

Common Core 3.0

**200 Level: Foundation
Block Knowledge & Skill
Reinforcement Lab:
Trauma-informed
Practice & Key Issues**

Trainee Guide



April 30, 2019

Table of Contents

| | |
|--|----|
| Table of Contents | 2 |
| Introduction to Common Core | 3 |
| Curriculum Introduction..... | 4 |
| Agenda..... | 5 |
| Learning Objectives | 6 |
| Review of Key Concepts—Trauma-informed Practice & Key Issues in Child Welfare..... | 7 |
| Article: Birth Parents with Trauma Histories and the Child Welfare System | 19 |
| Team-Based Learning: Application Activity Questions | 22 |
| Discussion Questions for Co-occurring Disorders Videos Supporting Parents with Co-occurring Disorders (COD) in Child Welfare | 26 |
| Cultural Iceberg | 30 |
| Putting Theory into Practice: Case Scenarios..... | 31 |
| Case Vignette Worksheet (Think Tank Activity) | 35 |
| Blank Cultural Iceberg..... | 37 |
| Personal Learning Plan | 38 |
| Bibliography and References | 39 |
| Resources | 41 |

Introduction to Common Core

Common Core curriculum and training for new child welfare workers in California is designed to be generalizable across the state, cover basic child welfare knowledge and skills and is important for all CWS positions within an agency.

California's Common Core Curricula for Child Welfare Workers is the result of the invaluable work and guidance of a great many people throughout the child welfare system in California and across the country. It would be impossible to list all of the individuals who contributed, but some groups of people will be acknowledged here.

The Content Development Oversight Group (CDOG) a subcommittee of the Statewide Training and Education Committee (STEC) provided overall guidance for the development of the curricula. Convened by the California Social Work Education Center (CalSWEC) and the California Department of Social Services (CDSS), CDOG membership includes representatives from the Regional Training Academies (RTAs), the University Consortium for Children and Families in Los Angeles (UCCF), and Los Angeles County Department of Children and Family Services.

In addition to CDOG, a Common Core 3.0 subcommittee comprised of representatives from the RTAs, the Resource Center for Family Focused Practice, and counties provided oversight and approval for the curriculum development process.

Along the way, many other people provided their insight and hard work, attending pilots of the trainings, reviewing sections of curricula, or providing other assistance.

California's child welfare system greatly benefits from this collaborative endeavor, which helps our workforce meet the needs of the state's children and families.

The Children's Research Center provided technical support as well as The Structured Decision Making System that includes the SDM 3.0 Policy and Procedure Manual and Decision Making Tools. These resources are used in compliance with CRC copyright agreements with California. Additionally, content in this curriculum has been adapted from CRC's SDM 3.0 classroom curriculum to meet the training needs in California.

In compliance with the Indian Child Welfare Act (1978) and the California Practice Model, social workers must identify American Indian/Alaska Native children in the system. For an overview of *implementing the Indian Child Welfare Act* view: <https://www.youtube.com/watch?v=BIQG65KFKGs>

The curriculum is developed with public funds and is intended for public use. For information on use and citation of the curriculum, please refer to: http://calswec.berkeley.edu/CalSWEC/Citation_Guidelines.doc



FOR MORE INFORMATION on California's Core Curricula, as well as the latest version of this curriculum, please visit the California Social Work Education Center (CalSWEC) website: <http://calswec.berkeley.edu>

Curriculum Introduction

The 200 Level Foundation Block course, *Key Issues & Trauma Informed Practice*, is a one day knowledge & skill reinforcement lab in which trainees will learn about the correlation between children and parents' personal, historical and/or cultural experiences related to exposure to trauma and some behaviors associated with substance use disorders, intimate partner violence and/or behavioral health disorders. This training will include an end of block exam to evaluate knowledge gained through eLearning, classroom and field modules.

Some content in this curriculum was informed by NCCD and the Northern California Training Academy as part of the Safety Organized Practice Curriculum. Safety Organized Practice (SOP) is a collaborative practice approach that emphasizes the importance of teamwork in child welfare. SOP aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members. A central belief in SOP is that all families have strengths. SOP uses strategies and techniques that align with the belief that a child and his or her family are the central focus, and that the partnership exists in an effort to find solutions that ensure safety, permanency, and well-being for children. Safety Organized Practice is informed by an integration of practices and approaches including:

- Solution-focused practice¹
- Signs of Safety²
- Structured Decision making³
- Child and family engagement⁴
- Risk and safety assessment research
- Group Supervision and Interactional Supervision⁵
- Appreciative Inquiry⁶
- Motivational Interviewing⁷
- Consultation and Information Sharing Framework⁸
- Cultural Humility
- Trauma-informed practice

¹ Berg, I.K. and De Jong, P. (1996). Solution-building conversations: co-constructing a sense of competence with clients. *Families in Society*, pp. 376-391; de Shazer, S. (1985). *Keys to solution in brief therapy*. NY: Norton; Saleebey, D. (Ed.). (1992). *The strengths perspective in social work practice*. NY: Longman.

² Turnell, A. (2004). Relationship grounded, safety organized child protection practice: dreamtime or real time option for child welfare? *Protecting Children*, 19(2): 14-25; Turnell, A. & Edwards, S. (1999). *Signs of Safety: A safety and solution oriented approach to child protection casework*. NY: WW Norton; Parker, S. (2010). *Family Safety Circles: Identifying people for their safety network*. Perth, Australia: Aspirations Consultancy.

³ Children's Research Center. (2008). *Structured Decision Making: An evidence-based practice approach to human services*. Madison: Author.

⁴ Weld, N. (2008). The three houses tool: building safety and positive change. In M. Calder (Ed.) *Contemporary risk assessment in safeguarding children*. Lyme Regis: Russell House Publishing.

⁵ Lohrbach, S. (2008). Group supervision in child protection practice. *Social Work Now*, 40, pp. 19-24.

⁶ Cooperrider, D. L. (1990). Positive image, positive action: The affirmative basis of organizing. In S. Srivasta, D.L. Cooperrider and Associates (Eds.). *Appreciative management and leadership: The power of positive thought and action in organization*. San Francisco: Jossey-Bass.

⁷ Miller, W.R. & Rollnick, S. (2012). *Motivational Interviewing*, (3rd Ed.). NY: Guilford Press.

⁸ Lohrbach, S. (1999). *Child Protection Practice Framework - Consultation and Information Sharing*. Unpublished manuscript; Lohrbach, S. & Sawyer, R. (2003). Family Group Decision Making: a process reflecting partnership based practice. *Protecting Children*. 19(2):12-15.

Agenda

| | |
|--|---------------------|
| Segment 1: Welcome and Introductions to the Training | 9:00am – 9:10 am |
| Segment 2: Review of Trauma and Key issues in child welfare | 9:10 – 9:40 am |
| Segment 3: Working with Parents Who Have Been Impacted by Trauma | 9:40 – 10:45 am |
| Break | (15 minutes) |
| Segment 4: Supporting Parents with Co-occurring Disorders (COD) | 11:00 am – 12:05 pm |
| Lunch | (60 minutes) |
| Segment 5: Putting Theory into Practice | 1:05 – 1:25 pm |
| Segment 6: Think Tank Activity: Putting It All Together | 1:25 – 2:35 pm |
| Break | (15 minutes) |
| Segment 7: Wrap Up, Reflection, and Application | 2:50 – 3:00 pm |
| Segment 8: End of Block Evaluation and Debrief | 3:00 – 4:00 pm |

Learning Objectives

Knowledge

- K1. The trainee will describe the correlation between child(ren) and parent's exposure to trauma and some behaviors associated with substance use disorders, intimate partner violence, and/or behavioral health disorders.
- K2. The trainee will recognize the increased likelihood of a person re-experiencing trauma when these maladaptive behaviors are present and not adequately assessed, and addressed by culturally relevant interventions.

Skill

- S1. Using a vignette, the trainee will be able to demonstrate at least three strategies of Trauma-Informed Practice that mitigate the impact of trauma and support healing as it relates to increasing safety and reducing re-occurrence of future child maltreatment.

Values

- V1. The trainee will adopt the use of strengths-based, trauma-informed, culturally humble and collaborative approaches to address the impacts of substance use disorders, intimate partner violence, and/or behavioral health issues on child safety and risk.
- V2. The trainee will recognize that their role as part of a government system may be perceived or experienced by children and families as traumatic rather than helpful, based on personal, historical, and/or cultural experiences.

