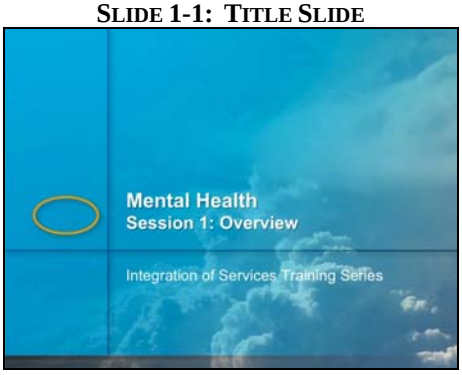
The Integration of Services Training Series

MODULE 2. MENTAL HEALTH

Session 1: Dynamics and Impacts

SLIDE 1-1: TITLE SLIDE



Welcome the participants.

Introduce yourself as trainer.

Say:

- *Today we are going to talk about mental health. When we think about mental health, the first thing that often comes to mind is mental illness.*
- *Mental Health however is a much broader concept and includes not only illness but emotional wellness. The sense of well-being is usually associated with a person's emotional state.*

Ask:

When you think of emotional well-being what comes to your mind?

Facilitate a brief discussion on emotional well-being emphasizing descriptions that bring the concept alive through examples, experiences, etc.

Participant Guide
Module 2, p.2

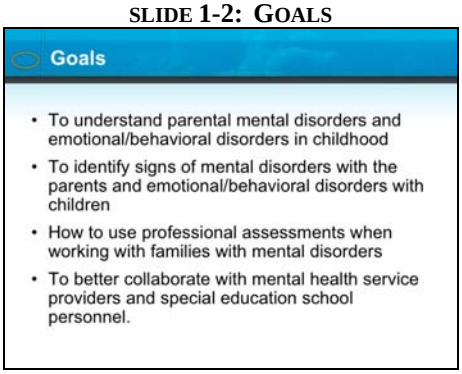
Refer to the Participant Guide, Module 1, page 2. Ask them to complete the Before and After Training Survey.

The directions are written on the survey.

Emphasize that this is not a test with right and wrong answers and it is anonymous.

Ask the participants to please keep the survey in their participant guide because, as the name implies, we will be using it at the end of the day as well and will collect them.

SLIDE 1-2: GOALS



Summarize *the goals.*

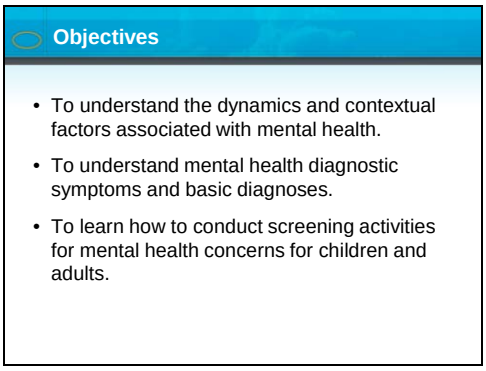
- These goals focus on understanding how family functioning is affected by parents and children with mental disorders. Session 1 provides an overview of mental disorders.
- Being able to identify signs of mental disorders will help child welfare workers address key issues with families.
- Session 2 is dedicated to screening and assessments and discusses the importance of your role in both functions.

SLIDE 1-3: AGENDA

Summarize:

- Session 3 includes a discussion of treatment from a broad perspective and addresses the importance of collaborations with the mental health professionals and school personnel, if applicable, to help the family address their issues in a comprehensive and coordinated manner.
- Mental disorders may be long-lasting. Therefore, to address family stability it may be necessary to ensure that mental health issues are going to be adequately addressed by a mental health provider before case closure. This issue will be discussed in Session 3.
- Please note that throughout this training, we use the terms 'mental disorders', 'psychiatric disorders', and 'mental illness' interchangeably.

SLIDE 1-4: OBJECTIVES

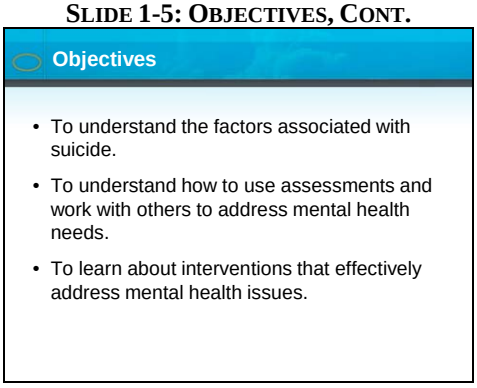


Review the objectives for the session.

Refer the participants to the participant guide, page 3. Have them think critically about what their personal goals are with this module.

