MENTAL HEALTH ISSUES IN CHILDREN

SECTION I – INTRODUCTION

TIME: 45 Minutes (9:00 – 9:45)

Council On Accreditation (COA) Standards Addressed

- G7.1.05 (a)
- G7.1.05 (c)
- G7.2.02
- G7.2.03
- G7.3.01
- G7.3.02
- G7.3.03
- G7.3.07 (c)

Individual Training Needs Assessment (ITNA) Competencies Addressed

- 303-3
- 304-3
- 315-1

Objectives: Participants will

- Receive general housekeeping information
- Review the Agenda and Competencies for training
- Introduce themselves
- Identify their learning goals for Mental Health Issues in Children

Materials

- Participant Manuals
- Whiteboard or flipchart stands and markers

Trainer Note: Have several flipcharts labeled with the term "Learning Goals" and as participants arrive, ask them to write down their learning goals for the training. This will help the trainer to assess the participants' expectations regarding the training.

A. Introduction

Welcome the participants to the training. Introduce yourself and provide information about your education, experience, and background. The trainer may choose to have group members introduce themselves or interview one another in pairs and then introduce their partner. Some of the information you may want to ask the participants to provide is: how long they have been

with DCFS, county they will be working in, previous work experience, educational background, family, and any other personal information they wish to share.

B. Housekeeping

Cover the following housekeeping rules:

- Sign-in Sheets. Sign-in sheets must be completed in the morning and afternoon of each day.

- Travel Reimbursement: Workers should complete their forms for travel reimbursement (TR-1s) in their county offices. Questions about travel reimbursement should be directed to the worker's supervisor.

- Smoking Areas. Training rooms are non-smoking environments. Direct smokers in the group to approved smoking locations.

- Training Center Facilities. Direct participants to the location of bathrooms, phones, message boards, and other important facility sites.

- Restaurants. Give participants a list of restaurants in the vicinity of the training center. (This list should be developed by each center.)

- Pagers/Cell Phones/Office Work. Do not bring pagers to classroom training. Turn cell phones off during training. Do not bring office work to training. Telephone messages will be posted at a designated place in the facility. Messages may be returned during breaks.

C. Agenda

Quickly thank the participants for jotting down the information on the "Learning Goals" flipcharts. Briefly address any items that will not be addressed in the training today. Offer to speak with any participants who have identified information that is outside the scope of this training during the break. Address the topics that will be covered in training by reviewing the agenda for the training with the group. Refer participants to the agenda on page 1 of their manuals.

D. Competencies

Review the Competencies for Mental Health Issues in Children on page 2 of the Participant Manual.

E. Ice Breaker

Purpose

To address the nature of stigma and the connection between physical and mental illness.

Set-up
Write the following question on a flip chart or the white board.

What do you think of when you think of mental illness?

Method

Ask participants to open the participant manual to page 3 – Opening Exercise.

Ask participants to write down words they have heard, heard other people use or know of which describe children or adults who have mental illness. ***These words do not have to be politically correct.***

Allow no more than a couple of minutes for the exercise. Trainer can begin sharing by writing a few words either on the flip chart or white board, e.g., needy, indigent, crazy, etc. Ask participants to share the descriptive words they generated.

Now ask the participants to write down words they have heard, heard other people use or know of which describe children or adults who have a chronic physical illness such as diabetes or heart disease.

The trainer can begin sharing by writing additional descriptive words for chronic "health" problems, e.g., ill, unwell, disease, and sick.

Processing

Ask the participants what differentiates mental illness from physical illness. Allow the participants to provide input into what distinguishes an illness of the body from an illness of the mind or brain. There is space provided on page 4 of the participant manual, Mental and Physical Health, where the participants can make notes.

What really separates illnesses of the body from illnesses of the mind is the way that most people think of them, the language we use and the distinction in the health care system.

The notion of the mind/body split was first proposed in the 7th century and put forth that emotions and thoughts were separate and distinct from the functions of the body.

However, modern research has helped to shed light on how the brain works at very fundamental levels. Sophisticated research methods now allow researchers to pinpoint areas of the brain responsible for emotions, behaviors, etc.

Thinking about the mind (or brain) and the body as separate and distinct ignores current research findings. For example, many people have heard of the growing body of data indicating that meditation and/or prayer have positive "physical" health benefits. Similarly, physical illnesses, particularly chronic or long-term illnesses, such as arthritis or heart disease, can affect mental status. There are numerous articles published about the effects of stress and/or anxiety on physical health, about the positive benefits of physical activity on anxiety and depression.

Despite growing understanding by the general public that mental and physical processes are interconnected, stigma **(Trainer: briefly explain or define that stigma is shame and disgrace)** associated with mental illness continues to be widespread today. It is now commonly accepted that mental health problems and mental illnesses are not the result of lack of character.

The results of stigma are:

- fear of those with mental health problems,
- people with mental health problems not seeking treatment,
- people not wanting to work or live with those identified as mentally ill, and
- general public refusing to fund research and treatment efforts aimed at mental illness.

Just as we learn more about the interconnectedness of the functioning of the brain and the body, we also learn more about the changing nature of mental health over a person's lifetime.

SECTION II – MENTAL HEALTH ISSUES FROM A DEVELOPMENTAL LIFESPAN PERSPECTIVE

Time: 30 Minutes (9:45 – 10:15)

Objectives: Participants will

- Understand the importance of viewing mental health issues from a developmental perspective across the lifespan of the individual

Materials

- Participant Manuals
- Whiteboard and/or flipchart and markers
- Developmental stages cards
- Developmental tasks cards

Trainer Note: This section contains an exercise to get people moving and interacting. The information should be a review. Conduct this exercise quickly and move into the discussion.

A. Large Group Exercise –

Purpose

To highlight how mental health is ever changing and developing along with the brain and life experiences and to review developmental information.

Setup

Trainer will need to have the information in Developmental Stages and Developmental Tasks printed out and available to use as cards for this activity. These can be found in the Trainer Resource section of the Trainer Manual.

Methodology

The participants will each get a card with different developmental stages printed on the card or a card with various developmental tasks associated with each stage printed on the card.

Ask half of the participants to stand up and go to one side of the room while the remaining participants stand on the other side of the room. Give half of the participants a card with a life stage printed on the card. Give the other half of the participants a card with a developmental task printed on the card.

Have the participants to match the stages and tasks for each stage. Allow no more than 5 minutes for the participants to "match up".

Direct participants to Page 5, Developmental Perspective in the participant manual and allow an opportunity for participants to "re-match" with correct stage or task if necessary.

When the participants have found their "match", their assignment is to spend a few minutes identifying mental health issues or problems which may occur at that specific stage of development.

They will report on the discussion points to the larger group.

Processing

Although it may seem that a discussion and review of development is outside the scope of a training on mental health, it is necessary to remember that individuals are constantly growing and changing. Each stage in the lifespan is associated with a unique developmental "crisis" or task that must be mastered.

Mental health and mental illness is dynamic and fluid. As we grow and change, our mental health changes. Mental health must be viewed within the context of development across the lifespan. The brain interacts with and responds to multiple influences continuously across every stage of life.

At different stages, mental health or mental illness may be expressed in different ways. For example, separation anxiety is considered a normal aspect of development for very young children. However, the display of similar anxiety upon separation from a loved one at a later stage in life may be indicative of underlying problems. Also, different stages of development are associated with vulnerability to different kinds of problems. For example, immediately following a significant change in family makeup (such as with a birth of a child or a child leaving home), an individual may be more vulnerable to changes in mental status.

Children's mental health issues must be considered within the context of their development, social environment, family, friends, physical and cultural surroundings. Current research on mental health in children focuses on:

- developmental processes,
- attempts to understand and predict what factors keep children and adolescents mentally healthy,
- which factors place some children at risk, and

- what protects some children but not others despite exposure to the same risk factors.

BREAK

SECTION III – INTRODUCTION TO MENTAL HEALTH ISSUES IN CHILDREN

Time: 30 Minutes (10:30 – 11:00)

Objectives: Participants will

- Gain awareness of the many mental disorders typically diagnosed in children and adolescents.

Materials:

- Participant Manuals

A. Brief overview of disorders

Have participants turn to page 6 in the participant manual to review and make notes on the disorders usually first diagnosed in infancy, childhood, or adolescence. Instruct participants to take a few minutes now to review the information on pages 6-7. Allow the group approximately 5-10 minutes, depending on the needs of the group.

The disorders first diagnosed in infancy, childhood, or adolescence include:

Mental Retardation:
Characterized by significantly subaverage intellectual functioning with onset before age 18 and concurrent impairments in adaptive functioning

Learning Disorder:
Academic functioning substantially below what would be expected given the person's age, intelligence and education. Examples are Reading Disorder, Mathematics Disorders, and Disorder of Written Expression.

Motor Skills Disorder:
Developmental Coordination Disorder where motor coordination is substantially below what would be expected given age and intelligence.

Communication Disorders:
Difficulties in speech or language, e.g., Expressive Language Disorder and Stuttering.

Pervasive Developmental Disorders:
Characterized by severe deficits and pervasive impairment in multiple areas of development. Examples include Autism, Rett's Disorder (begins after 5 months of apparently normal development, often associated with severe or

profound Mental Retardation, characteristics similar to Autism) and Asperger's Disorder (severe impairment in social interactions and presence of restricted, repetitive patterns of behavior, interests, activities.

Attention Deficit Disorder:
Characterized by prominent symptoms of inattention and/or hyperactivity or impulsivity. The type of ADD depends on the predominant symptom presentation, i.e., Predominantly Inattentive type, Predominantly Hyperactive-Impulsive Type, or Combined Type.

Disruptive Behavior Disorders:
Classified as patterns of behavior that violate the rights of others or major norms or rules, e.g., Conduct Disorder and Oppositional Defiant Disorder.

Feeding and Eating Disorders:
Includes Pica (eating non-food substances over period of time) and Rumination Disorder (regurgitation and rechewing of food). Anorexia and Bulimia Nervosa are classified in another Eating Disorders section.

Tic Disorders:
Includes Tourette's Disorder which includes multiple motor tics and at least one vocal tic and Chronic Motor or Vocal Tic Disorder

Elimination Disorders:
Includes Encopresis (age-inappropriate defecation in clothes or other inappropriate places) and Enuresis (age-inappropriate urination on clothes or in bed).

