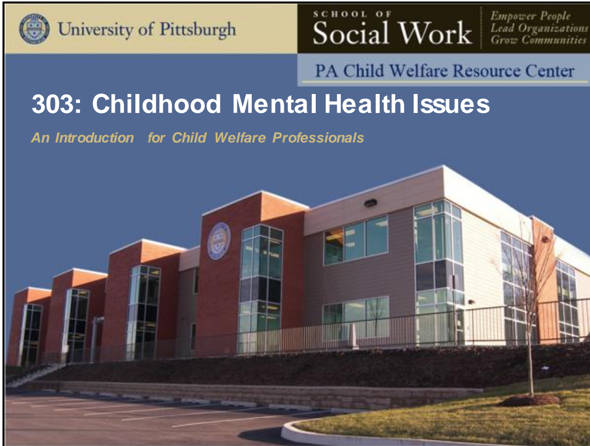

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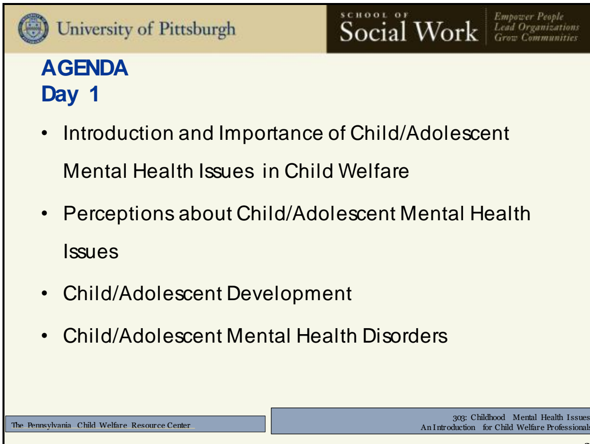

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AGENDA
Day 1
• Introduction and Importance of Child/Adolescent Mental Health Issues in Child Welfare
• Perceptions about Child/Adolescent Mental Health Issues
• Child/Adolescent Development
• Child/Adolescent Mental Health Disorders
The Pennsylvania Child Welfare Resource Center
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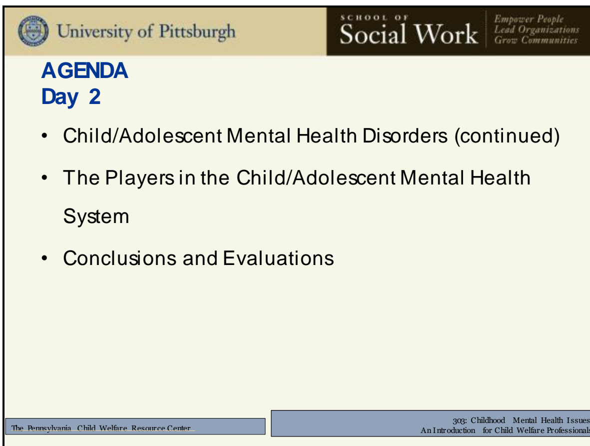

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AGENDA
Day 2
• Child/Adolescent Mental Health Disorders (continued)
• The Players in the Child/Adolescent Mental Health System
• Conclusions and Evaluations
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Learning Objectives

- Recognize safety threats and risk factors that might lead to or result in additional child abuse and neglect in children/adolescent with mental health issues
- Recognize how and when a caseworker needs to intervene to assure safety, permanency and well-being for children/adolescents with mental health issues
- Apply solution-focused questioning strategies with children and families coping with child/adolescent mental health issues

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Learning Objectives, continued

- Collaborate with the Mental Health system while still abiding by the laws and regulations associated with confidentiality and release of records
- Explain how effective outcome-based treatment is based on comprehensive, ongoing assessment of children/adolescent with mental health issues

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Child and Adolescent Mental Health in Child Welfare Practice

- One in five children in U.S. ages 3-17 experience a mental disorder in a given year
- 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% have emotional disturbances severe enough to impair their functioning (SAMSHA, 2013)

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Child and Adolescent Mental Health in Child Welfare

- Only 50.6% of children with mental disorders received treatment for their disorder within the past year
- Children with anxiety disorders were the least likely (32.2%) to have received treatment in the past year (U.S. Department of Health and Human Services, 2010)
- 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)

Biopsychosocial Factors

- Temperament
  - Flexible, feisty temperament
  - Negativity or positive affectivity
- Genetic
  - Heritability
- Physiological
  - Low birth weight
  - Medical conditions
- Environmental
  - Adverse childhood experiences
  - Life stressors

Perceptions and Attitudes About Mental Health Issues

1. Mental health disorders are not true medical illnesses like heart disease and diabetes.
2. If a 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 is not the result of bad parenting.
5. Children with enuresis/encopresis have been abused or neglected.

