303:
Childhood Mental Health Issues: An Introduction for Child Welfare Professionals

Standard Curriculum

Developed By:
Jeanne Schott, MSW

Revised By:
H. Elizabeth Coyle, D.Ed.

For
The Pennsylvania Child Welfare Resource Center

University of Pittsburgh, School of Social Work Pittsburgh, PA

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The Pennsylvania Child Welfare Resource Center
University of Pittsburgh, School of Social Work
403 E. Winding Hill Road
Mechanicsburg PA, 17055
Phone (717) 795-9048 Fax: (717) 795-8013
www.pacwrc.pitt.edu

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Elizabeth Coyle, Independent Trainer

Kathleen A. Davis, Pennsylvania Child Welfare Resource Center
Eugene Detter, Pennsylvania Child Welfare Resource Center
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Janice Miller, Pennsylvania Child Welfare Resource Center
Jana Hitchcock, Pennsylvania Child Welfare Resource Center
Jody Price, Pennsylvania Child Welfare Resource Center
Christine Reese, Pennsylvania Child Welfare Resource Center
Judith Jhriad-Reich Ph.D., Private Consultant

Kathy Jones Kelley, Pennsylvania Child Welfare Resource Center
Reed Reynolds, Pennsylvania Child Welfare Resource Center
Jeanne Schott, Pennsylvania Child Welfare Resource Center
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Agenda for a Two-Day Workshop on Childhood Mental Health Issues: An Introduction for Child Welfare

Professionals Day One

Estimated Time	Content	Page
35 minutes	Section I: Introduction and the Importance of Child/Adolescent Mental Health Issues to Child Welfare	3
40 minutes	Section II: Perceptions about Child/Adolescent Mental Health Issues	9
1 hour, 45 minutes	Section III: Child/Adolescent Development	14
3 hours	Section IV: Child/Adolescent Mental Health Disorders	23

Day Two

Estimated Time	Content	Page
3 hours	Section IV: Child/Adolescent Mental Health Disorders (Continued)	41
2 hours, 30 minutes	Section V: The Players in the Child/Adolescent Mental Health System of Care	57
30 minutes	Section VI: Conclusions and Evaluations	67

303: Childhood Mental Health Issues: An Introduction for Child Welfare Professionals

Section I: Introduction and the Importance of Child/Adolescent Mental Health Issues to Child Welfare

Estimated Length of Time:

35 minutes

Key Concepts:

- ✓ Child/adolescent mental health issues are prevalent issues that impact the responsibilities of child welfare professionals.
- ✓ Child/adolescent mental health issues can impact child/adolescent's safety, permanency, and well-being.

Method of Presentation:

Lecture, large group discussion

Materials Needed:

- ✓ What's in it for Children and Families (WIIFCF) – Instructor Prepared Flip Chart
- ✓ Markers
- ✓ Name Tents
- ✓ Masking Tape
- ✓ 2 Flip chart pads
- ✓ 2 Flip chart stands
- ✓ Post-it Notes on each table
- ✓ LCD Screen and Projector
- ✓ **Handout #1 (Childhood Mental Health Issues PowerPoint)**
- ✓ **PowerPoint Slide #2 (Agenda Day 1)**
- ✓ **PowerPoint Slide #3 (Agenda Day 2)**
- ✓ **PowerPoint Slides #4-5 (Learning Objectives)**
- ✓ **PowerPoint Slides #6-7 (Child/Adolescent Mental Health in Child Welfare Practice**
- ✓ **PowerPoint Slide #8 (Biopsychosocial Factors)**
- ✓ **PowerPoint Slide #9 (CFSR Outcomes)**

Outline of Presentation:

- Welcome the participants to the training.
- Review the training environment and expectations.
- Review the agenda and learning objectives.
- Review the pre-work.
- Discuss the prevalence of child/adolescent mental health issues as it pertains to Child Welfare practice.
- Explain the purpose of the Resource Book.
- Discuss the importance of the biopsychosocial perspective in assessing risk and safety factors and how they impact child and family functioning.

Section I: Introduction and the Importance of Child/Adolescent Mental Health Issues to Child Welfare

Step #1: (15 minutes) Welcome and Introductions

Arrange seating for four to six participants at each table; three tables is ideal. Prepare the training room byplacing the name tents, markers, and Post-it notes on each table.

> **Instructor Note:** Instructors are to label a flip chart:
> What's in it for Children and Families? (WIIFCF).

Do: Welcome participants to the training. As participants enter the training room, encourage each participant to take a Post-it note from their table and write down how their learning about childhood and adolescent mental health issues helps children and families. Participants should then place the Post-it note on the flip chart entitled "What's in it for Children and Families? (WIIFCF)."

Introduce yourself making sure to include your background and experiences of working in the fields of Mental Health and Child Welfare. If you choose, please share your pronouns during your introduction.

Instruct participants to complete name tents by including:

- Agency Name
- Position at the agency
- How long they've been working in Child Welfare
- If they so choose, their pronouns

> **Instructor Note:** Point out that one of the pre-work assignments was for participants to evaluate the prevalence of child/adolescent mental health issues on their caseload.

Say: Here we offer space for you to share your personal pronouns, if you so desire, because we don't want to make assumptions and cause trauma to anyone. We don't call pronouns preferred, because they are your pronouns, and we respect you and your identity. Some people may not wish to share their personal pronouns or may ask us to use their name, and that is okay too. Please show mutual respect for one another. For more about personal pronouns, check out mypronouns.org.

Do: Please introduce yourself to the larger group, including your:

- Name

- Agency Name
- Position at the Agency
- How long you've worked in child welfare
- Pronouns, if you choose
- How prevalent child/adolescent mental health issues are among the families you work with

Step #2: (2 minutes) Training Environment and Expectations

Say: This training is instructor-led and participant-centered. You possess a great deal of knowledge and have experience working withchildren and families with mental health concerns; therefore, I welcome participant input, experiences, and feedback.

The "15-minute" rule states that participants cannot miss more than 15minutes of the entire training, or they will not receive training credit for the training.

Please remember that lateness can be disruptive to the group, silence cell phones during the training, and limit their use to breaks, lunch, and assigned activities. This time is for the purpose of learning new skills to improve performance back at the office.

Step #3: (3 minutes) Review Training Agenda

Say: This training provides an overview of child/adolescent mental health issues, including the main categories of mental health disorders commonly found in children and adolescents as well as how children and families are impacted by these mental health issues. Child welfare professionals will gain insight about the importance of continuous assessment of risk and safety threats regarding child/adolescent mental health issues in relationship to child/adolescent's development and throughout the caseprocess so you can learn how and when to intervene to ensure a child/adolescent's overall safety, permanency and well-being.

Do: Take this opportunity to review the items posted by participants on the flip chart entitled, **"What's in it for Children and Families (WIIFCF)"**

Display and review **PowerPoint Slides #2-3 (Agenda).**

Step #4: (2 minutes) Review Learning Objectives and Competencies

Do: Display **PowerPoint Slides #4-5 (Learning Objectives)** and discuss the overall learning objectives with the participants. Distribute **Handout #1 (Childhood Mental Health Issues PowerPoint**) and tell participants that they can take notes on this handout as the PowerPoint slides which are reviewed throughout the training.

Say: This training session touches upon many of Pennsylvania's Child Welfare Competencies with special emphasis on Engagement, Assessment, and Teaming.

Step #5: (3 minutes) Review of Pre-Work

> **Instructor Note:** Pre-Work included:
> - Assessment of the prevalence of child/adolescent mental health issues on thetrainee's caseload;
> - Review a mental health evaluation of a child/adolescent; and
> - Review what mental health services are available in your county.

Say: During introductions we talked about the prevalence of child/adolescent mental health issues on your caseloads, across job titles and agencies. Assessment and treatment of child/adolescent mental health issues is important throughout all phases of the casework process.

Step #6: (10 minutes) Why Child/Adolescent Mental Health is Important to Child Welfare Practice?

Do: Display and review **PowerPoint Slides #6-7 (Child/Adolescent Mental Health in Child Welfare Practice).**

Say: In the U.S. one in five children ages 3-17 experience a mental health disorder each year and an estimated $247 billion is spent each year on childhood mental disorders (Centers for Disease Control and Prevention, 2013). Among children between ages 9 and 17, 5 to 9 percent have emotional disturbances severe enough to impair their functioning, according to the Substance Abuse and Mental Health Services Administration (2013).

However, data from the Centers for Disease Control and Prevention's National Health and Nutrition Examination Survey (NHANES) indicate that only 50.6 percent of children with mental disorders had received treatment for their disorder within the past year.

There were some differences between treatment rates depending on the category of mental health disorder. Children with anxiety disorders were the least likely (32.2 percent) to have received treatment in the past year (U.S. Department of Health and Human Services, 2010). Emphasize that this lack of treatment for children/adolescents diagnosed with mental health disorders places them at higher risk for abuse and neglect (Administration for Children and Families, 2012).

Additionally, an individual is at greater risk for developing mental illness when there are multiple risk factors present. Children and adolescents with these multiple struggles often come to the attention of the Child Welfare System. Therefore, it is necessary for child welfare professionals to look at these factors when assessing the safety of the child, risk factors associated with abuse/neglect as well as a family's protective capacities. It is helpful to look at these risk factors from a biopsychosocial perspective.

Do: Display and review **PowerPoint Slide #8 (Biopsychosocial Factors)**.

Say: Child welfare professionals need to assess these and other factors when working with children and families.

Take note of the Adverse childhood experiences concept or ACEs. ACEs are potentially traumatic childhood events that may include violence, abuse, growing up in a family with mental health or substance use. The toxic stress from these experiences can affect brain development in childhood and affect how the body responds to stress, with physical, mental, and emotional effects that can last into adulthood (CDC.gov).

Biopsychosocial factors (temperament, environment, genetic and physiological) influence the child/adolescent's development, as well as ongoing child and family functioning. Negative aspects within each dimension may constitute "safety threats" or "risk factors" for the child/adolescent.

Positive aspects within each dimension, in contrast, constitute "protective factors" for the child. The same holds true for family functioning. The balance of protective factors versus safety threats and risk factors of the child/adolescent and family strongly influences the path of a child/adolescent's development and the extent to which a particular child/adolescent will be resilient and/or vulnerable. It remains important that you assess and separately understand each dimension of the biopsychosocial triad to best meet the needs of each individual child/adolescent.

Furthermore, we must consistently evaluate our ability to meet the needs of children and adolescents with whom we work. As we progress through the next two days of training, we will reflect back on these biopsychosocial factors not only to determine whether or not safety threats or risk factors exist, but also to explore how we as child welfare professionals need to respond when these factors exist.

Section II: Perceptions about Child/Adolescent Mental Health Issues

Estimated Length of Time:

40 minutes

Key Concepts:

- ✓ Stigmas impact people's understanding and acceptance of child/adolescent mental health disorders.
- ✓ Tuning in to one's perceptions about child/adolescent mental health disorders is thefirst step in the preparatory phase of working with a child/adolescent with mentalhealth disorders.

Method of Presentation:

Large group activity, large group discussion, lecture

Materials Needed:

- ✓ Markers
- ✓ Masking tape
- ✓ 2 Flip chart pads
- ✓ 2 Flip chart stands
- ✓ Projector/Screen
- ✓ **PowerPoint Slide #9 (Perceptions and Attitudes about Mental Health Issues)**
- ✓ **PowerPoint Slide #10 (Stigma)**
- ✓ **Appendix # 1 (Scaling Signs)**

Outline of Presentation:

- Gain insight about people's perceptions of child/adolescent mental health disorders.
- Review interactional skills of Tuning in to Self and Tuning in to Others so that one can be culturally sensitive to people's perceptions and beliefs about child/adolescent mental health disorders.
- Discuss the stigmas associated with mental health disorders.
- Discuss the concepts of "living well, playing well, loving well and expecting well."

Section II: Perceptions about Child/Adolescent Mental Health Issues

Step #1: (15 minutes) Perceptions and Attitudes about Mental Health Issues

Say: Each of us comes to this training with our own thoughts, perceptions, and beliefs abouthow to work with children and adolescents with mental health disorders. Therefore, it is crucial to begin to explore each of our own thoughts and beliefs about child/adolescentmental health disorders. We also need to take the time to explore how the children/adolescents and their families feel about mental health and mental illness. Tuning in to your thoughts and the family's beliefs about mental health disorders will better prepare you to collaborate with the child/adolescent, their family and the other partners involved in the child/adolescent mental health system.

Instructor Note: Prior to this section, post the five scaling signs on different walls in the training room. See **Appendix #1 (Scaling Signs)**. Be sure to spread out the signs to assure that you will have room for participants to clearly move to the sign that best reflects their response. If participants feel uncomfortable, they do not have to participatein this activity.

Do: Display **PowerPoint Slide #9 (Perceptions and Attitudes about Mental Health Issues)** and read each statement aloud one at a time.

Ask: Ask participants to respond by moving by/near the sign that best represents their agreement with the following statements:

1. Mental health disorders are not true medical illnesses like heart disease and diabetes.
2. If the child has a parent who is mentally ill, the child will have mental health issues too.
3. Infants and toddlers can be diagnosed with mental health disorders.
4. Mental illness cannot result from bad parenting.
5. Children who have enuresis/encopresis (wetting or soiling their clothes) have been abused/neglected.

Instructor Note: The purpose of this activity is to provide a visual image about the different opinions that people will have about mental health/illness. The goal is not to change people's opinions or challenge their beliefs, but rather to show that peoplehave different ideas about mental health disorders. The PA Child Welfare Practice Model emphasizes that all members of the team should be treated with dignity and consideration despite their differing opinions. It is essential that individuals with mental health disorders receive the services they need and are provided support without judgement and that individuals tune into their own biases.

Do: Conduct a brief large group discussion based on each of the above statements, highlighting similarities and differences in the participant responses.

Step #2: (10 minutes) Stigmas Associated with Mental Illness

Say: In addition to understanding that people have different ideas about mental health issues, we must also acknowledge that individuals with mental health issues are often stigmatized. Stigmatization of people with mental illness has been prevalent throughout history and many of these stigmas still exist. People often show prejudice, distrust, fear, awkwardness, anger and avoidance of those who have mental health issues. The impact of these stigmas can be very overwhelming to families and it is even more detrimental for those children/adolescents with mental health issues because stigmas can further lower self-esteem, increase isolation, and one's feelings of hopelessness.

Even more damaging is when it is the parent who is angered by a child/adolescent's behavior or the parent avoids their child/adolescent because they are in denial or are afraid of their child/adolescent's mental health issues.

Do: Display **PowerPoint Slide #10 (Stigma)** and initiate a brief, large group, discussion about what society's ideas and beliefs are about people who have mental illness.

Ask: What stigmas might be associated with people who have mental illness?

Instructor Note: The purpose of this discussion is to allow participants an opportunity to tune in to what others might think about people who have mental health issues.

