The Integration of Services Training Series

MODULE 2: MENTAL HEALTH

PARTICIPANT GUIDE

The Integration of Services Training Series

Before and After Training Survey

Before and After Training Survey — Module 2

Directions: Rate your skill or knowledge level on a scale of 1-10 for each of the following statements. This is not a test. Don't over think your rating. The training will be on these skills and knowledge. You are not expected to have a high level for all items before the training.

Before Training: Write a **A** in the numbered box that indicates your skill or knowledge level for each item. Use the scale to the right to guide your rating. Keep the survey in a safe place for use again after the training. **After Training:** Write a **B** in the numbered box that indicates your skill or knowledge level for each item. You may change your "before" rating if you'd like.	**1-2**	**Novice**
	3-6	**Competent**
	7-8	**Proficient**
	9-10	**Expert**

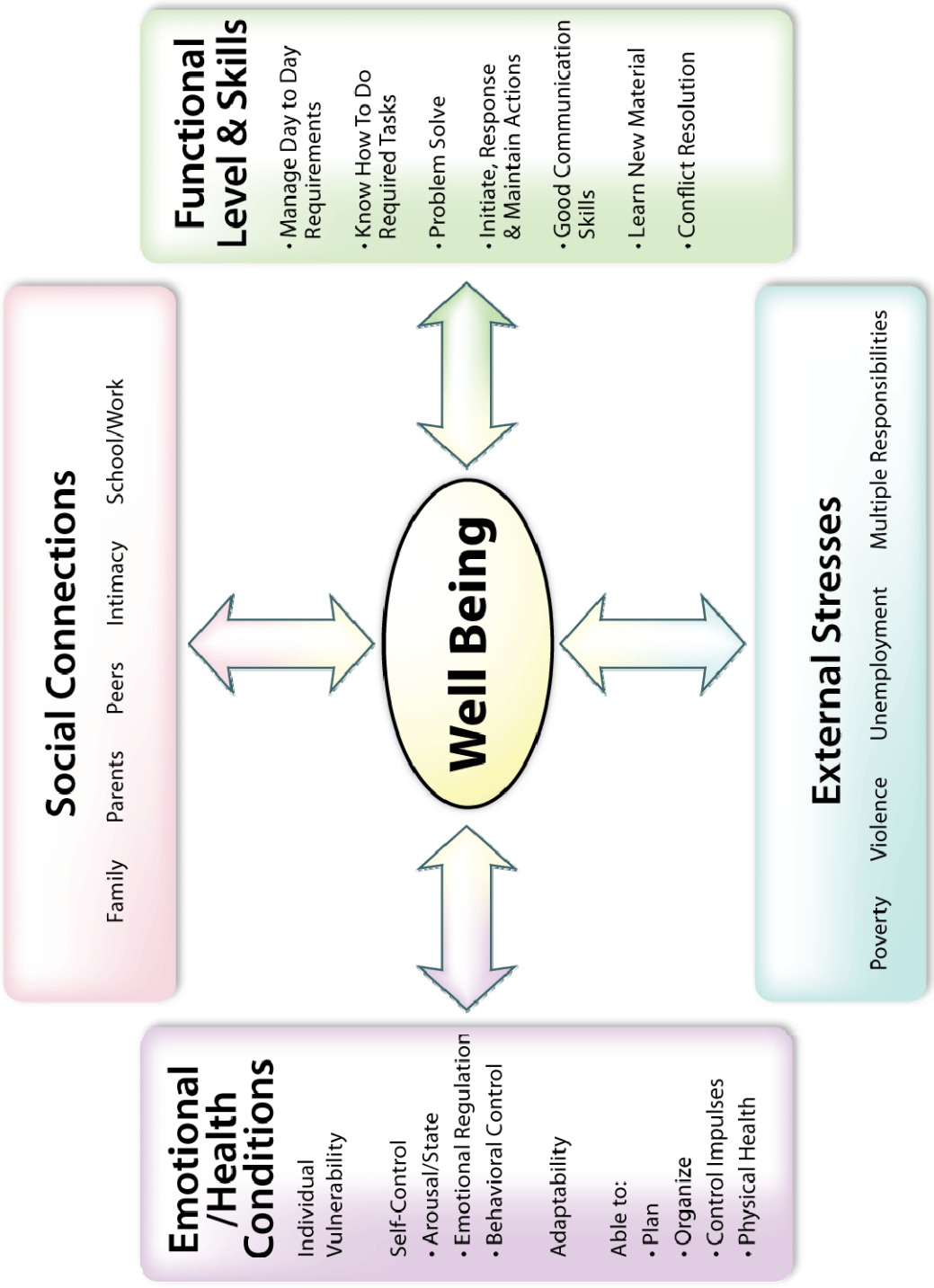
Knowledge/Skill Items	**Rating**									
1. Describe why some people may be more likely to develop a mental disorder.	1	2	3	4	5	6	7	8	9	10
2. Describe how people experience emotions.	1	2	3	4	5	6	7	8	9	10
3. Understand the contextual view of adult mental disorders.	1	2	3	4	5	6	7	8	9	10
4. Understand the Diagnostic and Statistical Manual IV-TR multiple axis system.	1	2	3	4	5	6	7	8	9	10
5. Understand how mental disorders may or may not impact parenting.	1	2	3	4	5	6	7	8	9	10
6. Describe how mental disorders may be seen across generations.	1	2	3	4	5	6	7	8	9	10
7. Describe the different evaluation and assessments used in mental health services.	1	2	3	4	5	6	7	8	9	10
8. Know the questions to ask parents and children concerning mental disorders.	1	2	3	4	5	6	7	8	9	10
9. Describe how to work effectively with mental health professionals.	1	2	3	4	5	6	7	8	9	10
10. Describe the importance of natural supports in the recovery process.	1	2	3	4	5	6	7	8	9	10
11. Understand what constitutes a mental health evidence based practice.	1	2	3	4	5	6	7	8	9	10
12. Understand how the Comprehensive Behavioral Health Assessment, the DSM-IV-TR diagnosis (if any) and the case plan should align.	1	2	3	4	5	6	7	8	9	10
13. Describe what a family team might look like for children and families with mental health disorders.	1	2	3	4	5	6	7	8	9	10

Goal-Setting for Today
Working with Mental Health Issues

•I want to be able to…

•The things I struggle most with…

•The barriers to success that I often encounter are…


Functional Level & Skills
• Manage Day to Day Requirements
• Know How To Do Required Tasks
• Problem Solve
• Initiate, Response & Maintain Actions
• Good Communication Skills
• Learn New Material
• Conflict Resolution
Social Connections
Family Parents Peers Intimacy School/Work
Well Being
External Stresses
Poverty Violence Unemployment Multiple Responsibilities
Emotional /Health Conditions
Individual Vulnerability
Self-Control
• Arousal/State
• Emotional Regulation
• Behavioral Control
Adaptability
Able to:
• Plan
• Organize
• Control Impulses
• Physical Health

Overview of Mental Health Diagnoses

Anxiety Disorders

Anxiety disorders are the most common group of mental disorders. The term anxiety means being very nervous, having a lot of tension, feeling apprehensive, or feeling fear like the feeling of danger. The anxiety is usually considered to be greater than should be experienced given the individual's life situation. For example, it is normal to feel fear if you are walking down a lonely dark street and hear footsteps fast approaching from behind. It usually is not normal to feel great fear about entering a classroom full of people that you know. Descriptions of anxiety disorders will now be given.