Patricipant Guide
Module 2, p. 3

SLIDE 1-5: OBJECTIVES, CONT.



WORKING AGREEMENT

Say:

As we have in other modules in this training, today we want to strengthen our working agreement and make sure we understand your goals for the day as well as give you a sense of what we are planning to cover and are prepared to offer. This may include modifying our plan for how we will work together.

TRANSITION

Throughout these modules, we've attempted to select content that will help you improve child safety, permanency, and well-being and that content was described above in the goals.

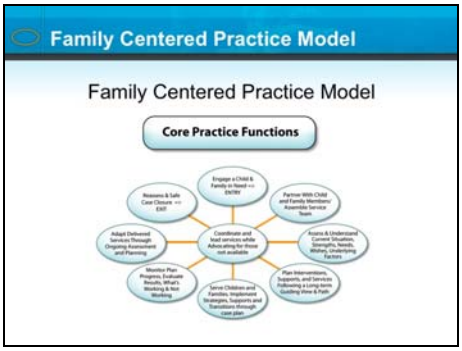
Ask:

Based on that overview, what are your goals and expectations from today's work?

FLIPCHART

- List responses on the flipchart and as participants respond, acknowledge topics that we are planning to cover and areas that we can try to address, as a group, although they may not be scripted or documented in our materials.
- Further acknowledge that some objectives may be covered in the fifth module of the series on Service Integration and Collaboration, where we will go more in-depth about how to approach teaming.

SLIDE 1-6: FAMILY CENTERED PRACTICE MODEL



Relate today's training to the family centered practice model.

Summarize:

- Our training will address a number of the core functions of the family centered practice model introduced in the family centered practice training series.
- Our main emphasis will be in the functions of: engagement, partnering, screening/assessing, planning, monitoring, and safe case closure.
- Also we need to briefly discuss how we will interact. Throughout the day, we will be dealing with sensitive areas. I will be asking you questions, but there is no need to feel that you should provide any personal information. This agenda is designed to discuss your experiences as an investigator or case manager, so please don't feel pressured in any way to disclose personal information.

TRANSITION

We are now going to discuss emotional responses.

Given the type of work you do, you encounter children and adults everyday who are either very angry, sad, hurt, frightened etc. To further understand these emotions it is helpful to look at the components of emotional responses.

Materials:
None

ACTIVITY 1-1: Experiencing Your Emotions

PURPOSE: For participants to remember their own emotional responses and tie those to their own tendencies, experiences, and memories.

TIME: 10 MINUTES

DIRECTIONS:

Lead the participants through this form of guided imagery, allowing them time to think about the questions you are asking.

Say:

Think about the last time you went to your childhood home or another very familiar place that you have been to many times and that you have an emotional attachment to. Be sure that it is a place that you feel safe. Get that place clearly in your mind. Now think about walking in the door.

Ask:

What do you feel?

Pause

Can you identify the emotions that you are feeling?

Pause

Think about what you might be smelling? Lemon furniture polish, dinner cooking?

Pause

What do you see?

Pause

Are the things there very familiar and comforting?

Pause

Do you see something that makes you feel a little upset?

Pause

Think about what made you feel good.

Process:

Ask the group to share generally what they thought created a feeling of calmness or relaxation and stimulate a discussion.

Summarize Key Points:

- Smells, a tone of voice, an object, a sudden sound, a song etc. can stimulate an emotional response. Often, people are not even aware why they are feeling a certain way.
- People often have different reactions to different sights, sounds, smells, touch, and taste.

TRAINER NOTE

The trainer may want to share some of their personal responses to these stimuli.

Summarize:

- Sometimes it can be the way someone acts that can cause a reaction.
- There are many very subtle events or experiences that can create an emotional response.

Say:

Now let's take a minute and think about "anger".

TRAINER NOTE

Trainer will describe an experience in which he/she went from calm to upset very quickly.

Say:

I remember a time when I went from calm to irate within seconds? Let me describe it to you.

Pause allowing time for participants to think about the description.

Ask:

Was my reaction "rational" or was it something about the situation that just "pushed my button?"

Ask:

Does anyone want to share generally where their "buttons" may have come from?

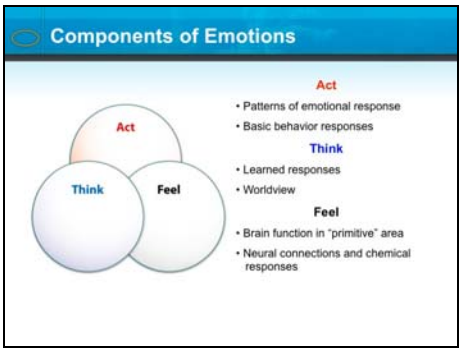
Process:

Facilitate discussion. Explain that participants need not give the specifics of the experiences just generally mention them.