Example to consider: An autistic child might naturally express joy by widely flapping their hands and the parent might be embarrassed and ask them to stop because it shows difference or makes other people uncomfortable even though it is an expression of happiness.

Do: Encourage participants to periodically tune in to their own thoughts and perceptions about those with mental health issues and reiterate the importance engaging children and families in discussions about their ideas and beliefs about mental health issues.

Ask: What can you learn by taking the time to tune in to your own thoughts and beliefs?

Instructor Note: The following are Shulman's definitions of Tuning in to Self and Tuning into Others (Shulman, 2006):

- Tuning in to Self: The worker's effort to get in touch with potential feelings/concerns/beliefs that the worker themself may bring to the helping encounter.
- Tuning in to Others: The worker's effort to get in touch with potential feelings and concerns that the family may bring to the helping encounter.

Ask: What can you learn from the families by tuning in to them during conversations about their thoughts and beliefs about mental health?

- You may learn about your own or the families' biases, cultural norms, generational

differences, values, regarding mental health and whether or how treatment is discussed or pursued. You may learn that access to mental health services is limited due to a rural location, transportation, lack of insurance, or lack of providers.

- It is important to approach all conversations about mental health with cultural humility

Say: Once you have engaged the child/adolescent and the family regarding their potential feelings and beliefs surrounding mental health issues you are better prepared to work more effectively with the family. The next step is to gain information about whether the child/adolescent is exhibiting normal developmental behaviors or whether the child/adolescent's behaviors cross over into behaviors that cause concern.

Step #3: (15 minutes) Mental Health vs. Mental Illness

Say: Use the biopsychosocial perspective to assess whether a child/adolescent is exhibiting behaviors that are developmentally normal, whether the behaviors cause concern, and whether the behaviors might cross over into the realm of mental illness. Distinguishing between mental health and mental illness for children is not clear-cut. It is not always easy to determine if a child's behavior is developmentally normal, delayed, or indicates a mental illness. Therefore, focus on how the child functions in their environment which includes home, school, and community. To do this, we need to explore if the child is "living well, playing well, loving well and expecting well." In other words:

- Are they able to form relationships with their family, extended family, peers,and community members?

- Are they actively participating and being successful in school?

- Do they have hope or a positive outlook on their life and their future?

In order to determine what *normal* is and what is not, it is helpful to gather information from multiple perspectives - i.e. the child/adolescent, parents, caregivers and other observers such as school personnel and extended family members. By gathering information from multiple individuals who are part of the child/adolescent's family and social environment, you are better able to picture what is going on with the child/adolescent and their family. If concerning behaviors are identified, those same individuals can provide information about what that behavior specifically looks and sounds like, as well as the frequency, intensity and duration of that behavior.

Consider the following examples:

<u>Living</u>: A child/adolescent who is afraid of speaking in front of an audience. In this example it is important to gather information about whether this child is experiencing a normal case of nerves or if the fear crosses over into other aspects of their life preventing them from functioning in their activities of daily living.

<u>Playing</u>: A child who never plays with others. It is important to gather information about if this is developmentally appropriate based on the child's age, if there are

developmental delays, or if this is an indicator of a possible mental illness.

Loving: A child who shies away from contact with others, even family members. In this example it is important to gather information about whether the child has a fear of their caregivers and family members, whether there is any attachment to the caregivers and family members, or whether the child is shy.

Expecting: An adolescent who feels sad and gloomy. In this example it is important to gather information about if this child is experiencing a passing case of the blues, whether it is a teen experiencing normal developmental feelings or whether the adolescent's expectation of life is so poor that the feelings cross over to depression and require treatment intervention." (Garmezy, 1991).

Do: Using flip chart paper, place the headings "Look" and "Sound" at the top of the flip chart. Ask participants to provide examples of descriptive behaviors that a parent might share with them about a child/adolescent's concerning behaviors. List the responses under the appropriate category. Encourage participants to gather information about the frequency, intensity and duration of the behaviors listed. This information is useful to gain greater insight into whether or not the behaviors are developmental issues, behaviors that cause concern, or whether there are risk and safety factors that need to be addressed due to a child/adolescent's mental illness.

Instructor Note: This is a good time to have the morning break of Day 1 (15 minutes).

Section III: Child/Adolescent Development

Estimated Length of Time:

1 hour, 45 minutes

Key Concepts:

- ✓ Child welfare professionals need to assess children/adolescent's development across multiple domains (behavioral, socio-emotional and cognitive).
- ✓ Child abuse/neglect impacts child/adolescent development and mental health.
- ✓ A parent/caregivers' presence or lack of protective capacities further impacts child/adolescent development and mental health.
- ✓ Solution-focused interventions assist child welfare professionals in engaging the family, identifying child and family strengths, and creating a positive vision of the future.

Method of Presentation:

Lecture, small group discussion, large group discussion, small group activity

Materials Needed:

- ✓ Markers
- ✓ Masking tape
- ✓ 2 Flip chart pads
- ✓ 2 Flip chart stands
- ✓ **Handout #2 (Normal Developmental Tasks vs. Indicators of Concern)**
- ✓ **Handout #3 (Factors that Influence Developmental Problems in Maltreated Children/Adolescents)**
- ✓ **Handout #4 (Childhood Mental Health Issues: A Resource Guide)**
- ✓ **Handout #5 (Case Scenario: Nicole Adams)**
- ✓ **Handout #6 (Solution-Focused Questions)**
  - ✓ **PowerPoint Slide #11 (Helping Parents/Caregivers Understand Their Child/Adolescent's Development)**
  - ✓ **PowerPoint Slides #12-13 (Solution-Focused Questions)**
  - ✓ **Appendix #2 (Sample Solution-Focused Questions for Nicole Adams Activity)**

Outline of Presentation:

- Review the various stages of development by looking at healthy child development and developmental indicators of concern based on the

biopsychosocial model.

- Discuss the factors that influence developmental problems in maltreated children.
- Review the concept of Strength-Based Solution-Focused interventions and focus on three Solution-Focused questions.
- Apply three Solution-Focused strategies to a case scenario.

Section III: Child/Adolescent Development

Step #1: (45 minutes) Normal Developmental Tasks vs. Indicators of Concern

Say: Another component of the child welfare professional's role in information gathering is to collect information about child development. Child/adolescent development is thought tobe affected by physical and mental predispositions (characteristics predetermined by genetic makeup), as well as the conditions in the environment. Growth and development is the product of biological, psychological, and social factors concerning the child; therefore, child/adolescent development is based on the influences of both nature and nurture.

It can be helpful to gain understanding about a child/adolescent's temperament. Temperament refers to our inborn personality traits, which are genetic in nature. The different ways children/adolescents interact with and react to their environment and experiences are reflective of their temperament, or behavioral style. Temperament can fall into three categories: flexible, feisty, and fearful.

We talked about the biopsychosocial model and the importance of comprehensive information gathering. It is important to be familiar with the different developmental domains when assessing achild/adolescent's development. Domains are specific spheres of growth and development containing a set of common characteristics. The domains that we focus on are:

- Physical;
- Cognitive;
- Social; and
- Emotional.

Physical development consists of the development of the body structure, including muscles, bones, and organ systems. Physical development usually describes the relationship between the person's ability to perceive the environment, and to respond tothose perceptions by interacting within the environment. Thus, physical development is generally comprised of *sensory* development, dealing with the organ systems underlying the senses and perception; *motor* development, dealing with the actions of the muscles; and the nervous system's coordination of both perception and movement.

Cognitive development is sometimes referred to as “intellectual” or “mental” development. Cognitive activities include thinking, perception, memory, reasoning, concept development, problem-solving ability, and abstract thinking. Language, with its requirements of symbolization and memory, is oneof the most important and complicated cognitive activities.

Social development includes the child's interactions with other people, and the child's

involvement in social groups. The earliest social task is attachment. The development of relationships with adults and peers, the assumption of social roles, the adoption of group values and norms, adoption of a moral system, and eventually assuming a productive role in society are all social tasks.

Emotional development includes the development of personal traits and characteristics,including a personal identity, self-esteem, the ability to enter into reciprocal emotional relationships, and mood and affect (feelings and emotions) that are appropriate for one's age and for the situation (Ormrod, 2014).

Do: Divide participants in six groups. Assign each group one of the six stages of child/adolescent development (Infancy, Toddlerhood, Early Childhood, Middle Childhood, Early Adolescence and Adolescence). Have participants use **Handout #2 (Normal Developmental Tasks vs. Indicators of Concern)**.

Say: The handout includes the major *normal* developmental benchmarks listed by the developmental domains; however, given that your focus is to identify indicators of concerns so that we might facilitate appropriate interventions, we need to identify the developmental concerns for each age group.

Take 10 minutes to review the normal developmental tasks and identify and list indicators of concern for your assigned stage of development. Record your assigned stage of development and the indicators of concern on flip chart paper so you can present this information to the large group.

Do: Allow 30 minutes for all the groups to report out.

Be sure to highlight the similarities and differences between each age group. Further highlight the critical factors to which participants should pay particular attention.

Ask: What is the child welfare professional's role once they identify concerns about a child/adolescent's development?

Participants should state that they are to talk to parents about these concerns. It's important to note that not all parents/caregivers will agree with an assessment of the concerns about a child/adolescent's development. Child welfare professionals must also connect the family to appropriate professionals for further assessment and diagnosis, if applicable. It is not the role of the child welfare professional to formally diagnose a child or adolescent and teaming with appropriate professionals will be essential.

Ask: How can child welfare professionals ensure that parents/caregivers are knowledgeable about child/adolescent development?

Do: After the participants have shared some examples, display and review **PowerPoint Slide #11 (Helping Families Understand Their Child/Adolescent's**

Development). Stress that it is necessary to discuss the developmental concerns in a culturally sensitive and easily understandable way.

Ask: How might you talk to parents/caregivers about indicators of developmental concerns?

Ask: How might you tune in to a parent/caregiver to determine if they are fearful or in denial about their child, not comprehending the impact of developmental delays, etc.?

Step #2: (15 minutes) The Impact of Child Maltreatment on Child/Adolescent Development

Say: It is necessary to talk to parents/caregivers about child/adolescent development, and to assess safety and well-being by looking for any potential developmental problems or mental health issues in maltreated children/adolescents. Developmental problems in maltreated children/adolescents vary based on several factors.

Do: Briefly review **Handout #3 (Factors that Influence Developmental Problems in Maltreated Children/Adolescents)**.

Say: Children/adolescents who are maltreated often experience psychological damage, which can, in turn, impact their mental health (Manly, Kim, Rogosch and Cichetti, 2001).It is important to assess developmental domains (behavioral, cognitive, and social-emotional functioning) at all times but particularly if a child/adolescent was exposed to trauma.

Do: Distribute **Handout #4 (Childhood Mental Health Issues: A Resource Guide).**

Say: The informational resources in *Trauma* section (page 1) of this handout can deepen knowledge about children's exposure to trauma.

Do: Assign each group one of the three websites to review and ask each group to Ask participants to report out a summary of the information they found.

Instructor Note: Each time **Handout #4 (Childhood Mental Health Issues: A Resource Guide)** is referenced throughout the training, ask participants to identify which sources of information might be most helpful based on the mental health needs of children and families currently on their caseload.

Do: Display **Handout #5 (Case Scenario: Nicole Adams)**.

Divide participants into small groups. Have participants read the case scenario individually and then have small groups answer the five questions. The small groups are to: assess the behavioral,socio-emotional and cognitive concerns of Nicole Adams; examine how concerning behaviors in each of these developmental domains can lead to mental illness; and explore the impact of these behaviors on overall family functioning. Once small groups have completed their responses, facilitate a large group discussion about their findings.

Instructor Note: Each small group should respond to all questions; however, if time runs short, instructor may opt to assign each group one question to report out to the large group.

Say: How the parent/caregiver responds to a child/adolescent's behavioral, socio-emotional and cognitive concerns, whether it is positively or negatively, further impacts the child/adolescent's development and mental health. One strategy to gain further insight into a parent's protective capacities in managing the child's behaviors is to utilize solution-focused questioning, a strength-based method for identifying what's working and what isn't.

Step #3: (45 minutes) Finding Strengths through Solution-Focused Interventions

Say: Solution-focused interventions (Shulman, 2006) offer you and the child/adolescent's parents/caregivers an opportunity to gain further insight about their ability to cope with the child/adolescent's behaviors. So often in child welfare, there is a focus on problems and what is not working. In addition, we often think we are required to intervene and fix the problems.Solution-focused interventions provides opportunities to have families talk about their own strengths. By talking about a family's strengths, family members feel a greater sense of hope and are more engaged in the casework process. Furthermore, solution-focused interventions encourage the family to identify their own solutions for change.

The PA Child Welfare Practice Model emphasizes skills of assessing, planning, monitoring, and adjusting which include identifying child and family strengths and exceptions to the problem, developing well-formed, family driven goals and promoting change through small steps by continuously analyzing and evaluating the impact and effectiveness of the plan and modifying responses to successes until the goals are achieved.

Say:

"Take a moment to think about your most difficult client… Wait. Let me rephrase that. Think about the family on your caseload who is struggling the most."

After a few moments **Ask:** "What did I rephrase in that question and why?"

(*client* to *family* because family is more personal and real; *difficult* to *struggle* because it's often not about the family being difficult it's about the situation

they're in. Consider: What happened to you: not what did you do?). Try to talk about the children and families the same way you would as if they were here in the room with us and be sure not to share any details that are too personal.

Ask for a volunteer to list three problems that family is experiencing. The volunteer will often quickly identify problems. Then, ask the volunteers to identify and share three strengths of their individuals.

Do: Point out that it can be a struggle to identify strengths when we are so often focused on the problems we are called in to help with. Further emphasize that when individuals focus on problems it is very easy to become frustrated and disenfranchised; however, when we focus on strengths, we and the families can renew hope and empowerment.

Encourage participants to allow families time to think about their responses, as they probably haven't even stopped for a moment to even consider how well they are coping with the struggles they face; and to incorporate what the family is doing well into their case work planning and decision-making.

Say: Let's look at how to use this strength-based solution-focused approach to elicit information about a family's strengths and ability to cope.

Do: Review **PowerPoint Slides #12-13 (Solution-Focused Questions)** and **Handout #6 (Solution-Focused Questions)** and explain that the solution-focused approach combines the identification of family strengths, a positive vision of the future, inclusion of family goals, building on the exceptions to the problem, optimism about family potential and connecting the child and family's behavior to outcomes into a cohesive model for change.

Say: For the next activity, we will focus on three different types of solution-focused questions, although there are more.

Instructor Note: The following provides examples of the Solution-Focused Questions that are focused on in this workshop.

Exception Questions: “Are there times when your daughter’s anger outbursts don’t happen or are less severe? When? How are these outbursts different?”

Scaling Questions: “On a scale of 0 to 10, with 0 being no struggles at all and 10 being completely overwhelmed and ready to snap, how are you currently able to cope with your child’s oppositional behavior?”