Panic Disorder:

Some people have panic disorders and have panic attacks. A panic attack is a period of intense fear or discomfort that develops very quickly and reaches its height within a few minutes. The person may experience hyperventilation, trembling, sweating, dizziness, numbness, or the feeling like they are choking. The person may feel like they are dying or are going to do something uncontrollable. Panic attacks are very frightening and the person may be very afraid that they will experience them again.

Phobia:

When individuals develop fear related to an activity, person, or situation the anxiety disorder is called a phobia. The situation, activity, person, place, or thing is dreaded, feared, and something that the person wishes to avoid. Examples of some well known phobias are fear of open spaces (agoraphobia), fear of being around others (social phobia), or fear of being in a confined or enclosed space (claustrophobia). The person may avoid these encounters to the extent that they do not go places, travel, or do other routine activities. Phobias can be very intense and prevent the person from living a normal life. Panic attacks are sometimes associated with phobias, but phobias can exist without full panic attacks.

Generalized Anxiety Disorder:

When there is no specific focus of the anxiety the disorder it is called a generalized anxiety disorder**.** This disorder involves excessive worry, and fearfulness that something bad will happen in the individual's life. These feelings must happen most days over a six-month period for the person to be diagnosed with an anxiety disorder. The fears and worries are not directly related to something actually happening in the person's day-to-day events or are stronger than would be expected given the situation.

Obsessive-compulsive disorder (OCD):

OCD is an anxiety disorder where the person is compelled to complete activities or have continual thoughts that cause them anxiety. **Obsessions** are thoughts that are repeated over and over again in the person's mind and may keep them from paying attention to other issues. Also, the person may experience impulses to do certain things and the impulses also cause them anxiety. Examples of obsessions are being

afraid of hurting others, fear of germs, or being afraid of making a mistake. The feelings are much stronger than are normally experienced when people worry about such issues. **Compulsions** are rituals or acts that are repeated over and over again, and the person feels driven to do them. The person experiences anxiety if they cannot complete the acts. Examples of these rituals are repeated hand washing, checking something continually to be sure that it is correct, and repeating words to themselves. These thoughts and actions can seriously keep the person from doing the activities that they are required to do in their daily lives.

Post-Traumatic Stress Disorder (PTSD):

Sometimes when individuals experience a terrible event such as witnessing death, abuse, rape, combat, or violence, they develop a mental disorder known as post-traumatic stress disorder (PTSD). When persons suffer from PTSD they re-experience the trauma through re-occurring images or thoughts, dreams, or actually believing that they are re-living the event. People with PTSD often have problems sleeping, can be irritable, watch everything closely all the time (hypervigilance), and have an exaggerated startle response. They often try to avoid activities, feelings, and thoughts associated with the traumatic event.

Psychosis

Psychosis is a thought disorder. It refers to the inability to determine what is real and what is not. People who have a psychosis cannot easily tell the difference between what is really happening in their environment and what is happening inside their thoughts. This can be, and often is, a very scary and disturbing experience for them. Their psychosis "tells" them that the problems are real and not in their mind. However, the part of the person that is still based in reality knows something is wrong. The most common psychotic symptom is withdrawal from others due to delusions or hallucinations.

When people begin to become ill with a thought disorder, it is so troubling that they want to be isolated and avoid other human contact. They can become overwhelmed by their thoughts. With hallucinations, the person's sensory perceptions such as seeing, hearing, or touching are disturbed. The person believes that something is happening that is not, and may "see", "hear", or "feel" something that others do not. Hallucinations can also include smell but this is quite rare and usually indicates that some overt physical problem is happening. Delusions happen when the person has beliefs about something that are false, such as that the TV is talking to them or someone is trying to harm them. Hallucinations and delusions are very serious symptoms of illness and are difficult for the person who is experiencing them to handle. They are frightened and confused because they don't know whether something is happening to them or not.

In some cases, symptoms of psychosis can occur when the person has a brain tumor, infections, or a reaction to drugs. These symptoms tend to last only while the person is under the influence of drugs or during the illness. People may make a full recovery from these symptoms when they are caused by the above situations. This is why a thorough physical exam should be required for all people who are seeking behavioral health

services, since other medical conditions may be causing symptoms that look like mental illness but are not.

Schizophrenia:

Psychotic symptoms that are a result of mental disorders can be long lasting. Schizophrenia is a mental health disorder where the individual experiences psychotic symptoms and is considered to have psychosis, at least part of the time. These symptoms can result in very strange behaviors. The person may have serious problems with language and talking, what they are thinking about, how they view things around them, and how they view themselves. Their symptoms may include some or all of the above conditions, hallucinations, delusions, or thought disorders (general problems understanding what is going on around them.). The symptoms often are grouped and clinicians refer to the type of schizophrenia by the grouping of these symptoms. These are described below:

Paranoid Type: The major symptoms are auditory (hearing) hallucinations and delusions. This kind of disorder is present in people who think that others are out to do them harm. The person may think that the television is sending threatening messages to them, or think that they are being chased by the police, or are going to be hurt or harmed by some group. However, the facts do not support their beliefs.

Disorganized Type: The major symptoms with this type are problems with speech, and odd, silly behavior. The person may giggle or make faces inappropriately and act inappropriately in social situations. The problems are much more serious than giggling when a person is nervous or sometimes "goofing off". The behaviors are very odd and can be observed in many situations in the treatment setting.

Catatonic Type: A person with this type of schizophrenia develops serious problems in their speech, their senses, and movements. They may stand in one position continually, or walk up and down a hall constantly, or refuse to talk. They sometimes will go into a stupor where they will not respond to anything and then quickly start acting very excited. This type of schizophrenia is very rare.

Undifferentiated Type: With this type there is no single symptom or group of symptoms.

Residual Type: In this type, the major psychotic symptoms have been reduced but the person is considered to have an illness that needs treatment to help them continue to do well.

People diagnosed with schizophrenia are described as having negative and positive symptoms. Positive symptoms are those conditions that are experienced in the mind but that should not be present. They are pretty obvious, and include hallucinations, delusions, problems in thinking, and agitation. These are symptoms that have been focused on in the past, and dealing with those symptoms has been the primary purpose of treatment, usually with medications. Medications and treatment can reduce or eliminate many of these symptoms, but the person may still experience other symptoms of the disease that can greatly affect their lives. In addition,

medications that treat positive symptoms also cause side effects that are difficult to deal with.

The term "positive" is a little misleading because it does not describe conditions that are good for the person. Instead, positive means that the person is experiencing symptoms that are obvious and of concern. The negative symptoms of thought disorders are just as difficult for the person as positive symptoms. In fact, it is the negative symptoms that often cause the person to not be able to do the activities of their daily living. The negative symptoms include flat or blunted affect (not showing any emotion), childlike thinking and inability to think abstractly, inability to experience pleasure (anhedonia), and poor motivation, spontaneity and showing initiative. Family, friends and people working with persons with schizophrenia sometimes do not understand that the lack of motivation or follow-through on tasks is not out of laziness or not caring, but is in fact a behavior that is a part of the illness.