Review of Key Concepts—Trauma-informed Practice & Key Issues in Child Welfare

| Best Practices in Child Welfare | |
|--|--|
| Best practices | <p><i>Best practice approaches for working with children, youth and families in Child Welfare:</i></p> <ul style="list-style-type: none"> – Trauma informed practice – Strengths-based practice – Culturally humble approach – California Core Practice Model (CPM) behaviors – Structured Decision Making (SDM) |
| Trauma Informed Practice | |
| What is trauma? | <p>Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being. - SAMHSA(www.samhsa.gov)</p> <p>Child trauma:</p> <ul style="list-style-type: none"> • An event that <u>overwhelms</u> the child’s ability to cope and causes fear, helplessness, or horror, expressed by sadness, withdrawal, or disorganized / agitated behavior. • <u>Witnessing or experiencing</u> an event that poses a <u>real or perceived</u> threat to the life or well-being of the child or someone close to the child. |
| What is Trauma informed practice? | <p>Trauma informed practice is a "strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma...that emphasizes physical, psychological, and emotional safety for both providers and survivors...and, that creates opportunities for survivors to rebuild a sense of control and empowerment." –(Hopper, Bassuk & Olivet, 2010, pg. 82)</p> <p>According to SAMHSA’s concept of a trauma-informed approach, “A program, organization, or system that is trauma-informed:</p> <ul style="list-style-type: none"> • <i>Realizes</i> the widespread impact of trauma and understands potential paths for recovery; • <i>Recognizes</i> the signs and symptoms of trauma in clients, families, staff, and others involved with the system; • <i>Responds</i> by fully integrating knowledge about trauma into policies, procedures, and practices; and • Seeks to actively resist <i>re-traumatization</i>." |
| Types of trauma | <p>There are several different types of trauma, including:</p> <ul style="list-style-type: none"> ➤ Acute trauma ➤ Chronic trauma ➤ Complex trauma ➤ Historical trauma |

| | |
|---------------------------------|---|
| <p>Acute trauma</p> | <p>Examples include but are not limited to:</p> <ul style="list-style-type: none"> • Sexual & physical • Medical trauma • School shootings • Police shootings • Bullying • Serious accidents • Street violence • Violent death of a relative or friend • Home invasion • Loss of home in fire • Terrorist attacks • Immigration issues • Natural disasters • Many, many more |
| <p>Chronic trauma</p> | <p>Examples include but are not limited to:</p> <p>Environmental Factors</p> <ul style="list-style-type: none"> • In utero experience • Homeless victims • Ongoing sexual abuse • Domestic violence • Gang zones • War zones • Combat zones • Neglect • School campus violence |
| <p>Complex trauma</p> | <p>The term complex trauma describes both children’s exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure.</p> <p>These events are severe and pervasive, such as abuse or profound neglect. They usually begin early in life and can disrupt many aspects of the child’s development and the very formation of a self. Since they often occur in the context of the child’s relationship with a caregiver, they interfere with the child’s ability to form a secure attachment bond. Many aspects of a child’s healthy physical and mental development rely on this primary source of safety and stability.</p> <p>Source: The National Child Traumatic Stress Network: http://www.nctsn.org/</p> |
| <p>Historical trauma</p> | <p>What is historical trauma?</p> <ul style="list-style-type: none"> • Collective and cumulative emotional wounding across generations. • Cumulative exposure to traumatic events that not only affects an individual, but continues to affect subsequent generations. • The trauma is a psychological injury held personally and transmitted over generations. <p>Negative impacts of cultural / historical trauma: Individual:</p> |

| | |
|--|--|
| | <ul style="list-style-type: none"> • Lack of belief in a just world/lack of trust • Depression • Self-hatred • Self-destructive behaviors • Survivor guilt • Disassociation • Hopelessness/ loss of meaning • PTSD <p>Community:</p> <ul style="list-style-type: none"> • Loss of tradition • Loss of resources and knowledge for self-sufficiency • Loss of cultural practices • Loss of rites of passage • High rates of substance abuse • High rates of violence • High rates of physical illness • Distrust of larger society and those within the community <p>Family:</p> <ul style="list-style-type: none"> • Impaired family communication • Loss of extended family relationships • Loss of traditional child rearing practices and knowledge • Increased rates of child abuse • Increased rates of domestic violence <p>Other examples include:</p> <ul style="list-style-type: none"> • Impacts on child rearing in tribal communities over many generations of trauma • Increased incidences of child abuse are often attributable to the parents own wounding and the learning of negative child rearing practices in boarding schools. • Parents interacting with the system, due to distrust etc. • For some parents the hopelessness and sense of powerlessness can interfere with reunification if a parent believes that once a child is removed they will never come home again.⁹ |
| <p>Secondary traumatic stress</p> | <p>Distress that results when an individual hears about the firsthand trauma experiences of another. Symptoms mimic those of PTSD.</p> <ul style="list-style-type: none"> • Re-experiencing personal trauma or • Changes in memory/perception; • Depletion of personal resources; |

⁹Brave Heart, M. Y. H. (2000). Wakiksuyapi: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare*, 21-22, 245-266.

Brave Heart-Jordan, M. Y. H. (1995). *The return to the sacred path: Healing from historical trauma and historical unresolved grief among the Lakota: A dissertation based upon an independent investigation*. Northhampton, MA: Smith College School of Social Work.

| | |
|--------------------------------|--|
| | <ul style="list-style-type: none"> • Disruption in perception of safety, trust, independence. • Social workers are at risk <p>Sources of secondary traumatic stress:</p> <ul style="list-style-type: none"> • Child or family member death on an active or recently closed case • Investigating abuse and neglect • Working in violent communities • Working with families with extensive abuse histories • Removing a child under distressing circumstances • System frustrations • Verbal or physical assault by parents or community members |
| <p>Impact of trauma</p> | <p>Impact on the brain:</p> <ul style="list-style-type: none"> • Trauma can have serious consequences for the brain. • Trauma-induced alterations in biological stress systems can adversely affect brain development. • Trauma-exposed children and families display changes in their levels of stress hormones similar to those seen in combat veterans. • Plasticity means the brain continues to change in response to repeated stimulation. <p>Impact on development:</p> <ul style="list-style-type: none"> • Child traumatic stress reactions vary by developmental stage. • Children who have been exposed to trauma expend a great deal of energy responding to, coping with, and coming to terms with the event. • This may reduce a child’s capacity to explore their environment and to master age-appropriate developmental tasks. • The longer traumatic stress goes untreated, the farther children tend to stray from appropriate developmental pathways. <p>Child behaviors related to stress/fear/trauma:</p> <ul style="list-style-type: none"> • Sleep terrors • Oppositional to request • Passivity • Regressed development • Hitting others • Verbally abusing others • Stealing & lying • Eating problems • Aggression disorders • Hurting self and others • Unable to sit still • Hyper-alertness • Hiding from adults • Controlling/clinging • Flat affect/withdrawal • Extreme fearfulness |

- Poor social skills
- Learning difficulties
- Chronic inflexibility
- Despair

Impact on parents:

- Compromise parents’ ability to make appropriate decisions about their own and their children’s safety
- Interfere with their ability to form and maintain secure and trusting relationships (with their children, partners, and service providers)
- Impair parents’ ability to regulate their emotions
- Lead to maladaptive coping strategies including substance use disorders
- Cause parents to be triggered by their children’s traumas and/or systems interventions

Adverse Childhood Experiences Study (ACES)

The Adverse Childhood Experiences (ACES) Study was originally conducted by Kaiser Permanente from 1995 to 1997 to evaluate the impact of ACEs on health and behavior.

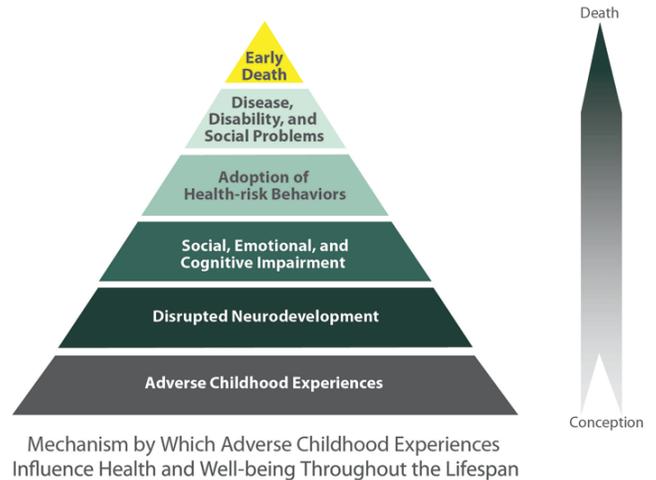
The Center for Disease Control (CDC) continues to study ACEs by assessing the medical status of original study participants through assessment of morbidity and mortality data.

The ACE Pyramid represents the conceptual framework for the ACE Study. The ACE Study has uncovered how ACEs are strongly related to development of risk factors for disease, and well-being throughout the life course.