Miracle Question with Follow-up Questions: “Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that your child was no longer anxious about going to school. However, because you were sleeping, you don’t know the miracle happened, so when you wake up tomorrow morning, what will be the first thing you notice that would tell you that a miracle has happened?” (Follow up questions) “What might others (mother, father, siblings) notice about you that would tell them that a miracle has happened? Have there been times when you have seen pieces of this miracle happen? What’s the first step you can take to begin tomake this miracle happen?”

Do: Remind participants to think back to Nicole Adams and her family situation.

Do: Divide participants into four small groups and assign each group one of the following roles:

1. Nicole Adams
2. Nicole’s mother, Mrs. Adams
3. Nicole’s teacher at school
4. Nicole’s Adams’ mental health provider (TSS)

Say: Each group will develop an Exception Question, a Scaling Question, and a Miracle Question with follow-up questions, if appropriate, that a child welfare professional would ask their assigned person. If possible, develop a question to address a stigma about Nicole’s possible mental health issue(s). Place your questions on flip chart paper.

Instructor Note: Instructor should be prepared to offer constructive feedback to the small groups questions as it may be the first time they develop questions from a solution-focused perspective. Instructors can refer to **Appendix #2 (Sample Solution-Focused Questions for Nicole Adams Activity)** for possible responses.

Say: These strength-based interventions allow you to show respect for the child’s struggles. By showing respect, you have a greater chance to build a positive working relationship with the child, which in turn allows them to feel more comfortable sharing information. Engaging the family in these discussions also allows you to gather more information. This provides an opportunity for a more comprehensive assessment about

strengths and concern of a child/adolescent and their family as well as planning which service options might best meet their needs.

Instructor Note: This is a good time to break for lunch during Day 1. Depending on time,you may need to conduct the large group report out from this small group activity after lunch.

Section IV: Child/Adolescent Mental Health Disorders

Estimated Length of Time:

6 hours Total time

Day 1 – 3 hours (Steps 1, 2, 3, 4, and 15-minute break)

Day 2 – 3 hours (Steps 5, 6, 7, 8, and 15-minute break)

Key Concepts:

- ✓ There are various types of mental health disorders found in children/adolescents.
- ✓ Knowledge and awareness about emotional and emotional, behavioral, or developmental indicators associated with a variety of mental health disorders isimportant for casework practice.

Method of Presentation:

Lecture, video, small group discussion, large group discussion, small group activity, large group activity

Materials Needed:

- ✓ External Speakers for Laptop
- ✓ Markers
- ✓ Masking tape
- ✓ 2 Flip chart pads
- ✓ 2 Flip chart stands
- ✓ **Handout #4 (Childhood Mental Health Issues: A Resource Guide)(revisited)**
- ✓ **Handout #7 (Anxiety Disorders and Obsessive-Compulsive Disorder: Case Scenarios)**
- ✓ **Appendix #3 (Enhancing Assessments Toolkit)**
- ✓ **PowerPoint Slides #14-15 (Mental Health Service Use for Children)**
- ✓ **PowerPoint Slides #16-17 (Categories of Disorders)**
- ✓ **PowerPoint Slide #18 (Co-Morbidity and Co-Occurrence Statistics)**
- ✓ **PowerPoint Slide #19 (Major Depressive Disorder Indicators)**
- ✓ **PowerPoint Slides #20-21 (Depression and Suicide Statistics)**
- ✓ **PowerPoint Slide #22 (Mania and Hypomania Episode Indicators)**

- ✓ **PowerPoint Slide #23 (Disruptive Mood Dysregulation Disorder)**
- ✓ **PowerPoint Slide #24 (Types of Anxiety Disorders**).
- ✓ **PowerPoint Slide #25 (Anxiety Disorders: Common Threads**)
- ✓ **PowerPoint Slide #26 (Prevalence Rates of Anxiety Disorders**)
- ✓ **PowerPoint Slide #27 (Obsessive-Compulsive Disorder Indicators**)
- ✓ **PowerPoint Slides #28-29 (Reactive Attachment Disorder Indicators)**
- ✓ **PowerPoint Slide #30 (Disinhibited Social Engagement DisorderIndicators)**
- ✓ **PowerPoint Slide #31 (Exposure to Trauma)**
- ✓ **PowerPoint Slide #32 (Posttraumatic Stress Disorder Indicators)**
- ✓ **PowerPoint Slide #33 (Oppositional Defiant Disorder Indicators)**
- ✓ **PowerPoint Slide #34 (Intermittent Explosive Disorder Indicators)**
- ✓ **PowerPoint Slides #35-36 (Conduct Disorder Indicators)**
- ✓ **PowerPoint Slide #37 (Feeding and Eating Disorder Statistics).**
- ✓ **PowerPoint Slide #38 (Anorexia Nervosa Indicators)**
- ✓ **PowerPoint Slide #39 (Bulimia Nervosa Indicators)**
- ✓ **PowerPoint Slide #40 (Binge-Eating Disorder Indicators)**
- ✓ **PowerPoint Slide #41 (Feeding and Eating Disorders Recommendations)**
- ✓ **PowerPoint Slide #42 (Autism Spectrum Disorder Indicators)**
- ✓ **PowerPoint Slide #43 (Attention Deficit Hyperactivity Disorder)**
- ✓ **PowerPoint Slides #44-45 (Attention Deficit Hyperactivity DisorderIndicators)**
- ✓ **PowerPoint Slide #46 (Mental Health Evaluation Referral Checklist)**
- ✓ **Link Provided: (Day for Night: Recognizing Teenage Depression)**
- ✓ **Link Provided: (Through Our Eyes – Children, Violence, Trauma-Introduction)**
- ✓ **Link Provided: (Ask an Autistic #9: Sensory Processing Disorder)**

Outline of Presentation:

- Review six categories of child/adolescent mental health disorders.
- Discuss symptomology and prevalence of Depressive and Bipolar Disorders; Anxiety Disorders and Obsessive-Compulsive Disorder; Trauma and Stressor-Related Disorders; Disruptive, Impulse-Control, and Conduct Disorders; Feeding and Eating Disorders; and

Neurodevelopmental Disorders.

- Outline how specific mental health disorders may create challenges for families.
- Discuss how and when child welfare professionals can intervene to better improve outcomes for children/adolescents' safety, permanency and well-being.

Section IV: Child/Adolescent Mental Health Disorders

Say: We already discussed the importance of tuning in to the various perceptions that people might have about mental illness. We also established that the child welfare professional gathers information in a comprehensive biopsychosocial assessment about child development and how the child and family manage a child/adolescent's behaviors. We will now take a closer look at the differences and similarities of the emotional, behavioral, or developmental indicators commonly associated with child/adolescent mental health disorders to include those most prevalent among the children and adolescents with whom you work.

Step #1: (10 minutes)

Categories of Mental Health Disorders Commonly Found in Children/Adolescents

Say: Data collected by the U.S. Department of Health and Human Services (2010) indicate that 11.3 percent (nearly 7.4 million) of children ages 2-17 in the United States (13.4 in PA) are reported by their parents to have been diagnosed with emotional, behavioral, or developmental conditions. Nearly one-quarter (24.8 percent) have family incomes below the Federal poverty level (23.6 percent in PA) and 29.4 percent of diagnosed children with insurance were reported by their parents to have insurance that did not usually or always meet their needs.

Research has shown that living in a poor or low-income household increases the risk for mental health issues for both children and adults AND that those same people are least likely to have access to high-quality mental health care (Hodgkinson S., 2016 et al).

Do: Display and review **PowerPoint Slides #14-15 (Mental Health Service Use for Children)**. Results from the Mental Health Surveillance of Children-United States, 2005-2011 (Centers for Disease Control and Prevention, 2013) indicate that ADHD was the most prevalent current diagnosis among children ages 3-17; boys were more likely than girls to have ADHD, behavioral or conduct problems, autism spectrum disorder, anxiety, and Tourette Syndrome; girls were more likely than boys to be diagnosed with depression. Suicide was the second leading cause of death among children ages 12-17.(Centers for Disease Control and Prevention, 2013).

Assessment of a child/adolescent's functioning is a mandated casework task. A tool that can aid your initial assessments is the *Enhancing Assessments Toolkit* which has a section dedicated to mental health. Pass around a copy of **Appendix 3: Enhancing Assessments Toolkit** and inform participants that they can find this toolkit on the Child Welfare Resource Center website at:
www.pacwrc.pitt.edu/Resources/PA%20Enhancing%20Assessments%20Toolkit.pdf

Do: Write this website on flip chart for participants to copy. It is important to remind participants that this is a guide and that any concerns should be discussed in supervision. It is also important to emphasize that assessment is an on-going process that should occur throughout the life of a case.

Instructor Note: In addition to passing around a hard copy of the *Enhancing Assessments Toolkit* and providing the link, the instructor may find it useful to access the link via the internet and project the tool on the screen to show participants: www.pacwrc.pitt.edu/Resources/PA%20Enhancing%20Assessments%20Toolkit.pdf

Say: This section of the training will help you understand some of the emotions and behaviors commonly associated with some child/adolescent mental health disorders and how mental health issues can impact the child/adolescent and their family. There are more mental health disorders diagnosed in children/adolescents; however, we only have time to cover some of the commonly occurring disorders.

Do: Display **PowerPoint Slides #16-17 (Categories of Disorders)** and review the six covered categories:

- Depressive and Bipolar Disorders
  - Major Depressive Disorder
  - Persistent Depressive Disorder (Dysthymia)
  - Bipolar Disorder
  - Disruptive Mood Dysregulation Disorder
- Anxiety and Obsessive-Compulsive Disorders
  - Separation Anxiety Disorder
  - Generalized Anxiety Disorder
  - Obsessive-Compulsive Disorder
- Trauma and Stressor-Related Disorders
  - Reactive Attachment Disorder
  - Disinhibited Social Engagement Disorder
  - Posttraumatic Stress Disorder
- Disruptive, Impulse Control, and Conduct Disorders
  - Oppositional Defiant Disorder
  - Intermittent Explosive Disorder
  - Conduct Disorder
- Feeding and Eating Disorders
  - Anorexia Nervosa
  - Bulimia Nervosa

- Binge-Eating Disorder

- Neurodevelopmental Disorders
  - Autism Spectrum Disorder
  - Attention Deficit Hyperactivity Disorder

Step #2: (15 minutes) Co-Morbidity and Co-occurrence

Do: Display and review **PowerPoint Slide #18 (Co-Morbidity and Co-Occurrence Statistics)**. Point out that several individuals with one mental disorder are at a higher risk for also having a second one (co-morbidity). According to a 2010 U.S. Department of Health and Human Services report, 40.3 percent of diagnosed children have more than one emotional, behavioral, or developmental condition, and 45.8 percent of children with one or more emotional, behavioral, or developmental conditions also had learning disabilities when compared to 2.7 percent of children without these conditions. For example, children/adolescents with Oppositional Defiant Disorder are also at increased risk for Anxiety Disorders and Major Depressive Disorder.

People are said to have co-occurring disorders when they have one or more disorders related to the use of alcohol and/or other drugs of abuse as well as one or more mental health disorders. Estimated rates of co-occurring mental illness among adolescents with Substance-Related Disorders range from 60 to 75 percent (Substance Abuse and Mental Health Services Administration, 2010). Among adolescents with no prior substance use, the rates of first-time use of drugs and alcohol in the previous year are higher in those who have had a major depressive episode than in those who did not.

Say: Other commonly documented co-occurring mental disorders include Conduct Disorder,Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Anxiety Disorders, and Posttraumatic Stress Disorder (Substance Abuse and Mental Health Services Administration, 2010).

Untreated youth with co-occurring disorders have high rates of death by suicide, medical problems, homelessness, unemployment, incarceration, and truancy. They have difficulty concentrating in school or focusing attention on tasks at home, at part-timework or during extracurricular activities, and poor peer and parental relations (Substance Abuse and Mental Health Services Administration, 2010).

Children/adolescents with these struggles (poor peer/parental relations, truancy, and homelessness) often come to the attention of child welfare professionals. Therefore, you need to know how to look for emotional, behavioral, or developmental indicators that might be associated with mental health issues to better assure child/adolescent well-being outcomes; however, children and adolescents behave differently. Therefore, it is important for you to gain knowledge and awareness about the different indicators exhibited by children and adolescents so you can complete the most comprehensive assessment, and informed decision-making and improved child safety, permanency, and well-being outcomes.

Remember to assess the risk and safety of the children/adolescents with whom you work

at every contact, to include assessment of emotional well-being.

Step #3: (1 Hour) Symptomology and Prevalence of Depressive Disorders and Bipolar Disorders

Say: Now we will discuss mental health disorders that fall under the umbrella of Depressive Disorders and Bipolar Disorders.

Say: Please close your eyes and picture a child. What did you picture?

Most participants will answer happy, playing, singing, smiling etc. The instructor will make the point that most of us don't envision a child who is sad, angry, or has low energy.

Say: Clinical depression is an illness, found in both children and adolescents, in which feelings of depression persist and interfere with a person's ability to function in the world around them. In other words, it affects a child/adolescent's mood as well the ability to live, love, play and expect well.

Major Depressive Disorder: (30 minutes)

Say: Next, we are going to see a short clip from the **Video (Day for Night: Recognizing Teenage Depression)**. This includes teens, parents, and a Mental Health Professional as they describe depression and mania. Please write down the descriptions shared by the individuals as they describe depression and mania. Gather information about both what you see and hear.

Do: Play the video clip using the link here Day for Night (it is also located in the Curriculum Materials folder under 303 – Remote Delivery: *Childhood Mental Health Intro: Recognizing Teenage Depression*)

Do: Ask participants what they saw and heard about depression and add to the flip chart. Some of the descriptions shared in the video include:

Depression:

- "In a box, can't get out"
- "Cup with holes in it and everything is pouring out"
- "Surrounded by darkness"
- "The world doesn't understand you"
- "Buried"
- "Locked inside yourself"
- "Walking under water"
- "Anvil on your head"
- Sleep too much or too little
- Feel alone

- Worthless
- Guilty
- Aggressiveness

Do: Display and review **PowerPoint Slide #19 (Major Depressive Disorder Indicator**s

Do: Ask participants to link the descriptions of depression described in the video to the diagnostic criteria for Major Depressive Disorder included in the DSM-5. Note that five or more of the symptoms must be present during the same 2-week period and representa change from previous functioning. Also note that at least one of the symptoms is either depressed mood or loss of interest or pleasure (American Psychiatric Association, 2003). Remind participants that the child welfare professional must work with mental health professionals for a formal diagnosis to be made. It is not the child welfare professionals' role to diagnose a child or adolescent, but to be aware of indicators of concern to connect the family to the appropriate services.

Say: Because normal behaviors vary from one stage of development to another, parents/caregivers may find it difficult to tell whether a child/adolescent is just going through a temporary phase, whether it is the child's temperament, or whether the child suffers from something more serious.