Schizophreniform disorder:

Although schizophrenia is the best-known psychotic disorder there are other types of psychotic disorders. Schizophreniform disorder has many of the symptoms of schizophrenia but is different because the beginning of the disorder is sudden and the person often recovers within a few weeks. Some people have the condition more than once across a period of time.

Schizoaffective disorder:

Schizoaffective disorder includes delusions, auditory hallucinations or problems with thinking, but the person also has symptoms similar to those of mood disorder. People with schizophrenia often appear to be without emotions. People with schizoaffective disorders have similar signs of a thought disorder but their display of emotions doesn't seem to be affected (see below). Individuals with the diagnosis of **delusional disorders** have well developed delusions but lack the other symptoms usually present with other psychotic disorders. There are six types of delusional disorders: persecutory (thinks people trying to hurt them), grandiose (think that they have greater abilities than they really do), jealous, somatic (think they have some type of physical illness) and unspecified (no one type of delusion).

Mood Disorders

Most people understand the meaning of the word mood. It addresses feeling like sadness, anger, guilt, or happiness. Some people cannot regulate their feelings and can have extreme feelings of happiness and excitement, or become very sad. These conditions are called mood disorders. Persons with mood disorders often have problems sleeping or sleeping too much, changes in how much and how frequently they eat, or problems with concentration, memory, and a general felling that life is hard and not fun.

Major depression:

Major depression is a serious type of mood disorder. A person with this disorder may be extremely depressed for at least two weeks at a time. During the period of

depression the person often feels worthless and has problems making decisions. They may have a loss of energy and may feel that the slightest activity or action requires overwhelming effort. The person also may have no interest in doing activities of daily living and may avoid friends and family. Persons with major depression can have serious episodes many times in their life. Untreated, the condition can last for many months.

Mania:

Another set of behaviors and feelings are called mania. When experiencing mania the person feels extreme pleasure in every aspect of their life. They become very active (hyperactive), sleep very little, develop very grand plans—thinking they are going to be famous or make large amounts of money—or spend large amounts of money on shopping. The person also may talk very fast and excitedly, but not make good sense as they talk (incoherent). The person may not continue to work and may experience serious problems socially. Without treatment the condition can last up to about six months. People can have mania or another stage called hypo-mania where they act much like what was just described but do not lose touch with reality. Many famous people have been diagnosed with these kinds of illnesses. The symptoms can result in high levels of creativity

Bi-polar:

When a person just experiences one type of mood problem the condition is described as unipolar. Mania usually does not happen alone. Sometimes, people who experience episodes of mania have times when they are not manic but depressed. This condition is known as bi-polar. The mania occurs for a period of time and then stops, with the person starting to feel very depressed. The person goes from feeling terrific to despair. Clinicians describe bi-polar disorders as bi-polar II and bi-polar I. In bi-polar II the person has severe depression but does not experience full-blown mania and can function fairly well during the manic stage. Bi-polar I disorders include both severe depression and full manic episodes (Durand and Barlow, 2003).

Personality Disorders:

Another set of disorders is also very important when discussing mental disorders. These conditions are different from those discussed above and are included in Axis II of the diagnoses. These Personality Disorders are patterns in the way that the person thinks about their life and environment and are part of the person's way of thinking and behaving. The beliefs are usually problematic and cause the individual difficulties when relating to others and functioning in their daily lives. They are not easily treated. Unlike anxiety, psychosis, and mood disorders, personality disorders are not illnesses that a person contracts. Instead, they are fundamental problems about who they are, how they feel, how they see themselves, how they cope with problems, and how they act with other people (Hales and Hales, 1996). These personality problems are very hard to change and can cause the person considerable difficulties throughout their life. The DSM-IV lists specific personality disorders. These are briefly described below:

- **Antisocial personality disorder**: A person with this disorder has a history of antisocial behavior, such as academic failure, poor job performance, illegal activities, recklessness, and impulsive acts. Symptoms may include the inability to tolerate boredom, feeling that they are a victim, and a reduced ability to form intimate relationships.
- **Borderline personality disorder**: A person with this disorder has unstable moods and self-image, and unstable, intense, interpersonal relationships. These people often display extremes of over-valuing themselves and under-valuing themselves. They have mood shifts, and experience intense anxiety and impulsiveness.
- **Narcissistic personality disorder**: This disorder has an overriding pattern of the person feeling like they are great and can do great things but they lack a sense of concern for others and are very sensitive to criticism of others.
- **Passive-aggressive personality disorder**: A person with this disorder lacks the ability to be appropriately assertive with others. They do not directly challenge a situation but are passively resistant. They usually do not realize that they are resentful and hostile toward others and that they are showing this through their passive resistance.
- **Avoidant personality disorder**: This disorder includes social discomfort, an increased sensitivity to both criticism and rejection. They may appear timid, and have some depression, anxiety, and anger about their problems with social situations.
- **Obsessive-compulsive personality disorder**: A person with this disorder wants to have everything perfect and can be very inflexible. Symptoms may include distress about having to make decisions and expressing tender feelings. They may experience feelings of depression and anger about being controlled by others. The person may also be very sensitive to criticism. They are also extremely conscientious, very honest, and judgmental.
- **Histrionic personality disorder**: A person with this disorder is very emotional and seeks attention excessively. Behavior may include constant seeking of approval or attention. The person may be described as very self-centered or sexually seductive at inappropriate times.
- **Dependent personality disorder**: A person with this disorder may think that they need a lot of help and assistance from others, and may be very submissive. They often feel anxious and depressed, and may experience intense discomfort when alone for more than a brief period of time.
- **Paranoid personality disorder**: Individuals with this disorder interpret the actions of others as intentionally threatening, demeaning, and untrustworthy.
- **Schizoid personality disorder**: A person with this disorder shows indifference to social relationships and has a limited amount of emotions and expressions.
- **Schizotypal personality disorder**: A person with this disorder has problems with interpersonal relationships and may have bizarre ideas, appearance, and behavior. The person also may have anxiety and depression (Prinz, 2004).

Co-occurring Disorders

Co-occurring disorders are conditions in which a substance abuse disorder and mental disorder exist at the same time. People who are experiencing mental health problems may turn to alcohol or drugs to help relieve some of the symptoms. This is referred to as "self-medicating". Additionally, many of the factors related to substance abuse also are related to mental disorders, making it more likely that a person will develop both problems. Compared to persons that have a mental disorder or a substance abuse disorder alone, persons with both disorders often experience more severe and longer lasting medical, social, and emotional problems. It is now understood that people with one disorder are at a high risk to have both disorders. At one time, clinicians tried to determine which of the disorders were primary. That practice, though, is changing and programs are trying to provide services for both conditions at the same time. Another term that sometimes is used to talk about persons with both disorders is "dually diagnosed". However, many people now use the term co-occurring when talking about people with both substance abuse disorders and mental disorders. The term "dually diagnosed" is also used when addressing people with both a mental disorder and a developmental disability.