Find out more here: <https://www.cdc.gov/violenceprevention/acestudy/>

How to support children with ACEs:

- Be nurturing/comforting
- Be Flexible
- Be Honest – even if it’s difficult
- Be patient – the effects of trauma can be long-lasting with a long process for recovery
- Provide a consistent pattern for the child’s day
- Discuss behavioral expectations/discipline
- Talk and share info with child’s BH Clinician
- Don’t be afraid to talk about the trauma if the child wants to, and listen if they do – follow the child’s cues
- Don’t over-react



| | |
|---|--|
| | <ul style="list-style-type: none"> • Don't underestimate how important it is for children to know their caretakers are "in control" • Don't be afraid to ask for help |
| Social worker interventions / strategies | <p>How social workers can help children, youth, parents and families heal:</p> <ul style="list-style-type: none"> • Consider the impact of trauma on the child's developing brain. • Recognize that children and parents' behavior is sometimes an adaptation to trauma and may be related to altered physiology. • Remember that young children can store pre-verbal trauma memories in their bodies. • Maximizing physical and psychological safety is key. • Early intervention, treatment, and positive caregiving can shape the brain to help repair the effects of trauma. • Understand parents anger, fear, resentment, or avoidance as reactions to past trauma • Assess parent's trauma history • Understand that traumatized parents are not bad and do not judge or blame them • Build on parents' desires to care for their child • Help parents understand impact of their own past trauma • Recognize that children and parents' behavior is sometimes an adaptation to trauma and may be related to altered physiology. • Be aware of how a parent's past or present trauma can make it difficult for them to work effectively with case workers and resource parents towards reunification with their children • Let children know they can talk about experiences or fears if they want to • Listen carefully when they do talk • Notice behaviors; take into consideration the developmental stage and cultural considerations of the child and how it intersects with their trauma experience • Give the child choices and some sense of control • Referrals to trauma – informed mental health services, medical and educational programs |
| Essential elements of trauma-informed child welfare practice | <ol style="list-style-type: none"> 1. Maximize the child's sense of safety. 2. Assist children in reducing overwhelming emotion. 3. Help children make new meaning of their trauma history and current experiences. 4. Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships. 5. Coordinate services with other agencies. 6. Utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services. 7. Support and promote positive and stable relationships in the life of the child. 8. Provide support and guidance to child's family and caregivers. 9. Manage professional and personal stress.¹⁰ |

¹⁰ The National Child Traumatic Stress Network. (March 2008). Child Welfare Trauma Training Toolkit: The Essential Elements.

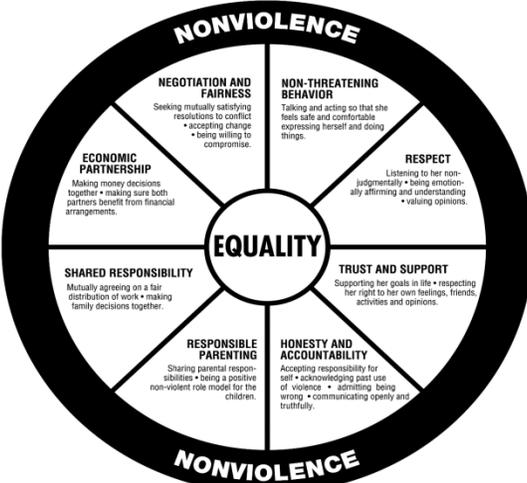
| | |
|---|---|
| | |
| Key Issues in Child Welfare (Behavioral Health Issues) | |
| Key concepts | <ul style="list-style-type: none"> • Affect all ages, child, adolescent and adults • Children and parents who experience trauma have a higher risk factor for behavioral health disorder. • Co-occurring Substance Use & Behavioral Health issues • Psychotropic medications • Parenting with mental health disorders • |
| Key Issues in Child Welfare (Substance Use Disorders) | |
| Key concepts | <ul style="list-style-type: none"> • Substance use is an issue that affects all of us. • There is always an underlying reason. • Most individuals with serious substance use issues begin using in adolescence. Chronic use can cause fundamental and permanent changes in the brain. • Primary classifications: Uppers, Downers, and All Rounders • There is a continuum: Mild – Moderate – Severe • Impact on children • Formal and informal treatment options <p>Indicators of possible substance use:</p> <ul style="list-style-type: none"> • A report of substance use is included in the CPS call or report • Drug paraphernalia (e.g., a syringe kit, charred spoons, a large number of liquor or beer bottles) • The scent of alcohol or drugs • A child or other family member reports alcohol or drug use by a parent • A parent appears to be under the influence of a substance, admits to having a substance use disorder, or shows other signs of addition or abuse (e.g., needle marks) |
| What about relapse? | <p>Remember that relapse is a normal and expected part of the recovery process</p> <ul style="list-style-type: none"> • Relapse can be an opportunity to enhance recovery • Try a trauma-informed response vs. punitive response <ul style="list-style-type: none"> – What happened? – What were you thinking of at the time? – What have you thought about since? – Who has been affected by what you have done? In what way? – What do you think you need to do to make things right?¹¹ |
| | |

¹¹ White, Samantha. (2012). Time to Think: Using Restorative Questions. International Institute for Restorative Practices. Retrieved from <http://www.iirp.edu/news/1976-time-to-think-using-restorative-questions>

| Stages of change ¹² | Stage of change | Characteristics | Techniques |
|--------------------------------|-------------------|---|--|
| | Pre-contemplation | Not currently considering change "Ignorance is bliss" | Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk |
| | Contemplation | Ambivalent about change: "Sitting on the fence" Not considering change month | Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations |
| | Preparation | Some experience with change and are trying to change: "Testing the waters" Planning to act within 1 month | Identify and assist in problem solving re: obstacles Help patient identify social support Verify individual has underlying skills for behavior change Encourage small initial steps |
| | Action | Practicing new behavior for 3 to 6 months | Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits |
| | Maintenance | Continued commitment to sustaining new behavior Post-6 months to 5 years | Plan for follow-up support Reinforce internal rewards Discuss coping with relapse |

¹² Prochaska, J.O., & Velicer, W.F. (1997). The Transtheoretical Model of health behavior change. American Journal of Health Promotion, 12, 38-48.

| | | | |
|--|--|-----------------------------|---|
| | Relapse | Resumption of old behaviors | Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies |
| Resources | Substance Abuse and Mental Health Services Administration (SAMHSA) website: https://www.samhsa.gov/disorders | | |
| Key Issues in Child Welfare (Intimate Partner Violence) | | | |
| Key Concepts | <ul style="list-style-type: none"> • Safety first for adult survivors and children • Hold the person who batters accountable • Child being a witness is a traumatic and serious event • Intimate partner violence (IPV) is a learned behavior • Family violence is an equal opportunity • It's about power and control • Acknowledge survivor's right to choice • Advocate • Safety planning | | |
| Teen Dating Violence | <p>Warning signs of teen dating violence include:</p> <ul style="list-style-type: none"> • Excessive jealousy. • Constant checking in with you or making you check in with him or her. • Attempts to isolate you from friends and family. • Insulting or putting down people that you care about. • Is too serious about the relationship too quickly. • Has had a lot of bad prior relationships - and blames all of the problems on the previous partners. • Is very controlling. • This may include giving you orders, telling you what to wear, and trying to make all of the decisions for you. • Blames you when he or she treats you badly by telling you all of the ways you provoked him or her. • Does not take responsibility for own actions. • Has an explosive temper ("blows up" a lot). • Pressures you into sexual activity with which you are not comfortable. • Has a history of fighting, hurting animals, or brags about mistreating other people. • Believes strongly in stereotypical gender roles for males and females. • You worry about how your partner will react to the things you say or you are afraid of provoking your partner. • Owns or uses weapons. • Refuses to let you to end the relationship. | | |