It can be helpful to determine whether there are any risk factors present that might lead to a child/adolescent developing depression.Three risk factors can lead to Major Depressive Disorder:

- Temperamental (neuroticism or negative affectivity);
- Environmental (adverse childhood experiences, particularly if there are multiple experiences of diverse types);
- and Genetic and Physiological (first-degree family members of individuals with Major Depressive Disorder have a risk for Major Depressive Disorder two- to fourfold higher than that of the general population.

Temperamental neuroticism or negative affectivity can lead to cognitive skewing in which the individual views typical life experiences through a predominantly negative lens (American Psychiatric Association, 2013).

Instructor Note: Instructor should add the following information on another depressive disorder diagnosed in children and adolescents. Persistent Depressive Disorder (Dysthymia) is a depressed mood that occurs for most of the day, for more days than not, for at least one year in children and adolescents (mood can also present as irritablein youth). Additionally, two or more of the following symptoms must be present during the depressed mood: poor appetite or overeating; insomnia or hypersomnia; low energyor fatigue; low self-esteem; poor concentration or difficulty making decisions; feelings ofhopelessness (American Psychiatric Association, 2003).

Other disorders that frequently co-occur with Major Depressive Disorder are Substance-Related Disorders, Panic Disorder, Obsessive-Compulsive Disorder,

Anorexia Nervosa, and Bulimia Nervosa (American Psychiatric Association, 2013).

Say: Death by suicide is a serious public health problem that affects even young people. In September of 2019, the Pennsylvania General Assembly adopted House Resolution No. 399, which urges the commonwealth to “adopt and utilize sensitive language related to suicide.” It is hoped that the language changes, along with prevention, education, public policy changes, and community support, will reduce stigma and decrease underreporting. The following terms are discouraged for the listed reasons:

- The term "committed suicide" implies a level of criminality while "completed suicide" implies earlier attempts when there may have been none.
- Both terms perpetuate the stigma associated with suicide
- Using the words "successful" or "failed" to describe suicide

Instead, the terminologies of "**Died by suicide**" or "**died of suicide**" as well as "**suicide death**" and "**fatal suicide behavior**" are recommended.

Say: Depressed children/adolescents may say they want to be dead or talk about hurting themselves. Children and adolescents who make these statements are at increased risk for attempting or committing suicide.

Do: Display and review the following statistics on **PowerPoint Slides #20-21 (Depression and Suicide Statistics)** about the prevalence of suicide in young children and adolescents that was compiled in a report by the Centers for Disease Control and Prevention (2013).

- 13.84% of youth ages 12-17 report having suffered from at least one major depressive episode in the last year (Mental Health America, 2021)
- Suicide is the second leading cause of death for youth between the ages of 10 and 24 that results in approximately 6,188 lives lost each year (NIMH, n.d.)
- The top three methods used in suicides of young people include firearm, suffocation, and poisoning (NIMH, n.d.);
- A nationwide survey of youth in grades 9–12 in public and private schools in the United States (U.S.) found that 16 percent of students reported seriously considering suicide, 13 percent reported creating a plan, and 8 percent reported trying to take their own life in the 12 months preceding the survey (NIMH, n.d.)
- Boys are more likely than girls to die from suicide. Girls, however, are more likely to report attempting suicide than boys (NIMH, n.d.)
- A nationally representative study of adolescents in grades 7–12 found that lesbian, gay, and bisexual youth were more than twice as likely to have attempted suicide as their heterosexual peers (NIMH, n.d.)
- Cultural variations in suicide rates also exist, with Native American/Alaskan Native youth having the highest rates of suicide-related fatalities. A nationwide survey of youth in grades 9–12 in public and private schools in the U.S. found Hispanic youth were more likely to report attempting suicide than their Black and white, non-

Hispanic peers (NIMH, n.d.).

- Documented rise of depression, attempted suicide, and death by suicide during the Covid-19 pandemic, with the pandemic disproportionately impacting racial and ethnic minorities (APA, 2021)

Ask: What interventions are available in your agencies to reduce the safety threats and risk factors associated with suicidal ideation?

Do: Explain that as a child welfare professional, it is important to know that certain protective factors can buffer people from the risks associated with suicidal behavior.

Instructor Note: Take a few moments to check in on participant well-being after discussing this (or any other topic) that may be particularly difficult or trigger emotional trauma. Remind participants not to share traumatic stories, details, or names as doing so just shares the traumatic load. Rather, allow participants time to process their feelings and coping mechanisms. What helps them get through? What helps them build resilience?

Bipolar Disorder: (15 minutes)

Ask: "How are children/adolescents with Bipolar Disorder similar to children/adolescents with Depression?"

Do: Wait for responses; then, explain that individuals diagnosed with Bipolar Disorder are similar to depressed children/adolescents except they may have an ongoing combination of extremely high and low moods.

Say: According to the American Psychiatric Association (2013), there are two types of Bipolar Disorder:

- Bipolar I Disorder criteria require at least one episode of major depression and at least one manic episode
- Bipolar II Disorder criteria require at least one episode of major depression and at least one hypomanic episode.

Note that the criteria for a MajorDepressive Episode for Bipolar I Disorder and Bipolar II are the same as those indicators covered in the previous section, Major Depressive Disorder.

Do: Display and review **PowerPoint Slide #22 (Mania and Hypomania Episode Indicators**).

Ask: If you have had a child/adolescent diagnosed with Bipolar Disorder on your caseload, what were the exhibited behaviors?

Do: Connect the examples to the indicators displayed on **PowerPoint Slide #22 (Mania**

and Hypomania Episode Indicators).

Do: Return to **PowerPoint Slide #19 (Major Depressive Disorder Indicators)** and connect the participant examples to the Bipolar I and Bipolar II criteria for a Major Depressive Episode.

Say: Note that the risk for death by suicide in children and adolescents diagnosed with Bipolar I and Bipolar II should be carefully evaluated**.** Although exact rates for children and adolescents diagnosed with Bipolar Disorder are unknown, the lifetime risk of death by suicide for all individuals diagnosed with Bipolar Disorder is 15 times higher than the general population (American Psychiatric Association, 2013).

Bipolar Disorder I and Bipolar Disorder II in childhood may not present with clear intervals of depression and mania or hypomania as seen in adults. Children with pediatric Bipolar Disorder rarely fit the classical pattern of Bipolar Disorder found in adults, which can lead to misdiagnosis. It is difficult to determine with precision what is normal or expected at any given developmental stage. Therefore, each child should be evaluated according to their own baseline (American Psychiatric Association, 2013).

More and more children/adolescents, including young children, are being diagnosed with Bipolar Disorder, which has caused some concern. Among children diagnosed with a psychiatric condition in 1996, 1 in 10 was deemed to have Bipolar Disorder. By 2004, 4 out of 10 children with a psychiatric condition were told they had Bipolar Disorder (Coghalan, 2007).

Ask: Have you seen an increase in the diagnoses of Bipolar Disorder in children on you caseload?

Say: Bipolar Disorder in children and adolescents can be hard to tell apart from other problems that may occur in these age groups. While irritability and aggressiveness can indicate Bipolar Disorder, they also can be symptoms of other disorders (i.e. Depressive Disorder, Conduct Disorder, and Oppositional Defiant Disorder), but unlike developmentally normal mood changes, a child with Bipolar Disorder has significantly impaired functioning in school with peers, and at home with family (American Psychiatric Association, 2013). Evaluation by a child/adolescent psychiatrist is important when identifying symptoms, but it is important for you to share specific information, to include frequency, duration and intensity of behaviors so that a thorough assessment can be completed and appropriateinterventions can be determined.

Disruptive Mood Dysregulation Disorder: (15 minutes)

Say: Another consideration is Disruptive Mood Dysregulation Disorder. Its' major feature is the presence of persistent irritability and frequent episodes of extreme behavioral dyscontrol. Children with this symptom pattern typically develop unipolar depressive disorders or anxiety disorders rather than bipolar disorders as they mature into adolescence and adulthood (American Psychiatric Association, 2013).

Do: Display and review **PowerPoint Slide #23 (Disruptive Mood Dysregulation Disorder**). Note that the criteria must be present in two of three settings (at home, at school, or with peers) and are severe in at least one of these settings. The diagnosis should not be made for the first time before age 6 or after age 18 and cannot coexist with Oppositional Defiant Disorder (American Psychiatric Association, 2013).

Instructor note: This is a good time to take the afternoon break on Day 1. (15 minutes)

Step #4: (1 hour, 30 minutes) Symptomology and Prevalence of Anxiety Disorders and Obsessive-CompulsiveDisorder

Say: Anxiety and fear are emotions experienced by all individuals from time to time. Some fears and worries are justified.

Say: Think about something that caused you anxiety or fear when you were a child, that you now know was nothing to be afraid of. *(Some participants may say large dogs, riding the school bus for the first time, or lightning).*

Say: Please share some of the physiological and behavioral reactions you experienced when you were worried or anxious as a child. *(Participants will usually answer sweaty palms, heart racing, hyper vigilance, or running from the situation).*

Ask: How long did those responses last? *(In most cases it is very short-lived).*

Say: Children often experience anxiety at specific times throughout normal development. For example, from approximately age 8 months through the preschool years, healthy youngsters may show intense distress at times of separation from their parents or others with whom they are close. However, when anxieties become severe and interfere with daily childhood activities, such as separating from caregivers, attending school, and making friends, they may be symptoms of an Anxiety Disorder which would require further intervention.

Say: Now we will talk about anxiety disorders.

Do: Display and review **PowerPoint Slide #24 (Types of Anxiety Disorders**). The most common types of anxiety disorders found in children and adolescents are: separation anxiety, selective mutism, specific phobia, social anxiety (social phobia), panic disorder, agoraphobia, andgeneralized anxiety. Note that these disorders are listed in order of the typical age of onset (American Psychiatric Association, 2013).

Do: Display and review **PowerPoint Slide #25 (Anxiety Disorders: Common Threads**).

Say: According to the American Psychiatric Association (2013) all of these disorders share features of excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat. Fear is more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger and escape behaviors.

Anxiety is more often associated with muscle tension and vigilance in preparation for

future danger and cautious or avoidant behaviors. While anxiety disorders tend to be highly co-morbid with each other, they can be differentiated by examination of the types of situations that are feared or avoided and the content of the associated thoughts or beliefs. Many of the anxiety disorders develop in childhood and tend to persist into adulthood if not treated (American Psychiatric Association, 2013).

Do: Display and review **PowerPoint Slide #26 (Prevalence Rates of Anxiety Disorders**).

Say: The Lifetime prevalence of “any anxiety disorder” in studies with children or adolescents conducted in the U.S. is about 15 percent to 20 percent (Beedso, Knappe, and Pine, 2011). The most frequent disorders among children and adolescents are: separation anxiety (2.8 percent to 8 percent); selective mutism (.03 percent to 1 percent); and specific and social phobias, with rates up to around 10 percent and 7 percent respectively. Agoraphobia and panic disorder are low-prevalence conditions in childhood (1 percent or lower); higher prevalence rates are found in adolescence (2 percent–3 percent for panic and 3 percent–4 percent for agoraphobia).The prevalence of generalized anxiety disorder in adolescents is .09 percent. Girls are affected with anxiety disorders at twice the rate of boys (Beesdo, Knappe, & Pine, 2011).

Do: Display and review **PowerPoint Slide #27 (Obsessive-Compulsive Disorder Indicators**).

Say: Let’s look at Obsessive-Compulsive and Related Disorders. According to the American Psychiatric Association (2013), Obsessive-Compulsive Disorder is characterized by the presence of obsessions and/or compulsions.

Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. Recent epidemiological studies report prevalence rates of .25 percent in 5–15-year-old children, although earlier studies suggested rates as high as 1-2 percent in children and adolescents (Heyman, Mataix-Cols, & Fineberg, 2006). Other obsessive-compulsive related disorders are characterized primarily by recurrent body-focused repetitive behaviors, such as hair pulling (Trichotillomania) and skin picking (Excoriation Disorder) (American Psychiatric Association, 2013).

To cope with their feelings, a child may develop "rituals" (a behavior or activity that they repeat). Sometimes the obsession and compulsion link to one another. A younger child diagnosed with Obsessive-Compulsive Disorder (OCD) may fear that they or a family member may come to harm, for example by an intruder entering an unlocked door or window. The child may compulsively check all the doors and windowsof their home after their parents are asleep in an attempt to relieve anxiety. The child may then fear that they may have accidentally unlocked a door or window while last checking and locking doors and windows and then must compulsively check again. An older childor a teenager diagnosed with OCD may fear that they will become ill with germs or contaminated food. Children/adolescents often feel shame and embarrassment about their diagnosis of OCD.

Instructor Note: It may be helpful to assign the groups in the following way: Scenario 1 –Placement and Foster Care workers; Scenario 2 – In-home and Ongoing workers; Scenario 3 – Intake and CPS workers.

Do: Share **Handout #07 (Anxiety Disorders and Obsessive-Compulsive Disorder: Case Scenarios)**. Divide participants into three groups and assign each group a case scenario.

Do: Have participants read their assigned case scenarios and then respond to the following statements:

1. List the concerning behaviors of the child/adolescent.
2. Write down 3 questions that you, the child welfare professional, should ask to elicit more information about the frequency, intensity and duration of the child/adolescent's behaviors.
3. Identify the next steps in working with this child/adolescent.

Each small group should be given flip chart paper to document their responses. Give each group 15 minutes to complete this activity. Then, have each small group provide the large group with a brief synopsis of the case situation and have each small group share their responses to the three statements, one at a time.

After a group reports out, the instructor should discuss the possible mental health disorder that is associated with thescenario and elaborate on the emotional and behavioral indicators commonly found in children/adolescents with this disorder as well as what a child welfare professional needs to know when working with a child/adolescent with these emotional and behavioral indicators.

Scenario 1 – Generalized Anxiety Disorder:

Suggested responses for Scenario 1 include:

1. *On edge; difficulty sleeping; awakening in the middle of the night scared; invalid concern over performance on school work; a level of paranoia over school work; invalid concerns about his health; concerned about others becoming ill; nausea and headaches (possibly psychosomatic); and not leaving the home to play with friends, but will invite friends to his home.*
2. *How often does Michael have difficulty sleeping and how long does it take him to fall asleep? How often does Michael awaken in the middle of the night frightened and how long does it take him to fall back to sleep? How often does Michael think about his physical health and what does he fear is wrong? How frequently does Michael complain of nausea and headaches? How severe are the nausea and headaches? How long do the nausea and headaches last? What are the circumstances surrounding his nausea and headaches (if any)? What happens if Michael goes to a friend's home to play? How often is Michael on edge and what does that look like? Does Michael worry every night about his school work? If not how frequently does this occur? Did these problems exist when he was living*

with his mother? (NOTE: All of the above questions should be asked of the mother)

3. *Psychiatric evaluation and follow all recommendations; Possible sleep study (depending on results of psychiatric evaluation); Educate Resource/Adoptive Parents on child's problems and identify ways they can be supportive and helpful.*

- According to the American Psychiatric Association (2013), the essential diagnostic feature of Generalized Anxiety Disorder (GAD) is excessive anxiety and worry (apprehensive/expectation) occurring more days than not for a period of at least 6 months and revolves around a number of events or activities;
- Children and adolescents with Generalized Anxiety Disorder (GAD) go through the day filled with excessive anxiety and worry, about a number of events or activities, occurring more days than not for at least 6 months;
- Children/adolescents find it difficult to control their worry;
- The anxiety or worry are associated with three or more of the following symptoms: restlessness or feeling keyed up or on edge; being easily fatigued; difficulty concentrating or mind going blank; irritability; muscle tension; and sleep disturbances;
- Unlike adults, children/adolescents don't often realize that their anxiety is more intense than the situation warrants; therefore, children will require frequent reassurance from the adults in their lives;
- The symptoms of GAD may resemble other medical conditions or psychiatric problems, so it is important to refer the child for a comprehensive assessment to rule out medical or other mental health problems;
- The child who has persistent symptoms of Generalized Anxiety Disorder and does not receive professional assistance has the serious potential for long-term effects as an adult; and
- About half of all adults seeking treatment for this disorder report that it began in childhood or adolescence (American Psychiatric Association, 2013).

