Mental Health Technician
Orientation Handbook

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Introduction

This Orientation Handbook is designed to teach those competencies that a newly hired Mental Health Technician will need before engaging in their work. Completion of this handbook is required before completion of an MHT’s probationary period.

Shodair Children’s Hospital is an 86 bed facility devoted to the psychiatric care of emotionally disturbed children from 3-18 years of age from the State of Montana. Care of these children is provided on an acute, short term crisis stabilization unit and three long term Residential Units.

Clinical Departments:

Nursing:
The Department of Nursing is staffed by a Director of Nursing, Nurse Managers for the three residential Units and the acute unit, two Nursing House Supervisors, Ward Clerks, Registered Nurses, Licensed Practical Nurses, Mental Health Technicians and a Staffing Coordinator. This staff provides care twenty-four hours a day, 7 days a week. The Director of Nursing and the four Unit Managers rotate “Nursing Administrator on Call” duties, twenty four hours a day, seven days a week.

Clinical Therapies:
The Department of Social Services is staffed by a Director of Social Work and 10 core clinicians who provide services seven (7) days a week on four different units – child/adolescent acute unit (Grasslands), three residential treatment units, (High Desert, Yellowstone and Glacier). Each child at Shodair is assigned a primary therapist on their unit.
The Allied Therapies Department is staffed by a Manager/Certified Recreation Therapist, four Certified Therapeutic Recreation Specialists, a Music Therapist and four recreation therapy aides who are responsible for service on the day and evening shifts, seven days a week on the 4 treatment units.

Education:
The Department of Education is staffed by a Director of Education, eight Special Education teachers, four Educational Aides a Speech Pathologist and a School Psychologist, who provide services to the Residential Programs and the acute unit. Educational Services are offered 5 days a week.

Psychiatry:
The Department of Psychiatry is staffed by a Medical Director (child psychiatrist), and 4 staff child psychiatrists who provide psychiatric care to Shodair’s patients 24 hours a day, seven days a week. Each child is assigned a primary psychiatrist who oversees their care throughout their stay on either the acute unit or one of the residential units. Call is rotated among the medical staff to ensure medical coverage around the clock. The Department of Psychiatry is also staffed with a psychologist.

Clinical Intake: The Clinical Intake Department is staffed by a bachelor’s prepared Manager of Clinical Intake and five bachelor prepared clinical intake workers who screen and coordinate all admissions to Shodair, (Monday thru Friday). Clinical Intake manages insurance certifications and also performs certain case management functions related to discharge referrals
Patient Care Units:

Grasslands Unit:
- Short term crisis stabilization unit for children from ages 3-18 years.
- Length of stay is from 7-10 days on average.
- Varying psychiatric diagnoses including mood disorders and psychosis.
- Behaviors include severe aggression, suicidality and self-harm, emotional dysregulation.
- Treatment Team includes: Psychiatrist, Unit Manager, RN’s, MHT’s, Primary Therapist, Recreation Therapist, Music Therapist and Teacher.
- Treatment provided is focused on assessment and rapid stabilization.
- Programming includes Individual and group therapy, medication management, nursing education groups, recreation and music therapy and classroom activities.
- Primary focus of nursing staff is patient safety and providing a compassionate, nurturing environment.

High Desert Unit:
- Residential Treatment for children from ages 4-9 years
- Length of stay is 3-4 months on average
- Varying psychiatric disorders including mood disorders, and psychosis
- Wide variety of learning disorders seen frequently
- Behaviors include severe aggression (biting, hitting), emotional dis-regulation, self-harm, encopresis, enuresis.
- Treatment Team includes: Psychiatrist, Unit Manager, RN’s, MHT’s, Primary Therapist, Recreation Therapist, Music Therapist and Teacher.
- Programming includes Individual and group therapy, medication management, nursing education groups, recreation and music therapy and classroom activities and lessons.
- Primary focus of nursing staff is patient safety and providing a compassionate, nurturing environment in order to teach children healthier coping skills.

Yellowstone Unit:
- Residential Treatment for children from ages 10-13 years
- Length of stay is 2-3 months on average
- Varying psychiatric disorders including mood disorders, and psychosis
- Wide variety of learning disorders seen frequently
- Behaviors include severe physical aggression, (fighting hitting, swearing, verbal aggression), severe emotional dysregulation, self—harm and property destruction.
- Treatment Team includes: Psychiatrist, Unit Manager, RN’s, MHT’s, Primary Therapist, Recreation Therapist, Music Therapist and Teacher.
- Programming includes Individual and group therapy, medication management, nursing education groups, recreation and music therapy and classroom activities and lessons.
- Primary focus of nursing staff is patient safety and providing a compassionate, nurturing environment in order to teach children healthier coping skills.
Glacier Unit:
- Residential Treatment for children from ages 14-17 years
- Length of stay is 2-3 months on average
- Varying psychiatric disorders including mood disorders, and psychosis
- Wide variety of learning disorders seen frequently
- Behaviors include physical aggression (hitting) verbal aggression, (swearing, threatening) severe emotional dysregulation, suicidality and self-harm.
- Treatment Team includes; Psychiatrist, Unit Manager, RN's, MHT's, Primary Therapist, Recreation Therapist, Music Therapist and Teacher.
- Programming includes Individual and group therapy, medication management, nursing education groups, recreation and music therapy and classroom activities and lessons.
- Primary focus of programming is; development of social skills within a supportive peer community, development of healthy coping skills to minimize emotional dis-regulation.
- Primary focus of nursing staff is patient safety and providing a compassionate, nurturing environment in order to teach children healthier social and emotional coping skills.