| | |
|---------------------------------------|--|
| <p>Power and control wheel</p> | <p>Duluth model – Wheel of power and control</p> <p>Overview:</p> <ul style="list-style-type: none"> • Outer ring: Physical and sexual violence • Using intimidation • Using emotional abuse • Using isolation • Minimizing, denying and blaming • Using children • Using male privilege • Using economic abuse • Using coercion and threats  <p>The diagram is a circular wheel with 'POWER AND CONTROL' in the center. It is divided into eight segments, each representing a tactic of abuse. The outer ring is labeled 'PHYSICAL VIOLENCE' on the left and 'SEXUAL VIOLENCE' on the right. The segments are: 1. USING COERCION AND THREATS (Making another carrying out threats to do something to hurt her, threatening to leave her, to commit suicide, to report her to welfare-making her drop charges-making her do legal things); 2. USING INTIMIDATION (Making her afraid by using looks, actions, gestures, menacing things, destroying her property-abusing pets- displaying weapons); 3. USING EMOTIONAL ABUSE (Putting her down-making her feel bad about herself-calling her names-making her think she's crazy-playing mind games-humiliating her-making her feel guilty); 4. USING ISOLATION (Controlling what she does, who she sees and talks to, what she reads, where she goes-limiting her outside involvement-using jealousy to justify actions); 5. MINIMIZING, DENYING AND BLAMING (Making light of the abuse and not taking her concerns about it seriously-saying the abuse didn't happen-shifting responsibility for abusive behavior-saying she caused it); 6. USING CHILDREN (Making her feel guilty about the children-using the children to relay messages-using visitation to harass her-threatening to take the children away); 7. USING MALE PRIVILEGE (Treating her like a servant-making all the big decisions-acting like the 'master' of the house-taking the care to define men's and women's roles); 8. USING ECONOMIC ABUSE (Preventing her from getting or keeping a job-making her ask for money-giving her an allowance-taking her money-not letting her know about or have access to family income).</p> <p>DOMESTIC ABUSE INTERVENTION PROJECT 202 East Superior Street Duluth, Minnesota 55802 218-722-2781 www.duluth-model.org</p> |
| <p>Equality Wheel</p> | <p>Duluth model: Equality wheel (the opposite of power and control)</p> <p>Overview:</p> <ul style="list-style-type: none"> • Outer ring: Nonviolence • Non-threatening behavior • Respect • Trust and support • Honesty and accountability • Responsible parenting • Shared responsibility • Economic partnership • Negotiation and fairness  <p>The diagram is a circular wheel with 'EQUALITY' in the center. It is divided into eight segments, each representing a principle of equality. The outer ring is labeled 'NONVIOLENCE' at the top and bottom. The segments are: 1. NEGOTIATION AND FAIRNESS (Seeking mutually satisfying resolutions to conflict-accepting change-being willing to compromise); 2. NON-THREATENING BEHAVIOR (Talking and acting so that she feels safe and comfortable-expressing herself and doing things); 3. RESPECT (Listening to her non-judgmentally-being emotionally affirming and understanding-valuing opinions); 4. TRUST AND SUPPORT (Supporting her goals in life-respecting her right to her own feelings, friends, activities and opinions); 5. HONESTY AND ACCOUNTABILITY (Accepting responsibility for self-acknowledging past use of violence-accepting being wrong-communicating openly and truthfully); 6. RESPONSIBLE PARENTING (Sharing parental responsibilities-being a positive non-violent role model for the children); 7. SHARED RESPONSIBILITY (Mutually agreeing on a fair distribution of work-making family decisions together); 8. ECONOMIC PARTNERSHIP (Making money decisions together-making sure both partners benefit from financial arrangements).</p> <p>DOMESTIC ABUSE INTERVENTION PROJECT 202 East Superior Street Duluth, Minnesota 55802 218-722-2781 www.duluth-model.org</p> |
| <p>Resources</p> | <p>Duluth Model: https://www.theduluthmodel.org/ National Domestic Violence Hotline: http://www.thehotline.org/</p> |

Trauma & Key Issues – How do they intersect?

How do trauma and key issues intersect?

- When intimate partner violence (IPV) is experienced, it is related with depression, suicidality, generalized anxiety disorder, and PTSD.
- Intimate partner violence is associated with increased substance use, and increased substance use is associated with an increased risk of IPV.
- It is recommended that interventions for IPV, substance use disorder, and behavioral health be integrated and trauma informed.
- Development of strong social networks have been reported to be helpful.

Social Worker Interventions / Strategies

Strategies for Co-Occurring Disorders (COD)

1. Proper identification / watching for signs:
 - a. Presenting symptom: Substance abuse, then realize they have mental health issues they are dealing with...using to medicate
 - b. Kids not supervised...missing school
2. Consult with a mental health professional or substance use treatment provider
3. Build a relationship with the person – allow the person to tell their story in a safe space
4. Be an ally, a good listener – build trust
5. Anticipate barriers to recovery such as relapse....recovery timelines look different for each person—learning about personal and systemic barriers
6. Creative and individualized case planning
7. Check for biases!
8. Bring hope to the family
9. Build strong support networks
10. Celebrate small successes
11. Be aware of cultural factors
12. Treat the parent as the experts of their own lives

Build rapport and relationship with the family

- Ways to build rapport¹³:
- Be open-minded
 - Find out what is important to the family
 - Use mirroring
 - Listen to the family’s explanation of the situation without correcting or arguing
 - Ask questions
 - Clarify expectations and purposes
 - Clarify commitment and obligations to the working relationship
 - Acknowledge difficult feelings, and encourage open and honest discussion of feelings
 - Be consistent, persistent, and follow through
 - Promote participatory decision-making (team meetings)

¹³ DePanfilis, D., & Salus, M.K. (2003). Child Protective Services: A Guide for Caseworkers. Child Abuse and Neglect User Manual Series. U.S. Department of Health and Human Services. Retrieved from <https://www.childwelfare.gov/pubPDFs/cps.pdf>

| | |
|--|---|
| <p>Seek support for decision making</p> | <ul style="list-style-type: none"> ➤ Consult with your supervisor or other agency/community partner who has expertise in substance use disorder, intimate partner violence, and/or behavioral health disorders ➤ Realize that you are not an expert and seek support when needed ➤ Remember to use SDM tools to support decision making (Safety Assessment & Risk Assessment tools) |
| <p>Teaming with families and their support networks</p> | <ul style="list-style-type: none"> ➤ All safety planning and/or case planning activities should be done collaboratively with the family and their support network, including key service providers (intimate partner violence, behavioral health, substance use treatment, and trauma service providers). <ul style="list-style-type: none"> ○ Home visits / office visits ○ Family team meetings ○ Child and family team meetings |



Birth Parents with Trauma Histories and the Child Welfare System

A Guide for Child Welfare Staff

KAREN'S STORY

Karen has two children, Jonathan, age 3 and Crystal, age 6. Karen was reported to child welfare authorities by Crystal's teacher, who was concerned about Crystal's excessive absences from school. The investigation revealed that Karen's boyfriend physically abused her and her children, and evidence emerged that she had physically abused them as well. There were several attempts to engage her in services, but because of her lack of follow-through and the ongoing safety concerns, her children were removed from her home and have been in foster care for six months.

Linda, Karen's caseworker, has referred Karen to parenting classes, domestic violence services, and for a mental health evaluation. Karen has not followed through on the referrals, is often not home when Linda has a scheduled visit, and when the foster parent last brought the children for visitation, Karen was alternately angry and defensive towards Linda and the foster parent and disengaged from her children. Linda is concerned because of the amount of time Crystal and Jonathan have been in foster care. A decision will be made shortly about their permanency plan, and Linda believes that she hasn't been able to engage Karen in either addressing her family's issues or identifying her strengths, much less come up with a plan that builds on them. Linda's supervisor asked Karen why she has made no progress and noted that the last visit between Karen and her children got "out of control," but did not offer any concrete suggestions to Linda as to how she could have handled it differently. When Linda tries to talk with Karen about the urgency of the situation, Karen minimizes her concerns and appears increasingly angry towards Linda and the system.

Just as many children in the child welfare system have experienced different kinds of trauma¹, many birth parents involved with child welfare services have their own histories of childhood and/or adult trauma. Untreated traumatic stress has serious consequences for children, adults, and families. Traumatic events in childhood and adolescence can continue to impact adult life, affecting an adult's ability to regulate emotions, maintain physical and mental health, engage in relationships, parent effectively, and maintain family stability. Parents' past or present experiences of trauma can affect their ability to keep their children safe, to work effectively with child welfare staff, and to respond to the requirements of the child welfare system. Providing trauma-informed services can help child welfare

¹ In this fact sheet, trauma refers to events outside the typical range of human experience—that is, events involving actual or threatened risk to the life or physical integrity of individuals or someone close to them.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS).

¹⁴ National Child Traumatic Stress Network, Child Welfare Committee. (2011). Birth parents with trauma histories and the child welfare system: A guide for resource parents. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

workers and parents meet the child welfare system's goals of safety, permanency, and well-being of children and families.

How Can Trauma Affect Parents?

A history of traumatic experiences may:

- Compromise parents' ability to make appropriate judgments about their own and their child's safety and to appraise danger; in some cases, parents may be overprotective and, in others, they may not recognize situations that could be dangerous for the child.
- Make it challenging for parents to form and **maintain** secure and trusting **relationships**, leading to:
 - Disruptions in relationships with infants, children, and adolescents, and/or negative feelings about parenting; parents may personalize their children's negative behavior, resulting in ineffective or inappropriate discipline.
 - Challenges in relationships with caseworkers, foster parents, and service providers and difficulties supporting their child's therapy.
- Impair parents' capacity to regulate their emotions.
- Lead to poor self-esteem and the development of **maladaptive coping strategies**, such as substance abuse or abusive intimate relationships that parents maintain because of a real or perceived lack of alternatives.
- Result in **trauma reminders**—or “triggers”—when parents have extreme reactions to situations that seem benign to others. These responses are especially common when parents feel they have no control over the situation, such as facing the demands of the child welfare system. Moreover, a child's behaviors or trauma reactions may remind parents of their own past trauma experiences or feelings of helplessness, sometimes triggering impulsive or aggressive behaviors toward the child. Parents also may seem **disengaged or numb** (in efforts to avoid trauma reminders), making engaging with parents and addressing the family's underlying issues difficult for caseworkers and other service providers.
- Impair a parent's **decision-making ability**, making future planning more challenging.
- Make the parent more **vulnerable to other life stressors**, including poverty, lack of education, and lack of social support that can worsen trauma reactions.