Other Disorders of Infancy, Childhood, or Adolescence

Separation Anxiety Disorder
Reactive Attachment Disorder of Infancy or Early Childhood
Selective Mutism
Stereotypic Movement Disorder
Disorders of Infancy, Childhood, or Adolescence NOS

Mood Disorders

Depressive Disorders
Bipolar Disorders

Anxiety Disorders
Includes Panic Disorder, Agoraphobia, Phobias (specific or social), Obsessive Compulsive Disorder, Post Traumatic Stress Disorder and Generalized Anxiety Disorder.

Eating Disorders
Anoxeria Nervosa
Bulimia Nervosa

Substance Related Disorders
There are numerous substance related disorders. These disorders are categorized according to the substance, i.e. alcohol related disorders, alcohol induced disorders, amphetamine related or amphetamine induced, etc.

Schizophrenia and Other Psychotic Disorders
Includes Schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to general medical condition or substance.

B. Criteria for Specific Disorders

Direct participants to the resource section of the participant manual. Some of the disorders noted above are included in the resource section with all of the criteria for the disorder listed. Allow the participants a few minutes to look over the information. Tell the participants that we will not try to cover the signs and symptoms of all of the various disorders during this day of training. Rather the focus will be on broader mental health issues and on assisting the caseworker in negotiating the mental health system.

SECTION IV – ASSESSING CHILDREN AND ADOLESCENTS

Time: 45 Minutes (11:00 – 11:45)

Objectives: Participants will

- Recognize the difficulties inherent in the assessment and diagnosis of mental health problems in children and adolescents.
- Become aware of when referrals for mental health assessments should be made

Materials:

- Participant Manuals
- Pictures from magazines

A. The Difficulties of Diagnosis

There is space provided on Page 8, Challenges of Diagnosing in the participant manual for participants to take notes on this section.

There are many difficulties with diagnosing children and adolescents. There are problems inherent in the assessment process itself. Typically, assessment by a mental health (MH) provider consists of:

- Gathering information from several sources
- Observing the child's or adolescent's behaviors
- Additional testing

From these various dimensions, the MH provider must make determinations about the child's functioning at home, at school, and in the community.

Unfortunately, not all MH providers are appropriately trained in techniques relevant to the assessment of children. For example, MH providers may have limited training or knowledge about the complexities of children's language skills or in depth knowledge of the specifics of development throughout childhood. Development is all about transitions and changes. One of the ways that clinicians assess problems is to look for changes from previous functioning. Within the developing child, the provider must look beyond changes in behavior to changes in behavior which cause distress or which lead to problems in functioning. Finally, some MH providers may focus more on family systems or on substance abuse or may be the only provider in the area and have to deal with any and every need in an area.

Of course, there is a diagnostic classification system available to MH providers (the DSM-IV.) However, even with a well respected and widely used system such as the DSM-IV, there are challenges to assessment and diagnosis in children. Some of the challenges are:

- Children are often unable to verbalize their thoughts and feelings.
- Normal developmental changes complicate the picture.
- Most of the diagnostic criteria for children are derived from the adult criteria, with little or no research done with children.

B. Individual Exercise – What do you see?

Purpose
To highlight the complexities of arriving at accurate diagnoses in children and adolescents.

Setup
The trainer will need a picture of an individual for each participant attending. The picture can come from a magazine or book or can be a photograph of someone provided by the trainer. These should not be photos of the participants' families, acquaintances, etc. Ideally, there needs to be something in the background, some scenery.

Methodology
Give each participant a picture. Instruct the participants to write down a description of the person in the picture. Do NOT tell the participant how long they will have for this exercise. Allow the participants to keep the picture for about a minute. Ask everyone to stop and collect the pictures.

Instruct the participants to complete their descriptions. Expect some protests. Tell the participants to do the best they can to finish describing the person in the picture. Also, tell the participants to describe the background or scenery in the picture. Allow the participants a couple of more minutes and then stop the activity. Ask the participants to share their descriptions.

Processing
It is highly likely that the participants will express frustration over not getting to keep the picture for a longer time. Some will not want to share their descriptions. Allow people to vent a little. Respond to this by letting them know that they did the best they could based on the limited time and information available to them.

This exercise is designed to help participants see and feel the difficulties that mental health professionals experience when trying to accurately assess/diagnose children, adolescents and even adults. Remind participants that mental health professionals work under less than ideal circumstances. Some of those are:

- There is a limited amount of time to gather information.

- The person being assessed may not be able to provide much information.
- There may be limits on getting information from other sources.
- The MH provider is often dealing with very large caseloads, just as DCFS caseworkers are.

The MH provider is asked to diagnose or assess a child or adolescent after having spent a couple of hours with the person. This description is really a "snapshot" in time, it may indicate what is going on right then. The multidimensional nature of assessment may be hampered by barriers such as limited time and lack of reliable sources of information. It takes time to truly learn what is going on with complex human beings.

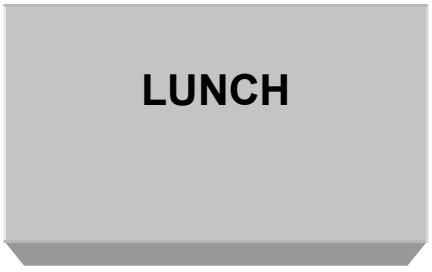
When is it appropriate to refer a child for a mental health assessment?

Anytime the caseworker becomes aware of problems, behaviors that represent a change in functioning or status for the child (can be observed by worker or communicated to worker by foster parent, school, etc.)

When the initial health screening (done 24/72 hours upon bringing a child into Foster Care) indicates a need for mental health assessment or screening.

When the Comprehensive Health Assessment indicates a need for mental health assessment.

Conclude this section by asking if the group has any questions or comments about the topics covered this far. Allow group discussion and break for lunch.



SECTION V- BUILDING EFFECTIVE WORKING RELATIONSHIPS WITH MENTAL HEALTH PROVIDERS

Time: 45 Minutes (1:00 – 1:45)

Objectives: Participants will

- Identify barriers to collaborating effectively with MH providers
- Identify strategies to improve collaboration with MH providers
- Become aware of the sometimes conflicting objectives of DCFS and MH

Materials:

- Participant Manuals
- Flipcharts/whiteboards
- Two lengths of rope or heavy string approximately 5 feet in length
- 3-5 balloons, blown up and tied
- Cardboard cards labeled Child welfare services, Mental health services, Juvenile justice services, Medical services, School, Judge, CASA, Law enforcement, CADC, SCAN
- Hole punch
- Cords, string

A. Brainstorming activity

Purpose

To identify barriers to having effective working relationships with mental health providers.

Methodology

Have participants work in small groups (either the tables where they are seated or in other groups of 3-5.) Have the groups to elect a scribe by determining who is the oldest in the group. Instruct the groups to write down difficulties that exist in working with MH providers. Allow 10-15 minutes for the brainstorming to continue.

Ask for a group to volunteer to present the information they have discussed. Following the presentation, ask if any of the other groups have described or discussed anything significantly different. Allow any groups with different information to offer their information.

At this point, do not try to address any of the barriers identified. Now ask the participants to stand. Each group should rotate to the next table. Each group is now to generate strategies to address the barriers generated by the

previous group. Allow groups to continue to work on solutions for approximately 10 minutes.

Processing

There may not be readily apparent ways to overcome some of the barriers identified. Address this and note that there will always be difficulties working with other providers because of time constraints, caseloads, funding or resource issues, and differing mandates or objectives. However, there are many barriers to collaboration that can be addressed at the individual or county level. Some steps that individuals and county offices can take include making an appointment to meet with the provider(s) in the area, telephoning providers to introduce self, returning phone calls, realizing that the MH providers have very large caseloads, recognizing that MH providers are working with the same limited resource base that DCFS is working with, providing as much information in the referral as possible.

Likely, there will be identified barriers that seem insurmountable. Try to determine if these are system barriers, that is, do these barriers exist due to organizational policy or state or federal laws. If the answer is "yes," spend a few minutes in discussion about the nature of changing public policy over time. An example of how law and policy have changed in mental health over the last 30 years is the move from institutionalization to treatment in the community. As public knowledge about mental illness increases, there will continue to be changes in the approach to treating MH issues.

As caseworkers in the child welfare system, the participants may want to find out more about the laws impacting services and become advocates for change. Further, as providers, these workers may also want to become familiar with their local and state representatives who fashion the legislation that drives the organizational policy.

Finally, to provide a visual image of the importance of a unified approach from MH, DCFS, and the other service providers, conduct the following exercise.

B. Large Group Exercise – Building the Support Net(work)

Purpose
To highlight the importance of a unified approach among service providers.

Setup
Trainer should have 2 pieces of rope approximately 5 feet long. The trainer will need to have 4-5 balloons blown up and tied. Trainer can use a marker and draw faces on the balloons if desired.

This exercise will require an area where the participants can face each other in a circle that is about 4-6 feet in diameter.

The trainer should have "provider" cards with strings attached (to be hung around the neck) with the following information printed on the cards:

- Child welfare services
- Mental health services
- Juvenile justice services
- Physical health services
- School
- Courts
- CASA
- Law enforcement
- CADC
- SCAN

To involve every person in the class, have enough cards printed for each participant; you can have several cards with the same providers if needed.

Methodology

Try to involve everyone in this exercise.

Have the participants come to the area described above where the exercise will be conducted. Ask each of the volunteers to choose a provider card and hang it around his or her neck.

Provide participants with a balloon and instruct them to blow up the balloon. Now ask the "providers" to form a circle. Give 2 of the "providers" the pieces of rope. Now tell the two providers with rope to identify a service that each might provide to a child or a need each "provider" might meet, i.e. immunizations, skill of reading.

As each "provider" identifies a service, he or she should keep the end of the rope and pass the bulk of the rope to another "provider". These "providers" should then identify a service provided or need met, keep a section of the rope and pass the bulk of the rope to another "provider." **(Trainer Note: this should begin to look like a spider's web or net.)**

After allowing the "providers" to form the basis of a web or net, take one of the balloons and place it in the center of the web or net. The task for the "providers" is to not allow the balloon to fall through the cracks and hit the floor. They must "keep the balloon afloat". Allow the participants a few bounces and then begin adding other balloons. Ask the "providers" what the balloons might represent (the children).

Now stop the providers and ask if they need to work on the web or net they have created to keep the children afloat. Allow several minutes for the "providers" to do so. They can pass the ropes around as they continue identifying services provided or needs met.

After the participants have worked to improve the net, allow them the opportunity to keep more balloons afloat.

Processing
Ideally, with the improved net or number of services provided and increased contact among providers it should be a much easier task of keeping the balloons afloat.