Summarize Key Points:

- "Hot Buttons" often come from childhood experiences when something happened that was very upsetting.
- They often come up when people feel threatened or in a stressful situation.
- Some people are more prone to reacting quickly to issues than others.

SLIDE 1-7: OVERLAPPING COMPONENTS OF EMOTION



Say:

- *The slide shows that emotional responses are impacted by the individual's unique behavioral repertoire, what they have learned and experienced, and their biological responses.*
- *The top circle includes the type of behaviors that the person has learned as their typical responses to situations. For example, some people may get very quiet and alert when they are angry, while others may lash out immediately.*

- *The "think" circle illustrates the impact of learning on experience and the world view that has emerged from these experiences. These factors impact how a person views a situation, how they process information and how they tend to approach problems in their environment.*
- *The unique development and brain functioning strongly impacts how the brain processes an event and the resulting sensations or feelings as shown by the "feeling" circle. As we learned in the Health and Development Module, living in high risk environments, especially as a young child, can compromise physiological development and impair the ability to regulate emotion, cognitive development, and other developmental capabilities.*

Ask and discuss:

In our work we see so many different responses to situations. What type of emotional responses do you usually get at the beginning of an investigation?

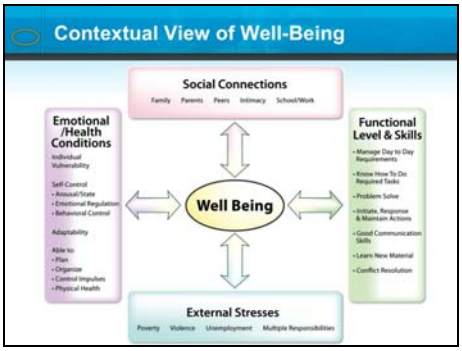
FLIPCHART

Facilitate discussion and record responses on the flipchart.

Summarize Key Points:

- Fear, anger, sadness, distress, excitement are all emotions that we see every day.
- Given the situation that you work in, these emotions are expected.

SLIDE 1-8: CONTEXTUAL VIEW OF WELL-BEING



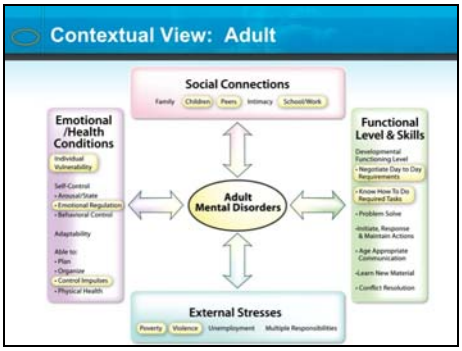
Participant Guide
Module 2, p. 4

Say:

- *Take a moment to look over this slide. It is also in your Participant Guide on page 4.*
- *The slide shows four factors that influence a person's well-being: social connections, functional levels, emotional/health condition, and environmental stressors.*
- *Understanding these conditions and how they influence parents also help us look at safety issues and the degree of risk the children may be facing.*
- *As the conditions shift in each of these areas the parent's ability to respond to the needs of their children may shift as well.*

- *Think about some of our responses to family needs. Let's consider the **functional** area. Helping families better understand child development, money management, parenting practices, how to access services strengthens this dynamic.*
- *Now let's look at **social connections**. When a parent is having problems with parenting or with managing their own emotions, we may help them access natural supports through a family member, church, or friend.*
- *When we think about **psychological issues** we usually look at the purple area. It is in this area that we see the biological vulnerabilities, such as a predisposition for diagnosable mental disorders.*
- *We also see how we manage and regulate emotions and stress. Remember from Health and Development how childhood experiences can directly impact brain development which may result in diminished ability to regulate emotions and process stress.*
- *Think about the results of the Adverse Childhood Experiences study. Our childhood experiences can impact our health and mental health for a life-time.*
- *Think about the exercise that we did earlier. We recognized that each of us responds in unique ways to emotional situations and that our reactions may be very different than others to the same set of circumstances.*
- *Looking at this diagram we can see why so many of the children and families may be susceptible to disruptions in their emotional well-being and emotional status.*
- *This figure shows multiple areas that provide opportunities for intervention.*
- *When helping the family construct their team, the contextual view provides a way to consider needs and help locate natural supports.*