<u>Scenario 2 – Separation Anxiety Disorder:</u>

Suggested responses for Scenario 2 include:

1. *Truancy; upset every morning before school (screaming and crying, sometimes to the point of vomiting); tearful in the evening about going to school the next day; difficulty falling asleep because she is upset about leaving her mother for school; follows mother around and will not let her out of her sight; frequently asks mother what she will be doing when Colleen goes to school and if she will still bethere when Colleen returns from school*
2. *How frequently does Colleen miss school? How long does Colleen remain upset in the mornings before school? Does the tantrum continue when she is in school and, if so, for how long? What works to calm her down? How long does she remain upset in the evenings prior to school? How long does it take her to fall*

asleep and what helps her to fall asleep? How frequently is she upset in the evening about going to school?

3. *Psychiatric evaluation and follow all recommendations; Meeting with the school to identify ways that the school can assist; Help mother to understand what the child is going through and what she can do to be helpful and supportive.*

Remind participants that what they have learned about human development shows that a certain amount of anxiety concerning separation from a primary caregiver is part of the normal developmental process in infants and young children. Furthermore, children,from the first year of life through the preschool years typically exhibit periodic distress and worry when separated from their parents or other individuals to whom they have an attachment.

Child welfare professionals should be assessing any problem behaviors that a child/adolescent might exhibit and how those behaviors might impact the child/adolescent's daily activities, especially when those behaviors go beyond minor distress. Young children experiencing separation anxiety may be clingy and follow their parents around. They may express general fear or apprehension, experience nightmares, or complain of somatic symptoms (e.g., dizziness, headaches, stomachaches, nausea). Older children may complain about not feeling well, may think about illness or tragedy that may happen to them or their caregivers, become apathetic and depressed, and be reluctant to leave home or to participate in activities with their peers. When these issues impede a child/adolescent's well-being and the child/adolescent's ability to learn, play and interact with others, then it is important to consider further assessment to determine if the child/adolescent may be struggling with Separation Anxiety Disorder. Separation Anxiety Disorder appears to be more prevalentin children than adolescents, with a prevalence rate of 4 percent in children and 1.6 percent in adolescents (American Psychiatric Association, 2013).

Genetics and environmental conditions play a role in the development of Separation Anxiety Disorder. Children/adolescents are more prone to developing an anxiety disorder if their parents have been diagnosed with anxiety problems (American Psychiatric Association, 2013). It is important that child welfare professionals examine the relationship between the child/adolescent and their parent/caregiver because children who are insecurely attached are more likely to develop Anxiety Disorders, especially Separation Anxiety Disorder. Parents who are anxious and depressed themselves may further promote much of this insecure attachment due to the fact that their own mental health issues might get in the way of their roles and responsibilities as a parent. Parental overprotection and intrusiveness may also be associated with Separation Anxiety Disorder (American Psychiatric Association, 2013). Additionally,child welfare professionals should be aware that Separation Anxiety Disorder often develops after a life stress, especially a loss such as parental divorce or placement (American Psychiatric Association, 2013).

One of the most common times in a child's life when the issue of separation anxiety is most visible is during the transitions to starting elementary school as well as transitioning from elementary school to middle school. Going to school usually is an exciting, enjoyable event for young children. For some, it brings intense fear or panic. Parents should be

concerned if their child regularly complains about feeling sick or asksto stay home from school with minor physical complaints.

Not wanting to go to school may occur at anytime but is most common in children ages 5 to 7 and 11 to 14 (American Academy of Child and Adolescent Psychiatry, 2010), ages when children/adolescents deal with the new challenges in elementary and middle schools. These children/adolescents may suffer from a paralyzing fear of leaving the safety of their parents and home. The child/adolescent's panic and refusal to go to school is very difficult for parents to cope with. The child/adolescent may complain of a headache, sore throat, or stomachache shortly before it is time to leave for school. The illness subsides after the parent/caregiver allows the child/adolescent to stay home, only to reappear the next morning before school. In some cases, the child/adolescent may simply refuse to leave the house.

Children/adolescents with an unreasonable fear of school may:

- Feel unsafe staying in a room by themselves;
- Display clinging behavior;
- Display excessive worry and fear about parents or about harm to themselves;
- Shadow the mother or father around the house;
- Have difficulty going to sleep or staying asleep due to nightmares;
- Have exaggerated, unrealistic fears of animals, monster, burglars;
- Fear being alone in the dark; and
- Have severe tantrums when forced to go to school (American Academy of Child and Adolescent Psychiatry, 2010).

Child welfare professionals are often contacted when a child/adolescent becomes excessively truant at school. Truancy issues are often based on deeper issues than a child just not wanting to go to school (American Academy of Child and Adolescent Psychiatry, 2010). Although all children who are truant don’t have Separation Anxiety Disorder, it is important to look at the behaviors of the child/adolescent and the attachments between the parent and child/adolescent when assessing the cause of whya child/adolescent is truant.

Scenario 3 - Obsessive-Compulsive Disorder:

Suggested responses for Scenario 3 include:

> *Truancy issues; grades have declined; didn’t go to school because he didn’t feel he could go without a rubber band around his wrist; particular about belongings and routines; extreme anger and frustration if routine is interrupted; Jay has to put his right pant leg on first, placing his foot directly in his shoe so it does not touch the floor; if routine is broken while getting dressed, Jay has to undress and begin his routine over; Jay has “rituals”, including shutting the toilet seat, lifting it again, and closing it; turning on and off light switches; touching the same point onthe wall when he goes down the stairs; etc.*

1. *How often does Jay go to school late or skip school? Over what period have his grades declined and to what extent? What are more specifics about routines and how long they take to complete? Are Jay's bouts of anger and frustration the same intensity every time? Are Jay's bouts of anger and frustration different intensities for different routines? Does the school see the same problems?*
2. *Psychiatric evaluation and follow recommendations; Meeting with school to identify issues that they are seeing and ways that the school can make changes to help Jay through the day; Help father to understand what Jay is going through and ways he can be supportive and helpful; Continue to assess Jay's safety due to Jay's altercation with his father.*

Do: Refer participants to **Handout #4** (**Childhood Mental Health Issues: A Resource Guide) (revisited).**

Do: Assign groups to review websites listed under the *Depressive and Bipolar Disorders* (page 2 – two group, ensuring they don't pick the same disorder and the *Anxiety and Obsessive-Compulsive Disorders* (page 3 – one group) sections of the handout. Ask groups to report out the information they found.

Instructor Note: If time permits, you want to share some techniques in working with children/adolescents who struggle with anxiety. One such technique is C.O.P.E. (Calm, Operationalize a plan, Persevere, Evaluate) developed by Dacey andFiore (2000) and described in their book *Your Anxious Child: How Parents and Teachers Can Relieve Anxiety.*

Instructor Note: This would be a good time to end Day 1.

Step #5: (1 hour) Symptomology and Prevalence of Trauma- and Stressor-Related Disorders

Instructor Note: It is suggested to begin the day by asking participants to share one thing that they learned yesterday and/or one thing that they will now do differently in their case practice based on information discussed during Day 1 of this training. Then review the Agenda for Day 2.

Say: Trauma- and Stressor-Related Disorders share the core diagnostic criterion of exposureto a traumatic or stressful event. Distress following exposure is quite variable among children/adolescents. Some youth rebound from these events without developing symptoms of a mental health disorder while others develop an anxiety disorder.

However, for some youth, exposure to catastrophic or adverse events results in the inability to feel pleasure from experiences usually found enjoyable, externalizing angry and aggressive symptoms, and/or dissociation (detachment) (American Psychiatric Association, 2013). Three disorders found under the category of Trauma- and Stressor-Related Disorders are: Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, and Post Traumatic Stress Disorder. These three disorders have particular relevance for children who are maltreated and/or are exposed to a major stressful event, such as domestic violence (American Psychiatric Association, 2013).

Reactive Attachment Disorder: (15 minutes)

Do: Display and review **PowerPoint Slides #28-29 (Reactive Attachment Disorder Indicators).**

Say: According to the American Psychiatric Association (2013), serious social neglect is a diagnostic requirement for Reactive Attachment Disorder and the only known risk factor for the development of the disorder. Social neglect or pathogenic care can result from: persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection by caregiving adults (i.e., neglect); persistent disregard of the child's basic physical needs; repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care); and rearing in institutional settings with high child-to-caregiver ratios.

The child displays a consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by the child rarely or minimally seeking comfort when distressed and rarely or minimally responding to comfort when distressed.

Additionally, children diagnosed with RAD exhibit persistent social and emotional disturbance characterized by at least two of the following: minimal social and emotional responsiveness to others; limited positive affect; episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with caregiving adults. These behaviors must be evident before age 5, although the diagnosis cannot be made until the child reaches the developmental age of at least 9 months (American Psychiatric Association, 2013).

The overall prevalence for Reactive Attachment Disorder is rare. However, there is a greater likelihood that a child welfare professional might come into contact with a child

with symptoms of Reactive Attachment Disorder as children whose attachments are disrupted are more likely to come to the attention of a Child Welfare agency. In populations of severely neglected children, the prevalence of RAD is approximately 10 percent (American Psychiatric Association, 2013).

Child welfare professionals are given the task of trying to achieve safety, permanency and well-being for children. It can be a struggle to achieve permanency for a child/adolescent with attachment issues. The impact of separation and placement can create a high risk of crisis for children and their families. You must understand and consider the dynamics of this crisis when developing placement plans and strategies in order to prevent further crisis due to its potentially damaging consequences. Traumatic separations can interfere with the development of healthy attachments and can affect a child/adolescent's ability and willingness to become involved in relationships in the future (American Psychiatric Association, 2013). Furthermore, when children/adolescents remain in placement for extended periods of time, they remain in emotional limbo. They cannot reverse the loss by returning home; nor can they fully grieve the loss and reestablish themselves in new families and communities. Therefore lack of permanency can lead to emotional chaos and diminished emotional well-being.

Ask: What can you do to try to foster attachments for children/adolescents involved in the Child Welfare System? Some ideas include:

- Pre-placement visits – diminish fears and worries about the unknown; facilitates transfer of attachments; initiates grieving process; empowers new caregivers; and encourages making commitments towards the future.
- Post-placement contacts – prevents denial or avoidance; resurfaces emotions about separation at manageable levels; provides an opportunity to support feelings; decreases magical thinking; decreases loyalty issues; and continues transference of attachment/empowerment of new caretakers
- Contact with family of origin – allows for the assessment of parent-child attachment; facilitates the grieving process; decreases loyalty conflicts; strengthens attachments or bonds; facilitates changes in family relationships; andfacilitates reunification.
- Use of life books – helps children/adolescents understand the past, prepare for the future, come to terms with losses, and makes sense of life events and transitions.

<u>Disinhibited Social Engagement Disorder</u>: (15 minutes)

Do: Display and review **PowerPoint Slide #30 (Disinhibited Social Engagement Disorder Indicators)**.

Say: Similar to Reactive Attachment Disorder, serious social neglect (pathogenic care) is a diagnostic requirement for Disinhibited Social Engagement Disorder (DSED). However, unlike RAD, children diagnosed with DSED may or may not have formed attachments to a primary caregiver (American Psychiatric Association,2013).

The primary feature of DSED is a pattern of behavior that involves inappropriate, overly

familiar behavior with relative strangers (American Psychiatric Association, 2013). It's manifested by at least two of the following:

- Reduced or absent reticence in approachingand interacting with unfamiliar adults
- Overly familiar verbal or physical behavior that is culturally and developmentally inappropriate
- Diminished or absent checking back with adult caregivers after venturing away, even in unfamiliar settings
- A willingness to go off with an unfamiliar adult with minimal or no hesitation (American Psychiatric Association, 2013).

In the high-risk population of children who have been severely neglected and subsequently placed in foster care or raised in institutions, the prevalence rate of DSED is 20 percent (American Psychiatric Association, 2013).

Do: After reviewing the diagnostic criteria for DSED, ask participants to share examples of behaviors exhibited by children on their caseload who display some of these characteristics.

Posttraumatic Stress Disorder: (30 minutes)

Do: Display and review **PowerPoint Slide #31 (Exposure to Trauma)**.

Say: Children who come to the attention of child welfare professionals have often experienced multiple traumas including serious neglect, abuse, exposure to domestic violence, and witnessing violence in the communities in which they live. In fact, 34 percent of children and youth involved in the Child Welfare System and 28 percent involved in the Juvenile Justice System experience four or more types of traumatic events (Substance Abuse Mental Health Services Administration, 2012). The most common trauma experienced by all children in the U.S. is interpersonal violence (National Child Traumatic Stress Network, 2013).

Do: On a previously prepared flip chart write the following questions:

1. What are the types of trauma described in the video?
2. What are the signs that a child has been exposed to trauma?
3. What are the potential long-lasting physical and mental health outcomes of exposure to trauma during childhood described in the video?

Ask participants to write their responses to the three questions on the flip chart as they watch the video they are about to see. Show the **Video *Through Our Eyes – Children, Violence, Trauma*** (7.54 minutes) in its entirety (https://www.youtube.com/watch?v=z8vZxDa2KPM). Ask participants to share their responses to the questions and record the information on a flip chart. Refer to these responses to provide examples of the information covered in the remaining segment on Posttraumatic Stress Disorder.

Do: Emphasize that not all children/adolescents respond the same to trauma. In fact, some children/adolescents with a high-level of resilience may be minimally affected and show remarkable capacity to overcome adversity. Explain that children/adolescents respond to trauma differently based on their developmental age as well as other factors, such as the degree of exposure, perceived life threat and personal injury, as well as the child's temperament and genetic predisposition for developing mental health disorders (American Psychiatric Association, 2013).

Ask: What are different ways that children/adolescents react to trauma during different stages of development?