STIGMA

Stigma is a severe social disapproval of personal characteristics or beliefs that are against cultural norms.

Helping Families Understand Their Child/Adolescent's Development

- Share information on developmental expectations that fit the philosophy, cultural worldview and current patterns within the family.
- Encourage connections with family members and friends that have experience with child rearing.
- Identify mentors who can provide individualized education
- Arrange for parenting classes, parent support groups
- Provide resource materials
- Model appropriate interactions and expectations

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Solution-Focused Questions: Exception and Scaling

Exception Questions

- Elicit information about times when their problems could have occurred but didn't or were less severe
- Focus on the who, what, when, and where NOT why

Scaling Questions

- Invite clients to put their observations, impressions, and predictions on a scale of 0 (no chance) to 10 (every chance)
- Need to be specific

(Shulman, 2006)

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Solution-Focused Questions: Miracle Questions

- Give permission to think about an unlimited range of possibilities for change
- Move the focus away from problems toward a more satisfying life

(Shulman, 2006)

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Mental Health Service Use for Children

- 11.3% of U.S. children ages 2-7 (13.4% in PA) are reported by their parents to have been diagnosed with emotional, behavioral, or developmental conditions
- 24.8% have family incomes below the Federal poverty level (23.6% in PA)
- 29.4% had insurance, but it did not meet their mental health needs

(U.S. Department of Health and Human Services, 2010)

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Mental Health Service Use for Children, continued

- ADHD was the most prevalent 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 to be diagnosed with depression
- Suicide is the second leading cause of death among children ages 12-17

(Centers for Disease Control and Prevention, 2013)

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Categories of Disorders

- 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

Categories of Disorders, continued

- 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

Co-Morbidity and Co-Occurrence Statistics

- 40.3% of diagnosed children have more than one emotional, behavioral, or developmental condition
- 45.8% of children with one or more emotional, behavioral, or developmental conditions also had learning disabilities when compared to 2.7% of children without these conditions (U.S. Department of Health and Human Services, 2010)
- Estimated rates of co-occurring mental illness among adolescents with Substance-Related Disorders range from 60 to 75% (Substance Abuse and Mental Health Services Administration, 2010)

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Major Depressive Disorder Indicators (5 or more in same two-week period)

- Depressed mood
- Diminished interest or pleasure in activities
- Weight loss or weight gain
- Insomnia or hypersomnia
- Psychomotor agitation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Diminished ability to think or concentrate or indecisiveness
- Recurrent thoughts of death, suicidal ideation, or suicide attempt/plan

(American Psychiatric Association, 2013)

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Depression and Suicide Statistics

- 13.84% of youth ages 12-17 report at least one major depressive episode in the last year
- Suicide is the second leading cause of death for youth between the ages of 10 and 24
- Top three methods used in suicides of young people include firearm, suffocation, and poisoning
- Lesbian, gay, and bisexual youth in grades 7-12 attempt suicide at twice the rate of their heterosexual peers

(Mental Health America, 2021; Centers for Disease Control and Prevention, 2013)

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Depression and Suicide Statistics, continued

- Native American/Alaskan Native youth have the highest rates of suicide-related fatalities
- Hispanic youth in grades 9-12 were more likely to report attempting suicide than their Black and white, non-Hispanic peers
- Documented rise depression, attempted suicides, and death by suicide during the Covid-19 pandemic, with disproportionate impact on ethnic minorities

(NIMH, n.d.; Centers for Disease Control and Prevention, 2013; APA, 2021)

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Mania and Hypomania Episode Indicators

Mania (at least 1 week)
- Distinct period of abnormally and persistently elevated, expansive, or irritable mood
- Abnormally and persistently increased goal-directed activity or energy
- Significant impairment in functioning

Hypomania (4 days)
- Distinct period of abnormally and persistently elevated, expansive, or irritable mood
- Abnormally and persistently increased goal-directed activity or energy
- Does not cause significant functioning impairment

