EPRESS

Questions from Directors

We hear all this talk about improving families' lives, but for some families, it just doesn't seem to be happening. Everyone here is just frustrated over one family in particular. It seems like nothing we do helps. There has to be SOMETHING we can do.

You've done everything we've talked about, so now we'll talk about something different. It's time to try *micro-goals* as a part of your goal setting. There's an article in this EPress about goal setting, but I want you to focus on micro-goals. Sometimes that's all you will get in a case.

Instead of your past bigger, broader goals, like "We will improve parenting," and getting frustrated at the lack of movement toward that goal, let's look at small goals for visits. What do they look like? Here are some examples:

Macro Goals	Micro Goals – Choose One or Two
Improving parenting Teaching parent how to interact in an age-appropriate manner with child Ensuring that child is comfortable and safe with parent Increasing parent's knowledge of child development Increasing parent's consistency in parenting Moving parent toward safe, unsupervised visits	• Having parent offer child two choices of activities and allowing child to choose • Teaching parent how to say one encouraging thing to the child during the visit, such as "it's great to see you" or "you did such a good job at reading that book." • Giving the parent one developmental milestone for his/her child's age, and pointing out after the visit how that milestone was demonstrated by the child. Repeating at next visit. • Finding one thing that the parent did appropriately, and complimenting him or her on it specifically. • Having the parent get through one

	activity without losing his or her temper.

The advantage of micro-goals is that they are generally manageable, and they allow all parties involved to see something positive coming out of a visit. They encourage the parent, and they reinforce the staff's goals.

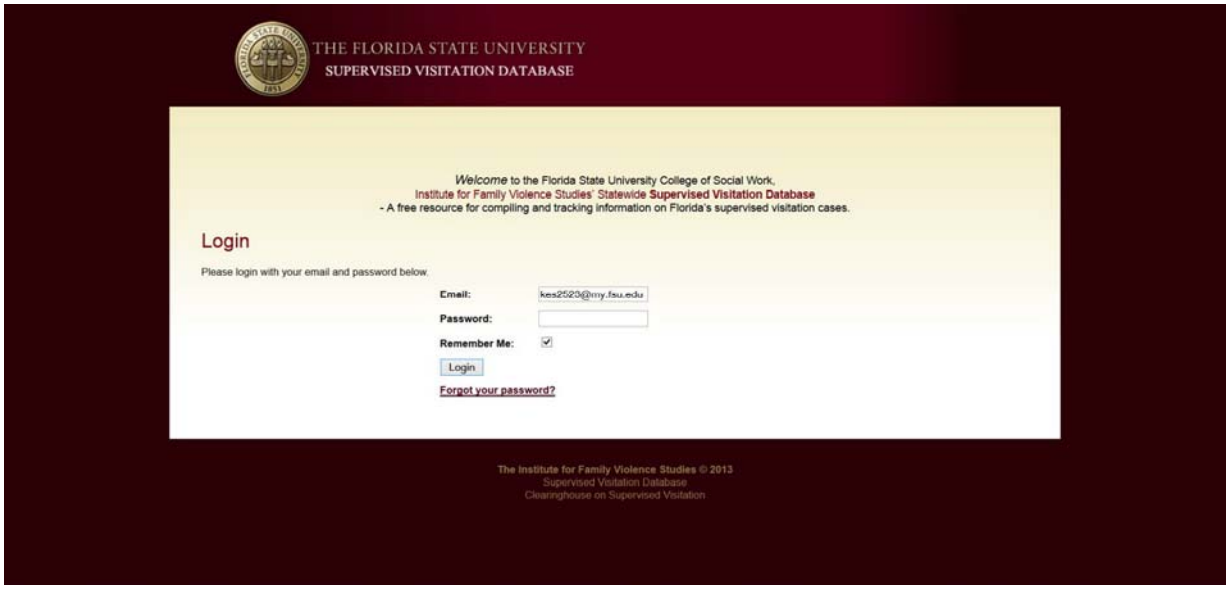
Be sure to highlight to staff the micro-goals so that they see positive outcomes, no matter how small. That said, it may also be helpful for staff to remember that visits provide important things like safety, a chance for the child to spend time with his or her parent, a chance for the parent to learn new skills, and a way for the court to know that the parent is complying with the court order. Don't forget about these important outcomes of every visit!

The Joys of Reading

Many parents read to their children during visits. The Clearinghouse circulated over 5,000 books to give to visiting parents for their children last year. It might be helpful to remind staff that some parents don't intuitively know how to engage a child in reading. Many parents themselves were not read to as children. Because of this, staff might remind custodial and noncustodial parents of a few tips to create joyful readers. Remember though, there are many "right" ways to read!

1. Read using different voice tones. When parents voice the characters, they can use high pitched or low pitched voices that attract children's attention. ("The little bear squealed: give me back my toy!")
2. Ask the child questions about what's on the page. This can include pointing out aspects of the illustration, asking the child to point to things in the illustration, asking the child questions ("How do you think the bear feels about getting the ball taken away from him?")
3. Talking about the book or the story or the character later, after closing the book. ("You know, I was thinking about that bear we read about, and I wanted the squirrel to tell him that it was OK to feel angry.")
4. Acting out the scenes from a book. (Some children don't sit still very long, and acting out scenes can help them appreciate books and stories.)

The Revised Supervised Visitation Database is almost ready to launch!



All the same useful features you regularly use, but with a faster and more modern interface!

Easier Searching

Faster Reporting

More Capabilities

Coming Soon

You will receive easy login instructions and a beautiful new page-by-page user manual!

(Your new Login will be your e-mail address but your password will stay the same.)

For Parents: Talking to Children and Adolescents about Drug Use

Ember Urbach, MSW

Introduction

It can be difficult to talk to children and adolescents about drug use. However, studies show that children who are properly informed about drug use and the risks involved are less likely to experiment with drugs. Parents who are educated about drugs can talk to children about the risks before a child is ever in a situation to use drugs.

The old saying "just say no" does not provide adolescents and children with the reasons why they should not use drugs, the safety concerns with drug use, or the legal consequences of drug use. So instead of just saying no, consider the information below before talking about drug use.