Note that it is important to gather information about the traumatic experience(s). Although you can talk directly to the child/adolescent about the experience, it can also be helpful to gather information from others (parents, caregivers, siblings, etc.) who might have knowledge about the traumatic event(s). Also, stress the importance of obtaining a full picture of the child's range of emotional, behavioral, and developmental reactions to trauma, as well as thefrequency and intensity of the responses described by the child and caregivers. When discussing individuals' trauma it is essential to use a trauma-informed approach.

Do: Display and review **PowerPoint Slide #32 (Posttraumatic Stress Disorder Indicators)**.

Say: In order for a diagnosis of PTSD, children/adolescents who experienced exposure to actual or threatened death, serious injury, and/or sexual violence must exhibit a cluster of symptoms that fall into four categories:

- Intrusion symptoms associated with the traumatic event(s) following exposure;
- Avoidance of stimuli associated with the traumatic event(s);
- Changes in cognition and mood associated with the traumatic event(s); and
- Significant changes in arousal and reactivity associated with the traumatic event(s) (American Psychiatric Association, 2013).

Instructor Note: You may need to remind participants that children often re-enact trauma through play, whereas adolescents talk about the trauma they experienced. Vary approaches to gathering information based on the child's age. Also, remind participants the importance of teaming with mental health professionals.

Ask: Thinking about children who have been on your caseload, what are some examples of emotions, thoughts, and behaviors of those who have been diagnosed with PTSD?

Do: Connect the examples to the cluster of symptoms required for a diagnosis of PTSD. Be sure to facilitate so that sharing is limited to the emotions, thoughts and behaviors, not the specific stories or experiences of the children. Check in on participants' well-being and coping mechanisms when the work with children exhibiting PTSD, and ensure they are okay now talking about the topic.

Step #6: (1 hour) Symptomology and Prevalence of Disruptive, Impulse-Control, and ConductDisorders

Say: Now we will look into Disruptive, Impulse-Control, and Conduct Disorder and will focus on Oppositional Defiant Disorder (ODD), Intermittent Explosive Disorder, and Conduct Disorder (CD). A central feature of these three disorders is self-regulation of emotions and behavior, however, there are clear cut differences. The criteria for CD focus mainly on difficulty controlling behaviors that violate the rights of others while the indicators for Intermittent ExplosiveDisorder fall mainly around the inability to control emotions (most commonly anger).

Criteria for ODD fall rather evenly between self-control of emotions and behaviors (American Psychiatric Association, 2013).

Some of the most difficult behaviors for parents and caregivers to manage are associated with a child/adolescent's oppositional, aggressive, and impulsive behaviors. To better help families cope with these disorders, it is necessary to understand the behaviors that children/adolescents display and how those behaviors impact the family.

<u>Oppositional Defiant Disorder</u>: (20 minutes)

Ask: What are some emotional and behavioral indicators of ODD?

Do: Ensure that participants touch on the following:

- Frequent temper tantrums;
- Excessive arguing with adults;
- Active defiance and refusal to comply with adult requests and rules;
- Deliberate attempts to annoy or upset people;
- Blaming others for their mistakes or misbehavior;
- Often being touchy or easily annoyed by others;
- Frequent anger and resentment;
- Mean and hateful talking when upset; and
- Seeking revenge (American Psychiatric Association, 2013).

Do: Show and review **PowerPoint Slide #33 (Oppositional Defiant Disorder Indicators)**

Do: Connect the emotional and behavioral examples just provided by the participants to the three clusters of symptoms (angry/irritable mood, argumentative/defiant behavior, and vindictiveness) displayed on the slide.

Say: It is not unusual for children/adolescents to show symptoms only at home and only with family members; however, teachers may also see the symptoms in the classroom and during interactions with peers. The rate of ODD among children and teens ranges

from 2 to 16 percent (AACAP, 2019). Note that in children/adolescents, ODD is more prevalent in families where childcare is disrupted by a succession of different caregivers or in families in which harsh, inconsistent, or neglectful child-rearing practices are commonly used (American Psychiatric Association, 2013).

The rigidity and demanding attitude exhibited by children/adolescents diagnosed with ODD can overwhelm parents/caregivers. For some, the behaviors become so overwhelming that a parent might lash out at their child/adolescent. Other parents might not have any hope and might "throw in the towel." Most parents feel worn down because they can no longer put up with their child/adolescent's continual refusal and excessive arguing.

Due to the struggles that a parent/caregiver might experience when dealing with an oppositional child/adolescent, it is helpful to have several tools for the child welfare professionals to work with parents/caregivers in managing their child/adolescent's behaviors. We will now look at some tools offered by Ross Greene (2010) that you can offer a parent/caregiver who struggles with an oppositional child/adolescent. We will focus on:

1. Forced choice;
2. Picking the "hills to die on;" and
3. Positive reinforcement for delaying gratification.

Forced choice

Forced choice promotes cooperation and empowers children/adolescents. This technique is good for any behavior that parents/caregivers want their child/adolescent to start doing. For example, if a parent/caregiver of an ODD child wants the child to take a bath, the parent uses the forced choice technique by saying, "Are you using the pink bubbles or the blue bubbles to take your bath tonight?" The parent/caregiver should allow the child time to process the question. Most important is that the parent/caregiver ignores irrelevant questions, comments, or complaints from the child/adolescent.

Picking the "hills to die on"

Parents/caregivers of children/adolescents diagnosed with ODD need help in deciding the "hills they want to die on." In other words, you can assist parents in deciding which issues are non-negotiable (all risk and safety issues) and which issues are negotiable. Parents can be taught how to stand firm on non-negotiableissues and how to "negotiate" all other issues with their children/adolescents.

Positive reinforcement for delayed gratification

The basis of positive reinforcement is to catch your child/adolescent when they are doing on-target behavior, recognizing it and rewarding it very quickly and as often as possible. Rewards can include praise and affection such as a hug or a pat on the shoulder, or they could be more specific such as allowing the child/adolescent the option to pick what they want for dinner or choose what television program the family will watch that evening. The

most important part of this is to look the child/adolescent directly in the eye and say, "I noticed that you were able to wait for me instead of rushing out the door in anger because I was on the phone." or "I see that you finished your homework without me asking you." Parents/caregivers should be reminded to positively reinforce their child/adolescent when they do exhibit the ability to wait ordelay gratification – even for short periods of time.

Without the parent/caregiver or other professional's interventions in managing these oppositional behaviors, some children/adolescents diagnosed with ODD are at higher risk for developing Conduct Disorder (American Psychiatric Association, 2013).

Instructor Note: If time allows, instructor may opt to add in other techniques that they have used that are successful with children/adolescents diagnosed with ODD.

Intermittent Explosive Disorder: (5 minutes)

Do: Display and review **PowerPoint Slide #34 (Intermittent Explosive Disorder Indicators)**.

Say: Children/adolescents diagnosed with Intermittent Explosive Disorder are sometimes described as "going from zero to 100 in 2 seconds" during their aggressive outbursts. These outbursts can take the form of verbal aggression, physical aggression, or destruction of property and that the aggressive response is out of proportion to the precipitating event or provocation. This diagnosis cannot be given to children under age 6. (American Psychiatric Association,2013).

Conduct Disorders: (35 minutes)

Say: Conduct disorder affects 6 percent of all children/adolescents and the disorder appears to be more common in boys than in girls. (American Academy of Child and Adolescent Psychiatry, 2010).

Ask: What behaviors are exhibited by children/adolescents diagnosed with CD and co-occurring conditions with conduct disorders such as those shown in the video?

Do: Be sure that the participants identify physical aggression, intimidation, weapon use, theft, fire setting, involvement with law enforcement, and substance abuse.

Do: Display and review **PowerPoint Slides #35-36 (Conduct Disorder Indicators)**.

Say: The major feature of this disorder is a pattern of behavior in which the basic rights of others or societal norms and rules are violated. To meet the required criteria for the diagnosis, the behaviors must fall into three out of four of the following categories: aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules (American Psychiatric Association, 2013).

Also, note that there are three subtypes of CD:

- childhood onset (prior to age 10);

- adolescent subtype (no symptoms prior to age 10);
- unspecified (not enough information to accurately determine age of onset)

Mental health professionals add a specifier code to the diagnosis if the symptoms reflect limited prosocial emotions (lack of remorse, empathy, concern about performance, or affect). Additionally, they specifywhether the symptoms of CD are mild, moderate, or severe (American Psychiatric Association, 2013).

Emphasize that the behaviors associated with CD might put the diagnosed child/adolescent or others (i.e. siblings) at risk for abuse. Assign each table one of the three (or all) of following tasks:

1. Identify how a child/adolescent exhibiting the listed emotional and behavioral indicators might be at risk of being a victim of abuse and have challenges in achieving permanency.
2. Identify how a child/adolescent exhibiting the listed emotional and behavioral indicators might put other children (i.e. siblings) at risk of being victims of abuse.
3. Identify the overall impact that these behaviors will have on the child/adolescent and their family.

In addition to completing one of the three (or all) above tasks, all groups should also identify how and when a child welfare professional might need to intervene to lower the risk and safety threats to the child/adolescent displaying these behaviors as well as the other children who come into contact with the child/adolescent who is acting out.

Acknowledge that more information may be necessary to know how quickly a child welfare professional would respond to safety threats or risk factors. Encourage participants to list what additional information they would want to know. Point out that this should, in turn, guide further information gathering, assessment, and referral.

Do: Give participants 10 minutes to complete this exercise and allow each small group 3-4 minutes to report their responses.

Say: Gathering as much information as possible from the child/adolescent, parents, caregivers and other individuals (i.e. teachers, counselors, siblings, etc.) with the ability to address these behaviors allows you the opportunity to conduct the most thorough assessment and in turn will allow you to best connect the child/adolescent and family to the most appropriate resources.

Instructor Note: This would be a good time to take the morning break on Day 2.

Step #7: (15 minutes) Symptomology and Prevalence of Eating Disorders

Ask: How do the images seen on television, commercials, and magazines impact many young women and men as they begin to grow and develop?

Say: Children and adolescents are influenced by the images they see and try to fit into the

portraits of femininity and masculinity that society portrays.

Eating disorders like Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder are on the increase among children and adolescents, and often run in families.

Do: Display and review **PowerPoint Slide #37 (Feeding and Eating Disorder Statistics).**

Say: Now we'll focus on three common Feeding and Eating Disorders found in children and adolescents: Anorexia Nervosa, Bulimia Nervosa, and Binge- Eating Disorder. Prevalence estimates include: Anorexia Nervosa (.4 percent), Bulimia Nervosa (1-1.5 percent), and Binge-Eating Disorder (1.6 percent in females and .8 percent in males) (American Psychiatric Association, 2013). The common thread among these three disorders is a persistent disturbance of eating or eating- related behavior that significantly impairs physical health or psychosocial functioning (American Psychiatric Association, 2013).

Parents/caregivers frequently ask how to identify symptoms of Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder, so we'll talk about that now.

<u>Anorexia Nervosa</u>: (5 minutes)

Do: Display and review **PowerPoint Slide #38 (Anorexia Nervosa Indicators).**

Say: The diagnostic criteria for Anorexia Nervosa are:

- Restriction of food intake leading to significantly low body weight
- Intense fear of gaining weight or becoming fat
- Disturbances in the self evaluation of body weight or shape (American Psychiatric Association, 2013).

Children/adolescents diagnosed with Anorexia Nervosa are typically perfectionists and high achievers in school. At the same time, these children suffer from low self-esteem, irrationally believing they are fat regardless of how thin they become.

Desperately needing a feeling of mastery over their life, the children/adolescents diagnosed with Anorexia Nervosa experience a sense of control only when saying "no" to the normal food demands of the body. In a relentless pursuit to be thin, they starve themselves. This act often reaches the point of serious damage to the body, and in a small number of cases may lead to death (National Association of Anorexia Nervosa and Related Disorders, 2013).

<u>Bulimia Nervosa</u>: (5 minutes)

Do: Display and review **PowerPoint Slide #39 (Bulimia Nervosa Indicators).**

Say: The symptoms of Bulimia Nervosa include: recurrent episodes of binge eating characterized by:

- Eating an amount of food within any 2-hour period that is significantly larger than what most individuals would eat
- A sense of lack of control over eating during the episode
- Recurrent behaviors to prevent weight gain, such as self-induced vomiting, misuse of laxatives, misuse of diuretics, fasting or excessive exercise; and self- evaluation that is unduly influenced by body shape and weight.
- Binge eating and purging behaviors both occur on average at least once a week for 3 months (American Psychiatric Association, 2013).
- Intense shame about the condition is often experiencedby children/adolescents with Bulimia Nervosa.
- Purging of Bulimia presents a serious threat to the patient's physical health, including dehydration, hormonal imbalance, the depletion of important minerals, and damage to vital organs (Mayo Clinic, 2013).

<u>Binge-Eating Disorder</u>: (5 minutes)

Do: Display and review **PowerPoint Slide #40 (Binge-Eating Disorder Indicators).**

Say: Binge-Eating Disorder is characterized by:

- Eating an amount of food within any 2-hour period larger than what most people would eat
- Sense of lack of control over eating during the episode
- Associated with eating much more rapidly than normal
- Eating until uncomfortably full
- Eating large amounts of food when not feeling physically hungry
- Eating alone due to embarrassment over the amount of food eaten
- Or feeling depressed or guilty after the episode
- Episodes occur on average at least once a week for 3 months (American Psychiatric Association).

Unlike Bulimia Nervosa, periods of binge-eating are not followed by purging, excessive exercise, or fasting. As a result, people with Binge-Eating Disorder often are overweightor obese. People with Binge-Eating Disorder who are obese are at higher risk for developing cardiovascular disease and high blood pressure. They also experience guilt,shame, and distress about their binge-eating, which can lead to more binge-eating (National Institute of Mental Health, 2012).

Caregivers often don't know the ways in which their frequent comments about body size, body image, and dieting impact their children/adolescents. Parents are key playersin providing protective capacities in preventing their child/adolescent's development of a Feeding and Eating Disorder. Display and review **PowerPoint Slide #41 (Feeding and Eating Disorder Recommendations)**. The following are suggestions from the National Association of Anorexia Nervosa and Associated Eating Disorders (2013) to create a healthy environment for promoting a child/adolescent's self-esteem and to counter some of the destructive media messages about body image flooding today's young people.

They include:

- Model healthy thoughts and behaviors;
- Prohibit teasing about body shape and size;
- Emphasize fitness and promote physical activity;
- Praise your children for who they are;
- Encourage healthy eating, not dieting;
- Don't forbid certain foods;
- Make mealtime pleasant;
- Talk to your children about the unrealistic images in magazines, TV, and in the movies;
- Demonstrate how a competent person takes charge, solves problems, negotiates relationships, and builds a satisfying life without resorting to self-destructive behaviors; and
- Get help when appropriate (National Association of Anorexia Nervosa and Related Disorders, 2013).

Step #8: (45 minutes) Symptomology and Prevalence of Neurodevelopmental Disorders

Say: Next we will look at Neurodevelopmental Disorders to includeAutism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder.