What becomes apparent in this exercise is that it requires a number of people to provide for all of the needs of the children and adolescents. Often, the caseworker or other providers may feel isolated or seem to feel completely responsible for meeting a child's needs. It is important for caseworkers to be reminded that there is a *community* of providers who are also working to keep children and adolescents from falling through the cracks. This is why relationship building with the other providers is so important for success.

The more contacts that providers have with one another and understand they are generally working on the same goals, the stronger the net of support will be.

Of course, there are times when providers are not necessarily working toward the same goals. Of all of the providers, DCFS has a mandate to work when possible to preserve the family, to keep families together when possible. Many of the other providers or agencies that interact with DCFS are not aware of the laws that require DCFS to try to keep families together if it can be done safely. As discussed in the very first module of training attended by new worker, this unique mandate can create challenges for DCFS workers as they interact with these other agencies.

BREAK

SECTION VI- RESOURCES AND SERVICES TO MEET THE MENTAL HEALTH NEEDS OF CHILDREN AND ADOLESCENTS

Time: 30 minutes (2:00 – 2:30)

Objectives: Participants will

- Gain knowledge about the resources and services available in the state.

Materials:

- Participant Manuals – Resource Section
- Directory of Mental Health Services

A. Children and Adolescent Service System Program (CASSP)

Direct participants to Page 9, Children and Adolescent Service System Program (CASSP) in the participant manual.

Allow participants to spend about 5-7 minutes looking over the description of CASSP.

The CASSP program is designed to address the needs of children with significant emotional problems and who need services from multiple agencies. Generally, this program is targeted to those children with diagnosed, mental, behavioral or emotional disorder of a long-term nature.

Ask participants this question, **"Have any of you worked with any children who are served by the CASSP program?"**

Spend a few minutes allowing the participants to share their experiences.

Direct participants to Page 10, Regional CASSP Coordinators in the participant manual. Encourage the FSWs to contact these coordinators to find out more about how CASSP works in each area and how the CASSP program can benefit the children served by our Agency.

B. Directory of Mental Health Services

Next, provide the participants with copies of the Directory of Mental Health Services provided by the Division of Mental Health.

Allow the participants a few minutes reviewing the information.

C. Small Group Brainstorming Exercise

Purpose

To allow participants an opportunity to share information about resources they are aware of in their areas.

Methodology

Have the participants work in small groups. The groups should elect a scribe (the youngest person in the group.) Direct the groups to spend about 5-10 minutes sharing information about resources in each of their areas. The scribe will record these on the flipchart to share with the other groups.

Processing

Allow the participants to share the resources or services they have discussed. Pay particular attention to the local, community based support services since many client families are more likely to utilize these types of services than formal publicly funded services.

SECTION VI – CASEWORK SCENARIOS

Time: 75 minutes (2:30 – 3:45)

Objectives: Participants will

- Have the opportunity to apply the information covered in training and provided in the materials to case examples (scenarios and personal cases.)

Materials:

- Participant Manuals
- Scenarios – Resource section of the Trainer manual, pages 23-26

Trainer Note: The remainder of the afternoon will be spent working on either the case scenarios provided or on actual cases the participants present. The trainer can ask the participants to present cases of their own (clients with mental health issues) that they would like to share with the group for case consultation purposes. It is likely that the participants will have specific questions related to case planning and service delivery for some of the client they are working with. The trainer can use the scenarios for the groups to work on. The trainer may choose to use both depending on time and the needs of the group.

Trainer Note: If the trainer chooses to use actual cases for the exercise, be sure to make the following statement, "Actual case names should not be used, the information must be presented in a general way. The information shared in the training for case consultation is considered confidential and is not to be shared outside of this setting." Obtain agreement from the participants that they understand the issue related to confidentiality.

A. Small Group Exercises – Scenario Work

Purpose

To provide participants with the opportunity to generate and share strategies for providing services to children with mental health needs.

Methodology

Have participants work in small groups (either the tables where they are seated or in other groups of 3-5.)

Provide each of the groups with different scenarios. If this is a large group, the trainer can give the same scenario to two different groups. These can be found in the resource section of the trainer manual. Instruct the participants to spend time individually reading the scenarios. Then the groups are to discuss the scenarios, using the questions or guidelines provided below to generate strategies for case planning and service delivery.

If the trainer has chosen to use actual cases, then each group should allow one person to present a case. The other group members should take notes and then ask questions of the person presenting to obtain additional information if needed. The group should spend the time given finding out what brought the client into care, what has been done so far, what services are currently being provided. (Often, it seems that new workers have questions about service delivery and case planning related to a lack of information from the assessment or from documentation about what has taken place so far.) Ideally, the group should then spend time generating solutions or strategies to assist the worker.

Instruct participants to turn to Page 11 – Information for Psychological Evaluation found in the participant manual. This information will be helpful to an assessor or evaluator. They can also use this information for the scenario work today.

Provide the participants with the following instructions: Using the information provided during discussion today, the information in the participant manual and their own knowledge and expertise, instruct the participants to answer the following questions:

- Given the child's age and history and considering what you know about normal development, what behaviors are of concern?
- If you recommend a psychological evaluation and do not have much information to share with the evaluator, how will you obtain that information?
- If you recommend a psychological evaluation, what are you going to ask for, what is the reason for referral?
- If you recommend counseling or therapy, what kind of information do you need to share with the counselor/therapist?
- Are there specific behavior management strategies that you can provide to the parents (and/or teachers) to help in the management of the child's behavior *right now*?

Processing

Dylan will need assessment for Attention Deficit Disorder and the sexual behaviors. Are Dylan's behaviors part of the normal curiosity and experimentation/play of this age or if there is advanced knowledge of sexual matters which may be indicative of sexual abuse?

Courtney will need a thorough psychological evaluation, including assessment of functioning. Is her cognitive development (particularly her language skills development) delayed? Her physical development seems to be lagging. Is she later in gaining certain skills than others her age or is she definitely behind? Her emotional development appears to be delayed. Courtney's mother will also need to be evaluated. She appears to have limited parenting skills. What is the mother's level of functioning?

Asha will need an assessment from mental health. Of particular concern are her history of depression, substance abuse, and self-mutilating behaviors. Asha should be involved as much as possible in her own case planning process. Clearly, plans for permanency should be focused on what she will do upon reaching 18. It is also very important to keep in mind her need for a stable family. Is adoption out of the question?

Steven needs a mental health assessment. Of particular concern are his behaviors which indicate he is depressed and possibly having suicidal ideation. His difficulties socially are of concern. More information is needed of course. Are the behaviors described different from his previous level of functioning? Are these "new" behaviors?

SECTION VII – CONCLUSION

Time: 15 Minutes (3:45 – 4:00)

Objectives: Participants will

- Review learning from the training
- Evaluate the training

Take a few moments to answer any lingering questions.

Ask the participants at each table to elect a scribe (based on who has the most cases) and to quickly list 1-3 things they learned today.

Encourage the participants to continue to seek out information and training on mental health issues in children.

Provide the participants with the evaluations.

MENTAL RETARDATION

Definition of Mental Retardation (MR):
Onset before age 18
Significantly subaverage intellectual functioning along with impairment in adaptive functioning in two or more of the following areas:

Communication	Self care
Home living	Social skills
Community use	Self direction
Health and safety	Functional academics
Leisure activities	Work

How common is MR?
2.5% – 3.0% of the general population (approximately 285 million in US – 2.5% of 285 million is 7,166,585)

What are the causes of MR?
The majority of children have mild mental retardation for which there is *no identifiable cause.*

The identified causes of cognitive delay include:
- Genetic/chromosomal abnormalities
- Infectious diseases
- Trauma
- Prematurity
- Iron deficiency
- Chemical substances
- Environmental hazards such as lead or mercury poisoning

What are some of the risk factors for cognitive delays?
Maternal malnutrition and/or substance abuse
Substandard living conditions
Environmental health hazards
Inadequate health care
Parental emotional problems
Lack of parent-child interactions
Lack of learning opportunities

Some strategies for collaborating with parents of a cognitively delayed child are:
Professionals may ignore and overlook parent's expertise about their children. Parents of developmentally delayed children may feel that they and the child are de-valued.
Pay attention to parental concerns about development.
Assist parents in obtaining necessary tests to assess for cognitive delay.
Help parents to learn how to advocate for their child.
Assist parents in locating and utilizing a support network.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

Either six (6) or more signs or symptoms of inattention or hyperactivity/impulsivity present for at least 6 months at a level that is maladaptive and inconsistent with developmental level:

Inattention:

- Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.
- Often has difficulty sustaining attention in tasks or play activities
- Often does not seem to listen when spoken to directly
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
- Often has difficulty organizing tasks and activities
- Is often easily distracted by extraneous stimuli
- Is often forgetful in daily activities

Hyperactivity

- Often fidgets with hands or feet or squirms in seat
- Often leaves seat when remaining seated is expected
- Often runs about or climbs excessively in situations when it is inappropriate (adolescents or adults may be subjective feelings of restlessness)
- Often has difficulty playing or engaging in leisure activities quietly
- Is often “on the go” or acts as if “driven by motor”
- Often talks excessively

Impulsivity

- Often blurts out answers before questions have been completed
- Often has difficulty awaiting turn
- Often interrupts or intrudes on others

*NOTE: the primary features of ADHD are inattention or hyperactivity – impulsivity. There must be early onset (at least some of the symptoms first appear before age 7) and the symptoms cause impairment in functioning.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

NOTES ON ADHD

Rate of occurrence:

3%-7% of school aged children
It is estimated that boys are affected 5 times more often than girls.

Signs/symptoms of the disorder:

Inattention
Hyperactivity
Impulsivity

Lack of Social Skills

Early identification:

It is important to identify early and initiate treatment of this disorder because the characteristics of ADHD interfere with normal emotional and cognitive development.

Common co-existing problems:

Difficulties in coordination, general cognition difficulties, tic disorders, speech and language delays
Learning Disorders
Mood disorders
Conduct disorders

Causes:
Precise cause is not known.
Appears to be a biological basis with a genetic predisposition for the disorder.
Injury and Illness at any stage of development may place children at risk for developing the disorder.

Treatment options:
Educational interventions
Parent education
Structure and consistency
Behavior therapy
Counseling
Social skills training
Psychotropic medications

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

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BEHAVIOR MANAGEMENT STRATEGIES FOR CHILDREN WITH ADHD

Organize the schedule at home. Set up specific times for waking up, eating, playing, doing homework, doing chores, watching TV or playing video games and going to bed. Write the schedule and post where your child will always see it. If your child can't read yet, use drawings or symbols to show the activities of each day. Explain any changes in routine in advance. Make sure your child understands the changes.