Dually Diagnosed (Mental Illness/Developmental Disability)

People with developmental disabilities are at a higher risk than the general population to develop mental disorders. For persons with intellectual disabilities (mental retardation) it may be difficult to tell if their problems are a result of intellectual disabilities or mental disorders. For persons with mild intellectual disabilities, their mental disorders are very similar to those in the general population. For persons with more severe disabilities and limited abilities to communicate, these problems are often called "behavioral" and the person may receive behavioral management services rather than the more traditional mental health services.

Disorders in Childhood and Adolescence

Many of the disorders that were discussed above also occur in children, but the symptoms may be different. Children are growing and learning all the time. Clinicians must take this into account when they are determining if an emotional disturbance exists. They also have to look at the behavior in light of the child's age and where the child should be developmentally. There are four diagnoses that are specific to children that are seen frequently in mental health settings. These are Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder and Conduct Disorders. These disorders are briefly described below.

Attention-Deficit/Hyperactivity Disorder (ADHD)

The term "hyperactive" is used very loosely and people sometimes use the word when they are talking about children who are normally full of energy and active. To be diagnosed as ADHD the child must meet the clinical definition in the DSM-IV-TR.

Children with this disorder can be very overactive, may not pay attention to things for a period of time, may be very impulsive, or may have problems following instructions. Children with ADHD have a much harder time in a structured activity such as the classroom than they do on the playground during free play. It is now known that the hyperactivity often becomes less of a problem as the child gets older, but problems with paying attention can last into adulthood (Hetherington and Parke, 1993).

Oppositional Defiant Disorder (ODD)

Children diagnosed with ODD have a consist pattern of not following adults requests, being negative and irritable, and getting angry very easily. Older children may yell, swear, make threats to others, and refuse to follow basic rules. Most children usually have some of these behaviors, but to be diagnosed ODD the child's actions must far exceed those of most children (Hales and Hales).

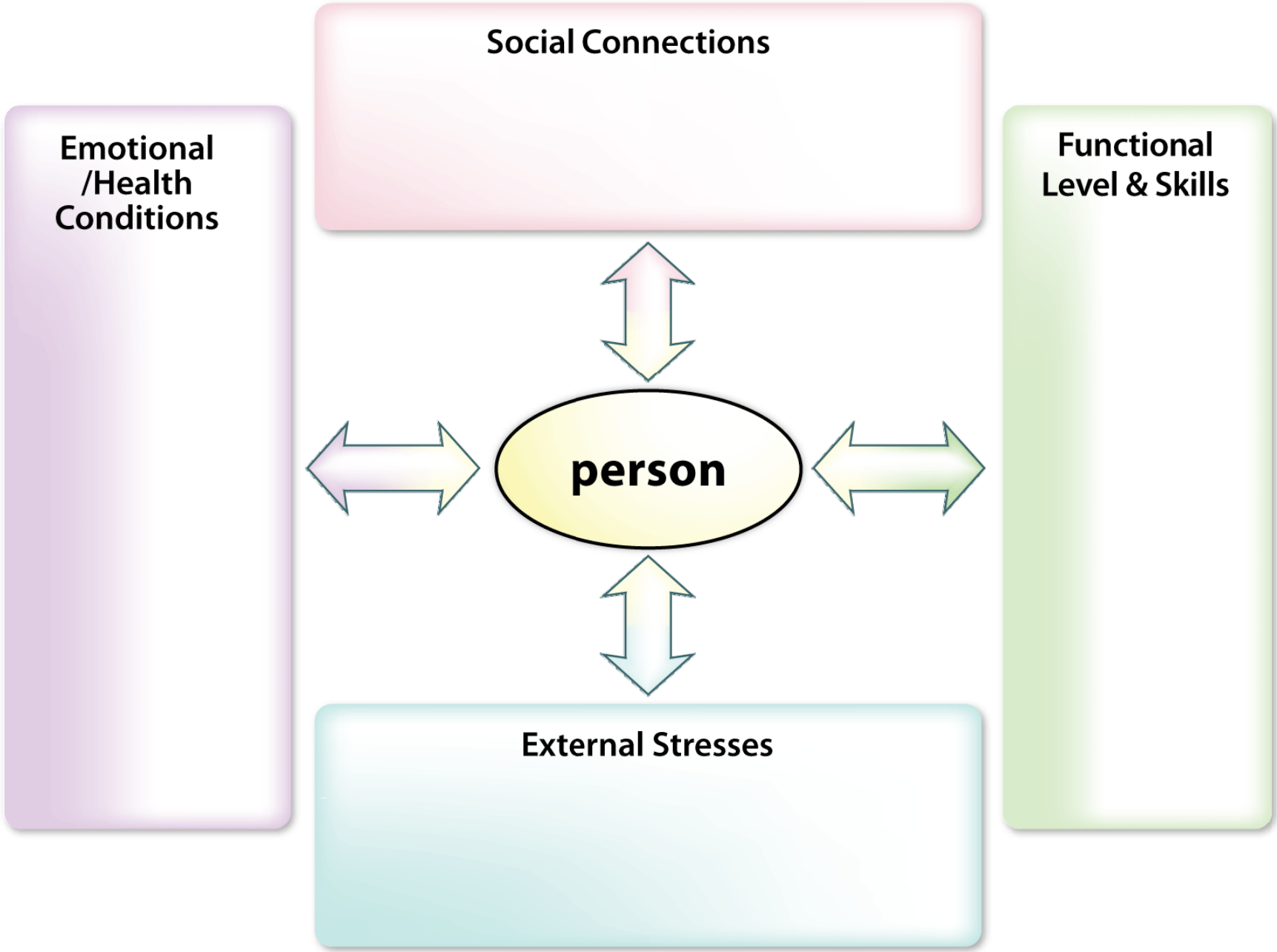
Conduct Disorder

Youth with this diagnosis often go beyond just not following rules, and may consistently ignore the rights of others and the rules of society. They may lack sympathy for others, do not express guilt or sadness about their behavior, and often do not take responsibility for their actions. They have problems getting along with other youth or adults and some can be cruel to animals. They may get involved with gangs, and/or commit serious crimes. Conduct disorders are often found in youth that have started early sexual encounters, drinking, smoking, and substance use or abuse.

Based upon the American Psychological Assocation's *DSM-IV-TR*, 2000, and Hepworth, Rooney, Rooney, Strom-Gottfried, and Larsen's *Direct Social Work Practice: Theory and Skill*, 7th Ed., 2006. Also Florida Certification Board draft Behavioral Technician Manual 2005 (unpublished).

Comprehensive Behavioral Health Assessment Worksheet

Activity for Mental Health Module 2



Activity 1-3: Treat Me As A person

Comments from Parents with Mental Disorders

Adapted from Vicki Cowling "The same as they treat everybody else," 2004. These comments are based upon synthesis of statements made in different groups of parents with mental disorders. They express the parent's perspective.