Disruptive Mood Dysregulation Disorder

- Severe recurrent temper outbursts (verbal rages or physical aggression)
- Outbursts are inconsistent with developmental level
- Outbursts occur on average three or more times/week
- Mood between temper outbursts is persistently irritable or angry
- Symptoms must occur in two out of three settings
- Cannot be diagnosed for the first time before age 6 or after age 18

(American Psychiatric Association, 2013)

Types of Anxiety Disorders

- Separation anxiety
- Selective mutism
- Specific phobia
- Social anxiety (social phobia)
- Panic disorder
- Agoraphobia
- Generalized anxiety

(American Psychiatric Association, 2013)

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Anxiety Disorders: Common Threads

- Excessive fear (emotional response to real or perceived imminent threat)
- Anxiety (anticipation of future threat)
- Behavioral responses (fight, flight, freeze)

(American Psychiatric Association, 2013)

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Prevalence Rates of Anxiety Disorders

- Lifetime prevalence of any anxiety disorder in U.S. children or adolescents (15-20%)
- Separation anxiety (2.8-8%)
- Selective mutism (0.03-1%)
- Specific and social phobias (10-7% respectively)
- Agoraphobia and panic disorder (1% in children) and (2-4% in adolescents)
- Generalized anxiety disorder (0.09% in adolescents)
- Girls are affected with anxiety disorders at twice the rate of boys

(Beedso, Knappe, and Pine, 2011)

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Obsessive-Compulsive Disorder Indicators

- Presence of obsessions and/or compulsions
- Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted
- 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

(American Psychiatric Association, 2013)

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Reactive Attachment Disorder Indicators

- A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, evident before age 5, and manifested by both of the following:
  - Rarely or minimally *seeks comfort* when distressed
  - Rarely or minimally *responds to comfort offered* when distressed
- A persistent social and emotional disturbance characterized by at least 2 of the following:
  - Minimal social and emotional responsiveness to others
  - Limited positive affect
  - Episodes of unexplained irritability, sadness, or fearfulness which are evident during nonthreatening interactions with adult caregivers

(American Psychiatric Association, 2013)

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Reactive Attachment Disorder Indicators, continued

- Child has experienced a pattern of extremes of insufficient care (pathogenic care) as evidenced by at least one of the following:
  - Persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection (i.e., neglect)
  - Persistent disregard of the child's basic physical needs.
  - Repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care)
  - Rearing in unusual settings such as institutions with high child/caregiver ratios that limit opportunities to form selective attachments
- Not due to Autism Spectrum Disorder

(American Psychiatric Association, 2013)

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Disinhibited Social Engagement Disorder

- Due to a pattern of insufficient care (pathogenic care)
- Attachment may or may not be present
- A pattern of behavior in which the child actively approaches and interacts with unfamiliar adults by exhibiting at least 2 of the following:
  - Reduced or absent reticence to approach and interact with unfamiliar adults
  - Overly familiar behavior (verbal or physical violation of culturally sanctioned social boundaries)
  - Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings
  - Willingness to go off with an unfamiliar adult with minimal or no hesitation

(American Psychiatric Association, 2013)

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Exposure to Trauma

- Children in the Child Welfare System often experience multiple traumas
  - Serious neglect, abuse, exposure to domestic violence, and violence in communities
- 34% of youth in the Child Welfare System and 28% in the Juvenile Justice System experience four or more types of traumatic events (Substance Abuse Mental Health Services Administration, 2012)
- Most common trauma experienced by all children in the U.S. is interpersonal violence (National Child Traumatic Stress Network, 2013).

Posttraumatic Stress Disorder Indicators

- 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)
- Significant changes in arousal and reactivity associated with the traumatic event(s)

(American Psychiatric Association, 2013)

Oppositional Defiant Disorder Indicators

- Angry/irritable mood
- Argumentative/defiant behavior
- Vindictiveness
- Rates range from 2 percent to 16 percent
- 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 used

(AACAP, 2019; American Psychiatric Association, 2013)

Intermittent Explosive Disorder

- Recurrent behavioral outbursts representing a failure to control aggressive impulses manifested by either of the following:
  - Verbal aggression or physical aggression that does not result in destruction of property or physical injury
  - Three outbursts within a 12-month period involving destruction of property and/or physical injury to animals or people
- Outbursts are grossly out of proportion to the provocation or precipitating stressor and are not premeditated
- Must be at least 6 years of age or developmental level

