *Guidelines for Using the Mental Health Screening Form III*.

The first four questions refer to whether or not the person has received, wanted, or been referred for mental health treatment. Previous service or referrals for service are general indicators that a referral for further assessment to a mental health treatment professional might be warranted. In response to a "yes" answer to any of these first questions, you might suggest to the parent that they get an assessment, "just to rule out the need for treatment."

Question 5 asks whether the person has had auditory or visual hallucinations. A "yes" answer would raise immediate concerns about psychosis (e.g., schizophrenia) or delusional disorders, and if they say it is currently happening (e.g., last week, last night, right now) the social worker should help arrange an assessment as soon as possible.

Question 6 asks about feelings of depression or self-harm, such as a suicide attempt. A "yes" answer indicates a need to be assessed for depressive disorders, of which there are several types. If the parent says they are currently thinking about harming themselves, the social worker should not leave them alone, and an immediate assessment should be arranged.

Question 7 asks about reactions or responses to traumatic events and is looking for indicators of post-traumatic stress disorder (PTSD). If the person answers "yes," it would be appropriate to ask about any trauma(s) they experienced, but a referral for assessment should also be made.

Question 8 asks about strong fear reactions to specific things--and explores phobias. It is important that this not be generalized fear of "life" or "the world", but rather is a response to specific things, stimuli, or circumstances. A "yes" answer should lead to a referral for assessment.

Question 9 asks about the person's aggressive or anger responses, especially if they have repeated or resulted in injury to others or property destruction. A "yes" answer means that an assessment should be conducted.

Question 10 is asking about delusions, or beliefs that someone holds something against them or is trying to influence their behavior in some way. A "yes" answer does not mean they are experiencing delusions (the perception may be true), but a referral for assessment should be made to make certain. A person with delusions has some difficulty operating well in the real world.

**[Slide III-11] MHSF-III – Questions - 2**

Question 11 is, of course, a sensitive question, since we think of sexual matters as very private, and it should be asked just the way it is worded on the screening form. A “yes” response should lead to a referral for further assessment by a treatment professional.

Question 12 is seeking to discover if the person may be experiencing an eating disorder, which is related to both self-image and food. A “yes” answer should lead to a referral for further assessment. Some communities have treatment professionals who specialize in identifying and treating such disorders.

Question 13 asks about manic periods, times when a person’s brain chemistry shifts out of balance and causes them to feel excessive energy and/or abilities. A “yes” answer should lead to a referral for further assessment.

Question 14 asks about panic attacks, or periods when the person has all the physical feelings of panic, even though there might not have been an obvious reason to be in panic. This is more generalized and more physical than the phobias covered by Question 8. A “yes” answer should lead to a referral for assessment.

Question 15 is exploring whether the person is experiencing obsessions and/or compulsions. An obsession is a strong mental or emotional focus on something specific, while a compulsion is a need to carry out certain actions, often repetitively but without benefit to the person. A “yes” answer should cause a referral for further assessment.

Question 16 is looking for the presence of a gambling disorder and is fairly self-explanatory. A “yes” answer should lead to a referral for further assessment. Some communities have treatment professionals who specialize in pathological gambling disorders, and they are more likely to be associated with the substance disorder treatment system.

Finally, Question 17 is an attempt to find out whether the person suffers from a learning disorder or some form of retardation. A “yes” answer should first lead you to make sure the person understands your questions and statements, and your judgment can be used about whether it is necessary to refer for further assessment. If you already wonder if the person understands you and what is happening in the child welfare system, a “yes” answer might appropriately lead to a referral to the developmental disability system so that you can better understand their ability to work productively with you towards case plan goals.

Again, this screen is not intended to make you a mental health professional, but it is a tool to help you decide when to refer to such a professional.

This has been a long session to sit through. Are there any specific questions I might answer?  
*[Limit questions and answers. Don’t answer questions if you don’t know the answer.]*

**90 – 105 minutes    *Break***

**15 min.**

**PRESENTATION 10**

**Deliver scripted Presentation 10 describing treatment models, trauma and stress, and links between mental disorders and violence. Slides III-12 through III-19. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on to the following discussion. Keep answers brief. Only answer questions to which you know the answer.**

**[Slide III-12] Module 3: Understanding Mental Disorders, Treatment, and Recovery: Model Interventions and Supports**

We've talked about the kinds of mental disorders that parents you encounter might experience, but what about helping them? It is also important that you have some understanding of the kind of treatments that might be offered in response to the identification of mental disorders. In this presentation, I am going to talk about model treatment, management of mental disorders, and treatment services, collectively known as "interventions and supports."