1. Please see us as parents first. The mental health diagnosis doesn't define us.
2. Don't assume that we don't know about the needs of our children.
3. Include the parents in the decision-making process regarding the health and safety of the children. This is equally important when other family members are involved.
4. Listen, value and respect the parent's points of view and experience.
5. The decisions about removal should be based upon the parent's ability to address the child's safety and not just because the parent has a mental diagnosis.
6. The parent's and other family members need to know the possible side effects of all medications and need to understand how the medications may affect behavior.
7. Professional support is needed for other family members when a parent is acutely ill,
8. The parent with a mental disorder and other family members should prepare for ongoing treatment, recovery and have contingency plans for crisis or acute episodes.
9. Confidentiality must be respected when talking with other people and family members regarding the person's mental disorder.
10. If the children are removed from the home, the parents likely experience terrible loss. Parents need support to address these issues.
11. If the children are not living with the parents, the parents want to know how their children are doing at school, emotionally, and physically.
12. Professionals should be aware of available services and help parents get the services that will help them address the needs of their children and be useful for the family.
13. Parents with mental disorders face many challenges, including stigma, and want to be seen as people working toward recovery.

Overview of the Diagnostic System

When individuals are assessed for Mental Health Issues, diagnosis is made in an inventoried style based on the **Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR, 2000)**. The DSM uses a multiaxial or multidimensional approach to diagnosing because many factors impact mental health. The DSM IV assesses five dimensions as described below:

Axis I: Clinical Syndromes

- This is what we typically think of as the diagnosis (e.g., depression, schizophrenia, social phobia)

Axis II: Developmental Disorders and Personality Disorders

- Developmental disorders include autism and mental retardation, disorders which are typically first evident in childhood
- Personality disorders are clinical syndromes which have more long lasting symptoms and encompass the individual's way of interacting with the world. They include Paranoid, Antisocial, and Borderline Personality Disorders.

Axis III: Physical Conditions which play a role in the development, continuance, or exacerbation of Axis I and II Disorders

- Physical conditions such as brain injury or medical conditions are included here.

Axis IV: Severity of Psychosocial Stressors

- Events in a person's life, such as death of a loved one, starting a new job, college, unemployment, and even marriage can impact the disorders listed in Axis I and II. These events are both listed and rated for this axis.

Axis V: Highest Level of Functioning

- On the final axis, the clinician rates the person's level of functioning both at the present time and the highest level within the previous year. This helps the clinician understand how the above four axes are affecting the person and what type of changes could be expected.

Notes on Diagnoses:

Within each diagnosis, there are criteria to be met. Assessors also have the ability to add 'Rule Out'. Denoting 'Rule Out' means that the assessor saw enough of the symptoms or characteristics to consider a diagnosis but the assessor was not certain that the individual met the criteria for diagnosis. The 'rule out' statement advises future practitioners to consider the diagnosis listed if the symptoms or characteristics become more prominent.

Signs of Mental Health Disorders in Children/Youth That Can Signal a Need for Help

A child or adolescent is troubled by feeling:

- Sad and hopeless for no reason, and these feelings do not go away.
- Very angry most of the time and crying a lot or overreacting to things.
- Worthless or guilty often.
- Anxious or worried often.
- Unable to get over a loss or death of someone important.
- Extremely fearful or having unexplained fears.
- Constantly concerned about physical problems or physical appearance.
- Frightened that his or her mind either is controlled or is out of control.
- A need to steal and/or hoard food.

A child or adolescent experiences big changes, such as:

- Showing declining performance in school.
- Losing interest in things once enjoyed.
- Experiencing unexplained changes in sleeping or eating patterns.
- Avoiding friends or family and wanting to be alone all the time.
- Daydreaming too much and not completing tasks.
- Feeling life is too hard to handle.
- Hearing voices that cannot be explained.
- Experiencing suicidal thoughts.

A child or adolescent experiences:

- Poor concentration and is unable to think straight or make up his or her mind.
- An inability to sit still or focus attention.
- Worry about being harmed, hurting others, or doing something "bad".
- A need to wash, clean things, or perform certain routines hundreds of times a day, in order to avoid an unsubstantiated danger.
- Racing thoughts that are almost too fast to follow.
- Persistent nightmares.

A child or adolescent behaves in ways that cause problems, such as:

- Using alcohol or other drugs.
- Eating large amounts of food and then purging, or abusing laxatives, to avoid weight gain.
- Dieting and/or exercising obsessively.
- Violating the rights of others or constantly breaking the law without regard for other people.
- Setting fires.
- Doing things that can be life threatening.
- Killing animals.

- **Child Parent Interactions: What do we want to learn about?**

- Is child getting needs met for food, comfort, stimulation, and basic care?
- Is there a strong and healthy attachment between parent and child?
- Is child getting appropriate stimulation and developing within expected ranges?
- Is child's temperament understood and accommodated?
- Is child being exposed to trauma?

Signs of Effective Parenting, Infancy Stage

- Parent has good routines
- Parent is responsive and attentive to child
- Parent can differentiate reasons for baby's crying and can respond appropriately
- Parent is not worried about spoiling the baby by responding to cries
- Parent is learning about child's unique temperament
- Parent's temperament and child's are a good fit
- Child is gaining weight
- Child is developing well
- Child is responsive to parents

Concerns about Mental Health in Infancy When:

- Poor fit between parent and child temperaments

- Parent:
  - Domestic violence present
  - Indications of parental substance abuse
  - High frustration with child's temperament
  - Severe depression
  - Difficulty reading and responding to child cues
  - Poor understanding of child development and parenting
  - Lack of concrete resources
  - Lack of partner and/or family support
- Infant:
  - Feeding difficulties (inadequate weight gain)
  - Signs of insecure attachment with mother
  - Excessive crying
  - Infant appears sad and lethargic
  - Lack of interest in sights, sounds, touch
  - Developmental milestones not met
  - Emerging health problems

Types of Mental Health Assessments

TYPE	DEFINITION	WHEN USEFUL
Bio-psychosocial For more information on Medicaid criteria, refer to Medicaid Provider Manual for Community Behavioral Health Services.	Describes the biological, psychological and social factors that may have contributed to the recipient's need for services. The evaluation includes a brief mental status exam and preliminary service recommendations.	The bio-psychosocial is an integrative assessment of an individual that brings medical, psychological, social, familial, educational, economic and cultural factors into a comprehensive evaluation of the person.
Bonding Assessment	Administered to determine the family culture, dynamic, and behaviors. This assessment occurs in the natural environment over 5-7 sessions with all family members present This assessment is beneficial to determine how the family interacts and to identify risk factors existing within the environment.	This tool is useful with children in foster care whose parent's rights may be terminated to determine the most appropriate and functional environment for the child to thrive. This tool is also useful for reunification family work as the therapist can observe and coach the family.
Child Health Check Ups For more information on Medicaid criteria, refer to Medicaid Provider Manual for Child Health Chuck Ups.	A Child Health Check-Up is a comprehensive, preventive health screening service. Child Health Check-Ups are performed according to a periodicity schedule that ensures that children have a health screening on a routine basis. In addition, a child may receive a Child Health Check-Up whenever it is medically necessary or requested by the child or the child's parent or caregiver. The required components are as follows: • Comprehensive Health and Developmental History including assessment of past medical history, developmental history and **behavioral health status**; • Nutritional assessment; • Developmental assessment; • Comprehensive unclothed physical examination; • Dental screening including dental referral, when required; • Vision screening including objective testing, when	If a child is diagnosed as having a medical problem, the child is treated for that problem through the applicable Medicaid program, such as physician, dental and therapy services. Medicaid Child Health Check-Up coordinators are located in the area Medicaid offices. The Child Health Check-Up coordinators provide outreach services to recipients and training to providers to encourage participation in the Child Health Check-Up Program. They assist recipients who are not in managed health care plans with scheduling appointments, arranging transportation, and following up on further diagnoses and treatment services Note: See the Florida Medicaid Provider General Handbook, for the