Objectives:

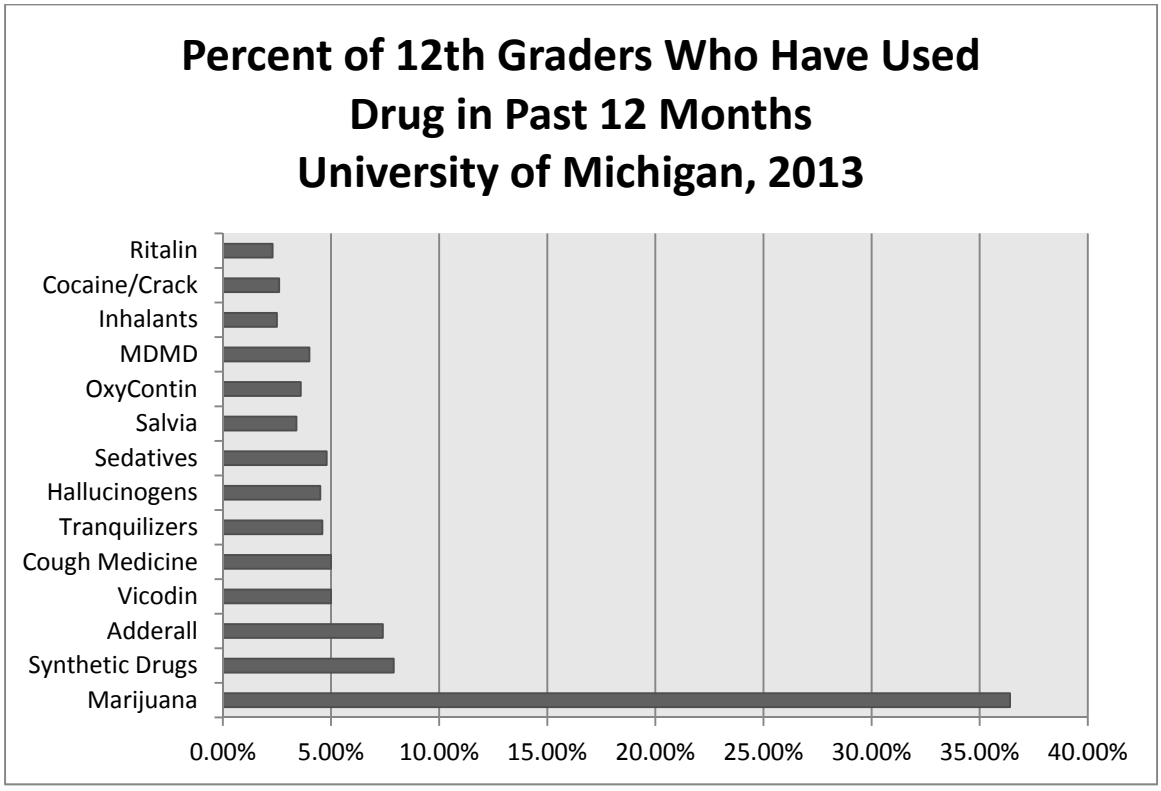
After completing this training, parents, caregivers, and social service workers will:

- Be aware of statistics regarding adolescent drug use
- Understand the physical and criminal risks of drug use
- Understand how to talk to children about the risks of drugs in an age-appropriate manner
- Be aware of community and national resources on drug use risk, talking to children about drug risks, and recovery options for adults and adolescents.

Statistics

- Children who learn about the risk of alcohol or drugs from parents/caregivers are:
  - 36% less likely to use marijuana
  - 50% less likely to use inhalants
  - 56% less likely to use cocaine
  - 65% less likely to use LSD
- 90% of Americans who meet the medical criteria for addiction started smoking, drinking, or using other drugs before age 18.

- 25% of Americans who use drugs before age 18 become addicted.
- Drug use among teenagers remains high, and has risen since the mid-2000s.
- New synthetic drugs are on the rise, but adolescent use is not. However, the risks associated with "synthetic marijuana" are often underestimated; they are much more dangerous than marijuana.
- Prescription drug use and over-the-counter medicine use makes up a large part of adolescent drug use.



How to Talk about Drug Use

How you talk to your child about drug use depends on his/her age and level of understanding. Review the following chart for tips on how to talk about drug use with your child. These conversations should happen early and often to reinforce facts and ideas and to let your child know he/she can ask you about drugs in a judgment free zone.

Age	How to Start the Conversation	Physical Risks	Legal/Social Risks
4-7	Find moments to start the conversation, like when giving the child medicine for a cold, or at the doctor. Talk to your child about how he/she should only take medicine that you, a specific caregiver, or a doctor provides, and never take medicine from a stranger, a friend, or other adults.	Let your child know that taking medicine he/she is not supposed to take can make him/her really sick. If your child is mature enough, explain that it can even cause death.	Focus on building trust between you and the child, and make sure he/she knows he/she needs to ask you to take any medicine from anyone other than you or a doctor.
8 – 12	Begin a conversation by asking your child what he/she thinks or knows about drugs. Ask questions in an open, non-judgmental way to get an honest response from your child. You do not want your child to think he/she is in trouble. Use examples in the news to help introduce the topic.	Talk to your child about specific drug names. Let them know drugs can cause addition, illness, and/or death. Ask your child if he/she has any questions.	Discuss how some people may think drugs are safe, but that drugs are not safe in any amount. Explain to your child that using drugs is against the law.
13-18	At this age, children are more likely to be exposed to drug use within their peer group. Talk to your child about specific scenarios, asking "what would you do?" Provide your child with ways he/she can leave an uncomfortable situation and say no to using drugs.	Talk to your child about specific drug names. Let him/her know drugs can cause addition, illness, and/or death. Ask your child if he/she has any questions.	Talk about how drug use can affect your child's ability to think, learn, go to college, drive, and live. Discuss your child's goals and how drug use will impede his/her goals.

What Would You Do?

The following scenarios can be shared between a parent/caregiver and child to facilitate a conversation about drug use and how to say no.