Although parents may experience the child welfare system as re-traumatizing because it removes their power and control over their children, there is potential for it to support their trauma recovery and strengthen their resilience. Caseworkers, as representatives of the child welfare system, can themselves serve as triggers to parents with trauma histories or can, through careful use of non-threatening voice and demeanor, be bridges to hope and healing. Viewing birth parents through a “trauma lens” helps child welfare staff—and parents themselves—see how their traumatic experiences have influenced their perceptions, feelings, and behaviors.²

How can caseworkers use a trauma-informed approach when working with birth parents?³

Caseworkers cannot reverse the traumatic experiences of parents, but they can:

² Although the focus of this fact sheet is birth parents, we acknowledge that other adults—including non-parent partners, grandparents, and step-parents—may also have histories of traumatic experiences and could benefit from trauma-informed child welfare practice as well.

³ For information about trauma-informed child welfare practice go to www.NCTSN.org/products/child-welfare-trauma-training-toolkit-2008.

- Understand that parents' anger, fear, or avoidance may be a reaction to their own past traumatic experiences, not to the caseworker him/herself.
- Assess a parent's history to understand how past traumatic experiences may inform current functioning and parenting.
- Remember that traumatized parents are not "bad" and that approaching them in a punitive way, blaming them, or judging them likely will worsen the situation rather than motivate a parent.
- Build on parents' desires to be effective in keeping their children safe and reducing their children's challenging behaviors.
- Help parents understand the impact of past trauma on current functioning and parenting, while still holding them accountable for the abuse and/or neglect that led to involvement in the system. For many parents, understanding that there is a connection between their past experiences and their present reactions and behavior can empower and motivate them.
- Pay attention to ways trauma can play out during case conferences, home visits, visits to children in foster care, court hearings, and so forth. Help parents anticipate their possible reactions and develop different ways to respond to stressors and trauma triggers
- Refer parents to trauma-informed services whenever possible. Parents will be more likely to attend services that address their needs. Generic interventions that do not take into account parents' underlying trauma issues—such as parenting classes, anger management classes, counseling, or substance abuse groups—may not be effective.
- Become knowledgeable about evidence-supported trauma interventions to include in service planning. Linkages with programs that deliver trauma-informed services can support caseworkers in developing a plan that meets their clients' needs.⁴
- Advocate for the development and use of trauma-informed services in the community.

How can child welfare professionals protect themselves from secondary traumatic stress?

When child welfare staff work with traumatized families and directly see or hear of traumatic events, they can experience extreme distress and sometimes secondary or vicarious traumatic stress.⁵ Supervisors, caseworkers, and administrators can—and should—find ways to take care of themselves and their staff and to address their own trauma reactions. Simply taking a walk at lunch or recognizing when they are getting overwhelmed or frustrated can make a difference.

Staff supervision can also be used to process the experience of working with traumatized clients.

This fact sheet is one in a series of factsheets discussing parent trauma in the child welfare system. To view others, go to <http://www.nctsn.org/resources/topics/child-welfare-system>

⁴ For information on adult trauma treatments and interventions, go to: National Center for PTSD at <http://www.ptsd.va.gov>; Sidran Institute at <http://www.sidran.org>; California Evidence-based Clearinghouse for Child Welfare at <http://www.cebc4cw.org>; and the National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov>. For help locating local adult trauma services, contact area rape crisis centers, domestic violence shelters, or Red Cross chapters.

⁵ Secondary or vicarious traumatic stress (also called compassion fatigue) describes trauma reactions in helping professionals following extensive exposure to clients' retelling of their trauma experiences, for more information on self-care, go to: http://www.nctsn.org/nctsn_assets/pdfs/CWT3_SHO_STS.pdf

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Team-Based Learning: Application Activity Questions

Instructions

After reading *“Birth Parents with Trauma Histories and the Child Welfare System,”* please answer the following questions:

1. Twelve months ago, John and Elaina had their three children (boys 8 and 14, and a daughter aged 9) removed from their care for chronic neglect. Twelve referrals had previously been made for general neglect based on the parent’s substance use. The children had been left alone in their apartment for three days while John and Elaina went on a drug binge. The three children have been living in the current resource family home for the past 10 months and are doing well overall except for a few incidents of sexualized behavior on the part of the younger children. When the resource family tried to talk with the children about the observed behavior, the children seemed confused and not able to understand the concerns. The parents deny observing any sexualized behavior by their children. The resource family is interested in adopting all three children. The social worker wants to reunify John and Elaina with their children, but thinks that their one bedroom apartment is not adequate. John and Elaina have successfully completed their substance use treatment and parenting program, and they visit their children as often as possible. They have made positive behavioral changes that show they can provide safety, and they continue to look for jobs.

What is the most appropriate trauma-informed approach the social worker can take?

- a. Recommend that services be continued for six months to obtain an assessment from a psychologist regarding the children’s sexualized behavior and begin therapy as needed.
- b. Reassess any potential biases and the Minimum Sufficient Level of Care. Convene a family team meeting to develop a safety plan with their support network to identify support for the parents so they can reunify with the children.
- c. Continue services for parents and add counseling recommendation for children and parents.
- d. Continue with concurrent plan of adoption.

2. Two teenage parents (Sarah, mother, 15 and Steve, father, 16) leave the hospital with their newborn without completing discharge paperwork after Sarah overhears that nurses suspect she was using drugs while pregnant. A social worker is called to the hospital but misses the parents. Due to prior involvement with the Sarah's family, the social worker goes to the maternal grandmother's (Mary) home where she finds Sarah with the baby. (Sarah had been a dependent of the court and removed from the Mary when she was 8 years old. They were reunified after 12 months.) Mary tells Sarah that she does not have to cooperate and says that she will assume responsibility for the baby and that Sarah, Steve and the baby can live in her house until she graduates from high school and they find an apartment. Sarah agrees to work with the social worker through a plan of family maintenance so that she can get child care while she is in school. She also agrees to attend a parenting class but denies a substance use problem of any kind and refuses a drug and alcohol assessment.

One month later, Mary calls the social worker to complain that the Sarah has been skipping school to "hang out with father;" they have begun to stay out overnight; have left the baby at day care; and have started fighting almost every night. When the fighting escalated to the father shoving Sarah and hitting her with his fist, Mary called the police and Steve was arrested. Sarah is seeking an emergency protective order. Mary says Sarah is not committed to the baby and she wants her grandchild placed with her and will adopt if necessary. She wants Sarah out of her house immediately.

What is the most important next step that the social worker should take in deciding whether the infant can be protected without removal?

- a. Meet with Sarah privately, discuss how things are going with Mary, and ask her to discuss her plans for raising her child with Steve.
- b. Discuss with Steve how he sees his role as a father, what his plans are for being involved in his child's life and what type of support system he has.
- c. Explain to Sarah the consequences of failing to comply with the terms of the family maintenance agreement and the possibility that the baby could be removed from her care.
- d. Review the mother's prior 300 dependency case file and help her identify current strengths, any past trauma and any therapeutic interventions that might help her better bond with the baby and increase her protective capacity.

3. Four months ago, Child Welfare Services opened a family maintenance case for Keesha’s family due to the intimate partner violence between Keesha’s parents (Sasha and Frank). Last week, the nurse at Keesha’s school reported to Child Welfare Services that Keesha, age 9, had told her teacher that most nights her father gets drunk and fights with her mother in front of her. These fights have included hitting, punching, and throwing things at each other. Case records show that at the initial family meeting, it was decided that the safety goal would consist of keeping Keesha in her home on the condition that the parents agree to call maternal grandma (Karen) when Frank starts drinking. The parents also agreed that Keesha will go to the next-door neighbor’s house when the parents have physical arguments, and the neighbor agreed.

One month after this initial meeting, the social worker was contacted by the school. Keesha’s grades have been falling, and for the past 2 weeks she has often been late, and her overall attendance has dropped. The social worker contacted Karen, who stated that she is worried that Keesha is often “right in the middle of the violence” between her parents and “it scares her, she closes down, and even has nightmares sometimes.” The social worker meets with Frank and Sasha and learns that Frank lost his job two weeks ago. They cannot afford to keep their apartment and are now facing eviction.

What is the best way for the social worker to assess if the family maintenance plan is sufficient to keep Keesha safe?