**[Slide III-13] Helping Models**

Persons within the mental disorder treatment field hold a wide range of beliefs about people in general, about mental disorders, and about the best type of care for these disorders when they are identified. Still, in broad categories, there are a few major approaches to these issues, including the following (Corsini and Wedding, 1995):

- *Behavioral Model* – This model posits that all behaviors are learned. Treatment focuses on decreasing problematic or painful behaviors and replacing them with more effective or positive behaviors. Conditioning and behavioral management skills are taught and supported. The Cognitive-Behavioral Therapies (CBT) reflect this model.
- *Biological Model* – The biological model is based on the idea that emotional and behavioral aberrations reflect physical problems or anomalies. Mental disorders may result from regulatory and/or management difficulties that stem from differences in the way a person's brain or body functions. Treatment focuses on finding the physical cause of the problems and treating it medically. Treatments include interventions like therapy, medication, repair or adjustment of physical functioning, rehabilitation, etc.
- *Ecological Model* – In this model, all behaviors are the consequence of interactions between the individual and his or her environment. The individual cannot be neatly separated from the environment. Treatment is designed to learn more about these interactions and make adjustments in the person, the environment, or both.
- *Interactive Model* – The interactive model acknowledges every other model in this list. It says that behavioral problems are the result of complex interactions between biology, environment, learned behaviors, and other factors. Treatment may include any number of approaches or combinations.
- *Psychoanalytic Model* – The psychoanalytic model says that behavioral disturbances result from the person's mental life and past experience. Treatment focuses on helping the person understand his or her thinking about the past, or gaining insight about the impact of past experiences through talking about their experience.

These are overly simplistic descriptions of major mental health models. Most treatment professionals combine elements of many of these models, depending on the individual in their

care and their symptoms. When talking with treatment professionals it is often helpful for the child welfare professional to ask them to explain the model or treatment approach they follow, so that you can better understand how to effectively coordinate your child welfare casework with the treatment interventions.

### **[Slide III-14] Mental Health Treatment**

Until recently, mental health treatment was based on the theories and instincts of the individual professional, but this made it difficult to gather any evidence about how effective different approaches might be. It was even harder to learn about what did and didn't work because so much of what takes place in treatment is personal and confidential, not to mention hard to define.

In the last 10 years or so, the mental health field has begun to use recognized scientific procedures to test interventions to see if they work with specific types of needs and types of people, as well as what interventions don't work as well. Interventions that are shown to be effective are called "evidence-based practices," or EBPs—and these EBPs are what the field considers current best practices for mental health treatments.

It is very important that you become familiar with EBPs and look for treatment programs that use them, even though in reality there are areas in this country, especially more rural and frontier areas, where EBPs are not yet available.

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

These EBPs incorporate a variety of consumer driven approaches. Overall, it appears that a consumer driven approach that includes a combination of medications and psychosocial supports (including education about the disorder) may be the most consistently effective approach, at least for many serious mental disorders.

Community-based care is a desired and effective care approach for persons with serious and persistent mental disorders, such as schizophrenia and bipolar disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2003). "Recovery" models appear to describe the most effective current approaches to achieving consumer-desired outcomes from publicly funded services and supports (US Department of Health and Human Services, 2005). Effective community-based care ensures that persons with a mental disorder have access to a range of services and supports and are actively helped to address and overcome any difficulties presented by the disorder, according to their choices.

- To learn more, visit the SAMHSA, Center for Mental Health Services, National Mental Health Information Center, Evidence-Based Practices: Shaping Mental Health Services Toward Recovery website. The link is provided on your internet resources list.