Age	Scenario	Answers
4 – 7	"What would you do if a teacher gave you pills at school?"	Call a parent/caregiver to ask permission before taking the pill.
	"What would you do if grandma gave you medicine?"	Discuss with your child if this person is allowed to give him/her medicine.
8-12	"What would you do if you saw drugs near you?"	Find a parent/caregiver or teacher and let him/her know
	"What would you do if a friend said he/she knew where to find drugs?"	Say drugs are not safe and that he/she should leave them alone.
13-18	"What would you do if you were at a party where people were doing drugs?"	Safely leave the room and do not use the drugs.
	"What would you do if a friend offered you drugs?"	Say that you do not use drugs and safely leave the situation.

References

http://www.drugabuse.gov/publications/drugfacts/high-school-youth-trends

http://www.casacolumbia.org/addiction-research/reports/adolescent-substance-use

http://www.hanleycenter.org/substance-abuse-prevention/substance-abuse-resources

Resources

Talking to Your Kids about Drugs:
http://kidshealth.org/parent/positive/talk/talk_about_drugs.html

Dealing with Peer Pressure:
http://kidshealth.org/kid/feeling/friend/peer_pressure.html?tracking=K_RelatedArticle

Teens and Drugs:
http://www.aacap.org/App_Themes/AACAP/docs/facts_for_families/03_teens_alcohol_and_other_drugs.pdf

Talking to Your Child about Drug Use

Ages Four to Seven Years

Parents who are educated about drugs can talk to children about the risks of drug use before a child is ever in a situation to use drugs. This helps protect children.

Start the Conversation

Find moments to start the conversation, like when giving the child medicine for a cold, or at the doctor. Talk to your child about how he/she should only take medicine that you, a specific caregiver, or a doctor provides, and never take medicine from a stranger, a friend, or other adults.

Explaining Physical Risks

Let your child know that taking medicine he/she is not supposed to take can make him/her sick. If your child is mature enough, explain that it can even cause death.

Focusing on Trust

Focus on building trust between you and the child, and make sure he/she knows permission is necessary before taking any medicine from anyone else besides you, other parent/caregivers(s), or a doctor. Establish a list of "safe" people your child can receive medicine from.

What Would You Do?

Ask your child "What Would You Do?" questions to encourage conversation about safety and drug use.

"What would you do if you found a pill at school?"

Tell the teacher or teacher's assistant.

Talking to Your Child about Drug Use

Ages Eight to Twelve Years

Parents who are educated about drugs can talk to children about the risks of drug use before a child is ever in a situation to use drugs. This helps protect children.

Start the Conversation

Begin a conversation by asking your child what he/she thinks or knows about drugs. Ask questions in an open, non-judgmental way to get an honest response from your child. You do not want your child to think he/she is in trouble. Use examples in the news to help introduce the topic

Explaining Physical Risks

Talk to your child about specific drug names. Let them know drugs can cause addition, illness, and/or death. Ask your child if he/she has any questions.

Focusing on Safety and Trust

Discuss how some people may think drugs are safe, but that drugs are not safe in any amount. Explain to your child drug laws and rules at school.. Continue to focus on creating a trusting, opening environment to talk about drugs.

What Would You Do?

Ask your child "What Would You Do?" questions to encourage conversation about safety and drug use.

"What would you do if you saw drugs near you?"

Find a parent/caregiver or teacher and let him/her know

"What would you do if a friend said he/she knew where to find drugs?"

Say drugs are not safe and that he/she should leave them alone, and notify an adult.

Talking to Your Child about Drug Use

Ages Thirteen to Eighteen Years

Parents who are educated about drugs can talk to children about the risks of drug use before a child is ever in a situation to use drugs. This helps protect children.

Start the Conversation

At this age, children are more likely to be exposed to drug use within their peer group. Talk to your child about specific scenarios, asking "what would you do?" Provide your child with ways he/she can leave an uncomfortable situation and say no to using drugs.

Explaining Physical Risks

Talk to your child about specific drug names. Let them know drugs can cause addition, illness, and/or death. Ask your child if he/she has any questions.

Focusing on Consequences and Safety

Talk about how drug use can affect your child's ability to think, learn, go to college, drive, and live. Discuss your child's goals and how drug use will impede his/her goals.

What Would You Do?

Ask your child "What Would You Do?" questions to encourage conversation about safety and drug use.

"What would you do if you were at a party where people were doing drugs?"

Safely leave the room and do not use the drugs.

"What would you do if a friend offered you drugs?"

Say that you do not use drugs and safely leave the situation. Discuss ways to firmly state that you will not use drugs.

How Trauma Affects a Child's Brain

By: Sally Petterson

Introduction

There is a myth that very young children are completely resilient in the face of trauma and that they have an easier time overcoming difficulties. Unfortunately, there is scientific proof that because children's brains are still developing, abuse, neglect, and other forms of trauma can actually alter connections in the brain, affecting how they will function later in life.

Some neurological effects of trauma include learning delays, regression, disconnection, hyper-vigilance, lack of impulse control, difficulty reasoning, depression, and hyper-arousal.

Objectives

What you will learn in this training:

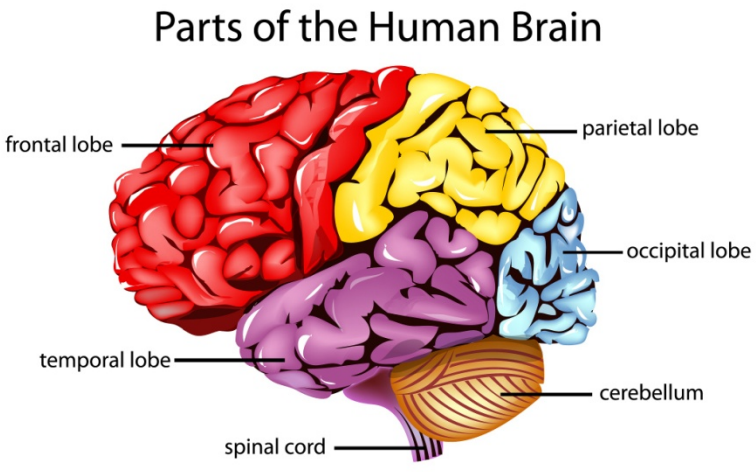
- How the brain develops
- How trauma affects a child's developing brain
- Later behaviors of adolescents who have been affected by trauma
- How to address and treat trauma

Brain Development

Early childhood trauma refers to children who have experienced a traumatic event between the ages of 0 to 6. They may not be able to verbalize how they feel about it, but even if they seem alright at first, without therapy or support systems, effects of the trauma will eventually show up as they continue aging.