<u>Autism Spectrum Disorder</u>: (15 minutes)

Say: Autism Spectrum Disorder affects 1 percent of the child/adolescent population, with a male to female ratio of 4:1 (American Psychiatric Association, 2013).

Symptoms of Autism Spectrum Disorder cluster around two areas: deficits in social communication and social interaction across multiple contexts; and restricted, repetitive patterns of behavior, interests, or activities (American Psychiatric Association, 2013) Diagnosticians code the level of symptom severity (mild, moderate, severe).

Do: Display and review **PowerPoint Slide #42 (Autism Spectrum Disorder Indicators)** and provide examples that fall under the two diagnostic criteria categories:

- Social communication and social interaction deficits
    - Social-emotional reciprocity
    - Nonverbal communication behaviors used for social interaction
    - Developing, maintaining, and understanding relationships
- Restricted, repetitive behaviors, interests, or activities
    - Stereotyped or repetitive movements, use of objects, or speech
    - Insistence on sameness
    - Fixated interests
    - Hyper- or hypo-reactivity to sensory input (American Psychiatric Association, 2013)

Say: You are about to see a brief video that describes the seven sensations that our brains integrate constantly throughout the day. They are: visual, auditory, tactile, smell, taste, proprioceptive (sensing body in space), and vestibular (movement) (Sensory Processing Disorder Foundation, 2013). Youth diagnosed with ASD often experience difficulty smoothly processing all of the informational input from these seven senses. The processing challenges can result in varying degrees of unusual behaviors, such as screaming when a sweeper is turned on (hyper sensitivity to sound), refusing to take a shower because the feel of the water hurts (tactile hyper sensitivity, or running into other children at recess due to inability to process the body positioning in space (proprioceptive) or movement (vestibular).

Do: Play the video *Ask an Autistic #9: Sensory Processing Disorder (10:39)*: https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv%3DupU-dc19Taw&data=04%7C01%7Cjeg121%40pitt.edu%7Cf2bd780353e9436ee64308da08fa010f%7C9ef9f489e0a04eeb87cc3a526112fd0d%7C1%7C0%7C637832167232286806%7CUnknown%7CTW

Ask: What behaviors typical of **Sensory Processing Disorder** have you observed in children in your work?

Say: Smooth integration of sensory input can be remediated by Occupational Therapy.

If a child/adolescent exhibits these or other characteristics of ASD, you need to follow through with a number of referrals so that the child/adolescent can receive further assessment and treatment. If a child's pediatrician is the first to suspect ASD, the child will benefit from being referred to professionals who specialize in diagnosing and treating Autism Spectrum Disorder including:

- Developmental pediatricians – Treat health problems of children with developmental delays
- Child psychiatrists – Medical doctors who may be involved in the initial diagnosis. They can also prescribe medication and provide help in behavior,

emotional adjustment, and social relationships

- Clinical psychologists – Specialize in understanding the nature and impact of neurodevelopmental disabilities, including ASD; may perform psychological and assessment tests, as well as help with behavior modification and social skills training
- Occupational therapists – Focus on practical, self-help skills that will aid in daily living such as dressing and eating; work on smooth integration of the seven senses
- Physical therapists – Improve the use of bones, muscles, joints, and nerves to develop muscle strength, coordination, and motor skills
- Speech/language therapists – Address communication skills, including speech, language, and conveying meaning during social interaction

Attention Deficit Hyperactivity Disorder: (15 minutes)

Do: Display and review **PowerPoint Slide #43 (Attention Deficit Hyperactivity Disorder).**

Say: About 9.4% of children/adolescents are diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) (CDC, 2021). Many caregivers become concerned when they receive a note from school relating that their child "won't listen to the teacher" or "is disruptive in class." One possible reason for the child's behavior could be Attention Deficit Hyperactivity Disorder (ADHD), but there maybe other reasons for such behaviors, including a child's temperament or sensory processing problems. The primary feature of ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development that is present before age 12 and manifests in two or more settings (American Psychiatric Association, 2013).

Although people are often aware of the indicators of ADHD, the existence of three subtypes within the disorder is less known. They include:

- Predominantly Inattentive;
- Predominantly Hyperactive/Impulsive; and
- Combined (American Psychiatric Association, 2013)

Ask: What are some behaviors associated with inattention and hyperactivity-impulsivity?

Do: Display and review **PowerPoint Slides #44-45 (Attention Deficit Hyperactivity Disorder Indicators)**.

Inattention (six or more)

- Fails to give close attention to details
- Difficulty maintaining attention
- Does not seem to listen when spoken to directly

- Does not follow through on instructions
- Difficulty organizing tasks or activities
- Often avoids, dislikes, or is reluctant to engage in tasks requiring sustained attention
- Loses things necessary for completing tasks or activities
- Easily distracted by extraneous stimuli
- Often forgetful in daily activities

Hyperactivity and impulsivity (six or more)

- Often fidgets with or taps hands or feet
- Leaves seat in situations when remaining seated is expected
- Runs about or climbs in situations where it is inappropriate
- Unable to play or engage in leisure activities quietly
- Is often “on the go,” acting as if “driven by a motor
- Often talks excessively
- Blurts out an answer before a question has been completed
- Difficulty waiting their turn
- Interrupts or intrudes on others (American Psychiatric Association, 2013)

Say: Children/adolescents with these behaviors might be at greater risk of abuse/neglect depending on their parent/caregiver’s tolerance level, coping skills,and support system. Therefore, it is critical to make sure parents and caregivers have adequate supports. Examples of such supports might include, but are not limited to:

1. Family (immediate and extended) – family members might be able to be a listening ear to the struggles often faced by caregivers;
2. Friends – a friend might be able to provide a respite for the child if the caregiver is feeling overwhelmed;
3. Neighbors – neighbors can compliment caregivers for a job well done and empathize with their difficult struggle; and
4. Community Supports – people who deal with similar issues can offer empathy and provide suggestions on how to cope based on personal experiences.

A child welfare professional, who is responsible for referring a child/adolescent who might have Autism Spectrum Disorder or Attention Deficit Disorder, should follow a similar process as other referrals for assessment of possible mental health issues.

Do: Display and review **PowerPoint Slide #46 (Mental Health Evaluation Referral Checklist).**

Ask: What might be helpful to include in a referral for a medical or mental health evaluation of a child/adolescent who is exhibiting emotional, behavioral, or developmental indicators of a mental health disorder, such as ASD or ADHD?

Do: Ensure that the following information is included:

- The identifying issues;
- Family health issues;
- Information about the pregnancy, labor, and delivery;
- Feeding/oral behaviors;
- Sleep patterns;
- Activity and motor development;
- Social skills and social environment;
- Coping mechanisms;
- Language and communication skills;
- Description of play;
- Mood;
- Fears and anxieties;
- Behaviors; and
- Relationships with others.

Emphasize the importance of gathering information about how a child/adolescent's behaviors sound and look as well as the frequency, intensity, and duration of behaviors. Gathering this information will assist Mental Health Professionals in providing the most accurate assessment during the diagnostic process.

Do: Refer participants to **Handout #4** (**Childhood Mental Health Issues: A Resource Guide) (revisited).**

Do: Ask participants to use their mobile devices to tour one or more of the websites listed under the following sections of the handout:

- *Trauma and Stressor- Related Disorders*
- *Feeding and Eating Disorders*
- *Neurodevelopmental Disorders*

Do: Have participants to report out what they found.

Say: Next we will learn more about the players involved in the Mental Health system, information on the continuum of care for and laws and regulations that guide the Child

Welfare and Mental Health systems; common communication barriers between various systems; the importance of collaboration in effective assessment and treatment interventions; and casework tasks associated with case management of children/adolescents with mental health issues.

Instructor Note: This is a good time to take lunch on Day 2.

Section V: The Players in the Child/Adolescent Mental Health System

Estimated Length of Time:

2 hours, 30 minutes

Key Concepts:

- ✓ There are multiple partners in the Child/Adolescent Mental Health System who must work together to improve child/adolescent safety, permanency and well-being outcomes.

Method of Presentation:

Lecture, small group activity, large group discussion

Materials Needed:

- ✓ Markers
- ✓ Masking tape
- ✓ 2 Flip chart pads
- ✓ 2 Flip chart stands
- ✓ **Handout #4 (Childhood Mental Health Issues: A Resource Guide)(Revisited)**
- ✓ **Handout #8 (Age of Consent for Mental Health Treatment in Pennsylvania)**
- ✓ **Handout #9 (Mental Health/Intellectual Disability)**
- ✓ **Handout #10 (Child and Adolescent Service System Program [CASSP])**
- ✓ **Handout #11 (Characteristics of a Quality Evaluation Report)**
- ✓ **PowerPoint Slide #47 (Managed Care in Pennsylvania)**
- ✓ **PowerPoint Slide #48 (Characteristics of a Quality Evaluation Report)**
- ✓ **PowerPoint Slide #49 (Treatment Approaches)**

Outline of Presentation:

- Review the importance of collaboration among the various players in the Child/Adolescent Mental Health System and offer tips for collaboration.
- Identify the roles of the various players in the Child/Adolescent Mental Health System.
- Review federal and state laws and regulations focusing on consent to treatment and control of mental health records.
- Discuss the importance of comprehensive evaluation and recommendations for appropriate treatment interventions.

Section V: The Players in the Child/Adolescent Mental Health System

Step #1: (20 minutes) Teaming/Collaboration

Say: Up to this point we have focused primarily on what you can do when working with families dealing with children's/adolescent's mental health. We are not, however, the only system involved with these families. Often our work to ensure safety, permanency, and well-being requires us to team with other systems. Teaming with other agencies can sometimes be challenging; it proves necessary to ensure that services offered to families remain consistent with the Family Service Plan (FSP) and Child Permanency Plan (CPP) goals and those services are delivered in a timely manner. Teaming across systems may take the form of placing a phone call to a Mental Health (MH) service provider or organizing a meeting of all the stakeholders involved in the child/adolescent's mental health treatment.

We'll talk about some challenges that may impact treatment services for children/adolescents:

- <u>Fragmented delivery system</u> – Separate funding and administration for public mental health and substance abuse services can contribute to the fragmented delivery of services to children and families. It is important for you to recognize these challenges and identify strategies to overcome them to promote teaming with education andjuvenile justice systems.
- <u>Gaps in public and private insurance coverage</u> – It is important for you to determine the type and extent of mental health and substance abuse coverage available to children and families. Inadequate coverage often limits families access to services. You can minimize this barrier by becoming aware of and referring families to any available public and private insurance programs.
- <u>Co-occurring disorders</u> – Increased challenges naturally occur when children, youth and parents experience co-occurring disorders. It is critical that you become more informed regarding co-occurring disorders and seek treatment providers who are skilled in providing services to address these complicated needs.
- <u>Inconsistent or unavailable treatment in detention or correctional facilities</u> – Youth with co-occurring disorders are often incarcerated, rather than treated. Two- thirds of the one million youth in formal contact with the justice system (i.e., charges and/or court appearance) have one or more alcohol, drug, and mental disorders. Youth with serious mental illnesses make up approximately a quarter of the population in the juvenile justice system, and their numbers are increasing. It is essential that when youth or parents are confined that they receive the necessary treatment. You must advocate for these youth and parents to receive appropriate treatment.

The PA Child Welfare Practice Model emphasizes the importance of teaming in working with a variety of service providers. You need to know your role, as well as the variety of systems, agencies and individuals that are involved in working with the child/adolescent

and their family. The practice model also stresses the importance of recognizing that the child/adolescent and their family are also team members with equal role and voice who are involved in the assessment and treatment process.

Step #2: (25 minutes) The Role of the Child Welfare Professional in the Child/Adolescent Mental HealthSystem

Instructor Note: Instructor should be familiar with the Mental Health laws related to this content.

Say: The Child Welfare System is one of the system partners in the Child/Adolescent Mental Health System. You may recall that your role includes:

- Building a rapport with the family by tuning in to the different perceptions that people have about mental health issues;
- Information gathering to include information about child/adolescent development and the frequency, duration and intensity of a child/adolescent's behaviors;
- Assessing the impact of child abuse/neglect in the development of mental health disorders as well as the risk factors associated with a child/adolescent being abused/neglected as a result of their mental health issues; and
- Assessing a parent/caregivers ability to manage their child/adolescent's mental health issues.

We have also touched on the importance of making referrals to the appropriate individuals/agencies so that children/adolescents and their families can receive further assessment and appropriate treatment interventions. We will now take a closer look at the laws and regulations that guide our practice and the practice of other system partners.

In addition to barriers previously discussed, some professionals involved in the Child/Adolescent Mental Health System cite the federal and state laws associated with consent to treatment and the release of records as barriers. To effectively assess and meet the needs of children and adolescents, you need to be aware of those Federal and State Laws and policies that are related to child/adolescent mental health issues as child welfare professionals have a legal responsibility to keep children safe and protected from risk of harm.

Ask: Which federal and state laws apply to Child Welfare and to children/adolescents with mental health issues?

Do: Point out that, in addition to Child Welfare legislation (i.e. The Juvenile Act and Child Protective Services Law), it is important to know about other federal and state laws and bulletins that pertain to children/adolescents with mental health issues. Provide a brief overview of:

- Mental Health and Intellectual Disabilities – MH/ID
- Mental Health Procedures Act of 1976 – MHPA

- Office of Children, Youth and Families Bulletin – OCYF Bulletin
- Office of Medical Assistance Programs – OMAP Bulletin
- Office of Intellectual Disabilities Bulletin – ODP Bulletin
- Office of Mental Health and Substance Abuse Services – OMHSAS

In addition, you need to be aware of the laws of confidentiality, who can consent to treatment, and who has control of mental health records.

Do: Review the content in **Handout #09 (Age of Consent for Mental Health Treatment in Pennsylvania)**.

Note: This topic might spark some discussion with participants due to frustrations about the challenges experienced pertaining to confidentiality and access to mental health records. Reiterate the tips for effective collaboration and remind participants that other system partners also struggle with these barriers. To better address these issues, child welfare professionals need to know what role other system partners play.

Step 3: (45 minutes) System Partners in the Child/Adolescent Mental Health System

Say: In your pre-work you reviewed which mental health services are available in your community.

Ask: What roles various do professionals and agencies play in your communities?

Do: Point out that each community has different services available, so it is important for each participant to become familiar with available resources within their community, especially due to their role and responsibilities of referring to and monitoring mental health services. After some large group discussion, explain that this training focusses on four agencies/partners thatinclude:

1. Educational System;
2. County offices of Mental Health/Intellectual Disabilities (MH/ID);
3. Child and Adolescent Service System Program (CASSP); and
4. Managed Care Organizations.

Educational System:

Say: One of the most frequent team members involved in assessment and screening for children/adolescents are schools and the Educational System. Most often the screening and assessment conducted within the Educational System focuses on non-physiological and non-medical factors and those things related to social learning and adaptation, as these are the biopsychosocial factors often looked at within the educational system.