SLIDE 1-9: CONTEXTUAL VIEW OF ADULT MENTAL DISORDERS



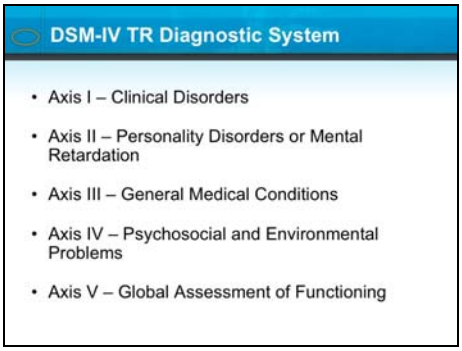
Say:

- *This slide is similar to the one that we just looked at, but it is slightly modified to focus on the vulnerabilities associated with mental disorders in adults.*
- *Look at the purple section. Notice that the individual vulnerability is now highlighted. Notice that the emotional and behavioral regulation is in jeopardy.*
- *What has happened to the functioning? Do you think that it is compromised?*
- *What are some of the complicating issues? Notice in the social connections— Let's say that a close relative is ill and a best friend is moving.*
- *Look at the stressors? They are also increasing? Maybe the rent is overdue and there was a gang fight in the neighborhood two nights ago?*
- *These issues could serve as triggers or the tipping point for emotions and behaviors to reach a diagnosable level. Or, perhaps the person has a mental illness diagnosis that has been well managed. The change in circumstances reduced the effectiveness of the coping mechanisms.*
- *When we talk about possible mental disorders we must do so within a contextual framework considering both strengths and vulnerabilities.*
- *Some people may have a diagnosable mental disorder but it is well-managed. The level of the functioning is what determines if a person is considered "seriously mentally ill."*

TRANSITION

- *Parental mental disorders may increase the probability of risk in child welfare cases. Again the degree of risk is dependent upon many factors such as the nature of the specific disorder, the person's ability to manage the illness, the degree of support available, and the person's ability to problem solve and manage stress.*
- *The symptoms and characteristics associated with a specific mental disorder may raise specific concerns for child safety and/or well-being. During the following section we will briefly discuss the main categories of mental illness and the possible corresponding symptoms that may be present.*

SLIDE 1-10: THE DSM-IV TR DIAGNOSTIC SYSTEM



Say:

- *Most of you are probably familiar with the DSM-IV TR Diagnostic System.*
- *The system provides a multi-dimensional method to classify mental disorders and to document other related conditions in a systematic way.*
- *When trying to understand a person's mental disorder it is important to have information on each Axis.*
- *Attention should be given to Axis V which shows the clinician's view of the person's functioning level.*

Say:

- As a child welfare practitioner, one of your responsibilities is to observe parental-child interactions. As with other parents you will want to be aware of:
  1) How the parent managers their emotions?
  2) Are they "there" for the child?
- Identify risks and protective factors.

Materials:
Participant Guide worksheets
Flipchart

ACTIVITY 1-2: MH Diagnoses and Parenting

PURPOSE: To understand how a mental disorder diagnosis may impact parenting.

TIME: 30 MINUTES

DIRECTIONS:

1. Form small groups of 3-4 participants.
2. Assign each group to two types of mental disorders from the list.
   - generalized anxiety disorder
   - depression
   - post-traumatic stress
   - bi-polar
   - obsessive compulsive disorder
   - schizophrenia
3. Tell the participants their task will be to identify ways that these mental disorders could impact parenting behaviors. As resources, they are to refer to their Participant Guide, pages 5 – 12 to read about their assigned mental disorder.

Participant Guide
Module 2, p. 5 – 12

Participant Guide
Module 2, p. 13


FLIPCHART

4. Ask the group to discuss and prepare to present the answers to the following questions:
    - How might this diagnosis impact the parent's ability to:
        - Be present?
        - Regulate emotions?
        - Be responsive to the child's needs?
5. Ask the participants to record their work on the worksheet on page 13 of the Participant Guide.
6. Allow them 15 minutes for the activity. Tell them that each group will give a brief report of its findings.
7. Have the groups give their reports. As they do, note the response of each mental disorder on the flipchart.

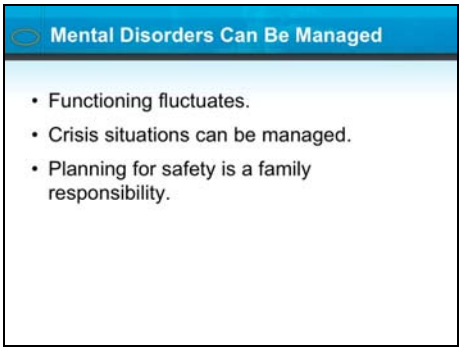
Process:

Point out the behavioral commonalities across diagnoses. What does that imply for child welfare work with the families?