The development of the brain and all five senses begins before birth and continues until around age 25. The development of the brain begins in the womb and moves very generally from the back to the front, and from the most primitive functions (the fight or flight response) to the more complex functions.

The brain stem (spinal cord) develops first, and controls the most basic functions such as breathing and heart rate. Next is the **cerebellum**, which controls balance and coordination. This part of the brain triples in size during the first year of life, when babies begin to sit up and crawl. The **cerebrum** is the next part of the brain to develop, and is the largest portion



of the brain. In fact, when one thinks of the brain, what they're usually picturing is the cerebrum (everything above the spinal cord and cerebellum). The cerebrum is involved in memory and learning. The outside layer of the cerebrum can be divided into four areas and continue developing in order: the **occipital lobes** control vision, the **parietal lobes** deal with body sensations such as pain or feeling heat or cold, the **temporal lobes** control language, hearing, and social skills, and the **frontal lobes,** which are the last area to develop, are involved in memory, abstract thinking, and impulse-control. The frontal lobes are still developing as a child moves through puberty into adolescence. In fact, most people would agree that teenagers have difficulty thinking before acting, planning, and controlling themselves.

Trauma's Effect on the Brain

The first three years of a child's life are the most sensitive to both positive and negative outside influences. There are specific periods when certain developments occur, which if interrupted by trauma, can impair later development and behavior. The brain develops as a chain reaction: if one connection is not made, it affects everything else that is supposed to come after it. The development of each part is dependent on receiving specific stimulation. Without making the connections on one level, the brain cannot just skip it and move on. For example, if a child does not develop attachment to a parental figure when they're young, they will have trouble trusting others later on and other developmental issues will develop. To stimulate the areas of the brain involved in language development to organize and develop, babies must be spoken to. If they do not have enough human interaction and attention, those connections disappear.

Our brain creates these connections based upon our surroundings, processing the nonstop stimulation we encounter in the womb, after birth, and for every single day after that. These patterns are embedded in our brain, and we learn to respond to our surroundings by what we

have previously encountered. If, as a baby, we find that people smile at us when we smile at them, our brains learn that this is a good way to respond to people. However, if we are abused, our brain internalizes that as well, and these experiences unconsciously shape how we interact later in life.

Some of these later effects may be delays in learning, lack of social skills, bed-wetting, difficulty adapting to new people and settings, hyper-vigilance (constantly scanning surrounding for safety), dissociation/detachment, hyper-arousal (when the fight or flight response is triggered due to loud noises or other unexpected situations, even if there is no threat of harm), depression, anger, lack of coping skills, shame, low self-esteem, risky behaviors, and drug or alcohol use.

Implications for Social Service Providers

Implications

The children you work with as a social service provider have all been through some type of trauma. In order to lessen the effects of this trauma, here are some ways to help parents and other guardians address and treat the trauma and help establish further brain development:

- Help the parent/caregiver form attachment bonds with the child through touch, interaction, play, and by comforting them. All of these should be displayed in appropriate contexts that are sensitive to their trauma.
    - For example, if a child has experienced sexual abuse, the caregiver needs to be aware of how they interact physically with the child, ensuring that they do not force a child to show affection, as this reminds them of the power context of their abuse. The caregiver needs to give the child a sense of control over their lives so they can develop autonomy.
    - If the child goes to them for a hug, they should hug them back, but never force contact.
- Teach the caregiver to identify the child's cues for eating, attention, sleeping, etc, especially if the child has difficulty communicating.
- Identify concrete supports and resources for the caregiver.

- Make sure the caregiver is consistent in their routine, discipline consequences, meal times and bed times. A child who has experienced trauma has known chaos and have little sense of continuity and order in their life. This makes it very difficult for them to feel secure or to trust anyone. A routine helps the child feel secure knowing that the same thing will happen at the same time every day or that the same consequences will be given for certain actions.
- Teach the caregiver not to shy away from talking about the trauma if the child brings it up. The child needs to process what happened to them, and may do it through talking, drawing, playing, or role-playing. Talking about the trauma does not need to be initiated by the caregiver, but they should not avoid it if the child wants to share.

Case Scenarios

Casey is a 7 year old girl attending supervised visitations with her mother. When she was 4, she witnessed her father get shot in a drive-by incident. At the time of the shooting, Casey's mother was abusing drugs and did not live with the family, only seeing Casey every few months. Recently, her mother has undergone rehab and is now sober, and wants to re-establish a relationship with Casey. During these visitations, her mother gets very frustrated at Casey's "day-dreaming" and unresponsiveness. As a skilled practitioner, you recognize that Casey is displaying dissociative symptoms. When her mother comes to you with her concerns, you give a short explanation of how the brain develops, and tell her that the trauma of seeing her father shot affected connections in her brain, which now cause her to stare off into space and not interact when her mother brings up the past, probably because it reminds her of her father. You explain how just playing with Casey might be a good way for her to communicate her feelings without having to talk, and also suggest comforting her and hugging her when she is open to it, to help establish more connected and attached feelings with her mother.

Resources

- *The Boy Who Was Raised as a Dog* by Dr. Bruce Perry and Maia Szalavitz. This is an interesting and informative book regarding the brain development of traumatized children through real-life case studies.
- An Intro to the Impact of Trauma- http://www.childtraumaacademy.com/surviving_childhood/. This is a great resource for supervised visitation practitioners to expand their knowledge on the effects of trauma in young children. It is

designed as a simple course, with short quizzes to gauge understanding of the material.