### **[Slide III-15] Mental Health Interventions**

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

- *Medication* – When the diagnosis is correct, an appropriate medication applied in appropriate dosages can counter the negative impact of many mental disorders. Medication should be monitored regularly for effect, and some medications require regular physical/blood tests to prevent or monitor potentially harmful side effects.
- *Education* – It is often effective to educate individuals about the nature and impact of mental illnesses they may have, giving them a chance to understand and take control of their own mental and physical health, using strategies that have been shown to be effective.
- *Counseling or Therapies* – Some persons are able to talk with others about their illnesses or symptoms in ways that help them gain insight and additional abilities to manage their own disorders. Therapies may be provided to individuals, to entire family groups, or to treatment groups of persons with similarities. Still, counseling and the various therapies are not necessarily effective for everyone with a mental disorder.
- *Care Management is also known as Case Management* – Some people with complex or very serious mental disorders respond well when a paraprofessional or professional staff person agrees to work with them to help manage the delivery of care through the community system. This role may be very simple or very involved. The field has used the term “case management” for many years, but consumers of this type of care are working to change the term to “care management” so that they are no longer thought of simply as “cases.”
- *Respite Care* – Many persons with mental illness have someone in their life that cares about them and looks after them, to varying degrees. Those caregivers may become exhausted or overwhelmed by the care responsibilities and may need periodic relief. Respite services provide relief like this on a scheduled and/or emergency basis.
- *Assertive Community Treatment (ACT) teams* – These teams provide multi-disciplinary expertise immediately accessible to those who are most seriously impacted by significant mental disorders, constantly assessing needs and managing system responses that assist the individual to remain outside institutional placements.
- *Day Treatment, or Intensive Day Programming* – Many people with mental disorders manage their difficulties well when they have daily access to a structured program with opportunities to develop socialization and other life skills and access to necessary supports. Many adults with mental disorders have someone caring for them, and day treatment programming may allow the caregiver to fulfill job responsibilities or get respite from the challenges presented by day-to-day care.
- *Self-Help* – Many consumer-led services and supports have emerged in the past decade and are effective for many people with mental disorders, helping them manage their own disorder and remain functional in their community. A wide array of self-help options exists across communities, with peer-to-peer relationships at the heart of successful support.
- *Institutions* – The most expensive and generally least effective (long-term) model of treatment for adults with mental illness is psychiatric hospitalization. This service is extremely important when it is needed briefly for stabilization, accurate diagnosis, or medication adjustment, but hospitalization is needed rarely and should be used as infrequently and as briefly as possible, unless it is the only environment in which the person is not a threat to themselves or others. The availability of hospital beds varies widely across States and communities.

Refer to Handout *Traditional Therapies* for more information. Refer to Handout *Mental Health Services Locator*. The CMHS Mental Health Services Locator provides you with comprehensive

information about mental health services and resources and is useful for professionals, consumers and their families, and the public. You can access this information in several ways by selecting a State or U.S. Territory from the map or drop-down menu.

It is a really good idea for child welfare professionals to learn about the credentials of treatment professionals they may refer families to. It is quite appropriate to take the time to ask about their training and their approach to helping persons with mental disorders. As people in different systems learn more about each other, stronger alliances are formed, which helps community members who need their services.

### **[Slide III-16] “Resistance” to Treatment**

Sometimes, people with mental disorders resist or reject the types of care that could help them function more effectively in society. This resistance doesn't make them “bad,” but it can reflect a predictable part of some mental disorders.

Such persons may need constant reinforcement and support to accept and receive appropriate care. It is also important to remember that treatment cannot be forced on anybody.

Also, certain medications used to treat thought or mood disorders can affect persons of different races somewhat differently, and this can explain some resistance to treatment. It is also important to use mental health professionals who are aware of such differences—and are willing to find another way to treat the person—without judging them!

#### ***[Optional Discussion: If time permits, ask the group:***

- ***Have you had experiences with parents who have appeared to ‘resist’ treatment you’ve recommended?***
- ***What kinds of reasons did they give?***
- ***How did you react?***
- ***Looking back, can you see a possible influence from the disorder?”***

***Remind participants that we all resist suggestions of change at various times in our lives; this state of “resistance” is not unique to persons with mental disorders. In this area, the field of treatment for substance use disorders has much to offer in the technique of motivational interviewing.]***

### **[Slide III-17] Impact of Trauma on Parents in Child Welfare**

There are a number of things you need to consider when you are working with parents involved with the child welfare system. Let's first consider parents who may have been impacted by trauma early in their lives.

One thing to keep in mind is that adults who experienced physical or emotional abuse or fear of abuse through childhood are at increased risk for experiencing mental disorders. But remember, while such a disorder does not define who they are, but it may substantially influence who they are.

When a person grows up with traumatic events (for example, as a victim of child abuse), their life in general and their parenting more specifically are likely to be affected in some way. . A parent who has been abused by their own parents sometimes grows up to treat their own

children the same way they were treated. In fact, child abuse is often cyclical, repeating itself through family generations.

On the other hand, although people raised with abuse may continue that abuse in their own parenting, growing up with abuse does not automatically mean that a person will abuse their children.

- To learn more, read *Chapter 3—Comprehensive Treatment for Adult Survivors of Child Abuse and Neglect* in Substance abuse treatment for persons with child abuse and neglect issues. Treatment Improvement Protocol (TIP) Series, No. 36. DHHS Pub. No. (SMA) 00-3357. The link is provided in your internet resources list.