TYPE	DEFINITION	WHEN USEFUL
	required; • Hearing screening including objective testing, when required; • Laboratory tests including blood lead testing, when required; • Appropriate immunizations; • Health education, anticipatory guidance; • Diagnosis and treatment; and • Referral and follow-up, as appropriate.	addresses and phone numbers of the area Medicaid offices.
Comprehensive Behavioral Health Assessment (CBHA) For children placed in shelter or foster care. Must be initiated within 72 hours of placement. For more information on Medicaid criteria, refer to Medicaid Provider Manual for Community Behavioral Health Services. CBHA, Birth – 5 years ---CANS-0-3	An in-depth and detailed assessment of the child's emotional, social, behavioral and developmental functioning within the family home, school and community. A comprehensive behavioral health assessment must include direct observation of the child in the home, school and community, as well as in the clinical setting. Family history should include history of mental health treatment of family and child, any known medical problems and early medical information which may affect the child's mental health status such as prenatal exposure, accidents, injuries, hospitalizations, etc. and history of current or past alcohol or chemical dependency of parents and child. In addition to above, any known medical problems including pre-natal, pregnancy and delivery history which may affect the child's mental health status. **A depression screen of mother is expected to be completed.** A specific diagnostic tool to assist with planning services to children from birth until three to achieve permanency, inclusion and health development. Utilizes commonly used clinical and diagnostic markers from psychology, pediatrics and	For children who are in shelter status, placed in out-of-home care. Purpose is to help determine the appropriate level of mental health treatment services. The assessment includes the following: 1) Provide assessment of areas where no other information exists; 2) Integrate and interpret all existing and new assessment information; 3) Problem presentation and symptoms 4) Risk behaviors 5) Functioning 6) Family and caregiver needs and strengths 7) Child strengths CANS-0-3 will assess child functioning across all domains, problems, risk factors, family/caregiver needs and strengths.

TYPE	DEFINITION	WHEN USEFUL
	obstetrics.	
Developmental Assessments Many tools available, some often used in FL include: Brief Infant-Toddler Social & Emotional Assessment (BITSEA) Ages and Stages Questionnaires©, Third Edition (ASQ-3)	Assess if child development in different domains is within appropriate ranges. The nationally-normed BITSEA is an effective screening test of children ages 12 to 36 months. BITSEA quickly determines the possibility of a problem or delay. 42-item Parent Form completed on-site or in family environment Professionals rely on ASQ for developmental and social-emotional screening for children from one month to 5 ½ years. Highly reliable and valid, ASQ looks at strengths and trouble spots, educates parents about developmental milestones, and incorporates parents' expert knowledge about their children.	Especially suited for settings with limited time, resources, and/or technical training ASQ-3 is an excellent tool for DCM and parent to complete together to assess child's developmental progress. Ages and Stages Questionnaire: Social/Emotional
Early Intervention Services, Screening, Children's Medical Services (CMS) Early Steps For more information on Medicaid criteria, refer to Medicaid Provider Manual for Early Intervention Services.	All children birth-3 years are to be referred for this screen. It is a brief assessment to identify the presence of a high probability of delayed or abnormal development. (May be up to three screenings per year.)	Early intervention screening and initial or follow-up evaluation is conducted at the earliest possible age in order to identify developmental delay(s) or condition(s) that could cause a developmental delay.
Early Intervention Services, Observational Assessment,(CMS) For more information on Medicaid criteria, refer to Medicaid Provider Manual for Early Intervention Services. These can only be billed by Early Steps providers.	Must be documented by qualified professionals from two or more disciplines and must include observation of atypical functioning in one or more of the following areas: • Sensory-motor responses • Activity level • Emotional or behavioral interactions; or • Behavior patterns. Examples of established conditions are:	Early intervention assessments can detect delays in the following domains: • Cognition; • Physical or motor; • Sensory (including vision and hearing); • Communication; • Social; • Emotional; or • Adaptive development.

TYPE	DEFINITION	WHEN USEFUL
	• Genetic and metabolic disorders; • Neurological abnormalities and insults; • Severe attachment disorder; Significant sensory impairments	
Functional Behavioral Evaluation (FBE)	Functional behavioral evaluation is generally considered to be a problem-solving process for addressing child problem behaviors. A functional behavioral evaluation looks beyond the behavior itself. The focus when conducting a functional behavioral assessment is on identifying significant, child-specific social, affective, cognitive, and/or environmental factors associated with the occurrence (and non-occurrence) of specific behaviors. This broader perspective offers a better understanding of the function or purpose behind child behavior.	Behavioral intervention plans based on an understanding of "why" a child misbehaves are extremely useful in addressing a wide range of problem behaviors. The FBE is used to create behavior plans, and also seeks to create strategies that assist individuals and teams in identifying functional means of positively expressing and responding to needs. This assessment ultimately leads individuals and teams to be able to strategize elimination of behaviors through meeting goals and needs driving current interactions and actions.
Functional Assessment, Limited For more information on Medicaid criteria, refer to Medicaid Provider Manual for Community Behavioral Health Services. These are used to track outcomes for persons served by the mental health providers under contract with the Department of Children and Families.	Administration of the Multnomah Community Ability Scale (MCAS) **Functional Assessment Rating Scale (FARS)** **Children's Functional Assessment Rating Scale (C-FARS)** or any other functional assessment required by the Department of Children and Families	Different tools to measure and track progress of people who receive behavioral healthcare services using specific "societal" outcome indicators (e.g., income and days employed in previous month, days "in community" in previous month (i.e., not in jails, hospitals, psychiatric inpatient).Useful in assessing current status of child receiving mental health treatment.
Home Assessment (Study)	This assessment is used to determine the family culture and appropriateness of the environment given the unique circumstances of the child and family.	Advised but not limited to placement and reunification circumstances where the match of the child's needs and the home environment can be assessed. In the case of reunification assessment, where the home environment compromised safety, the study of the home prior to reunification is an important means of determining readiness for return. **Note: DCF and DJJ have**