References

- Effects of Complex Trauma- http://www.nctsn.org/trauma-types/complex-trauma/effects-of-complex-trauma
- Baby's Brain- http://www.urbanchildinstitute.org/why-0-3/baby-and-brain
- Understanding Brain Development After Trauma- https://www.childwelfare.gov/pubs/braindevtrauma.pdf
- Understanding the Affects of Maltreatment- https://www.childwelfare.gov/pubs/issue_briefs/brain_development/how.cfm
- Brain Development in Adolescents- http://hrweb.mit.edu/worklife/youngadult/brain.html
- Baby's Milestone Chart- http://www.babycenter.com/milestone-charts-birth-to-age-3

Where's Your Focus?
Using Goal Setting to Improve Parenting

By: Sally Petterson

Introduction

Why is goal setting useful in teaching parents to successfully parent a child? Telling a parent who has low parenting skills that he or she can only have supervised visitation but must be a good parent during visits is sometimes like handing keys to a person who has never learned to drive and asking them to get in a car and go run errands. One must first show them the keys and how they turn in the ignition, explain each of the knobs and switches, describe safe driving practices, and perhaps most importantly, teach them how to drive by *showing* them. In a similar sense, social service providers are in a unique position to display appropriate behavior and reactions for a parent to learn from.

So what does it mean to be a good parent? By breaking this general statement into smaller, more definable pieces, a parent can begin to uncover areas that they can work on to be

more successful in their relationship with their child. These pieces can be addressed through the use of goals.

Objectives

This training will teach:

- What goal setting is and how to set good goals
- How to set goals that will help a parent learn new parenting skills
- Why setting goals as parents is important not only for the parent but for the child

How to Set Realistic Goals

Setting goals is a great way to motivate oneself to accomplish things in life. Many studies have shown that simply writing down a goal makes it more likely that a person will accomplish it. Organizing a vision into a goal that will give a person a greater chance of attaining it can be done by making sure goals follow the SMART acronym:

- **Specific** – Be detailed about what it is that needs to be accomplished. No generalizing!
- **Measurable** – There should be no doubt about whether the goal is reached or not.
- **Actionable** – When writing goals, use action words such as 'practice', 'quit', 'finish', instead of 'be', 'am', 'have'.
- **Realistic** – A goal should stretch a person just outside of their comfort zone, but it should not be unreachable. For example, it might be unrealistic to say "Be president of the Parent-Teacher Association (PTA)" if a parent works during the day and is unable to make it to meetings, but the goal could be rephrased to "Contribute to the PTA by baking cookies for their fundraising bake sale on September 12th".
- **Time-bound** – Every goal needs a date to be completed by, otherwise it is just a dream. By setting a time limit, a person is motivated to accomplish the goal before the time is up.

Using this acronym to structure goals helps to ensure that they will be met. For example, instead of the very general goal of "Find vocational training," the goal could be made much more specific by saying "Find a training program for my beautician certification by March 1st".

Goals should also be stated positively, rather than negatively. For example, instead of saying "Don't get frustrated with my child when they don't listen to me," a parent could say "Find 3 successful ways of

communicating with children" or "Practice patience with my child when they are not focused on me by calmly redirecting their attention."

How Do We Apply These Goal Setting Skills to Parenting?

There are many specific skills necessary to be successful at parenting. These might include flexibility, consistency and stability, nurturing, accepting responsibility for one's actions, and dealing with stress.

There is no single 'right' way to parent. But these skills will get a client involved in supervised visitations and in raising children to be successful adults.

So how can goals be created to focus on these parenting skills in a way that will be most beneficial? By breaking down general goals, they can be rephrased to be more specific and realistic:

- "Be reliable by spending time with my child"
    - To make this goal even more specific and tangible, it could be restated to, **"Be reliable by showing up to on time to the next 4 visitation appointments we have."** This assigns a number to the goal so it can be determined whether it was accomplished it or not. As these smaller goals are reached, more lengthy goals can be added to them (for example, "showing up on time to every visitation appointment for the next 2 months").
- "Be patient every time my child throws a tantrum"
    - This goal is too vague. A goal needs to have a specific action, as well as a time frame for the goal so it can be determined whether it is accomplished. For this goal, it can be made better by saying, **"Acknowledge my child's feelings the next time she has a temper tantrum and calmly explain why she cannot have the toy/candy/etc."**
- "Be loving toward my child"

- Again, setting a number of specific actions and a time frame is very important for completing a goal. This goal can be rephrased to, **"Hug my child 3 times throughout the next session and tell them I love them."**

- "Keep my temper in check when someone asks about my family/work"
  - There are several things about this statement that could be improved. It is too general, it is negatively stated, and it has no time frame or actions that need to be taken in order to reach the goal. To make this better, say **"Count to five to calm myself before speaking, the next time someone asks me about work (or other things I find stressful)"** or **"Look up 2 coping skills this weekend so that I can apply them during my supervised visits."**

Implications for Social Service Providers

Why Goal Setting is Important for Your Clients

As supervised visitation staff, we care most about the child's well-being. By being proactive about displaying appropriate discipline skills while supervising a visit, you are helping the parent to learn more successful ways of handling situations that they may have never been exposed to. Assisting a parent in learning parenting skills benefits the child in the long run, and a well-loved, safe, happy child will grow up to be a secure, compassionate, successful adult. We need more of those in the world!

Goal setting is a great tool to expose your clients to so they can set goals to improve their parenting skills. This can make their visitations and relationships with their children more successful. By learning to set goals themselves, your clients can eventually teach their children to learn to set goals as well, so they can grow up with attainable goals, self-discipline, and a feeling of accomplishment.

Case Scenarios

Heidi, the mother of Paul and Sara, comes to supervised visitation regularly to visit her children. After one visit, Heidi approaches you and tells you she is frustrated by her reactions to some of the things her children do, and asks you for advice. You ask if she has ten minutes, and when she responds that she does, you take her to your office and give a brief description of how to set goals. You then help her start to brainstorm some ways she can parent Paul and Sara better.

Her list includes:

1) Show Paul and Sara how much I love them.

2) Bring fun things to do with them when I visit.
3) Discipline them without feeling overwhelmed.

While these goals are good and meaningful, you notice that they can be made better by making them more attainable and specific. You tell Heidi about the SMART acronym of goal setting, and help her to rewrite these three goals so she will be able to know without a doubt when she has met them and can check them off her list.