- a. Meet with parents to determine if father will agree to enter a substance use treatment program.
- b. Immediately schedule a family team meeting to assess the safety plan
- c. Remove Keesha and place her with her grandmother.
- d. Amend the family maintenance plan to include domestic violence counseling and alcohol treatment for Father

4. The police called Child Welfare Services when Tina’s mother Susan was detained for prostitution. She explained to the Emergency Response (ER) social worker that she had recently lost her “lousy” minimum wage job, that prostitution was the only way to make enough money to keep a roof over her daughter Tina’s head, and that she only prostitutes at night while Tina (age 4) is asleep so it has no impact on her. She explained that a cousin lived next door and sometimes provides care for Tina. The police cited Susan, and she took the ER worker to her nearby apartment. When they arrived, Tina was asleep and the cousin was leaving the apartment. Tina awoke and was clingy with the relative and did not seem to notice when her mother entered or left the room.

Using a trauma lens, what is the best analysis of Susan’s thinking about her responsibility as a parent?

- a. Susan may have untreated trauma that affects the ways that she is able to connect with her child.
 - b. Susan may have untreated trauma that causes her to isolate herself from traditional social supports.
 - c. Susan may have untreated trauma that interferes with her ability to parent.
 - d. Susan may have untreated trauma that interferes with her ability to manage her impulses while parenting.
5. Cindi, age 20, is the mother of a 3-year boy (Sam) and an 18-month-old girl (Lucy). During a hospital visit for Lucy, she admits to the hospital social worker that she has been using meth on and off since she was about 15 and needs help. Child Welfare Services is called and during the interview, the Emergency Response (ER) social worker decides that the children are unsafe and must be removed due to Cindi’s use of meth and what appears to be the general neglect of the children. Cindi breaks down and tells the worker something she has never talked about with anyone, i.e., that she was sexually assaulted by her older brother approximately five years ago. She did not feel that she could tell her mother at the time because her older brother was her mother’s favorite and her mother would not have believed her.

What should be the first trauma informed support that the social worker offers Cindi?

- a. Tell Cindi that her past trauma is related to how she is currently coping by using meth.
- b. Take time with Cindi to reflect on how the removal and the presence of child welfare may have triggered memories of past trauma.
- c. Set a time to follow up and be prepared to connect Susan with trauma informed services.
- d. Take time with Cindi to explore what happened, her feelings about being assaulted, and how her life decisions may have been impacted.

Discussion Questions for Co-occurring Disorders Videos Supporting Parents with Co-occurring Disorders (COD) in Child Welfare

Video Link: <https://www.youtube.com/watch?v=Q4ccdNMtYlw>

| # | QUESTION | NOTES |
|---|--|-------|
| 1 | What are “co-occurring disorders (COD)?” | |
| 2 | Why is it important to understand how to identify and treat COD in child welfare? | |
| 3 | What are some ways that COD impact children and families receiving child welfare services? | |
| 4 | What are some strategies described in the video to work effectively with parents who have COD? | |
| 5 | Why is it important to celebrate small successes along the way? | |

Case planning that supports the path to recovery

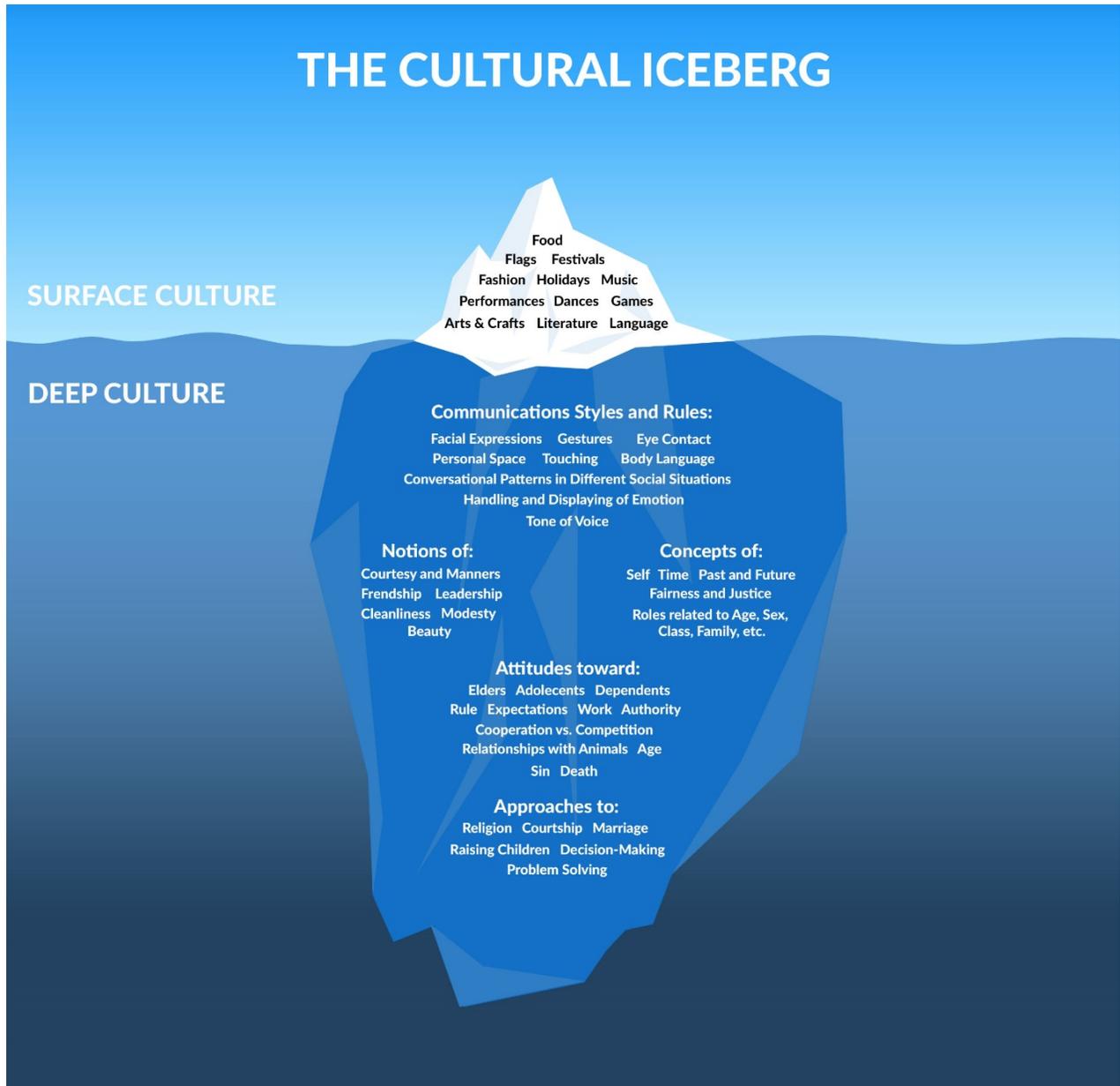
Video Link: <https://www.youtube.com/watch?v=ARQuTgXumok>

| # | QUESTION | NOTES |
|---|---|-------|
| 1 | What are some strategies used to treat co-occurring disorders in families as outlined in the video? | |
| 2 | Are these strategies similar or different to those used in your county and/or agency? | |
| 3 | After a co-occurring disorder is identified, what are some next steps for social workers working with the family? | |
| 4 | What are the benefits of collaborative case planning? | |
| 5 | Does your agency or community use integrated approaches as outlined in the video? If so, what are they and how can you partner with them to support the families you are working with? If not, how can you be creative in helping to use these concepts to help families? How can you enhance your current programs and services using a trauma lens? | |
| 6 | Please describe at least one intervention outlined in the videos that you would like to start using in your practice. | |

Integrated approaches, bias and meeting parents where they are

Video Link: https://www.youtube.com/watch?v=h_3bKM7IXyY

| # | QUESTION | NOTES |
|----------|---|--------------|
| 1 | What are some potential barriers to successful recovery for individuals with COD? | |
| 2 | What are some suggestions in the video for ways to avoid or manage bias when working with individuals with COD? | |
| 3 | What are the benefits of an integrated approach to case planning and service delivery? | |



Adapted from Beyond Culture (Hall, 1976)

Culture is an important piece to remember when working in child welfare. This handout looks at the surface culture, or what you can see, and the deep culture, those things that are not as easily seen but are inherent in each of us, such as our values and/or our sense of personal space. You will be asked to think about your own surface culture and deep culture and then the surface/deep culture of a family you are working with.