TYPE	DEFINITION	WHEN USEFUL
		respective Interstate Compact Units that initiate home studies for children being placed across state lines.
Medication Evaluation and/or Medication Management	Evaluates the appropriateness of or the need for specific medication, regiment, dose, frequency, duration, etc. to ensure that the maximum benefit is received.	**Medication Evaluation and/or Medication Management**
Neuropsychological Testing Neuro-psychological Testing, cont.	1. Establish the presence of, or rule out, brain damage, brain disease or a developmental abnormality. 2. Determine the clinical and functional significance of a brain abnormality. 3. Identify areas of neurobehavioral dysfunction, as part of a medically necessary evaluation. These areas of functioning include: • academic skills • attentional functioning • auditory and visual perceptual abilities • communication, speech and language abilities • executive control processes (organization, reasoning, problem solving, behavioral regulation) • gross and fine motor strengths, persistence, planning and sequencing abilities • sensory abilities • social and emotional information processing abilities • verbal and non-verbal memory • visual/spatial cognition --Boston Children's Hospital	A neuropsychological assessment is a way of determining a child's overall thinking, memory, attention and output abilities. It provides information on how a child's brain works. Recommendations designed to help promote child's personal, social and educational functioning. A good way to evaluate Attention Deficit issues, the autism spectrum, Pervasive Developmental Disorders or Delays, or specific Learning Differences. Recommended when there are specific learning, behavioral, or social concerns that seem to relate to a potential cognitive functioning or developmental concern.
Neuropsychiatric Testing	Neuropsychiatry is the branch of medicine that deals with problems of psychiatry as it relates to the neurologic function; combines the	Following a neuropsychiatric evaluation, to determine further treatment/intervention recommendations.

TYPE	DEFINITION	WHEN USEFUL
	specialties of neurology and psychiatry. This highly specialized evaluation would usually follow a neuropsychological evaluation and would help determine medication options.	
Occupational Therapy Assessment For more information on Medicaid criteria, refer to Medicaid Provider Manual for Therapy Services.	Evaluation of fine and gross motor skills, visual motor integration, visual perception or visual processing, and sensory integration. Children who are sensory sensitive are often overwhelmed by lack of structure, chaos, and crowds which results in acting out behaviors. An OT eval. Determines the causative factors within the environment that are contributing to behaviors.	Can be particularly helpful with physical challenges and/or in identifying specific details related to the autism spectrum and/or developmental delay**s.** **Note: An OT Assessment may be used first to help determine whether a Neuropsychological Evaluation is needed.**
Parenting Capacity Assessment	This evaluation is administered to determine parenting style, attitude, strengths, capabilities, risk and deficits. It must include direct observation of child-parent interactions in different environments across time.	
Psychiatric Evaluation For more information on Medicaid criteria, refer to Medicaid Provider Manual for Community Behavioral Health Services.	A comprehensive psychiatric evaluation may be necessary to diagnose any number of emotional, behavioral, or developmental disorders. An evaluation of a child, adolescent, or adult is made based on behaviors present and in relation to physical, genetic, environmental, social, cognitive (thinking), emotional, and educational components that may be affected as a result of the behaviors presented.	The psychiatric evaluation focuses on the diagnosis of mental disorder and the current mental state of a person. The examination concludes with a summary of findings, diagnostic formulation, and treatment recommendations.
Psychological Testing For more information on Medicaid criteria, refer to Medicaid Provider Manual for Community Behavioral Health Services.	The evaluation may include, but is not limited to: intelligence testing, educational achievement testing, personality evaluation, a vocational interest evaluation, assessment of brain damage, and neuropsychological examination. The psychological assessment uses various instruments to outline and define personality traits, emotional or psychological disorders and	It is important to distinguish the objective of the evaluation process during referral to focus the psychologist on desired information. **Note:** As part of developing educational plans for school-age children, schools often perform a variety of types of educational psychological tests that can be

TYPE	DEFINITION	WHEN USEFUL
	intellectual capacity.	extremely useful to the child welfare team members.
Psychosexual Evaluation	This test is administered to determine the level of risk associated with sexualized behavior.	Helpful to inform placement planning and caregiver supports.
Reading Assessment	Performed when children are having persistent difficulty learning to read. Reading assessments may include tests to assess language and/or reading comprehension, reading accuracy, and "decoding."	Child welfare workers should know if school-aged children on their case loads are reading at grade level. Even when children have an Individual Educational Plan (IEP) lack of progress with reading skills may mean that the IEP needs to be amended. A Reading Assessment done by the school district might be helpful in determining what the cause and educational interventions need to be.
Speech-Language Evaluation	Speech-language pathologists assess speech and language skills to determine if a communication disorder is present, to identify communication strengths and weaknesses, to make decisions about treatment, and to establish a baseline with which to measure progress. Assessment information is used to make professional diagnoses and conclusions, identify the need for treatment, determine the focus of treatment, determine the frequency and length of treatment, and identify the need for referral to other professionals. The speech-language evaluation is conducted through informal and formal methods. The clinician begins by interviewing the parents and/or individual regarding health history, developmental history, family history, speech and language behaviors and school history.	Important to obtain when children appear to have delays in speech and language. Children might benefit from speech-language therapy for a variety of reasons, including the following: • hearing impairments • cognitive (intellectual; thinking) or other developmental delays • weak oral muscles • birth defects such as cleft lip or cleft palate • autism • motor planning problems • respiratory problems (breathing disorders) • swallowing disorders • traumatic brain injury **Note:** As part of developing educational plans for school-age children, schools often perform a variety of types speech and

TYPE	DEFINITION	WHEN USEFUL
		language tests that can be extremely useful to the child welfare team members.
Substance Abuse Evaluation	Evaluation to be administered when there is a suspicion of substance abuse to assess and guide appropriate intervention and severity level.	
Trauma Evaluation	The purpose of the clinical evaluation of child sexual abuse is to determine whether 1) sexual abuse has occurred, 2) the child needs protection, and/or 3) the child needs treatment for medical or emotional problems.	

Latasha's Scenario

Latasha is a 23 year old African American woman with a four year old boy and a seven month old baby daughter. Both children attend child care. One afternoon Latasha failed to pick the children up from the child care center. A teacher took the two children home and the mother was not there. The neighbor told the teacher to "just go on in and leave the children" because the mother "does that all the time" and "she says they are fine alone for a couple of hours". The teacher called the Abuse Hotline to report the incident. She also reported that the children come to the child care center hungry, dirty, wear the same clothes repeatedly and often the baby arrives in soiled diapers.

When the protective investigator interviewed the mother she seemed "spacey" and did not seem to understand all the questions. She told him that she attended the Cornerstone Westside High School until she was 16 years of age. She became discouraged at school and quit because she was going to be held back in 9th grade for the second year.

Latasha reported that the man that she called "dad" left when she was 13 years old. He had lived with them since she was seven. She said that she was the oldest girl in the family. She had an older brother but he was killed in a car accident when she was 12 years old. She was "knocked out" during the accident and hurt as well but she recovered. Her "dad" was driving the car while intoxicated. Another passenger, a 15 year old neighbor was also killed. Her "dad" went to prison and she doesn't know where he is currently. After the accident, her mother was very sad for a long time and Latasha had to take care of her four younger siblings. She told the investigator that after that she just couldn't do her school work well and finally dropped out. She denied using drugs but says that she drinks beer sometimes and likes to have a joint once in a while.