Summarize Key Points:

- Note that there are many common symptoms across the different categories. Sometimes making a specific diagnosis can be challenging especially if the mental health professional does not have access to others who can provide historical and contextual information.
- Many people have symptoms associated with a specific diagnosis but they are not sufficient to meet the diagnosable level.
- You may notice that when you read a parent's or child's record that they have had different previous diagnoses. This is not uncommon.
- You also may have worked with people with the same diagnoses who presented very differently. This is also not uncommon.
- It is often very difficult or impossible to predict a person's expression of symptoms from just knowing the diagnoses. A person's behaviors and functioning level is dependent on many factors as we discussed earlier.

SLIDE 1-11: MENTAL DISORDERS CAN BE MANAGED



Say:

- *Some mental disorders have a very limited impact on a person's day to day functioning. While 26% of the adult population have a diagnosable mental illness within a 12 month period, only 6% of the population have a serious mental illness (NIMH 2005).*
- *Functioning is not static. The person may have periods where the mental disorder is well managed with little day to day impact. However, this functioning may be interspersed with periodic acute episodes and crisis.*
- *After learning to manage their mental illness, many people know what signs and symptoms indicate possible escalating problems and can develop contingency plans to keep their children safe.*

TRANSITION

We've talked about a functional approach to mental illness —seeing how the parent's behaviors affect parenting capacity rather than judging a person based on their mental disorder diagnosis.

Our next activity takes that theme even further . . . how do we see the parent as a unique person, worthy of our respect?

Materials:
Flipchart
Participant Guide Worksheets

ACTIVITY 1-3: Treat Me As A person

PURPOSE: To remind ourselves to see the person first, not just the mental illness

TIME: 10 MINUTES

DIRECTIONS:

1. Have the participants give responses to a question like:

   How do you think parents with mental disorders want us to "see" them?

2. Record the responses on the flipchart.
3. When the responses slow down, thank the participants for their ideas.
4. Check to see that the major items listed in the summary in the Participant Guide, page 14 are addressed in the list. If not, add them.

FLIPCHART

Participant Guide
Module 2, p. 14

FLIPCHART

5. Ask them which of the parent's comments are the hardest to do on a consistent basis? Mark those items on the flipchart.
6. Ask the group for strategies they have found to be effective when working with parents with mental disorders to address these points.
7. Discuss briefly.

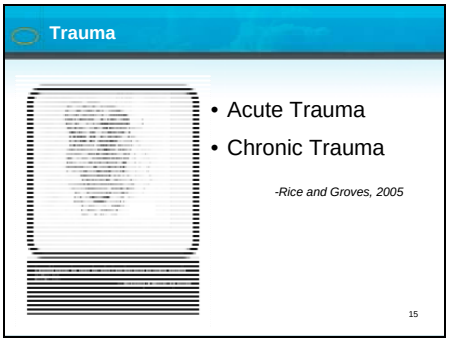
Summarize with these Key Points:

See the parent with a mental disorder as a parent first – focus on developing the quality of your relationship with that person. Focus on the person's behaviors and goals, not their psychiatric diagnosis.

TRANSITION

Now we have a better understanding of parental mental disorders, we are going to discuss emotional/behavioral disorders in childhood.

SLIDE 1-12: TRAUMA



Say:

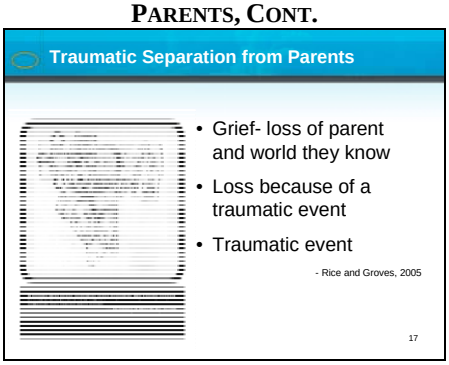
- *Acute trauma is a single traumatic event that overwhelms the person's ability to cope. Examples are car accidents, floods, seeing a murder, rape etc. People can experience more than one such event.*
- *Chronic trauma or complex trauma results when a person is exposed to traumatic situations on a regular basis. For example a child that lives in a violent neighborhood or home may witness both shootings and his mother's abuse by her boyfriend. Children exposed to physical abuse, sexual abuse or chronic neglect may become psychologically overwhelmed and are in a constant state of crisis. As we learned in Health and Development this is considered "Toxic Stress" that likely impacts brain development in a negative way.*
- *Many "behaviors" that we see with families were established as coping mechanisms to chronic trauma.*