Her new list says:

1) Show Paul and Sara how much I love them by complimenting each of them specifically, saying, "I like how you _____ when you _____."
2) Plan an activity for the next 3 visits that I can do with Paul and Sara. For the first visit, I will bring one of the books I had when I was a child to read to them. On the second visit, I will bring crayons to color with them. For the third visit, I will ask them to choose a puzzle that we can complete together.
3) (this goal we might want to break up into several smaller goals that can be more easily worked on)
    a. Take two deep breaths before I begin to speak the next time Sara or Paul frustrate me.
    b. Speak calmly during the visit so that Sara and Paul feel safe in my presence. Take deep breaths frequently to alleviate stress.
    c. Be consistent in my positive behaviors so that they learn that they can trust me.
    d. Ask for forgiveness the next time I lose my temper, even if I feel like they were misbehaving. Talk to them about how they want me to handle situations when they misbehave to promote positive communication between us.

These new goals are more expanded, but they are also more tangible, and therefore easier to see progress being made. Heidi feels less overwhelmed after having written everything down and finding specific ways to improve her interactions with her children. She resolves to work on two of these points during the next visit so that she is not overwhelmed by the goals, but can focus on them a few at a time. You make sure to touch base with her the next time she comes to visit so you both can reassess her goals and make changes or add more as needed.

Resources

The Beginner's Guide to Goal Setting- http://michaelhyatt.com/goal-setting.html.

Setting Goals, with examples- http://www.wikihow.com/Set-Goals

A List of Good Parenting Skills- http://www.livestrong.com/article/101740-good-parenting-skills-list/

Tips for Disciplining- http://childdevelopmentinfo.com/how-to-be-a-parent/parenting

Positive Parenting Tips- http://www.enjoysimpleliving.com/positive-parenting-tips.html

List of Encouraging Words to Say to Your Children- http://www.enjoysimpleliving.com/encouraging-words.html

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- Guide to Goal Setting- http://michaelhyatt.com/goal-setting.html.
- Written Goals- http://topachievement.com/goalsetting.html
- Setting Goals- http://www.wikihow.com/Set-Goals
- Teaching Parenting Skills article- http://onlinelibrary.wiley.com/doi/10.1046/j..1983.00626.x/pdf
- Taking Risks and Making Goals- http://www.carolinemiller.com/five-things-that-will-improve-your-life-in-2013/
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Early Head Start Mothers and Maternal Depression

By Cristina Batista

A federal report found that more than half of mothers whose children are in the Early Head Start program deal with some form of depression. It has also been found that in these cases, both the mother and child are faced with negative risks due to the illness. Because of this, Ferol Mennen, an associate professor at the USC School of Social Work in California, is determined to develop an intervention for this target population. It is her hope that through the intervention that provides therapy for mothers, positive effect will also be seen in the child daily life.

"When mothers are depressed, their children do less well in school, and they are more likely to have trouble with aggression. It affects their friendships, and it affects their relationships with teachers." Todd Sosna

It is important for child welfare providers to take in the state of mothers when looking to help children.

Early Head Start Program

What is Early Head Start?

The reauthorization of the Head Start Act in 1994 made it possible to establish Early Head Start as a program to serve infants and toddlers under the age of 3, and pregnant women.

Early Head Start provides early, continuous, intensive, and comprehensive child development and family support services to low-income infants and toddlers and their families, and pregnant women and their families.

The Goals of Early Head Start

- To provide safe and developmentally enriching caregiving which promotes the physical, cognitive, social and emotional development of infants and toddlers, and prepares them for future growth and development;
- To support parents, both mothers and fathers, in their role as primary caregivers and teachers of their children, and families in meeting personal goals and achieving self-sufficiency across a wide variety of domains;
- To mobilize communities to provide the resources and environment necessary to ensure a comprehensive, integrated array of services and support for families;
- To ensure the provision of high quality responsive services to family through the development of trained, and caring staff.

Maternal Depression

As many as one in four mothers will suffer from this biological illness at some point in her lifetime, including about 10 percent of new mothers who develop postpartum depression (PPD).

A majority of new mothers experience at least some symptoms of depression, but prolonged and severe symptoms of depression, also known as Postpartum Depression, can lead to many problems for both mother and child.

Symptoms of Depression in mothers include:

- Lack of interest in your baby
- Negative feelings towards your baby
- Worrying about hurting your baby
- Lack of concern for yourself
- Having trouble focusing or making decisions
- Lack of energy and motivation
- Feelings of worthlessness and guilt
- Changes in appetite or weight
- Sleeping more or less than usual
- Recurrent thoughts of death or suicide
- Withdrawing from friends and family
- Loss of interest or pleasure in activities you used to enjoy

Mothers struggling with depression may find it hard to respond to their baby with happiness or joyful expression. When depressed, a mother may unintentionally find herself feeling distracted or out of it and neglecting the baby's needs. The baby might lack appropriate supervision or environmental stimulation.

Unfortunately, it is common for a mother to feel ashamed or guilty when she is experiencing signs of depression. Instead of getting treatment, like any physical illness or ailment needs, she may see it as a sign of weakness or failure. As a mother, they may indulge in destructive thoughts about herself and her abilities. This may cause her to suffer in silence instead of talking to someone and seeking help, which as many as 2/3rds of all depressed women do. Even a mother who recognizes her symptoms can often assume that she's just stressed and will eventually snap out of it. She might even try to tough it out on her own, for fear of being considered weak or crazy.

Certain factors may increase a mother's risk of depression during and after pregnancy:

- A personal or family history of depression or another mental illness
- A lack of support from family and friends
- Anxiety or negative feelings about the pregnancy
- Problems with a previous pregnancy or birth
- Marriage or money problems

- Stressful life events
- Young age
- Substance abuse

Women who are depressed during pregnancy have a greater risk of depression after giving birth.

Risks Associated with Depression in Mothers

For Mother:

- heart disease
- chronic pain
- interrupted relationships with family and friends
- irritability
- difficulty handling family issues
- increased difficulty with parenting
- emotional insensitivity

For Child:

- language delay
- slower brain development
- more difficult temperament
- externalized disorders of aggression
- internalized disorders or withdrawal, anxiety, and passivity
- behavior problems or acting out
- increased risk for depression
- social withdrawal

A Recent Intervention Study

Under the direction of Ferol Mennen, an intervention has been developed in California hopes to provide aid to mothers with depression, and takes the form of interpersonal therapy for groups (IPT-G).