Set up house rules. Make the rules of behavior for the family simple, clear and short. Explain what will happen when the rules are obeyed and when they are broken. Write down the rules and results of not following them. Post this list next to the schedule. The punishment for breaking rules should be fair, quick and consistent.

Be positive. Tell your child what you want rather than what you don't want. Reward your child regularly for any good behavior--even little things such as getting dressed and closing doors quietly. Children with ADHD often spend most of their day being told what they are doing wrong. Catch them being good!

Make sure directions are understood. First, get your child's attention. Look directly into his or her eyes. Then tell your child in a clear, calm voice specifically just what you want. Ask your child to repeat the directions back to you. It's usually better to keep directions simple and short. For difficult tasks, give only one or two directions at a time. Then congratulate your child when he or she completes each step.

Be consistent. Only promise what you will deliver. Do what you say you are going to do. Repeating directions and requests many times doesn't work well. When your child breaks the rules, warn only once in a quiet voice. If the warning doe not work, follow through with the punishment that you promised. (Avoid physical punishment. This often makes matters worse.)

Make sure someone watches the child all the time. Because they are impulsive, children with ADHD need more adult supervision than other children their age. Make sure your child is supervised by adults all day.

Watch the child around his friend. It's hard for children with ADHD to learn social skills and social rules. Be careful to select playmates for your child with similar language and physical skills. Invite only one or two friends at a time at first. Watch them closely while they play. Reward good play behaviors often. Most of all, don't allow hitting, pushing and yelling in your house or yard.

BEHAVIOR MANAGEMENT STRATEGIES FOR CHILDREN WITH ADHD

Help with school activities. School mornings may be difficult for children with ADHD. Get ready the night before--lay out school clothes and get the book bag ready. Allow enough time for your child to get dressed and eat a good breakfast. If your child is really slow in the mornings, it's important to make enough time to dress and eat.

Set up homework routine. Pick a regular place for doing homework. This place should be away from distractions such as other people, television and video games. Break homework time into small parts and have breaks. For example, give your child a snack after school, let him play for a few minutes, and then start homework time. Stop frequently for short "fun breaks" that allow your child to do something enjoyable. Give your child lots of encouragement, but let your child do the school work.

Focus on effort, not grades. Reward your child when he tries to finish school work, not just for good grades. You can give extra rewards for earning better grades.

*Child Development Institute
http://cdipage.com
http://childdevelopmentinfo.com

TEACHING CHILDREN TO FOLLOW DIRECTIONS

Center for Effective Parenting
Department of Pediatrics, University of Arkansas for Medical Sciences
Written by Kristen Zolten, M.A. and Nicholas Long, PhD,

One of the most challenging tasks that parents often face is teaching their children to follow directions. It becomes frustrating for the whole family when parents have to repeatedly give their children the same directions ("Pick up your toys"). The recommendations below can be of assistance in teaching children to follow parental directions the first time they are given.

Be prepared to enforce. Parents should avoid giving their children a direction unless they are prepared to enforce it. If parents do not enforce their directions, then children learn that their parents don't mean what they say.

Get their attention. Parents should always get their children's attention before giving a direction. Parents should avoid yelling directions from another room.

Don't ask questions. Parents should avoid phrasing directions as questions (for example, don't say "Justin, would you like to pick up your toys now?").

Don't be vague. Parents should avoid giving vague directions such as "Be good," or "Be careful." There may be significant differences between how the parent and child interpret vague directions such as "being good." Parents should make their directions clear and specific.

Tell them what to do. Parents should try to give directions that tell children what to do instead of what not to do. For example, it is better to say, "Stay by my side," than "Don't run away."

Praise them. Parents should praise their children as soon as they have begun to follow the direction. Parents don't need to wait until the task is completed to offer praise.

Show appreciation. When the task is complete, parents should let their children know they appreciate their compliance.

Give time limit. If children do not start to follow a direction within ten seconds, parents should put them in time-out immediately.

Don't repeat warnings. Parents should avoid giving their children repeated warnings. Children can learn to follow directions after one or no warning just as easily as they can learn to follow directions after five or six warnings.

Repeat the direction. After the time-out is complete, parents should repeat the direction to their children. If they do not start to follow the direction, time-out should be used again. This process should be repeated until children comply with the direction.

OPPOSITIONAL DEFIANT DISORDER

A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames other for his or her mistake or misbehavior
- is often touch or easily annoyed by others
- is often angry and resentful]
- is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

REACTIVE ATTACHMENT DISORDER

Reactive Attachment Disorder (RAD) begins before age 5 and involves difficulties with social relationships. The child either does not initiate or respond appropriately in social interactions **or** is overly familiar with strangers.

These children may be seen as overly inhibited, watchful, isolated or not particularly interested in being close to others. Children with RAD may be excessively familiar with relative strangers or appear to be ready to attach to anyone. They may also show contradictory responses, that is, openly angry and defiant at times and affectionate at other times.

The behavior is not due to a developmental delay or a pervasive developmental disorder.

There is history or evidence of pathogenic (inappropriate) care such as:*

- Persistent disregard for the child's basic emotional needs for comfort, stimulation, and affection
- Persistent disregard for the child's basic physical needs
- Repeated changes in primary caregiver that prevent formation of stable attachments.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

AUTISTIC DISORDER

A disorder characterized by abnormal or impaired development of social interactions and communication and a restricted range of activities and interests.

Qualitative impairment in social interaction, as manifested by at least two of the following:

- marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- failure to develop peer relationships appropriate to developmental level
- a lack of spontaneous seeking to share enjoyment, interest, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- lack of social or emotional reciprocity

Qualitative impairments in communication as manifested by at least one of the following:

- delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
- in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- stereotyped and repetitive use of language or idiosyncratic language
- lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

- encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- apparently inflexible adherence to specific, nonfunctional routines or rituals
- stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupations with parts of objects

Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

SEPARATION ANXIETY DISORDER

It is a normal part of development for children to experience distress and anxiety over being separated from their primary caregiver during infancy and early toddlerhood.

Children with Separation Anxiety Disorder show ***inappropriate or excessive*** anxiety over separation from caregiver or home.

The child must experience three (3) or more of the following:*

- Distress when separation from home or major attachment figures occurs or is anticipated
- Worries about losing, or about possible harm befalling, major attachment figures
- Worries that an unpleasant event will lead to separation from major attachment figure (e.g. getting lost or being kidnapped)
- Reluctance or refusal to go to school or elsewhere because of fear of separation
- Fearful or reluctant to be alone without major attachment figures at home or without significant adults in other settings
- Reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
- Repeated nightmares involving the theme of separation
- Repeated complaints of physical symptoms such as headaches, stomachaches, nausea, or vomiting, when separation occurs or is anticipated.

The signs and symptoms must last at least 4 weeks and occur before the age of 18.

The disturbance causes significant distress or impairment in functioning.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

COPING WITH SEPARATION ANXIETY

Center for Effective Parenting
Department of Pediatrics, University of Arkansas for Medical Sciences
Kristen Zolten, M.A. and Nicholas Long, Ph.D.

While it is true that separations are an unavoidable part of children's lives, and many children will feel distress when they occur, there are many things that parents can do to ease the turmoil that their children experience.

Don't go out of your way to avoid separations. It is part of life for children to learn to accept and deal with separation from their primary caregivers. Therefore, it is not a good idea for parents to try to avoid the pain of separation and stay with their children at all times. Instead, parents should go about their normal lives and separate when necessary, but at the same time they should make sure their children have consistent, quality care when they are not there.

Introduce new caretakers (e.g., babysitters) gradually. It is a good idea to allow your children to get to know their caretakers before being left alone with them. Parents should invite new caretakers over to play with their babies while they are still present - at first until the two get used to each other. Of course, parents should carefully screen anyone they plan to hire to care for their children. When parents introduce their children to a childcare center, they should visit the center with their children and perhaps stay and play a few times before their children are left there. Whatever arrangements parents make for their children's care, consistency is an important element. For example, instead of hiring a different babysitter every time they go out, parents should try to enlist the services of perhaps one or two sitters, so their children have the opportunity to get used to and develop friendships with the people who are hired to care for them.

Provide transitional objects. Transitional objects are things that children often use to cope with separation. Such objects, for example a teddy bear, a doll, or a favorite blanket, provide comfort to children when they are separated from their primary caregivers. They can even be considered "a little piece" of their primary caretakers that they can have with them at all times (e.g., a parent's article of clothing or other possession). Many children become attached to such objects, especially at times of separation, for example bedtime. Transitional objects can be quite a comfort to children experiencing some form of separation.

Don't ignore your child's distress. The upset that children feel when they must be separated from their parents is real. Therefore, this distress should not be shrugged off or ignored by parents. Ignoring this distress can provoke more anxiety and will probably increase clinginess and distress. Instead, parents should, without making too big a deal out of it, address the upset. Certain separations are unavoidable, for example, when a mother must go to work and leave her child with a sitter. However, while at home, parents can try to accommodate a child who protests at being left alone by taking their child with him/her when they must leave the room that their child is in. Parents can use

baby backpack carriers or side carriers to keep their infants with them when they must, for example, get things done around the house.

Encourage your child to do things for himself/herself. Parents should begin teaching their children responsibility and independence while they are young. Of course, parents should be careful to give their children only responsibilities that they are developmentally capable of undertaking. Children who are able to do some things for themselves are likely to see themselves as self sufficient, and as a result will be less dependent upon their parents and less clingy.

Prepare children for your departures in advance. When parents must leave their children, they should prepare them for this event beforehand so that they have time to get used to the idea. For example, parents can mention to their children a couple of days in advance "Daddy and I will be going out on Friday night and Janie will be coming over to stay with you." Parents should repeat this information periodically until they are sure that their children understand.

Let your child know when you leave. Parents should never try to sneak out when they must leave their children. This can break down trust and increase clinginess. Children who are left in this way will be less apt to become absorbed in activities in the future because they will never know when they'll look up to find their parents gone. Instead, parents should always let their children know when they are about to leave.

Use "key phrases." A key phrase is something that a parent can say that will let their children know that they are getting ready to leave, such as "Good bye. I'll see you soon." Parents should use the same key phrase every time they leave so that this phrase will come to prepare their children for their leave-taking.

Let your child know when you plan to return. Parents should make sure that their children know when they will return. If children are too young to tell time, parents can mention time markers, for example, "I'll be back after your nap," or "I'll be back after Sesame Street is over." Parents should then make every effort to stick to the time frame they have given their children. If parents cannot be sure of what time they will return, they should tell their children this. It is important that parents not make promises that they can't keep. If there's a possibility that parents won't return when they say, it's best not to make the promise.