Latasha told the investigator that she got pregnant with her first child at the age of 18. At that time she was working at a fast food restaurant as a cook. However, she was sick all the time and had to stop working. She is not sure who the fathers of her children are and does not get child support. She has not worked since the birth of her first child. Latasha receives food stamps, child care and housing subsidies, and WIC but it is unclear where her other financial support is coming from.

The child care center said that Latasha's younger sister used to help her with the children but she moved away recently and that is when things started to deteriorate. The children seem have a close relationship with their mother and have not had behavioral problems at the center. The child care teacher said that she notices that both children are excited when Latasha picks them up in the afternoons and the baby goes to her and is easily comforted by her mother. Center staff said that Latasha is generally nice to them and used to be fairly regular in picking up the children. They also said that they were a little worried about her because about a month ago she had black and blue marks on the side of her face. Latasha told them that she fell and hit the side of her face and that her head hurt for some time. The staff told the investigator that they don't know if there is a new boyfriend at the home or not.

What assessments do you think that Latasha should receive?

_____
_____
_____
_____
_____

Please list the assessments in order of priority.

_____
_____
_____
_____
_____

Also please note why you selected those assessments and what you hope to learn from each of them.

_____
_____
_____
_____
_____
_____

CBHA Activity Worksheet

What actions should be taken as a result of the finding?

Do you think that the diagnostic information is consistent with the information that you have? Why or why not?

Infant Mental Health
Florida State University Center for Prevention and Early Intervention Policy

What is infant mental health?

Does the term "infant mental health" make you think of a baby on a couch telling his problems to a psychiatrist? So what is infant mental health? Infant mental health reflects both the social-emotional capacities and the primary relationships in children birth through age five.

Because young children's social experiences and opportunities to explore the world depend on the love and care they receive, the child and the child's relationships are central to "infant mental health." It is essential to ensure that first relationships are trusting and caring, as early relationships provide an important foundation for later development.

Why is infant mental health important?

The first years of life provide the basis for children's mental health and social-emotional development. Social development includes the ability to form healthy relationships with others, and the knowledge of social rules and standards.

Emotional development includes the experience of feelings about self and others, with a range of positive and negative emotions, as well as the ability to control and regulate feelings in culturally appropriate ways. The development of self-worth, self-confidence and self-regulation are important features of social-emotional development. Healthy social-emotional development is essential for success in school and in life.

How is infant mental health nurtured by relationships?

Loving, nurturing relationships enhance emotional development and mental health. When infants and toddlers are treated with kindness and encouragement, they develop a sense of safety and emotional security. A nurturing caring relationship provides a "secure base" from which children can begin exploring the world, frequently checking back for reassurance. They more they explore and try new things, the more success they experience.

They feel good about themselves. Kind, nurturing relationships also teach children how to treat others. Children watch adults and copy them. Good relationships help children feel valued. Children who feel loved and cherished grow up to be adults who care about others.

What can happen if a child does not have healthy early relationships?

 Children may respond to the lack of a healthy relationship in a variety of ways.
 Some children seem sad, rejected and lethargic. Because they lack a role model for smiling or happiness, they imitate a "flat affect" or lack of joy.
 Some babies may become depressed or develop eating problems due to the absence of a nurturing relationship.
 Some children try to meet their own needs. They "self-stimulate" or rock back-and-forth trying to nurture themselves. They may be so starved for affection that they seek hugs from any willing adult.
 Some children get angry. They are aggressive and hostile without provocation. They won't allow comforting, even when they are hurt, because past relationships have not been nurturing.

How can adults nurture children's emotional development and mental health?

 Surround children with nurturing relationships.
 Be happy--smile and laugh.
 Create a trusting environment.
 Provide stable and consistent caregivers at home and in child care.
 Understand and respond to children's cues.
 Spend unhurried time together.
 Comfort and reassure children when they are scared, angry, or hurt.
 Develop routines to promote predictability and security.
 Learn developmental stages and have appropriate expectations.
 Model good relationships and healthy ways to manage conflict.
 Consider how whatever you're doing or going through may affect your child.
 Identify early signs of emotional or mental problems.

Infants and Toddlers behaviors that may indicate emotional or mental health problems

 Displays very little emotion
 Does not show interest in sights sounds or touch
 Rejects or avoids being touched or held or playing with others
 Unusually difficult to soothe or console
 Unable to comfort or calm self
 Extremely fearful or on-guard
 Does not turn to familiar adults for comfort or help
 Exhibits sudden behavior changes

Preschool children behaviors that may indicate emotional or mental health problems

- Cannot play with others or objects
- Absence of language or communication
- Frequently fights with others
- Very sad
- Unusually fearful
- Inappropriate responses to situations (e.g., laughs instead of cries)
- Withdrawn
- Extremely active
- Loss of earlier skills (e.g., toileting, language, motor)
- Sudden behavior changes
- Very accident prone
- Destructive to self and/or others

Always Consider:

- How severe is the behavior?
- How many weeks or months has the behavior been occurring?
- How long does the behavior last (e.g., minutes, hours)?
- How does the behavior compare with the behavior of other children of the same age?
- Are there events at home or in child care that make the behavior better or worse?

If these behaviors and considerations lead to concern, you might:

- Talk with a colleague or supervisor
- Talk with the child's family
- Recognize cultural differences
- Get more information
- Seek professional help

Acknowledgements

Content was adapted from *What is Infant Mental Health?* by Dr. Joy Osofsky, Director, Harris Center for Infant Mental Health at LSU Health Sciences Center, and *For Early Childhood Professionals: Support Social and Emotional Development*, from HRSA Publication CA-0037.

Resources for Module 2: Mental Health

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Other Resources:

American Academy of Child and Adolescent Psychiatry, *Comprehensive Psychiatric Evaluation*- To learn more about what a thorough psychiatric assessment is visit *www.aacap.org*

American Association of Suicidology. (2010). *How do you remember the warning signs of suicide?* Retrieved June 29, 2010, from www.helppromotehope.com/documents/AAS_Warning_Signs.pdf

Bright Futures- Provides helpful tools for youth and families to learn about the normal developmental process and education about signs of abnormal development. *www.brightfutures.org*

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National Federation of Families for Children's Mental Health- A national advocacy group with local offices in several states. Offers information on partnering with families. *www.ffcmh.org*

SAMHSA. (2010). National registry of evidence-based programs and practices. Available from www.nrepp.samhsa.gov/

Pacer Center- Support and informational materials regarding children's mental health. The section on *Emotional or Behavioral Disorders* has some great information about understanding and determining if your child has an emotional, social, or behavioral impairment. *www.pacer.org*

State of Hawaii's Evidence-Based Practice Profiles- Is the EBP appropriate for all cultures, setting, age group, and gender? If not what are some practice elements of EBPs to implement? Visit the website: *http://hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html*

Suicide Prevention Resource Center. (2010). *Risk and protective factors for suicide*. Retrieved June 29, 2010, from www.helppromotehope.com/documents/RiskProtectiveFactor.pdf

The Center for Evidence-Based Practice: Young Children with Challenging Behaviors- To learn more about what it means to be an evidence-based practitioner and to know what questions to ask when selecting an evidence-based intervention, visit *www.php.com/center-evidence-based-practice-young-children-challenging-behavior*