Putting Theory into Practice: Case Scenarios

Maryann Martin

Child Welfare Services received a report from the school that 14-year-old Julie was alleging sexual abuse by her father. Julie is the oldest of three siblings. She was taken to the Child Advocacy Center and interviewed, where she disclosed the sexual abuse. She reported that on at least one occasion she was being sexually abused in the kitchen on the floor and her mother walked in, turned around, and walked out. At the Child Advocacy Center, Julie's mother, Maryann, acknowledged this but stated she did not know who her husband was having sex with. Maryann did not believe that it was Julie and did not want to make her husband leave the home. She did not believe what Julie was saying. Julie was placed in foster care and the other two children were placed with a relative. The relative did not want placement of Julie due to their religious background. The Martin family is Mormon. Maryann has talked with the elders in the Mormon Church, who encouraged her to support her husband.

Maryann was raised Mormon, with five siblings. Her parents were married and her mother stayed home and took care of the home and children while her father worked. Although there was no reported physical fighting, Maryann witnessed her father being emotionally abusive to her mother, putting her down, demeaning her and having other women come over to have sex with him. Maryann learned quickly to be silent and not to cause waves. At the age of 15, her mother became ill and Maryann took on the responsibilities of the home, including sharing a bed with her father. Maryann was sexually abused by her father until she married at age 18. Once married, her husband, the children's father, entered the military and they were transferred to four different states until landing in California. The children's father was discharged from the military for behavior unbecoming of an officer, including sexually harassing several of his direct reports.

- 1. Using your trauma lens, discuss what trauma reminders, triggers, or trauma-related issues are playing out in this family/parent.**
- 2. What would your first steps be in working with this family/parent?**
- 3. Are there cultural implications, and, if so, what are they? How do these interact with the trauma issues you have identified?**

Lucy

Lucy is a 26-year-old Native American woman who was raised on a small reservation, where she still lives. Lucy has four children and became a single parent after the death of her husband James about two years ago. James was fishing on the river and his boat capsized. His cousin was with him and was able to get to shore, but James did not make it and he died. James' body was never recovered.

Lucy and her children have been involved with Child Welfare Services for about six months. After James' death, Lucy began to drink. The children, age ranges from 4-9, were left by themselves for long periods while Lucy went out to drink with various family members. They would go down to the river, sit, and drink. The oldest child attempted to build a fire in the home to keep it warm and burned herself badly. She was able to send one of the other children to a neighbor who came and took her to the hospital. She was hospitalized and Child Welfare Services was called. Lucy was located and was intoxicated when she showed up at the hospital. The oldest child remained hospitalized and each time Lucy came to visit, she had been drinking. Lucy's other three children are residing with Tribal members in their community. Lucy was raised by her mother and father. She was raised as an only child after her mother gave birth to a stillborn baby. Her mother and father drank daily, physically disciplining Lucy. At age 15, Lucy got pregnant with her first child and her parents gave her permission to marry James.

- 1. Using your trauma lens, discuss what trauma reminders, triggers, or trauma-related issues are playing out in this family/parent.**
- 2. What would your first steps be in working with this family/parent?**
- 3. Are there cultural implications, and, if so, what are they? How do these interact with the trauma issues you have identified?**

Steven

Steven is 30 years old and father of a 2-year-old child, Matt. He resides with Matt in a cabin in a small town. Steven and Matt are involved with Child Welfare Services due to the condition of Steven's home – there is no electricity, no running water and often not enough food. Matt's mother was living with them but left about six months ago to go live with her dealer who supplies her with heroin. Steven is not involved in using drugs and is adamant that he will raise his child. Resources have been provided to Steven, but each time CWS comes back to the home, Steven has either not followed through or has refused to seek them out.

Child Welfare Services reports show Steven was raised in foster care after his mother was using substances and could not care for him. His father left when he was about one year old and he has not seen him since. Steven was moved many times in foster care, at least three times due to physical abuse and emotional abuse. Steven does not talk about himself much and will not talk about his time in foster care. When he aged out of the system, he was homeless for a while but was able to find work at a welding shop and became a member of the union. He currently only works a couple of days a week due to the downturn in the economy. Matt attends a day care through the Union on those days.

- 1. Using your trauma lens, discuss what trauma reminders, triggers, or trauma-related issues are playing out in this family/parent.**
- 2. What would your first steps be in working with this family/parent?**
- 3. Are there cultural implications, and, if so, what are they? How do these interact with the trauma issues you have identified?**

Falis and Calas

Falis and Calas are married with three children ranging in ages from six months to 13 years. They are all Somalian refugees who came to the US for a better life. The family left Somalia after their village was attacked and their home was burned down. Calas' sister died in the fires. The family resided in a refugee camp in Ethiopia for about a year until coming to the US. Falis' parents, his brother and their family came to the US with them. There are 11 people residing in a three bedroom apartment. The oldest child Naado, age 13, has been talking back to her parents, not wanting to follow traditional rules and is searching for more freedom. They have disciplined her by beating her. She has gone to school and told her teacher about this. Child Welfare Services then became involved with the family. Falis and Calas are at a loss at how to discipline Naado and worry she is setting a bad example for the younger children. Falis loses his temper and beats Naado, and her mother does not intervene.

- 1. Using your trauma lens, discuss what trauma reminders, triggers, or trauma-related issues are playing out in this family/parent.**
- 2. What would your first steps be in working with this family/parent?**
- 3. Are there cultural implications, and, if so, what are they? How do these interact with the trauma issues you have identified?**

Case Vignette Worksheet (Think Tank Activity)

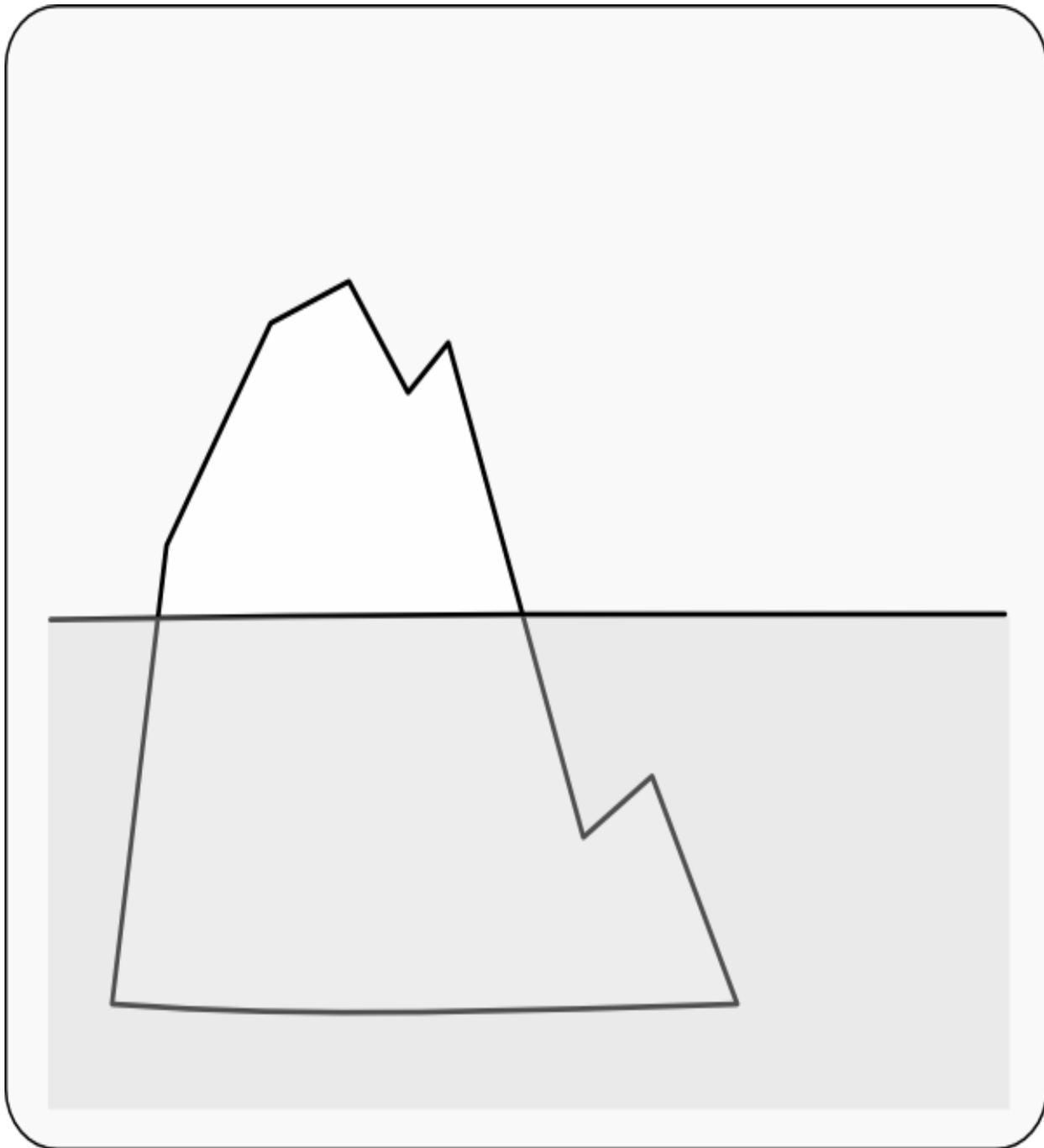
| | |
|--|---|
| <p>Activity Instructions</p> | <ol style="list-style-type: none"> 1. Assign a Case Vignette and a Blank Iceberg scribe (two separate scribes) 2. Each table group will come up with a case of a family they are working with that have any or all of the following child welfare key issues: <ul style="list-style-type: none"> <i>Intimate partner violence</i> <i>Substance use disorders</i> <i>Behavioral health issues</i> 3. Scribe will take notes on this “Case Vignette Worksheet” based on the case information presented to the team, including: <ol style="list-style-type: none"> a. <i>Family history, patterns, strengths and support network</i> b. <i>Reason for Child Welfare involvement and in key issues present in the family intimate partner violence, behavioral health issues, and/or substance use disorders)</i> c. <i>Current status of the case / referral</i> d. <i>Interventions previously used with the family</i> e. <i>Best practice interventions you may consider using in the future with the family (trauma informed & culturally relevant)</i> |
| <h3>Case Presentation Notes</h3> | |
| <p>Family History Demographics Strengths Patterns Support Network</p> | |
| <p>Reason for Child Welfare Involvement & Key Issues of Family (IPV, BH, substance use)</p> | |