### **[Slide III-18] Assessing Needs**

Stressors may come in many different forms, including personal and family relationships, economics, job/career, health, and other key life domains. Stressful life events can also impact the mental health of parents. As you assess a family's situation or investigate an allegation of child abuse or even in ongoing case management, it is important to remember these principles:

At any time, you are only seeing a moment or a snapshot in the lives of persons that are generally quite complex. Even in ongoing cases, there is always more taking place than the case workers can know or note in their reports.

Therefore, it is a good idea to try to find out what events or circumstances in that parent's past or present life might be influencing them today and what strategies have been successful for them.

The incidence of mental disorders—in both adults and children—is higher among those living in poverty, and adults with mental disorders often slide into poverty because of employment challenges. What does this mean? We don't know that one thing causes the other, but we do know that we need to be on the lookout for mental disorders when we are working with families that are poor (Hudson, 2005).

All adults experience stress in their lives, but every individual has different skills to handle it. Some do well most of the time but occasionally have more than they feel able to handle; others chronically respond ineffectively to stress; and others never have difficulty dealing with stress. Stress can contribute to the emergence of a mental disorder and can trigger recurring symptoms for a person with a known disorder.

Finally, try to be aware of the possibility for co-occurring disorders—especially mental and substance use disorders—in the same person when that person's life seems to have a high level of stress.

Recognizing and addressing some of the stressors in the lives of caregivers, or helping them to address such stressors, is likely to enable them to more successfully and safely care for their children, regardless of the presence of a mental disorder.

### **[Slide III-19] Mental Disorders and Violence**





Reaching out for help increases the strength and likelihood of improvement, whereas withdrawal or isolation generally tend to exacerbate mental health needs and disorders.

Individuals may seek support from wherever it is available. Ideally, parents with mental disorders will receive services and supports from persons qualified to help them in meaningful ways. Child welfare professionals should be familiar with appropriate resources in the community and help parents access those resources.

***[Note to trainer: Investigate what mental health treatment programs are available in your State, county or local community. You can generate a preliminary list that may be used as a handout. The Child Welfare agency may have a list of treatment programs. If time allows, use this opportunity to generate suggestions on available treatment programs that workers have used to provide referrals for clients. For example, you may ask the following questions:***

- ***Have you ever referred someone to a local treatment program? If so, which one?***
- ***What kinds of services does that treatment program provide?]]***

### **[Slide III-22] Context of Mental Disorders – 2**

Here are a couple of other important considerations.

Many people experiencing mental disorders (but not all) find themselves isolated from traditional sources of support, such as their family, often because of behavior associated with their disorder. These disorders can be hard on close relationships; they can also impact the ability to make good decisions. Some turn to sources of support (like gangs) that may put them in danger or may damage even further their primary relationships. And in some cases, people with a mental disorder may truly not realize that their behaviors are isolating them and putting themselves and their children at risk.

The development of children may or may not be delayed or damaged as the result of being parented by adults with mental disorders. When such a disorder is suspected or identified in the parent, child welfare workers must pay attention to the developmental milestones of children in the family and take action to address possible delays or difficulties. **[Refer to Module 6 for more information.]**

The goals of the child welfare professional are to help identify mental disorders and assure successful treatment, supporting a parent to successfully and safely care for their children. If a worker can provide direct assistance or if positive outcomes can be achieved through an appropriate referral to another helper, then prevention of a removal and/or family reunification can be supported.

To learn more, Refer to Handout *Parenting Issues for Women with Co-Occurring Mental Health and Substance Abuse Disorders Who Have Histories of Trauma*

- To learn more visit the Women, Co-Occurring Disorders and Violence Study website. The link is provided in your internet resources list.

### **[Slide III-23] The “Recovery Model” - Premises**

So let's talk for a moment about the process of recovery.

Many professionals in the mental health field are practicing under a “Recovery Model,” which is a term that describes an approach to mental health care that deliberately promotes hope and self-management of mental disorders. Refer to Handout *National Consensus Statement on Mental Health Recovery*.

The Recovery Model of care for people with mental disorders includes a set of “basic premises” or beliefs that people with a stake in this type of care agree on (Connecticut Department of Mental Health and Addiction Services, 2002).