SLIDE 1-13: TRAUMATIC SEPARATION FROM PARENTS

Say:

- *Children grieve the loss of their loved ones and the world as they know it. Children at different developmental stages experience "time" differently. For example, a toddler is not going to comprehend that he will see his mother in two weeks. All the toddler knows is that mom is not there.*

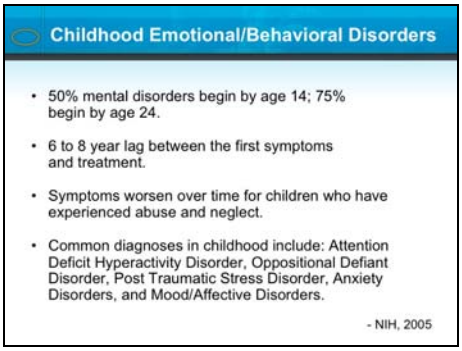
SLIDE 1-14: TRAUMATIC SEPARATION FROM PARENTS, CONT.



Say:

- *Children lose a sense of safety, security, and comfort when separated from their parents. This happens when a child is removed from their home. We see it as strengthening their security but children, especially young children, can't understand that. They may long for the times when mom hugged them, or they may want the feeling of their blanket etc.*
- *Children may show their distress, not through crying or words, but through behavior such as withdrawal or aggression. Young children may regress and stop toileting or talking.*
- *Frequent supported visitation with parents and siblings can help reduce the child's emotional pain and distress.*

SLIDE 1-15: CHILDHOOD EMOTIONAL/ BEHAVIORAL DISORDERS

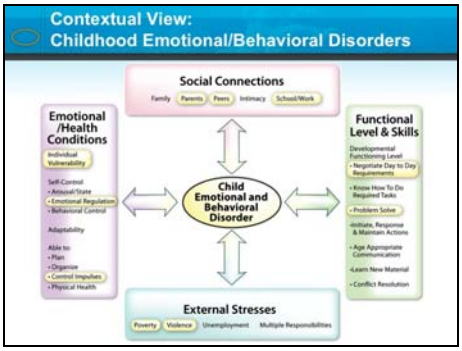


Say:

- *The National Institute for Health reported (2005) that the onset of most (75%) life-long mental disorders started before the person was 24.*
- *Young people with emotional/behavioral disorders face these challenges in the prime of their life when they are typically developing the skills for productive adulthood and intimacy.*
- *Research shows that most people do not seek treatment for 6 to 8 years after the onset of the first symptoms.*
- *This is a serious issue since it appears that the earlier in life the mental disorder begins, the slower the individual is to seek therapy, the more persistent the illness becomes.*

- *For children who have experienced abuse and neglect, the mental disorder seems to worsen overtime.*

SLIDE 1-16: CONTEXTUAL VIEW OF CHILDHOOD EMOTIONAL/BEHAVIORAL DISORDERS



Say:

This slide shows the contextual view but this time we are going to address a child. The highlighted areas indicate what issues the child is currently struggling with.

Ask:

What change in behaviors may result from changes in emotional regulation?

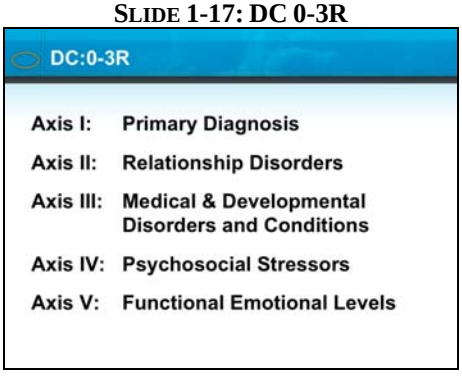
What about social connections?

Continue to generate discussion across the four domains.

Summarize Key Points:

- The child's behavior and mental status may shift based upon what is happening in his environment.
- A child who has problems managing his emotions may find he is having even more difficulty as the stress in his life increases.
- As his behavior deteriorates so does his peer group which causes more stress which results in reduced functioning.
- If the child has someone in his home that he can go to for comfort and support he may be able to deal with these issues.
- If he has a very strong predisposition for emotional/behavioral issues he may not be able to successfully manage the stress.