Provide reassurance. Many children need reassurance from their parents before and after separations. Parents should provide lots of love and affection through both words and gestures (hugs, kisses) to their children. Many children, when they must be separated from their parents, may erroneously believe that they are being left in someone else's care because they are bad, or because their parents just don't want to be with them.

Zolten, K and Long, N. COPING WITH SEPARATION ANXIETY. Center for Effective Parenting, Department of Pediatrics, University of Arkansas for Medical Sciences

Parents should make sure that their children know that they are not being left with a sitter or in a daycare because of anything they did or said. Parents should reassure their children that they love them and that they will return. When parents do return after a separation, they should try to set aside some special time to spend with their children.

Practice. Parents should try to help their children get used to separations at an early age. For example, parents can try leaving the room for a couple of seconds at a time, and then reappearing. This will help young children learn that you will indeed return after you go away. Older children, who do not need to be constantly monitored for their own safety, can be left alone for a couple of minutes at a time. As children get used to being separated from their parents for short periods their protests should decrease.

Try distraction. Many children can be distracted from their distress by a favorite toy or activity. Before leaving, parents can let their baby-sitter know what their children's favorite games and toys are. Then, when the parents leave, the baby-sitter can try to engage the child with his/her favorite toy or with a favorite game. Distraction should not be used to the point that the child is not aware that his/her parents are leaving. Parents should avoid "sneaking out."

Play peek-a-boo. Playing peek-a-boo is an excellent way to practice separation in a fun, enjoyable way. Small children enjoy this game precisely because it allows them to have control over the separation.

Don't punish. Parents should avoid punishing or teasing their children for expressing their natural, normal distress. Parents should avoid labeling their children as "sissies," "babies," etc. Nor should parents punish their children for expressing their distress. This may result in children feeling that they can't come to their parents when they are upset, which can get in the way of the development of a trusting, loving relationship. Parents should always remember that the distress children feel when they are separated from their parents is a normal part of development. Instead of punishing or teasing, parents should make an effort to be dependable, and to show their children that they will return when they say they are going to.

Handle leaving matter-of-factly. When parents must leave their children, they should simply say their goodbyes and leave without turning back. Parents should avoid turning their goodbyes into long, drawn out emotional times. Parents should simply say goodbye and leave. If parents make a big deal about going away, their children will likely see it as a big deal, too and get unduly upset.

Zolten, K and Long, N. COPING WITH SEPARATION ANXIETY. Center for Effective Parenting, Department of Pediatrics, University of Arkansas for Medical Sciences

MAJOR DEPRESSIVE DISORDER*

The diagnosis of Major Depressive Disorder requires one or more episodes of major depression lasting two weeks or longer.

An episode of depression is defined as:

Five or more of the following symptoms present during the same 2 week period and represent a change from previous functioning:

- Depressed mood most of the day nearly every day (NOTE: in children and adolescents the symptom may be irritable mood)
- Loss of interest or pleasure in all or almost all activities most of the day nearly every day
- Significant weight loss or gain or decrease or increase in appetite nearly every day (NOTE: in children, failure to make expected weight gains.)
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day (observable by others.)
- Fatigue or loss of energy nearly every day
- Feeling of worthlessness or excessive or inappropriate guilt nearly every day
- Diminished ability to think or concentrate or indecisiveness nearly every day
- Recurrent thoughts of death or suicidal ideation

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

BIPOLAR DISORDER

Bipolar Disorder is characterized by the presence of episodes of depression and mania. See criteria for depression on previous page.

A Manic Episode is defined as follows:

There is a distinct period of abnormally and persistently elevated expansive or irritable mood.

During the disturbance in mood, at least 3 of the following symptoms are present to a significant degree:

- Inflated self-esteem
- Decreased need for sleep
- More talkative than usual, pressure to keep talking
- Flight of ideas or subjective experience of thoughts racing
- Distractibility
- Increase in goal-directed activity
- Excessive involvement in pleasurable activities

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

SUBSTANCE ABUSE

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

- recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

- recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

- recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

- continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

The symptoms have never met the criteria for Substance Dependence for this class of substance.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

SUBSTANCE DEPENDENCE

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

Tolerance, as defined by either of the following:

- a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- markedly diminished effect with continued use of the same amount of the substance

Withdrawal, as manifested by either of the following:

- the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
- the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

The substance is often taken in larger amounts or over a longer period than was intended.

There is a persistent desire or unsuccessful efforts to cut down or control substance use.

A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driven long distances), use the substance (e.g., chain-smoking), or recover from its effects.

Important social, occupational, or recreational activities are given up or reduced because of substance use.

The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

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POSTTRAUMATIC STRESS DISORDER

The person has been exposed to a traumatic event in which both of the following were present:

- the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- the person's response involved intense fear, helplessness, or horror.

Note: In children, this may be expressed instead by disorganized or agitated behavior

The traumatic event is persistently reexperienced in one (or more) of the following ways:

- recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
- acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
- intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- efforts to avoid thoughts, feelings, or conversations associated with the trauma
- efforts to avoid activities, places, or people that arouse recollections of the trauma
- inability to recall an important aspect of the trauma
- markedly diminished interest or participation in significant activities
- feeling of detachment or estrangement from others
- restricted range of affect (e.g., unable to have loving feelings)
- sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- exaggerated startle response

Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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ANOREXIA NERVOSA

Refusal to maintain body weight at or above a minimally normal weight for age and weight

- (e.g., weight loss leading to maintenance of body weight less than 85% of that expected;
- or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

Intense fear of getting weight or becoming fat, even though underweight.

Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Restricting Type: *during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)*

Binge-Eating/Purging Type: *during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)*

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BULIMIA NERVOSA

Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

- a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

Self-evaluation is unduly influenced by body shape and weight.

The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Purging Type: *during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas*

Nonpurging Type: *during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.*

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

ASHA

Asha is a 16 year old African American female who has been in and out of foster care since age 9. She has been in foster care for 13 of the last 22 months.

Asha came into foster care as a result of sexual abuse by her mother's live-in boyfriend. Asha was sexually abused by this man beginning at age 6. She disclosed the abuse because she began to worry about getting pregnant and the boyfriend would not allow her to have friends and do things outside the family. The mother did not leave the boyfriend and relative placement was not considered at that time. Fairly regular contact was maintained between Asha and her mother at the beginning but has dwindled over the years. Asha has never returned to live in the mother's home, even on a trial basis.

Asha has moved countless times during her stay in foster care. She has been in therapeutic foster care for the last year and a half. Asha has a history of running away. She is sexually active and is considered to be promiscuous. Most recently, she was involved with the 29 year old son of the foster parents' neighbor. She has a history of alcohol abuse since age 12 and drug abuse since age 13. She has been in inpatient treatment three times since age 14 related to substance abuse and major depression. She has a history of self-mutilation. She rubs holes into her skin using pencil erasers and sometimes cuts herself with razors. She has a history of bulimia, she will binge and purge almost daily according to the current foster mother. She has attempted suicide at least once using alcohol and antidepressants.

Asha's school performance is varied. When she works and applies herself, she maintains A's and B's. Most often, she does not apply herself and does not attend school regularly. She is considering dropping out of school. She states she wants to attend cosmetology school to become a nail technician.

COURTNEY

There is an open protective services case for Mandy and her three children (ages 3 years, 5 years and 18 months) following an investigation for inadequate supervision. Mandy has left the children alone on several occasions and left them alone at least once for approximately 36 hours. The case has been open for almost six (6) months, although you are just receiving the case.

Courtney is the 3 year old daughter of Mandy and you have some concerns about her behaviors. You note that she does not seem to be developing at the "normal" rate. She seems much younger than 3. She does not talk as much as other 3 year olds and what she does say is difficult to understand. She mostly points and grunts to indicate what she wants. She seems to have only a few words she uses regularly.

She walked at about 15 months. She frequently falls when she walks and cannot seem to run. Mandy describes her as "clumsy".

She wears diapers and Mandy has made no effort to toilet train her. Mandy says that Courtney is too "hardheaded" and won't even try.

Her eating habits are limited. Courtney will usually eat only 3 things, bananas, dry Cheerios and bologna. She drinks apple juice throughout the day and she will drink chocolate milk when it is available. She gets very upset if Mandy tries to make her eat any other foods.

Mandy says that Courtney is "spoiled rotten". Mandy notes that Courtney seems to need constant attention. She is shy and withdrawn and does not seem to like meeting new people. Courtney gets very upset when Mandy has to leave her with a sitter. She is very afraid of the dark.

Mandy says that Courtney doesn't mind her all the time but will mind if Mandy "hollers". Courtney cries and seems scared when Mandy hollers.

DYLAN

Belle is the 21 years old mother of Dylan, a 6 year old first grader who has been having problems in school since kindergarten. Belle is "slow"; she is isolated and unhappy and is constantly complaining about the unfairness of her life. There is an open protective services case on Belle and Dylan due to environmental neglect.

Although Dylan does not appear to be developmentally delayed, he has many problems with his schoolwork. The school has called Belle on several occasions and has asked for a conference to discuss Dylan's problems. Belle has asked you to come along. The school is reporting the following:

At the conference, the following information becomes available, Dylan is not finishing his work during class and is not completing and returning homework. He usually does not have the supplies he needs and has to borrow pencils, paper, etc. from classmates.

Dylan has talked to girls in his class about "French kissing" and has been put in detention for pinching girls on the bottom during recess. Dylan often appears tired and his teacher says he sometimes falls asleep during class. He is frequently late. He is supposed to ride the bus home, however, he sometimes misses the bus and must be picked up from school by his mother. She is very slow to arrive at the school after the school calls her.

Dylan has only one or two friends. He does not seem to be well liked by anyone at school. In unguarded moments, Dylan appears quite sad but laughs off any questions about how he is doing. He has the reputation of being the class clown.

He pushes and shoves while in line at school. Dylan makes strange noises in class. He is very clumsy, seems to be accident-prone and hurts himself regularly on the playground.

The school wants to have Dylan tested for ADD. They are very concerned about what they call his "sexual" behaviors and want him referred to a counselor. There is concern about his home environment and the school would like the caseworker to "look into" the situation more closely.

STEVEN

Steven is 11 years old. He has been in foster care for the last 3 months. He was removed from a neglectful home. There were no other children in the home. His mother was described as being so depressed that she hardly ever got out of bed. The home was described by the caseworker as "one of the dirtiest houses she had ever seen."