Recovery Premise 1: *This premise is that all individuals are unique and have specific needs, goals, health attitudes and behaviors, and expectations for recovery.*

Recovery Premise 2: *Premise 2 states that persons in recovery with mental illness, alcohol or drug addiction, or both (co-occurring) share some similarities. However, management of their own lives and mastery of their own futures will require different pathways at times.*

Recovery Premise 3: *All persons shall be offered equal access to treatment and have the opportunity to participate in their recovery process.*

Recovery Premise 4: *The funding agency (for services to treat substance use and mental disorders) shall support a recovery-oriented system of care that requires their funded and/or operated treatment programs to treat individuals based on a set of recovery-based core values.*

Information presented on Recovery premises and dimensions is on the Connecticut Department of Mental Health and Addiction Services website. The State of Connecticut has developed an extensive list of core values for recovery from substance use and mental disorders and other information. To learn more, you can visit their website. The link is provided on your resource list.

Several other states have developed distinct models for recovery as well, and the treatment field is generally moving more broadly toward that model. However, it is not yet a universally employed approach and it is not used by all treatment professionals in all agencies and communities. You, as child welfare professionals, are strongly encouraged to find treatment professionals and agencies in your community who do recognize and use the Recovery Model in their treatment. It is also important for each of you to examine how this model fits with your own beliefs and the beliefs reflected in your agency’s policies and practices.

### **[Slide III-24] Recovery Dimensions - 1**

Let’s break down the Recovery Model a little more. In Connecticut, the model is described as a set of interlocking **dimensions** (Connecticut Department of Mental Health and Addiction Services, 2006). This image of interlocking dimensions is deliberate. It underscores the reality that no mental disorder is simple, that many factors are involved in both developing and recovering from a mental disorder, and that the interaction of those factors is unique for each recovering individual.

Dimension #1 - Supportive Relationships: Relationships are important to everybody-- those with and those without mental disorders. We all need to have relationships with people who care about and accept us, and we all need opportunities to care about and interact with other people as well. As child welfare workers, you may be able to support and/or facilitate such relationships for people whose disorder makes it hard for them to find such relationships for themselves.

Dimension #2 - Renewing Hope and Commitment: This dimension recognizes that everyone needs hope for the future in order to function effectively. Renewed hope can return after periods of lost hope. A sense of hope allows people to believe that they can change, can overcome challenges, can live a higher quality of life tomorrow than today, and can count on support from those around them. Sustaining hope requires a commitment from the individual and from those around them.

Dimension #3 - Finding a Niche in the Community: This dimension describes the importance of community recognition for each individual, no matter their challenges, and acceptance that they can contribute to the community when given a chance. Each person can have meaningful relationships with other community members, and everyone does not have to be the same to have or enjoy the benefits of community relationships.

Dimension #4 - Redefining Self: This dimension emphasizes the fact that people with mental disorders are much more complex than their "label" or diagnosis, that the mental disorder is only one part of what makes each individual unique. Each person has strengths and can make contributions to the greater community. Beliefs based on stigma can be wrong, and individuals with mental disorders can and do live meaningful, important lives.

Dimension #5 - Incorporating Illness: Mental disorders, or mental illnesses, are a reality for many people. The disorder is not something to be ignored or denied, nor should the person be judged negatively because they suffer from such a disorder. The disorder is a part of who they are, but they have many other parts. But with any of these disorders, setbacks or relapses may take place, but even individuals who experience such setbacks can still remain on their own unique path to recovery.

### **[Slide III-25] Recovery Dimensions - 2**

Dimension #6 - Overcoming Stigma: This dimension acknowledges that stigma exists, that it can hurt persons with mental disorders, and that those persons have the right to escape and recover from those negative effects. Persons with mental disorders have value, want friends who see them in positive ways, and want to contribute meaningfully to the community they live in.

Dimension #7 - Assuming Control: This dimension emphasizes the need for each person to be in control of their own life, rather than being controlled by a disorder or by systems or agencies trying to help or treat them. Helpers are partners in each person's efforts to manage their own life. Sometimes mistakes are made and those mistakes do not necessarily require that the person lose control of their life. Choices about all forms of treatment or care are important, as long as safety can be maintained.

Dimension #8 - Managing Symptoms: It is the manifestation of mental disorders that causes difficulties for the person or for others. Therefore, learning how to manage symptoms that express a mental disorder becomes a high priority for the individual and the community. The Recovery Model assumes that most people can learn to manage their own symptoms when they have proper treatment, education and support.

Dimension #9 - Becoming an Empowered Citizen: This dimension recognizes the potential of each person, including those with mental disorders, to participate effectively in their community. A mental disorder does not diminish the importance of a person's opinions or their potential contributions, though it may shape the way those contributions are expressed.



***The GOAL of this brief discussion is to help participants think about what they will take away from the session. At the end, thank them all for participating. If they will be receiving more modules in this series, remind them of what comes next, and when.***