SLIDE 1-17: DC 0-3R



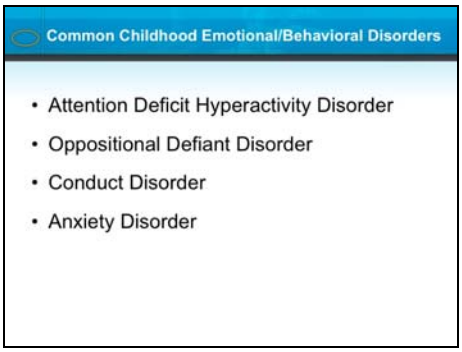
Say:

- *The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R) provides an alternative to the DSM-IVTR for infants and toddlers.*
- *Like the DSM-IV-TR, the classification system is based upon five axes which provide a method for describing early childhood emotional/behavioral disorders.*

Participant Guide
Module 2, p. 15

Refer participants to the participant guide on page 15. Review the overview of the Diagnostic System.

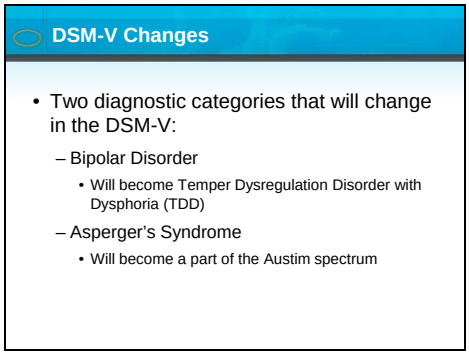
SLIDE 1-18: CHILDHOOD EMOTIONAL AND BEHAVIORAL DISORDERS



Say:

- *The DSM-IV-TR lists numerous diagnoses for mental disorders. Some are listed as those disorders that are primarily identified in childhood. These include areas such as Autism, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder etc. You have likely seen these in many of your records. Other disorders such as anxiety disorders are described for both children and adults.*

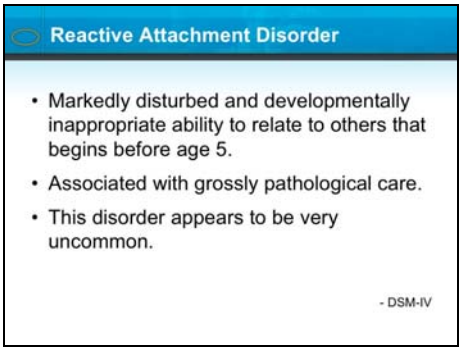
SLIDE 1-19: DSM-V CHANGES



Say:

- *The DSM is going to be revised as DSM V. It is likely that bi-polar disorder for children will be revised to Temper Dysregulation Disorder with Dysphoria (TDD). Asperger's Syndrome will become part of the Autism Spectrum.*
- *The DSM V incorporates some changes to the diagnostic process for children, which may impact how children in our system are view by assessors and treatment providers:*
    - Bipolar disorder will be only rarely diagnosed for children. Rather children who display symptoms previously thought to be the precursors to Bipolar Disorder will now be assessed for Temper Dysregulation Disorder with Dysphoria. This has to do with the biological and behavioral markers for children with these behaviors, and also has to do with research that did not find a link between children who were diagnosed with Bipolar Disorder did not usually develop adult symptoms.
    - Asperger's Syndrome will be one category with the continuum of Austim Spectrum Disorders.

SLIDE 1-20: REACTIVE ATTACHMENT DISORDER



Say:

- *In Health & Development, we discussed attachment issues. It is important to note that attachment problems are not a diagnostic category, with the exception of Reactive Attachment Disorders (RAD).*
- *RAD is a very rare condition.*
- *Also note that only conditions shown on Axis I of both the DSM-IV-TR and the DC:0-3R can be used for billing Medicaid or usually any other insurance source.*

Ask:

What diagnoses do you see most frequently?

Do you have any ideas why you would see these so often?

Materials:
Paper
Pencils
Participant Guide worksheet

ACTIVITY 1-4: DSM-IV-TR Diagnoses

PURPOSE: To review emotional and behavioral disorders seen in childhood.

TIME: 15 minutes

DIRECTIONS:

1. Remind participants that the DSM-IV-TR is a classification system. People are assigned a diagnosis when a sufficient number of behaviors, thought patterns, and emotional responses "match" a diagnostic category description. The classification system does not specify the etiology (cause) of the disorder.
2. Remind participants that emotional/behavioral conditions are the result of internal/physiological states; learned responses to situations, events, etc.; and strongly affected by external environments.
3. Tell the group that we are going to repeat the activity of the earlier adult session by analyzing the impact of childhood emotional disturbance on functioning while also considering adverse childhood experiences on behavior and functioning.
4. Assign each group a diagnosis, using pages 5 – 12 of the Participant Guide.

Participant Guide
Module 2, pgs. 5 – 12

- Childhood depression
- Attention Deficit Disorder (with Hyperactivity or Inattention)
- Oppositional Defiant Disorder
- Anxiety Disorder (i.e. phobias, etc.)