Steven spends a lot of time in his room. He will spend hours playing with legos and drawing. His foster mother reports that he is very "unpredictable".

He will play quietly for long periods of time by himself and then will scream at the top of his lungs and start throwing things around. He will shout that he hates everything and everybody. He wakes up in an irritable mood everyday. He comes home from school most days irritable. He throws his books down when he gets in from school and talks about how much he hates his teachers and the stupid kids he has to be around all day. He will kick the dog if she comes near him. A few times the foster mother has been worried that he might really hurt the dog if Steven is left alone with the animal.

He doesn't appear to have any friends. When he is with other kids, he is demanding and insists that they play his way. Usually, he and other children end up arguing. Frequently, it ends with Steven and the other child in a physical fight. At school, Steven has gained a reputation as a troublemaker with a bad temper. When he gets angry, he swears, kicks and throws things. He is often in trouble for his angry outbursts.

Steven says that he just wishes that people would stop bugging him. He doesn't understand why people have to be so stupid and everything would be okay if others would just leave him alone. He doesn't understand why he can't go home. Life wasn't perfect there but at least he had his own life. He says he is worried about his mother and wonders who is taking care of her. One time he has asked his foster mother if it hurts to die. Another time he asked her what she thought it would be like to be dead.

There have been several visits with his mother at the county office. The worker has observed that both the mother and Steven usually just sit and watch TV. There is little talking or interaction between the two. The worker says she has never seen Steven and his mother hug each other and often when the visit is over they don't even say goodbye. The worker reports that there doesn't seem to be much of a relationship.

INFANCY
Birth to 2 years

Toddlerhood
2-4

Early School
5-7

Middle School
8-12

Early Adolescence 13-17

Later Adolescence 18-22

Early Adulthood 23-34

Middle Adulthood 35-60

Later Adulthood
61+

- Attachment and Trust
- Object Permanence
- Learn to walk/talk

- Mastering walk/talk
- Autonomy
- Self Control

- Takes of values of family
- Enters school
- Group play

- Social Cooperation
- Skill learning (3 R’s)
- Self Evaluation

- Physical Maturation
- Formal Operations
- Membership in peer group

- Autonomy from parents
- Sex role identity
- Can identify moral issues/make moral decisions

- Marriage
- Work
- Childbearing

- Management of the household
- Child rearing
- Management of career

- Coping with physical changes
- Accepting one's life

Mental Health Issues in Children

Participant Manual

U·A·L·R

School of Social Work

MENTAL HEALTH ISSUES IN CHILDREN

Agenda

A. Welcome/Introductions
B. Review of agenda
C. Review of competencies
D. Ice breaker
E. Mental health issues from a developmental lifespan perspective
F. Introduction to mental health disorders first evident in infancy, childhood, and adolescence
G. Difficulties in diagnosis
H. Building working relationships with mental health providers
I. Resources/services
J. Case scenarios

COMPETENCIES

The worker knows common emotional disorders of children and the behavioral indicators of these disorders, and can refer the child to the proper professional for further assessment and/or treatment (303-3).

The worker knows the nature of and can recognize the primary developmental disabilities, including mental retardation, cerebral palsy, epilepsy, autism, spina bifida, Down Syndrome, and other conditions, and can identify early signs and symptoms (304-3).

* Division of Children and Family Services
FSW Competency List, 1
1999 Training Needs Assessment

OPENING EXERCISE

MENTAL AND PHYSICAL HEALTH

What distinguishes illnesses of the body from illnesses of the mind?

✓

✓

✓

Stigma is _____.

Results of stigma are

✓

✓

✓

✓

DEVELOPMENTAL STAGES AND TASKS

Infancy (Birth to 2 years)
- Attachment and trust
- Object permanence
- Learning to walk and talk

Toddlerhood (2-4)
- Mastering walking and talking
- Toilet training
- Autonomy

Early school age (5-7)
- Takes on values and standards of family
- Entering school
- Plays in group

Middle school age (8-12)
- Social cooperation
- Rapid skill development, reading, math, etc.
- Self-evaluation

Early adolescence (13-17)
- Physical maturation
- Formal operations
- Membership in peer group

Later adolescence (18-22)
- Autonomy from parents
- Sex role identity
- Able to identify moral issues and decide about moral behavior

Early adulthood (23-34)
- Marriage
- Work
- Childbearing

Middle adulthood (35-60)
- Child rearing
- Management of the household
- Management of a career

Later adulthood (61-)
- Coping with physical changes
- Acceptance of one's life

DISORDERS OF
INFANCY, CHILDHOOD, AND ADOLESCENCE

Mental Retardation:

- Significantly subaverage intellectual functioning
- Begins before age 18
- Concurrent impairments in adaptive functioning

Learning Disorder:

- Academic functioning substantially below what would be expected given the person's age, intelligence and education.
- Examples are Reading Disorder, Mathematics Disorders, and Disorder of Written Expression.

Motor Skills Disorder:

- Developmental Coordination Disorder where motor coordination is substantially below what would be expected given age and intelligence.

Communication Disorders:

- Difficulties in speech or language, e.g., Expressive Language Disorder and Stuttering.

Pervasive Developmental Disorders:

- Severe deficits and pervasive impairment in multiple areas of development.
- Autism,
- Rett's Disorder: begins after 5 months of apparently normal development, often associated with severe or profound mental retardation, characteristics similar to autism
- Asperger's Disorder: severe impairment in social interactions and presence of restricted, repetitive patterns of behavior, interests, and activities.

Attention Deficit Disorder:

- Prominent symptoms of inattention and/or hyperactivity or impulsivity.
- The type of ADD depends on the predominant symptom presentation:
    - Predominantly Inattentive type,
    - Predominantly Hyperactive-Impulsive Type,
    - Combined Type.

Disruptive Behavior Disorders:

- Patterns of behavior that violate the rights of others or major norms or rules, e.g., Conduct Disorder and Oppositional Defiant Disorder.

Feeding and Eating Disorders:

- Pica (eating non-food substances over period of time) and
- Rumination Disorder (regurgitation and rechewing of food).
- Anorexia and Bulimia Nervosa are classified in another Eating Disorders section.

Tic Disorders:

- Tourette's Disorder which includes multiple motor tics and at least one vocal tic
- Chronic Motor or Vocal Tic Disorder

Elimination Disorders:

- Encopresis: age-inappropriate defecation in clothes or other inappropriate places
- Enuresis: age-inappropriate urination on clothes or in bed.

Other Disorders of Infancy, Childhood, or Adolescence

- Separation Anxiety Disorder
- Reactive Attachment Disorder of Infancy or Early Childhood
- Selective Mutism
- Stereotypic Movement Disorder
- Disorders of Infancy, Childhood, or Adolescence NOS

Mood Disorders

Depressive Disorders
Bipolar Disorders

Anxiety Disorders

Includes Panic Disorder, Agoraphobia, Phobias (specific or social), Obsessive Compulsive Disorder, Post Traumatic Stress Disorder and Generalized Anxiety Disorder.

Eating Disorders

Anoxeria Nervosa
Bulimia Nervosa

Substance Related Disorders

There are numerous substance related disorders. These disorders are categorized according to the substance, i.e. alcohol related disorders, alcohol induced disorders, amphetamine related or amphetamine induced, etc.

Schizophrenia and other Psychotic Disorders

Includes Schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to general medical condition or substance.

CHALLENGES OF ASSESSING

Evaluation by mental health provider usually consists of:

✓

✓

✓

Some of the challenges of assessment and diagnosis of children are:

✓
✓
✓
✓

What do you see?

CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP)*

The Child and Adolescent Service System Program or CASSP was established in 1991.

It is designed to meet the multiple service needs of children with serious mental and emotional problems through interagency collaboration and coordination across systems.

CASSP is overseen by a Coordinating Council that has used regional planning teams to develop the program statewide.

When the current system of care is not meeting the needs of seriously emotionally disturbed children and adolescents, CASSP service teams are available throughout the state to develop multiagency plans of care.

The community mental health centers are the single point of entry for the CASSP process.

Referrals to CASSP are made to the CASSP Coordinator in each area.

Any agency or organization or parent or guardian can make the referral.

The CASSP coordinator will screen (or arrange for screening) the child or adolescent using all previous assessments and available information.

The referral source must provide all necessary release of information forms to allow the child to be served by the multi-agency service team.

Arkansas CASSP. Division of Mental Health Services, Children's Services. 1(1), April 2002.

REGIONAL CASSP COORDINATORS*

Agency	Counties Served	Coordinator	Telephone
Community Counseling Services	Clark, Garland, Hot Spring, Montgomery, Pike	Catherine Chaumont	(501) 624-7111
Counseling Associates	Conway, Faulkner, Johnson, Perry, Pope, Yell	Lee Roberson	(501) 354-1561
Counseling Clinic	Saline	Linda Bragg	(501) 315-4224
Counseling Services of Eastern AR	Cross, Crittenden, Lee, Monroe, Phillips, St. Francis	Laura Butler	(870) 734-3202
Delta Counseling Associates	Ashley, Bradley, Chico, Desha, Drew	Jim Morrison	(870) 367-9732
Little Rock Community Mental Health Center	Little Rock and South Pulaski	Cookie Higgins (Centers for Youth and Families)	(501) 666-8686 x 1244
Little Rock Community Mental Health Center	Little Rock and South Pulaski	Betsy Johnson (Child Study Center)	(501) 320-5150
Mid-South Health System	Clay, Craighead, Greene, Lawrence, Mississippi, Poinsett, Randolph	Derek Spiegel	(870) 972-4000
North Arkansas Human Services System	Cleburne, Fulton, Independence, Izard, Jackson, Sharp, Stone, Van Buren, White, Woodruff	Brian Coltharp	(870) 793-8925
Ozark Counseling Services	Baxter, Boone, Marion, Newton, Searcy	Beth Kennedy	(870) 425-5395
Ozark Guidance Center	Benton, Carroll, Madison, Washington	Vicky Strange	(479) 750-1903
Professional Counseling Associates	Lonoke, Prairie, North Pulaski (including North Little Rock)	Jannie Cotton	(501) 221-1843
Southeast AR Behavioral Healthcare Systems	Arkansas, Cleveland, Grant, Jefferson, Lincoln	Sharon Harrison Cagle	(870) 673-1633
Southwest AR Counseling and Mental Health Center	Hempstead, Howard, Miller, Lafayette, Little River, Sevier	Danny Stanley	(870) 774-9396
Western AR Counseling and Guidance Center	Crawford, Franklin, Logan, Polk, Sebastian, Scott	Rhonda Barnes	(479) 452-6650

*as of April 2002

INFORMATION FOR PSYCHOLOGICAL EVALUATIONS

Psychological assessment may be used to provide an understanding a person's functioning, to classify behaviors, and/or to establish a diagnosis. In general, a complete psychological evaluation will include structured tests, projective tests, interviews with the client and any significant other such as a parent, and the collection of a social history.