Schools most often use assessment tools (i.e. Weschler Intelligence Scale for Children [WISC-V], Child Behavior Checklist [CBCL], Scale for Assessing Emotional Disturbance [SAED], and the Behavior Rating Profile [BRP-2]) to ascertain whether a child/adolescent's educational functioning is impacted by emotional/behavioral problems.

It is important to note that the early screening of young children with possibleemotional and behavioral disorders is best practice. This is based on the assumption that early identification and treatment are more effective and efficient than waiting until behaviors become more severe. Within the educational system, assessment and screening is most often based on teacher-initiated referral, although parents can request evaluation. The time lapse between initial referral and actual assessment by a school psychologist can be significant in some school districts.

Backlogs for psychological evaluation exist in some schools with high numbers of at-risk students and in districts with limited special education and pupil personnel resources. Furthermore, there are often differences of opinions, even among experts, about children/adolescents with more mild behaviors or behaviors that are somewhat in the "normal" range. Schools and parents/caregivers are reluctant to incorrectly label a child with a mental health diagnosis when, in reality, the child just needs more time to develop and mature. This is especially true for younger children. Moreover, high costs and the overarching stigmas associated with child/adolescent mental health issues further limit schools in carrying out timely systematic evaluation for students with emotional/behavioral disorders.

Fortunately, the Educational System (in addition to the Child Welfare and Mental Health systems) has to comply with federal and state laws and regulations regarding the services offered to children/adolescents with mental health issues. Federal legislation contained in the Individuals with Disabilities Education Act (IDEA) (U.S. Department of Education, 2013) requires effort to identify all children and adolescents with disabilities. Federal rules under IDEA include:

- Involvement of multiple disciplines;
- All known or suspected disabilities must be assessed accurately and fairly;
- Assessment results must be confidential;
- Parents have a right to mediation or a due process hearing;
- Periodic re-evaluation is required;
- Parents are to be included in all steps from initial evaluation to placement;
- Transition planning must be part of the Individualized Education Plan (IEP) for students age 14 or older;
- Students with emotional or behavioral disorders (EBD) must be included in general assessments of educational progress; and
- Positive behavior intervention plans are to be based on a functional behavioral assessment, which is to be included in Individual Education Plans (IEPs).

Mental Health/Intellectual Disabilities:

Say: The Mental Health/Intellectual Disabilities program was created based on previous legislation which also provided the statutory basis for the development of community-based services for people with intellectual disabilities. In addition, people are provided

supports in their home whether that is their family home or their own home.

Ask: Have you worked with your county Mental Health/Intellectual Disabilities Office? What was that experience like for you?

Do: Review the services that are offered by each agency by having participants reference **Handout #10 (Mental Health/Intellectual Disability)**. Be sure tofocus on those services available for children located on page one.

CASSP:

Say: Another team member in the Child/Adolescent Mental Health system is the Child and Adolescent Service System Program (CASSP).

Ask: Have you worked with CASSP system? Was that a positive or challenging experience for you? If it began as a challenge and became positive, what do you feel helped with that switch?

Do: Review **Handout #11 (Child and Adolescent Service System Program [CASSP])**.

Instructor Note: Participants may reference struggles and barriers they come across in working with these systems. Encourage participants to share their struggles, but also request any positive experiences with these agencies as well. It may be helpful for you to share some of your own experiences in working with these agencies.

Explain that child welfare professionals aren't the only ones that struggle in navigating the system. Talk about the struggles that families might have in understanding servicesand resources available to them. Point out that in addition to assistance offered by MH/ID and CASSP, there are other partners that can assist families in navigating the Mental Health System, such as the Parents Involved Network (PIN) (Department of Behavioral Health and Intellectual Disabilities Services, 2013).

Managed Care Organizations:

Say: Other significant team members involved in the Mental Health system are Managed Care Organizations (MCO's). The State and various counties across the state have contracted with MCO's to provide for the physical and behavioral health needs of all MA recipients designed to allow recipients some choice in their medical/behavioral health care. This training focusses on behavioral health care services.

Managed Care, also known as Health Choices in Pennsylvania, defines their system as "a system designed to maximize the quality and accessibility of health care for Pennsylvania's Medical Assistance (MA) consumers while ensuring the continued fiscal accountability to the taxpayers." Although the Managed Care system was intended to offer further assistance in navigating the Mental Health system, many believe that thesystem actually minimizes the quality and accessibility of services. With that being said, it is important to gain insight into how to more effectively collaborate with this partner in the Mental Health system. One way is to gain greater understanding about the role that

MCO's play within the system and what information you need so that MCOs can better maximize the quality and accessibility of services of children/adolescents withMental Health issues.

Behavioral Health Managed Care Organizations (BH-MCO) cover both mental health and substance abuse services. Services are authorized based on "medical necessity." "Medical necessity" needs to be determined for authorization for residential treatment for mental health issues to include:

- Individual Residential Treatment (IRT)
- Community Residential Rehabilitation (CRR) Host Home
- Residential Treatment Facility (RTF)

As well as for various levels of care (continuum of care), usually focusing on the least restrictive environment:

- Out-patient
- Intensive Out-patient (IOP)
- Behavioral Health Rehabilitation Services (BHRS-formerly referred to as "wrap-around")
- Family-Based Services

No protocol can guarantee approval of requests made for a child/adolescent's mental health services, but the following information is suggested for working with MCOs:

- Timely submission of documents;
- Clear identification of service requests (to include frequency and intensity ofservices requested);
- Thorough psychological/psychiatric evaluations;
- Rationale for the proposed services requested;
- Coordination to a treatment plan; and
- Updated treatment plans.

These approaches can be made more difficult because different MCOs might request different information.

Do: Display and review **PowerPoint Slide #47 (Managed Care in Pennsylvania)**.

Say: There are different MCOs in different counties and arrangements change; therefore, you need to be cognizant of which MCO oversees the child/adolescent's services. This task is even more difficult when the child/adolescent moves from one MCO jurisdiction to another, which can occur based on the child/adolescent's need to transition from one level of care to another. You need ensure continuity of care for the child/adolescent and limit disruption in treatment and intervention services. Take time to discuss the continuum

of care found in the Child/Adolescent Mental Health system.

Services offered on the continuum of care are most often recommended by psychiatrists and/or psychologists. In the next section we will discuss what needs to be included in a referral to a person conducting a mental health evaluation as well as information that should be included in mental health evaluations.

Instructor Note: This is a good time to take the afternoon break on Day 2.

Step #4: (15 minutes) Individual Team Members in the Child/Adolescent Mental Health System

Say: Your pre-work included information on a psychiatric/psychological evaluation. Mental health evaluations vary as much as the number of people writing them and you might not always get the information you need. Keep in mind that the quality of an evaluation can depend on the information preceding the evaluation so referrals must be complete and include the following information:

- Basic information about the child/family
- Questions and concerns
- Risk and Safety Assessment information
- Past services/medication history
- Additional/relevant information

It is important for you to determine whether the mental health evaluation report is comprehensive and complete.

Do: Distribute and review **Handout #12 (Characteristics of a Quality Evaluation Report)** as defined in the Guidelines for BestPractice in Child and Adolescent Mental Health Services while also displaying **PowerPoint Slide #48 (Characteristics of a Quality Evaluation Report)**. Encourage participants to take time to read evaluations to assess the quality of the evaluation conducted.

Say: A comprehensive evaluation includes:

- Information about the child/adolescent's age, grade-level in school, type of class setting, place of residence, family composition, current mental health and other human services-related information, and other information that places the life of the child/adolescent in context;
- Description of observed concerns and symptoms;
- Information about health, illness, and treatment (both physical and psychiatric);
- Parent and family histories;
- Information about the child/adolescent's development, including incorporation of information from other professionals such as educational evaluations, psychological

evaluations, speech and language evaluations, etc.;

- Information about school and friends;
- Information about family relationships; and
- Any child psychiatric or psychological interviews conducted.

Say: Consider the list of characteristics of a quality evaluation and the sample evaluation you reviewed for pre-work.

Ask: Did the sample evaluation have thesecharacteristics? How? Do your agencies contract with multiple psychologists for evaluation, and, if so, is there different information included from different providers?

Say: In addition to the characteristics of a quality evaluation, a psychological evaluation should include recommendations for treatment and, when applicable, a diagnosis with a specific diagnostic code. Explain that the field of mental health uses the Diagnostic Statistical Manual (DSM-5) as a means to determine a diagnosis of a mental health disorder in children/adolescents based on the symptoms exhibited (American Psychiatric Association, 2013). The manual codes each disorder, describes the symptoms, prevalence rates, risk factors and culture-related issues for each disorder, offers differential diagnosis possibilities, provides qualifying conditions, and describes common co-morbid disorders.

This information is helpful to understand the specifics of an individual's diagnosis and helps to provide further insight into behaviors. DSM-5 diagnostic and codes are also used as the standard method to ensure payment and reimbursement both for private health insurance companies and public i.e. Medicaid, and are used to gather statistical information such as the prevalence statistics presented earlier in the training.

Additionally, the DSM-5 includes a glossary of cultural concepts of distress. The glossary of cultural concepts of distress is located on pages 833-837 in the DSM-5 (American Psychiatric Association, 2013).

Step 5: (45 minutes) Treatment and Prevention

Instructor Note: Instructor may want to share that periodically the government updates the ICD codes. If, for whatever reason, the child welfare professional cannot find the specific diagnostic code they are looking for, they should use the internet as a resource.

We have looked at several common child/adolescent mental health disorders identified in the DSM-5. Explain that once a diagnosis is made, the next step is to look at what treatment options might best meet the child/adolescent's needs, in addition to looking at possible preventative interventions might promote resiliency and improve overall well-being.

Following the part of the evaluation that lists the child/adolescent's diagnosis(es), the psychologist and/or psychiatrist will provide recommendations based on the discussed continuum of care. In addition to information about the different levels of treatment,

evaluation might also reveal specific treatment interventions that might be useful in addressing the child/adolescent's needs.

Do: Display and review **PowerPoint Slide #49 (Treatment Approaches)**.

Do: Refer participants to **Handout #5** (**Childhood Mental Health Issues: A Resource Guide) (revisited).**

Do: Assign one website listed under the *Treatment* section (page 6) of the handout to each group. (One website will not be assigned). Ask participants to use their mobile devices to tour their assigned website and prepare a summary of the treatment approaches described on the site. Ask participants to report out the information they found.

Point out that childhood is the ideal time to focus on prevention of mental health issues and to promote well-being. Prevention interventions focus on reduction of risk and the prevention of concerning behaviors. Intervention programs are available to children/adolescents at all stages of development:

Project Head Start, though generally thought of as an early childhood intervention program, is probably this country's best known prevention program. Early Intervention Programs offer early assessment, social interaction, health and education services, and most often they can accommodate home-based interventions services.

Infant Development Programs focus on preventive interventions targeted to at-risk populations and they focus on preventing the establishment of health, social, and mental health problems in young children by working with both the child and the child's mother, clearly a family- focused, child-centered intervention.

Schools also offer programs that offer an array of preventative services including peer groups, mentoring programs, and after-school programs. Communities also have prevention programs like Big Brother/Big Sister as well as support groups for both children and family members that are at risk or are struggling with mental health issues.

Crisis hotlines are available in all communities for those in immediate need of services and although someone may be in crisis, these services can still be considered preventative services.

Sometimes preventative resources are available within one's own family. Kinship resources can assist in providing respite or even providing a temporary home for a child at risk of out-of-home placement, but more often than not, families will need to access resources within the community.

The goal of these resources is to provide preventative interventions and treatment services that promote resiliency and improved well-being. In addition to knowing who and what players are involved and what resources they bring to the table, you need to know that you must collaborate with these players to best be able to meet the mission of child/adolescent safety, permanency, and well-being.

Section VI: Conclusions and Evaluations

Estimated Length of Time:

30 minutes

Key Concepts:

- ✓ Conclusion of the learning process requires a review of the learning objectives.
- ✓ Evaluation of the workshop offers a means to assure objectives have been met, content was relative to practice and that the instructor presented the materials effectively.
- ✓ Evaluation offers feedback for continued improvement of the training curricula.
- ✓ Transfer of learning supports application of materials covered to practical application on the job.

Method of Presentation:

Lecture, individual activity

Materials Needed:

- ✓ **Handout # 12 (Transfer of Learning)**
- ✓ **Handout #13 (References)**
- ✓ **PowerPoint Slides #4-5 (Learning Objectives) (revisited)**
- ✓ **PowerPoint #50 (Transfer of Learning)**

Outline of Presentation:

- Review the learning objectives.
- Provide closure by discussing the prevalence and statistics associated with child/adolescent mental health issues.
- Encourage transfer of learning and use of resources in the bibliography
- Distribute and collect training evaluations.

Section VI: Conclusions and Evaluations

Step #1: (5 minutes) Review of Learning Objectives

Do: Display **PowerPoint Slides #4-5 (Learning Objectives)**,

Say: Review learning objectives for the workshop and ensure that the group met the objectives. Review the items listed on the WIIFCF flipchart and check in to see if all of the items on the list have been discussed during the training. Ask the participants if they have any additional thoughts or questions.

Step #2: (5 minutes) Statistics

Say: The adverse effects of maltreatment are concentrated in behavioral, social, and emotional domains. The problems that children develop in these areas have negative impacts that ripple across the lifespan, limiting children's chances to succeed in school, work, and relationships. Studies have demonstrated that rates of mental illness are high among children who have experienced maltreatment and have been in foster care (U.S. Department of Health and Human Services Administration on Children, Youth and Families, 2012). Posttraumatic Stress Disorder (PTSD), Attention Deficit/Hyperactivity Disorder (ADHD), Major Depressive Disorder (MDD), Conduct Disorder (CD), and Oppositional Defiant Disorder (ODD) are the most common mental health diagnoses among this population (U.S. Department of Health and Human Services Administration on Children, Youth and Families, 2012). Many children meet diagnostic criteria for these disorders *before* entering foster care, indicating that it is frequently the experience of maltreatment rather than participation in foster care that predicates mental health problems.

By the time they are teenagers, 63% of children in foster care have at least one mental health diagnosis; 23% have three or more diagnoses (U.S. Department of Health and Human Services Administration on Children, Youth and Families, 2012). Share with participants the importance to assist these children and families by getting them the proper mental health diagnosis and treatment that they need.

Step #3: (10 minutes)Transfer of Learning

Do: Display **PowerPoint #50 (Transfer of Learning)**. Distribute **Handout #12 (Transfer of Learning)** and have the participants fill in their responses to the questions. Allow a few minutes for them to do this individually and then have them discuss in their small groups some ways they will transfer their learning from the training to their everyday work. Then ask volunteers to share their plan. Also, encourage participants to use **Handout #13 (References)** to access additionalinformation about the topics discussed.

Step #4: (10 minutes) Evaluation Forms

Do: Thank the participants for attending today's training and ask them to complete theevaluation forms for the training.