5. Ask the group to review the diagnostic category and answer the following questions:
    - How could these symptoms be a response to traumatic experiences of child abuse and neglect?
    - How could these symptoms in children impact parents in their parenting role?
    - Given these symptoms, what kind of environment and strategies might help the child succeed?
6. Distribute poster paper for groups to note their responses.

Process:

Ask each group to report how they addressed the questions.

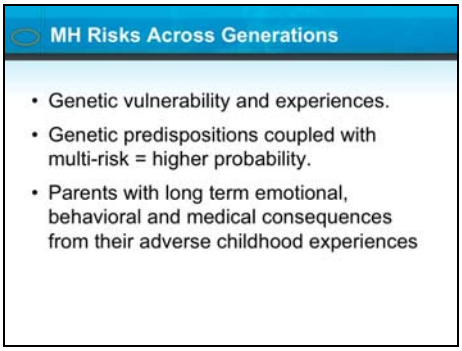
Points to make:

- Emphasize the possible contribution of adverse childhood experiences on the behavior.
- Emphasize that treatment must address all three contributing factors: physiological states, thought processes, and emotional/behavioral responses and environmental factors. Success is unlikely unless treatment is multi-faceted.
- Underscore the need for both environmental strategies assistant and coaching to parents/caregivers in assisting children in managing their symptoms, regardless of origin.

TRANSITION

Now we are going to discuss how mental health issues may impact the whole family.

SLIDE 1-21: MENTAL HEALTH RISKS ACROSS GENERATIONS



Summarize the slide:

- In Health and Development, we discussed the transactional developmental process through which environment can influence genetic expression.
- Basically this means that genetic predisposition does not mean that a disorder will materialize. It is the interaction between the relative strength of both of these factors and their interaction that influences the onset of a mental disorder.
- A child can be born with no predisposition for a mental disorder, but if she lives in an egregious situation during her early childhood it is very likely that she will develop an emotional/behavioral disorder. On the other hand, a child may carry such a strong genetic influence for mental disorders that even the most optimal family environment won't prevent the onset of mental illness.
- We must be extremely careful not to judge parents when we find out that one or more of their children have an emotional/behavioral disorder. We have no real way of knowing why a child is having these challenges.
- We do know that highly stressful environments do not promote healthy development, and that some parenting styles are more likely to result in emotional/behavioral problems in children.
- Some mental disorders have a very high rate of biological transmission.
- Regardless of the "cause" we know that children who encounter the child welfare system (both substantiated and not substantiated) are at a high risk for developing an emotional or behavioral disorder.


FLIPCHART

Ask/Discuss *the following set of questions. Record responses on the flipchart. Key summary points are provided after the questions.*

- ***Do you have many families in your caseload that you suspect emotional/behavioral disorders in the parents and in one or more of the children?***

  Pause for a response.

- ***What types of challenges does this create for you?***

Pause for a response – record key points on the flipchart.

- ***How does this impact out-of-home placement?***

  Pause for a response – record key points on the flipchart.

- ***How do these situation impact visitations?***

  Pause for a response– record key points on the flipchart.

- ***What kind of success do you have with reunification with these types of cases?***

  Pause for a response – record key points on the flipchart.

- ***What are the factors that help you reunify these types of cases?***

  Pause for a response – record key points on the flipchart.

Summarize *the comments, emphasizing the key points:*

- In these cases, the needs for both the parents and the children are very high.
- Chances are there are many other challenges in the family such as unemployment, housing issues, and few social connections.
- The children need therapeutic and likely academic support.
- The parents need therapeutic services that address both their individual needs and provide assistance in parenting.
- Placement is likely difficult because of the child's behaviors. Multiple moves will aggravate the situation.
- The parent will likely need therapeutic visitation to enable a productive visit with the child.
- Successful reunification will likely require intensive services at the time of the re-unification and possibly for several weeks after.
- Transition at the time of closure to another agency for case management and support would be beneficial to avoid re-entry.

Ask:

Would anyone like to share a story of a successful re-unification when the mother had a mental illness?

Process *the response with the group.*

SESSION SUMMARY

Summarize *with points like these:*

- As we can see, mental disorders are common in our society with many of the serious disorders starting in childhood.
- We also know from our work that many of the problems that we see with families are multi-generational. It seems like the abuse and neglect issues are passed down from family to family.
- Of course this is not always true. We know many people who experienced abuse and neglect as children and never maltreat their children.
- **Again let's give a cautionary note – all of this information talks about escalated risk, not direct causation.**
- In the next session, we'll discuss how to screen for these disorders.