The following information should be provided to the clinician:

- Child's full name, birth date, and address
- Other person's in the household and their relationship
- Family employment and sources of income
- Reason for referral to your agency and the services provided
- Current status and brief histories of significant relatives to child
- Child's current problems
- Medical history and any current medical problems
- Academic history and family's relationship to school
- Results of any previous testing
- Involvement with any other agencies within the community
- Any special needs of the child
- Parental support, or lack of it, for the current testing
- Cultural, religious, ethnic, or language factors which may impact the problem
- Other information you may have which may help the clinician to understand the child and family.
- Signed consent or release of information form.

Your referral letter should:

- List the behaviors of the child or adult that are of concern
- List the interactions between and among family members
- Point out strengths, needs, and possible contributing factors
- State the types of information you need

Adapted from Psychological Evaluations – An Aid to CPS Assessment. American Association for Protecting Children, Inc. Denver, Co, 1986.

MENTAL RETARDATION

Definition of Mental Retardation (MR):
Onset before age 18
Significantly subaverage intellectual functioning along with impairment in adaptive functioning in two or more of the following areas:

Communication	Self care
Home living	Social skills
Community use	Self direction
Health and safety	Functional academics
Leisure activities	Work

How common is MR?
2.5% – 3.0% of the general population (approximately 285 million in US – 2.5% of 285 million is 7,166,585)

What are the causes of MR?
The majority of children have mild mental retardation for which there is *no identifiable cause.*

The identified causes of cognitive delay include:
- Genetic/chromosomal abnormalities
- Infectious diseases
- Trauma
- Prematurity
- Iron deficiency
- Chemical substances
- Environmental hazards such as lead or mercury poisoning

What are some of the risk factors for cognitive delays?
Maternal malnutrition and/or substance abuse
Substandard living conditions
Environmental health hazards
Inadequate health care
Parental emotional problems
Lack of parent-child interactions
Lack of learning opportunities

Some strategies for collaborating with parents of a cognitively delayed child are:
Professionals may ignore and overlook parent's expertise about their children. Parents of developmentally delayed children may feel that they and the child are de-valued.
Pay attention to parental concerns about development.
Assist parents in obtaining necessary tests to assess for cognitive delay.
Help parents to learn how to advocate for their child.
Assist parents in locating and utilizing a support network.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

Either six (6) or more signs or symptoms of inattention or hyperactivity/impulsivity present for at least 6 months at a level that is maladaptive and inconsistent with developmental level:

Inattention:

- Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.
- Often has difficulty sustaining attention in tasks or play activities
- Often does not seem to listen when spoken to directly
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
- Often has difficulty organizing tasks and activities
- Is often easily distracted by extraneous stimuli
- Is often forgetful in daily activities

Hyperactivity

- Often fidgets with hands or feet or squirms in seat
- Often leaves seat when remaining seated is expected
- Often runs about or climbs excessively in situations when it is inappropriate (adolescents or adults may be subjective feelings of restlessness)
- Often has difficulty playing or engaging in leisure activities quietly
- Is often “on the go” or acts as if “driven by motor”
- Often talks excessively

Impulsivity

- Often blurts out answers before questions have been completed
- Often has difficulty awaiting turn
- Often interrupts or intrudes on others

*NOTE: the primary features of ADHD are inattention or hyperactivity – impulsivity. There must be early onset (at least some of the symptoms first appear before age 7) and the symptoms cause impairment in functioning.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

NOTES ON ADHD

Rate of occurrence:

3%-7% of school aged children
It is estimated that boys are affected 5 times more often than girls.

Signs/symptoms of the disorder:

Inattention
Hyperactivity
Impulsivity

Lack of Social Skills

Early identification:

It is important to identify early and initiate treatment of this disorder because the characteristics of ADHD interfere with normal emotional and cognitive development.

Common co-existing problems:

Difficulties in coordination, general cognition difficulties, tic disorders, speech and language delays
Learning Disorders
Mood disorders
Conduct disorders

Causes:
Precise cause is not known.
Appears to be a biological basis with a genetic predisposition for the disorder.
Injury and Illness at any stage of development may place children at risk for developing the disorder.

Treatment options:
Educational interventions
Parent education
Structure and consistency
Behavior therapy
Counseling
Social skills training
Psychotropic medications

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BEHAVIOR MANAGEMENT STRATEGIES FOR CHILDREN WITH ADHD

Organize the schedule at home. Set up specific times for waking up, eating, playing, doing homework, doing chores, watching TV or playing video games and going to bed. Write the schedule and post where your child will always see it. If your child can't read yet, use drawings or symbols to show the activities of each day. Explain any changes in routine in advance. Make sure your child understands the changes.

Set up house rules. Make the rules of behavior for the family simple, clear and short. Explain what will happen when the rules are obeyed and when they are broken. Write down the rules and results of not following them. Post this list next to the schedule. The punishment for breaking rules should be fair, quick and consistent.

Be positive. Tell your child what you want rather than what you don't want. Reward your child regularly for any good behavior--even little things such as getting dressed and closing doors quietly. Children with ADHD often spend most of their day being told what they are doing wrong. Catch them being good!

Make sure directions are understood. First, get your child's attention. Look directly into his or her eyes. Then tell your child in a clear, calm voice specifically just what you want. Ask your child to repeat the directions back to you. It's usually better to keep directions simple and short. For difficult tasks, give only one or two directions at a time. Then congratulate your child when he or she completes each step.

Be consistent. Only promise what you will deliver. Do what you say you are going to do. Repeating directions and requests many times doesn't work well. When your child breaks the rules, warn only once in a quiet voice. If the warning doe not work, follow through with the punishment that you promised. (Avoid physical punishment. This often makes matters worse.)

Make sure someone watches the child all the time. Because they are impulsive, children with ADHD need more adult supervision than other children their age. Make sure your child is supervised by adults all day.

Watch the child around his friend. It's hard for children with ADHD to learn social skills and social rules. Be careful to select playmates for your child with similar language and physical skills. Invite only one or two friends at a time at first. Watch them closely while they play. Reward good play behaviors often. Most of all, don't allow hitting, pushing and yelling in your house or yard.

BEHAVIOR MANAGEMENT STRATEGIES FOR CHILDREN WITH ADHD

Help with school activities. School mornings may be difficult for children with ADHD. Get ready the night before--lay out school clothes and get the book bag ready. Allow enough time for your child to get dressed and eat a good breakfast. If your child is really slow in the mornings, it's important to make enough time to dress and eat.

Set up homework routine. Pick a regular place for doing homework. This place should be away from distractions such as other people, television and video games. Break homework time into small parts and have breaks. For example, give your child a snack after school, let him play for a few minutes, and then start homework time. Stop frequently for short "fun breaks" that allow your child to do something enjoyable. Give your child lots of encouragement, but let your child do the school work.

Focus on effort, not grades. Reward your child when he tries to finish school work, not just for good grades. You can give extra rewards for earning better grades.

*Child Development Institute
http://cdipage.com
http://childdevelopmentinfo.com

TEACHING CHILDREN TO FOLLOW DIRECTIONS

Center for Effective Parenting
Department of Pediatrics, University of Arkansas for Medical Sciences
Written by Kristen Zolten, M.A. and Nicholas Long, PhD,

One of the most challenging tasks that parents often face is teaching their children to follow directions. It becomes frustrating for the whole family when parents have to repeatedly give their children the same directions ("Pick up your toys"). The recommendations below can be of assistance in teaching children to follow parental directions the first time they are given.

Be prepared to enforce. Parents should avoid giving their children a direction unless they are prepared to enforce it. If parents do not enforce their directions, then children learn that their parents don't mean what they say.

Get their attention. Parents should always get their children's attention before giving a direction. Parents should avoid yelling directions from another room.

Don't ask questions. Parents should avoid phrasing directions as questions (for example, don't say "Justin, would you like to pick up your toys now?").

Don't be vague. Parents should avoid giving vague directions such as "Be good," or "Be careful." There may be significant differences between how the parent and child interpret vague directions such as "being good." Parents should make their directions clear and specific.

Tell them what to do. Parents should try to give directions that tell children what to do instead of what not to do. For example, it is better to say, "Stay by my side," than "Don't run away."

Praise them. Parents should praise their children as soon as they have begun to follow the direction. Parents don't need to wait until the task is completed to offer praise.

Show appreciation. When the task is complete, parents should let their children know they appreciate their compliance.

Give time limit. If children do not start to follow a direction within ten seconds, parents should put them in time-out immediately.

Don't repeat warnings. Parents should avoid giving their children repeated warnings. Children can learn to follow directions after one or no warning just as easily as they can learn to follow directions after five or six warnings.

Repeat the direction. After the time-out is complete, parents should repeat the direction to their children. If they do not start to follow the direction, time-out should be used again. This process should be repeated until children comply with the direction.

OPPOSITIONAL DEFIANT DISORDER

A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames other for his or her mistake or misbehavior
- is often touch or easily annoyed by others
- is often angry and resentful]
- is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

REACTIVE ATTACHMENT DISORDER

Reactive Attachment Disorder (RAD) begins before age 5 and involves difficulties with social relationships. The child either does not initiate or respond appropriately in social interactions **or** is overly familiar with strangers.

These children may be seen as overly inhibited, watchful, isolated or not particularly interested in being close to others. Children with RAD may be excessively familiar with relative strangers or appear to be ready to attach to anyone. They may also show contradictory responses, that is, openly angry and defiant at times and affectionate at other times.

The behavior is not due to a developmental delay or a pervasive developmental disorder.

There is history or evidence of pathogenic (inappropriate) care such as:*

- Persistent disregard for the child's basic emotional needs for comfort, stimulation, and affection
- Persistent disregard for the child's basic physical needs
- Repeated changes in primary caregiver that prevent formation of stable attachments.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

AUTISTIC DISORDER

A disorder characterized by abnormal or impaired development of social interactions and communication and a restricted range of activities and interests.