(American Psychiatric Association, 2013)

Conduct Disorder Indicators

- Pattern of behavior in which the basic rights of others or societal norms and rules are violated
- Behaviors must fall into three out of four categories
  - Aggression to people/animals
  - Destruction of property
  - Deceitfulness or theft
  - Serious violation of rules

(American Psychiatric Association, 2013)

Conduct Disorder Indicators, continued

- Three subtypes
  - Childhood onset (prior to age 10)
  - Adolescent subtype (no symptoms prior to age 10)
  - Unspecified (not enough information to determine onset)
- Specifier code added if symptoms reflect limited prosocial emotions
  - Lack of remorse, empathy, concern about performance, or affect
- Higher risk for abuse (child with CD and others)

(American Psychiatric Association, 2013)

Feeding and Eating Disorders Statistics

- Common thread is a persistent disturbance of eating or eating-related behavior that significantly impairs physical health or psychosocial functioning
- Anorexia Nervosa (0.4%)
- Bulimia Nervosa (1-1.5%)
- Binge-Eating Disorder (1.6% in females and 0.8% in males)

(American Psychiatric Association, 2013)

Anorexia Nervosa Indicators

- 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)

Bulimia Nervosa Indicators

- Recurrent episodes of binge eating
  - Eating an amount of food within any 2-hour period that is significantly larger than what most individuals would eat and a sense of lack of control overeating during the episode
- Recurrent behaviors to prevent weight gain
  - Self-induced vomiting, misuse of laxatives, misuse of diuretics, fasting or excessive exercise
- Self-evaluation disturbances
  - Unduly influenced by body shape and weight
- Binging/purging both occur (once a week for 3 months)

(American Psychiatric Association, 2013)

Binge-Eating Disorder Indicators

- Eating an amount of food within any 2-hour period larger than what most people would eat and a sense of lack of control overeating during the episode
- Binge-eating episodes associated with eating rapidly, 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)

Feeding and Eating Disorders Recommendations

- Model healthy thoughts/behaviors
- Prohibit teasing about body shape/size
- Emphasize fitness
- Praise children for who they are
- Encourage healthy eating
- Don't forbid certain foods
- Talk about unrealistic media images
- Model how a competent person takes charge, solves problems, negotiates relationships, builds a satisfying life
- Get help when needed

(National Association of Anorexia Nervosa, 2013)

Autism Spectrum Disorder Indicators

- 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)

Attention Deficit Hyperactivity Disorder

- Primary feature is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development
- Present before age 12 and manifests in two or more settings
- Three subtypes within the disorder are less known:
  - Predominantly Inattentive
  - Predominantly Hyperactive/Impulsive
  - Combined

(American Psychiatric Association, 2013)

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 tasks requiring sustained attention
  - Loses things necessary for completing tasks or activities
  - Easily distracted by extraneous stimuli
  - Often forgetful in daily activities

(American Psychiatric Association, 2013)

Attention Deficit Hyperactivity Disorder Indicators, continued

- Hyperactivity and impulsivity (six or more)
  - Often fidgets with or taps hands or feet
  - Leaves seat in situations when being seated is expected
  - Runs/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 answer before a question has been completed
  - Difficulty waiting their turn
  - Interrupts or intrudes on others

(American Psychiatric Association, 2013)

Mental Health Referral Checklist

- Identifying issues
- Family health issues
- Information on 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
- Relationships with others

Managed Care in Pennsylvania (sample)

ACCESS Plus
ACCESS Plus and Voluntary Managed Care
HealthChoices Southwest
HealthChoices Lehigh/Capital
HealthChoices Southeast

Check with your supervisor for current information for your area.

Characteristics of a Quality Evaluation Report

- Comprehensive
- Organized
- Respectful
- Individualized
- Thoughtful

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Treatment Approaches

- Psychotherapy
- Behavior modification
- Cognitive behavioral therapy (CBT)
- Family therapy
- Play therapy
- Grief therapy
- Trauma-informed care
- Pharmacology (psychotropic medication)

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Transfer of Learning

- What are two things you learned today that you might apply immediately to your casework?
- What are three concepts you plan to share with your supervisor?
- Which resources/handouts from your session today do you plan to share with co-workers?

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