These groups will last 16-20 weeks, and will provide dinner and child care to encourage regular participation by mothers. For the intervention to be successful, it needs to be accessible, convenient and engaging.

The participants in the group therapy engage in group discussions intended to help them understand and change their relationships with partners, children, family members, co-workers and friends. In order to enhance social communication and problem solving skills, role playing exercises will be employed.

If the intervention is effective at both reducing maternal depression and lessening negative effects on child development and behavior, the researchers hope to educate other Head Start and early childhood education providers.

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The Impact of Psychotropic Medications on Supervised Visitation

Abby Novak

As of 2010, 25% of women, 15% of men, and 6% of children were taking at least one psychotropic medication used to treat mental illness. Many of these men, women and children will likely experience some sort of side effect from their medications. As a supervised visitation monitor, you should be conscious of the potential side effects of psychotropic medicine before assuming parents or children are disengaged and disinterested. Further, you should make an effort (if appropriate) to help children and parents overcome side effects and benefit from their time together.

What are the most common mental health diagnoses I'll see in visitation sessions?

The National Institute of Mental Health names some of the most common mental health disorders as:

- Schizophrenia
- Depression
- Bipolar Disorders
- Anxiety Disorders
- ADHD

Additional mental health diagnoses you may see in supervised visitation include mood disorders, panic disorders, and many other disorders not covered above. **It is important to recognize a mental health diagnosis does not necessarily impact a parent or child's ability to interact during supervised visitation.** You many never know a parent or child has a mental health disorder, and it may never present itself while you're with the family.

What are the most common side effects of psychotropic medications?

While medication may interact differently with different people, there are common side effects associated with different types of psychotropic medicine. For example, antipsychotic medications, used to treat schizophrenia, may cause:

- Drowsiness
- Dizziness
- Skin rashes
- Rapid heartbeat

Medication used to treat depression and depressive disorders may cause:

- Sleepiness or drowsiness
- Nausea
- Headaches
- Agitation
- Problems with the bladder

Mood stabilizers, medications used to treat Bipolar disorder and other mood disorders, may come with their own set of side effects, including:

- Seizures
- Blackouts
- Hallucinations
- Itching
- Frequent thirst/urination

Anxiety disorders are often treated with antidepressant medications and have similar side effects, including:

- Drowsiness
- Dizziness
- Confusion
- Headache
- Feelings of excitement
- Feelings of nervousness

Medication used to treat ADHD in children and adults can cause a change in eating patterns and difficulty sleeping.

How could these side effects impact supervised visitation?

Both parents and children taking psychotropic medication may experience no side effects inside or outside of supervised visitation. They may function in a healthy, appropriate way because of their medication. Unfortunately, not all people taking psychotropic medication tolerate the medicine in this way, and some experience side effects like those mentioned above. In supervised visitation, children may appear sleepy or disengaged; they may be very cranky and resistant to any activity. Children may also come across as dull, like they are not fully present mentally or physically. This may make the visit seem both difficult and unproductive.

Parents may have similar side effects. They may appear drowsy or fall asleep, may seem to be under the influence of a substance, or may be particularly agitated. They may attempt to play with their children and lose interest or focus quickly. Because it is easy to dismiss these parents as “bad parents,” it is important to remember that parents may be doing the best they physically can, given the side effects of their medication. Being tolerant of minor mishaps related to a mental health diagnosis is an important part of maintaining a safe, accepting visitation environment.

While it is important to recognize a parent may be doing their best**, it is also important to acknowledge when a side effect may make a situation unsafe for a child and/or parent and discuss this with your supervisor.**

For example, a mother may fall asleep frequently as a side effect from her antidepressant medication. If the mother's child is an eight month old, crawling baby, this may not be safe for the child, and the mother may need to adjust the time she takes her medicine, after talking with her doctor.

Similarly, a father with Bipolar disorder may experience frequent seizures and blackouts as a side effect of his medication. If the father has a small toddler, he may accidentally injure the toddler during a seizure or be unable to supervise the child during a blackout. In order to make the relationship safer for both the child and the father, the doctor may need to help with the medication.

Conclusion

As a supervised visitation monitor, understanding the side effects of psychotropic medications can help you better relate to parents and children in your center. Though empathy is essential, you must also be sure to monitor side effects closely and consult your supervisor if you feel a medication's side effect is placing parents or children in an unsafe situation.

For more information, see the resources below:

http://jmh.sagepub.com/content/8/1/82.full.pdf+html

http://pediatrics.aappublications.org/content/132/4/615.full.pdf+html

http://www.sciencedirect.com/science/article/pii/S0891422210001198#

http://www.nimh.nih.gov/health/publications/mental-health-medications/nimh-mental-health-medications.pdf

http://apd.myflorida.com/training/docs/common-side-effects-of-psychotropic-medications.pdf

http://apps.who.int/medicinedocs/documents/s19032en/s19032en.pdf

Substance Abuse in the Workplace

By Carly Starkey

Introduction

Substance abuse affects many people in the United States. Sixty percent of the world's illegal drugs are consumed by American drug users. This consists of two million Americans who use heroin, six million who use cocaine, and eighteen million who have alcohol abuse problems. With such widespread use, many people will encounter substance abuse in the workplace. Seventy percent of the estimated 14.8 million Americans who use illegal drugs are employed. This shows just how large of a problem substance abuse is in the workplace. It is important for supervised visitation workers to be aware of the potential for alcohol abuse in themselves and coworkers. This awareness will help keep the agency, the families, and the workers themselves safe.

Objectives

This training will:

- Show the prevalence of substance abuse in the United States and in the workplace
- Educate about some factors associated with substance abuse
- Inform about the ethical concerns of substance abuse, especially in the workplace
- Identify warning signs for substance abuse in the workplace
- Identify warning signs for substance abuse in oneself
- Provide case examples
- Provide resources about substance abuse

Causes of Substance Abuse

Substance use and abuse are extremely complicated concepts. Some people can use drugs and alcohol recreationally, without negative life-changing consequences, while others may more easily experience addiction due to many factors.