| | | |
|---|---|--|
| <p>Current Status of Case/Referral</p> | | |
| <p>Previous Interventions Used with the Family</p> | | |
| <p>Best Practice Interventions to Consider Using in the Future (Trauma informed / culturally relevant)</p> | | |
| <p>Chart on Flip Chart Paper:</p> | <p>What's working well for the family?</p> <ol style="list-style-type: none"> 1. 2. 3. | <p>What are the worries about the family?</p> <ol style="list-style-type: none"> 1. 2. 3. |

Additional Notes:

Blank Cultural Iceberg

Utilize this iceberg to identify the Surface Culture and the Deep Culture with your case vignette.



Personal Learning Plan

1. For you, what concepts, topics or practices stood out as important about how trauma is impacted by key issues in child welfare?
2. What are your key learnings from the day?
3. In what ways does this information integrate and translate into what you see in your county practices and/or attitudes about families experiencing trauma or any of the key issues? What conflicts might exist?
4. How has your understanding of trauma and key issues changed? What does this mean for your future practice?
5. When leaving today, what do you commit to doing to improve your own practices? How will you address any challenges?

Bibliography and References

- Balan, P., Clark, M., & Restall, G. (2015). Preparing students for Flipped or Team-Based Learning methods. *Education + Training, 57, 6*, pp. 639-657.
- Balan, P., Clark, M., & Restall, G. (2015). Preparing students for Flipped or Team-Based Learning methods. *Education + Training, 57, 6*, pp. 639-657.
- Brave Heart, M. Y. H. (2000). Wakiksuyapi: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare, 21-22*, 245-266.
- Brave Heart-Jordan, M. Y. H. (1995). The return to the sacred path: Healing from historical trauma and historical unresolved grief among the Lakota: A dissertation based upon an independent investigation. Northampton, MA: Smith College School of Social Work.
- Centers for Disease Control and Prevention. Adverse Childhood Experiences Study. Retrieved from: <https://www.cdc.gov/violenceprevention/acestudy/>
- DePanfilis, D., & Salus, M.K. (2003). Child Protective Services: A Guide for Caseworkers. Child Abuse and Neglect User Manual Series. U.S. Department of Health and Human Services. Retrieved from <https://www.childwelfare.gov/pubPDFs/cps.pdf>
- Duluth Model. Wheel of Power and Control. & Equality Model Retrieved from: <http://www.theduluthmodel.org/pdf/PowerandControl.pdf>
- Gullo, C., Ha, T.C., & Cook, S. (2015). Twelve tips for facilitating team-based learning. *Medical Teacher, 39:2*, 195-202. Retrieved from <http://dx.doi.org/10.3109/0142159X.2014.1001729>
- Hall, E.T. (1976). Beyond culture. Garden City, New York: Anchor Press.
- Hopper, E.K., Bassuk, E.L., & Olivey, J. (2010). Shelter from the storm: trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*, 80-100.
- Huggins, C.M., & Stamatel, J.P. (2015). An Exploratory Study Comparing the Effectiveness of Lecturing versus Team-based Learning. *Teaching Sociology, 43, 3*, pp. 227-235.
- Khoury, L., Tang, Y. L., Bradley, B., Cubells, J. F., & Ressler, K. J. (2010). Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population. *Depression and Anxiety, 27(12)*, 1077-1086.
- Lannert B.K., Garcia, A.M., Smagur, K.E., Yalch, M.M., Levendosky, A.A., Bogat, G.A., Lonstein, J.S. (2014). Relational trauma in the context of intimate partner violence. *Child Abuse and Neglect, 38 (12)*, 1966-75.
- National Child Traumatic Stress Network, Child Welfare Committee. (2011). Birth parents with trauma histories and the child welfare system: A guide for resource parents. Los Angeles, CA, and Durham, NC:
- National Child Traumatic Stress Network. (March 2008). Child Welfare Trauma Training Toolkit: The Essential Elements. Retrieved from www.nctsn.org
- National Center for Child Traumatic Stress. Making the Connection: Trauma and Substance Abuse. The National Child Traumatic Stress Network. Retrieved from www.nctsn.org
- Prochaska, J.O., & Velicer, W.F. (1997). The Transtheoretical Model of health behavior change. *American Journal of Health Promotion, 12*, 38-48.
- Pynoos, R. S., Steinberg, A. M., Ornitz, E. M., & Goenjian, A. K. (1997). Issues in the developmental neurobiology of traumatic stress. *Annals of the New York Academy of Sciences, 821*, 176-193
- Sibley, J., & Spiridonoff, S. (2014). Introduction to Team-Based Learning. University of British Columbia Faculty of Applied Science Center for Instructional Support. Retrieved from https://c.ymcdn.com/sites/teambasedlearning.site-ym.com/resource/resmgr/Docs/TBL-handout_February_2014_le.pdf.

Substance Abuse and Mental Health Services Administration – Health Resources and Services Administration. (2017). Trauma. Retrieved from: <http://www.integration.samhsa.gov/clinical-practice/trauma>

White, Samantha. (2012). Time to Think: Using Restorative Questions. International Institute for Restorative Practices. Retrieved from <http://www.iirp.edu/news/1976-time-to-think-using-restorative-questions>

Videos used in this course

Video #1: Supporting parents with COD in child welfare (6 minutes, 28 seconds)

<https://www.youtube.com/watch?v=Q4ccdNMtYlw>

Video #2: Case planning that supports the path to recovery (8 minutes, 25 seconds)

<https://www.youtube.com/watch?v=ARQuTgXumok>

Video #3: Integrated approaches, bias and meeting parents where they are (7 minutes, 16 seconds)

https://www.youtube.com/watch?v=h_3bKM7lXyY

Resources

A Social Workers Tool Kit for Working with Immigrant Families-Healing the Damage: Trauma and Immigrant Families in Child Welfare Systems

<http://cimmcw.org/wp-content/uploads/2015/03/CICW-toolkit-trauma-immigrant-families-March-2015.pdf>

Dual Diagnosis

<http://www.dualdiagnosis.org>

Chadwick Trauma-Informed Systems Dissemination and Implementation Project

<https://ctisp.org/trauma-informed-child-welfare-practice-toolkit/>

Help Guide

<http://www.helpguide.org/>

Implementing Trauma-Informed Practices

<http://childwelfaresparc.org/wp-content/uploads/2013/11/Implementing-Trauma-Informed-Practices.pdf>

National Child Traumatic Stress Network

<http://www.nctsn.org/>

National Coalition against Domestic Violence

<http://ncadv.org/learn-more/resources>

National Domestic Violence Hotline

<http://www.thehotline.org/>

SAMHSA's Concepts of Trauma and Guidance for Trauma-Informed Approach, July 2014

<http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>

Substance Abuse and Mental Health Services Administration

<http://www.samhsa.gov/>

Substance Abuse Toolkit

http://www.nctsn.org/sites/default/files/assets/pdfs/SAToolkit_1.pdf

The Amazing Brain: What every Parent and Caregiver Needs to Know and The Amazing Brain: Trauma and the Potential for Healing

<http://www.instituteforsafefamilies.org/materials/amazing-brain>

When a Parent Has a Mental Illness: Issues and Challenges

[https://www.mhawisconsin.org/Data/Sites/1/media/fact-sheets/sf_issues\[1\].pdf](https://www.mhawisconsin.org/Data/Sites/1/media/fact-sheets/sf_issues[1].pdf)