Qualitative impairment in social interaction, as manifested by at least two of the following:

- marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- failure to develop peer relationships appropriate to developmental level
- a lack of spontaneous seeking to share enjoyment, interest, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- lack of social or emotional reciprocity

Qualitative impairments in communication as manifested by at least one of the following:

- delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
- in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- stereotyped and repetitive use of language or idiosyncratic language
- lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

- encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- apparently inflexible adherence to specific, nonfunctional routines or rituals
- stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupations with parts of objects

Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

SEPARATION ANXIETY DISORDER

It is a normal part of development for children to experience distress and anxiety over being separated from their primary caregiver during infancy and early toddlerhood.

Children with Separation Anxiety Disorder show ***inappropriate or excessive*** anxiety over separation from caregiver or home.

The child must experience three (3) or more of the following:*

- Distress when separation from home or major attachment figures occurs or is anticipated
- Worries about losing, or about possible harm befalling, major attachment figures
- Worries that an unpleasant event will lead to separation from major attachment figure (e.g. getting lost or being kidnapped)
- Reluctance or refusal to go to school or elsewhere because of fear of separation
- Fearful or reluctant to be alone without major attachment figures at home or without significant adults in other settings
- Reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
- Repeated nightmares involving the theme of separation
- Repeated complaints of physical symptoms such as headaches, stomachaches, nausea, or vomiting, when separation occurs or is anticipated.

The signs and symptoms must last at least 4 weeks and occur before the age of 18.

The disturbance causes significant distress or impairment in functioning.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

COPING WITH SEPARATION ANXIETY

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While it is true that separations are an unavoidable part of children's lives, and many children will feel distress when they occur, there are many things that parents can do to ease the turmoil that their children experience.

Don't go out of your way to avoid separations. It is part of life for children to learn to accept and deal with separation from their primary caregivers. Therefore, it is not a good idea for parents to try to avoid the pain of separation and stay with their children at all times. Instead, parents should go about their normal lives and separate when necessary, but at the same time they should make sure their children have consistent, quality care when they are not there.

Introduce new caretakers (e.g., babysitters) gradually. It is a good idea to allow your children to get to know their caretakers before being left alone with them. Parents should invite new caretakers over to play with their babies while they are still present - at first until the two get used to each other. Of course, parents should carefully screen anyone they plan to hire to care for their children. When parents introduce their children to a childcare center, they should visit the center with their children and perhaps stay and play a few times before their children are left there. Whatever arrangements parents make for their children's care, consistency is an important element. For example, instead of hiring a different babysitter every time they go out, parents should try to enlist the services of perhaps one or two sitters, so their children have the opportunity to get used to and develop friendships with the people who are hired to care for them.

Provide transitional objects. Transitional objects are things that children often use to cope with separation. Such objects, for example a teddy bear, a doll, or a favorite blanket, provide comfort to children when they are separated from their primary caregivers. They can even be considered "a little piece" of their primary caretakers that they can have with them at all times (e.g., a parent's article of clothing or other possession). Many children become attached to such objects, especially at times of separation, for example bedtime. Transitional objects can be quite a comfort to children experiencing some form of separation.

Don't ignore your child's distress. The upset that children feel when they must be separated from their parents is real. Therefore, this distress should not be shrugged off or ignored by parents. Ignoring this distress can provoke more anxiety and will probably increase clinginess and distress. Instead, parents should, without making too big a deal out of it, address the upset. Certain separations are unavoidable, for example, when a mother must go to work and leave her child with a sitter. However, while at home, parents can try to accommodate a child who protests at being left alone by taking their child with him/her when they must leave the room that their child is in. Parents can use

baby backpack carriers or side carriers to keep their infants with them when they must, for example, get things done around the house.

Encourage your child to do things for himself/herself. Parents should begin teaching their children responsibility and independence while they are young. Of course, parents should be careful to give their children only responsibilities that they are developmentally capable of undertaking. Children who are able to do some things for themselves are likely to see themselves as self sufficient, and as a result will be less dependent upon their parents and less clingy.

Prepare children for your departures in advance. When parents must leave their children, they should prepare them for this event beforehand so that they have time to get used to the idea. For example, parents can mention to their children a couple of days in advance "Daddy and I will be going out on Friday night and Janie will be coming over to stay with you." Parents should repeat this information periodically until they are sure that their children understand.

Let your child know when you leave. Parents should never try to sneak out when they must leave their children. This can break down trust and increase clinginess. Children who are left in this way will be less apt to become absorbed in activities in the future because they will never know when they'll look up to find their parents gone. Instead, parents should always let their children know when they are about to leave.

Use "key phrases." A key phrase is something that a parent can say that will let their children know that they are getting ready to leave, such as "Good bye. I'll see you soon." Parents should use the same key phrase every time they leave so that this phrase will come to prepare their children for their leave-taking.

Let your child know when you plan to return. Parents should make sure that their children know when they will return. If children are too young to tell time, parents can mention time markers, for example, "I'll be back after your nap," or "I'll be back after Sesame Street is over." Parents should then make every effort to stick to the time frame they have given their children. If parents cannot be sure of what time they will return, they should tell their children this. It is important that parents not make promises that they can't keep. If there's a possibility that parents won't return when they say, it's best not to make the promise.

Provide reassurance. Many children need reassurance from their parents before and after separations. Parents should provide lots of love and affection through both words and gestures (hugs, kisses) to their children. Many children, when they must be separated from their parents, may erroneously believe that they are being left in someone else's care because they are bad, or because their parents just don't want to be with them.

Zolten, K and Long, N. COPING WITH SEPARATION ANXIETY. Center for Effective Parenting, Department of Pediatrics, University of Arkansas for Medical Sciences

Parents should make sure that their children know that they are not being left with a sitter or in a daycare because of anything they did or said. Parents should reassure their children that they love them and that they will return. When parents do return after a separation, they should try to set aside some special time to spend with their children.

Practice. Parents should try to help their children get used to separations at an early age. For example, parents can try leaving the room for a couple of seconds at a time, and then reappearing. This will help young children learn that you will indeed return after you go away. Older children, who do not need to be constantly monitored for their own safety, can be left alone for a couple of minutes at a time. As children get used to being separated from their parents for short periods their protests should decrease.

Try distraction. Many children can be distracted from their distress by a favorite toy or activity. Before leaving, parents can let their baby-sitter know what their children's favorite games and toys are. Then, when the parents leave, the baby-sitter can try to engage the child with his/her favorite toy or with a favorite game. Distraction should not be used to the point that the child is not aware that his/her parents are leaving. Parents should avoid "sneaking out."

Play peek-a-boo. Playing peek-a-boo is an excellent way to practice separation in a fun, enjoyable way. Small children enjoy this game precisely because it allows them to have control over the separation.

Don't punish. Parents should avoid punishing or teasing their children for expressing their natural, normal distress. Parents should avoid labeling their children as "sissies," "babies," etc. Nor should parents punish their children for expressing their distress. This may result in children feeling that they can't come to their parents when they are upset, which can get in the way of the development of a trusting, loving relationship. Parents should always remember that the distress children feel when they are separated from their parents is a normal part of development. Instead of punishing or teasing, parents should make an effort to be dependable, and to show their children that they will return when they say they are going to.

Handle leaving matter-of-factly. When parents must leave their children, they should simply say their goodbyes and leave without turning back. Parents should avoid turning their goodbyes into long, drawn out emotional times. Parents should simply say goodbye and leave. If parents make a big deal about going away, their children will likely see it as a big deal, too and get unduly upset.

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MAJOR DEPRESSIVE DISORDER*

The diagnosis of Major Depressive Disorder requires one or more episodes of major depression lasting two weeks or longer.

An episode of depression is defined as:

Five or more of the following symptoms present during the same 2 week period and represent a change from previous functioning:

- Depressed mood most of the day nearly every day (NOTE: in children and adolescents the symptom may be irritable mood)
- Loss of interest or pleasure in all or almost all activities most of the day nearly every day
- Significant weight loss or gain or decrease or increase in appetite nearly every day (NOTE: in children, failure to make expected weight gains.)
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day (observable by others.)
- Fatigue or loss of energy nearly every day
- Feeling of worthlessness or excessive or inappropriate guilt nearly every day
- Diminished ability to think or concentrate or indecisiveness nearly every day
- Recurrent thoughts of death or suicidal ideation

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

BIPOLAR DISORDER

Bipolar Disorder is characterized by the presence of episodes of depression and mania. See criteria for depression on previous page.

A Manic Episode is defined as follows:

There is a distinct period of abnormally and persistently elevated expansive or irritable mood.

During the disturbance in mood, at least 3 of the following symptoms are present to a significant degree:

- Inflated self-esteem
- Decreased need for sleep
- More talkative than usual, pressure to keep talking
- Flight of ideas or subjective experience of thoughts racing
- Distractibility
- Increase in goal-directed activity
- Excessive involvement in pleasurable activities

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

SUBSTANCE ABUSE

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

- recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

- recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

- recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

- continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

The symptoms have never met the criteria for Substance Dependence for this class of substance.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

SUBSTANCE DEPENDENCE

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

Tolerance, as defined by either of the following:

- a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- markedly diminished effect with continued use of the same amount of the substance

Withdrawal, as manifested by either of the following:

- the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
- the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

The substance is often taken in larger amounts or over a longer period than was intended.

There is a persistent desire or unsuccessful efforts to cut down or control substance use.

A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driven long distances), use the substance (e.g., chain-smoking), or recover from its effects.

Important social, occupational, or recreational activities are given up or reduced because of substance use.

The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

POSTTRAUMATIC STRESS DISORDER

The person has been exposed to a traumatic event in which both of the following were present:

- the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- the person's response involved intense fear, helplessness, or horror.

Note: In children, this may be expressed instead by disorganized or agitated behavior

The traumatic event is persistently reexperienced in one (or more) of the following ways:

- recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
- acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
- intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- efforts to avoid thoughts, feelings, or conversations associated with the trauma
- efforts to avoid activities, places, or people that arouse recollections of the trauma
- inability to recall an important aspect of the trauma
- markedly diminished interest or participation in significant activities
- feeling of detachment or estrangement from others
- restricted range of affect (e.g., unable to have loving feelings)
- sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- exaggerated startle response

Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

ANOREXIA NERVOSA

Refusal to maintain body weight at or above a minimally normal weight for age and weight

- (e.g., weight loss leading to maintenance of body weight less than 85% of that expected;
- or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

Intense fear of getting weight or becoming fat, even though underweight.

Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Restricting Type: *during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)*

Binge-Eating/Purging Type: *during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)*

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BULIMIA NERVOSA

Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

- a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

Self-evaluation is unduly influenced by body shape and weight.

The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Purging Type: *during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas*

Nonpurging Type: *during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.*

*American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.