Some factors that influence addiction are:

- Life circumstances and events
- Family history of addiction
- Abuse, trauma, or neglect in childhood

- Mental disorders
- Early onset of drug use
- Method of use

All of these factors can increase a person's vulnerability to addiction. Recreational substance use can often slowly and gradually turn into substance abuse and addiction. Rarely do people notice when a line is crossed, so it is important to be aware of the red flags in one's own life, as well as the lives of others, that could indicate substance abuse.

Working While Using and Abusing Substances

Some codes of ethics for those in helping professions contain guidance about substance use.

- The Social Work Code of Ethics states that "Social workers who have direct knowledge of a social work colleague's impairment…should consult with that colleague when feasible and assist the colleague in taking remedial action." It also states "Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility."
- The American Mental Health Counselors Association Code of Ethics states that "When mental health counselors have knowledge of the impairment, incompetence, or unethical conduct of a mental health professional, they are obliged to attempt to rectify the situation."

These organizations of helping professionals highlight the importance of not abusing substances and talking to co-workers who may be abusing substances. Supervised visitation workers have an obligation to their profession and their clients to establish good working habits and practice ethical behavior in the workplace.

Warning Signs of Substance Abuse

In the Workplace

It is often difficult to identify substance abuse in the workplace, but there are warning signs that can help to identify the possibility of substance abuse. Never assume a co-worker or employer is engaging in substance abuse, but do keep an eye out for it. Some common signs of substance abuse in the workplace are:

- Smell of alcohol or drugs on breath or clothing
- Slurred or incoherent speech
- Unusual nervousness or loss of memory

- Changes in mood, including irritability, depression, paranoia
- Being withdrawn or more talkative than usual
- Decreased productivity
- Absenteeism and tardiness
- Physical changes, such as bloodshot eyes, dramatic weight gain or loss, lost interest in personal care, etc.
- Safety issues, due to carelessness and engaging in risky behavior

Looking at Oneself

Just as within coworkers, it may be difficult to identify one's own patterns as substance abuse. Some signs that may indicate someone has a problem with substance abuse are:

- Built up drug tolerance
- Taking drugs to relieve withdrawal symptoms
- Abandonment of activities that used to provide enjoyment
- Neglecting responsibilities, such as failing a class, skipping work, or neglecting children due to drug use
- Using drugs under dangerous situations, such as driving on drugs, using dirty needles, or having unprotected sex while on drugs
- Problems in relationships, such as constant fighting, disappointing a boss, or loss of old friends
- Continuing to use drugs even when aware of the negative effects

Using drugs to fulfill a need, such as calming when anxious, energizing when depressed, or increasing confidence in social situations, is a common sign of substance abuse. A person should identify healthy solutions to these issues in order to replace the substance use. For instance, instead of using a substance to feel calm, one can go for a walk, read a book, or practice yoga. Finding alternative solutions can help a person meet his or her needs in a healthier manner.

Case Examples

Case Study #1: A supervised visitation worker notices her coworker Jill has been coming into work late frequently. At first the worker thinks Jill is just feeling added stress from a recent break-up, but then the worker starts to smell alcohol on her breath and clothes. Again, the worker doesn't want to assume anything and hopes Jill is just

re-wearing clothes from the night before. But when Jill starts to become irritable easily and starts to skip work often, the worker realizes this may indicate a larger problem. The worker talks to Jill about her concerns and Jill tells the worker not to worry. However, Jill's problematic behavior continues. The worker reports Jill's strange behavior to a supervisor and the supervisor says that she has also been worried about Jill's behavior. She handles the situation from here on out and Jill ends up enrolling in a program that helps with substance abuse issues.

What were some beneficial things this worker did in this example?

The worker took notice of the odd behavior. She initially became concerned and monitored Jill's behavior. Once she thought that Jill's behavior was not just from stress, the worker talked to Jill. When Jill still did not change, the worker went to her supervisor to talk about Jill's problematic behavior. In the end, Jill was able to get the help that she needed.

Case Study #2: John is a supervised visitation worker. John has recently gone through a divorce and started a new job, so he is experiencing a lot of stress. A friend who also recently became divorced uses Adderall to stay focused at work and to take care of her four children, while still having energy to go out and date. John's son also has an Adderall prescription for his ADHD and one day John decide to try this drug before work. He is unsure at first, but John is able to speed through his paperwork and even receives a compliment on his productivity. John starts to take Adderall every day before work and even before events on the weekends when he is tired. At first, John is happy with this lifestyle, but soon he is unable to sleep at night and he notices that he is becoming easily stressed out at little changes or situations at work. John also starts to lose weight. A friend at work comes to John and says she is concerned about him and his recent behavior. John tries to forget this encounter, but it sticks with him. A few weeks later, John's supervisor calls him into his office and states that he is worried about John's job performance. John leaves his office and decides to go see a counselor for treatment.

What were some problems you saw in this example?

John adopted drug use as a way of coping with the stress in his life. John begins taking his son's medication for his own use. This problematic pattern led to problems at work and in his relationship with coworkers. John initially rejected the support from the coworker and did not listen when she said she was concerned. The drug abuse continues to affect John's work until he

is confronted by a supervisor. After this confrontation, however, John makes a good choice to get help.

Resources

Help is out there. Here are some resources available to individuals worried about their substance use and abuse.

For Alcohol Abuse:

- Alcohol and Drug Abuse Hotline 1-800-821-4357
- Alcohol 24-hour Helpline 1-800-252-6465
- Alcoholism & Drug Treatment Addiction Center 1-800-383-4673
- Alcoholics Anonymous (AA) Hotline 305-371-7784

For Substance Abuse:

- Florida Department of Children and Families Adult Substance Abuse 305-377-5606
- Narcotics Anonymous Helpline (North Florida) 305-620-3875 (Support Groups)
- Narcotics Anonymous Helpline (South Florida) 305-265-9555 (Support Groups)
- Center for Substance Abuse Treatment 800-662-HELP

There are also a multitude of informal resources available to you. Try to find some resources that already exist around you. Do you have a network of friends or family concerned about you or willing to be there for you? That is a valuable resource for help and recovery. Seeing a therapist or counselor can also help, as well as seeking out twelve step recovery programs, healthcare providers, and community group members, such as in your faith, school, or work community, that may be willing to aid in helping you overcome this struggle.

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http://everydaylife.globalpost.com/substance-abuse-warning-signs-workplace-38786.html

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