The Treatment Team

Each patient on the unit works with a multidisciplinary treatment team, comprised of a number of health professionals who work together to ensure that the treatment plan is comprehensive and accurately reflects each patient’s needs. Members of the treatment team each have specific roles:

Medical Director: Is a board certified Child Psychiatrist who is responsible for the medical care provided to all the children at Shodair. He oversees all psychiatric and clinical practices and programming.

Attending Psychiatrist: is a child psychiatrist who supervises the treatment team and is responsible for final decisions about their assigned patient’s treatment and care. The attending psychiatrist meets with patients individually, consults regularly with other treatment team members and attends daily "rounds" to review the patient's progress.

Director of Nursing (DON): Is a Master's prepared Registered Nurse with experience in psychiatric nursing and administration. This position is responsible for the nursing care provided at Shodair. The Director of Nursing also has administrative responsibility for Allied Therapies and the Jack Casey Shodair Family House.

Unit Manager: is a Registered Nurse (RN) who supervises the nursing staff in all aspects of their care for the patient and problem-solves to make sure that the unit milieu is as efficient, safe, and effective as possible. The Unit Managers report to the DON. The Unit Manager also coordinates programming and develops nursing group content for the unit.
Nursing Supervisor: is a Registered Nurse who provides administrative oversight in the evenings and weekends ensuring the provision of quality patient care and adequate staffing. This position also provides staff development activities for the nursing department.

Transition Coordinator: Registered Nurse whose primary function is to coordinate and process patient admissions and discharges and facilitate the smooth transition of patients from one level of care to another.

Registered Nurses (RN): organize and implement a program of daily nursing care for each patient; collaborate with doctor’s orders; dispense medications; assess the effectiveness of the care given to the patient, direct crisis interventions and lead groups.

Other Nursing Staff: Licensed Practical Nurses (LPN), take direction from RNs in providing direct care and supervision for patients. LPN’s also dispense medications. Mental Health Technicians provide assistance with activities of daily living, escort patients throughout the hospital to activities and groups, monitor their whereabouts and behavior for safety, help the RN intervene in crisis situations and assist managing patient behaviors in multiple settings such as group therapies and activities.

Ward Clerk: coordinates patient appointments and medical records and maintains unit supplies.

Primary Therapist: (a Master’s prepared counselor or Social Worker) helps the patient and family cope with the psychiatric illness and its impact on their lives; and ensures that optimal discharge planning and aftercare arrangements are made on behalf of each patient.

Recreation Therapist (CTRS): A certified professional who works to promote the health and wellness of children using recreation and activity based interventions to address their needs, develop their natural abilities and instill new skills so that the child’s level of functioning can be restored, remediated and rehabilitated.

Recreation Aide: provides a structured safe place for children to practice their skills learned in therapy while supporting character development through recreational activities under the direct supervision of a recreational therapist.

Music Therapist (MT-BC): A board certified music therapist uses music-based interventions to assist children and adolescents in learning to identify, share and express their thoughts and feelings, thereby helping them to develop relationships and address issues they may not be able to address using words alone.

Psychologist: A licensed psychologist who conducts a broad range of psychological tests to clarify symptoms and accurately diagnosis mental illnesses in the children and adolescents treated at Shodair. The psychologist also provides consultation about functioning, recommendations, and
interventions that could be beneficial for patients. The psychologist also provides process orientated groups for the adolescents to allow the patients to examine their emotions, discuss their challenges, and recreate and process relational difficulties in the group setting.

School Psychologist: a School psychologist is certified through the Office of Public Instruction to provide psychological services in the school setting. The psychologist conducts psycho-educational evaluations as part of the school team. S/he also conducts functional behavior assessments, helps craft and carry out behavior intervention plans, conducts individual and group counseling sessions, leads classroom instruction on relevant topics and serves as a member of the special education team in the school setting to ensure that children with special learning needs are properly and adequately served.

Speech/Language Pathologist: Speech Language Pathologist (SLP): A certified pediatric speech language pathologist evaluates and treats individuals who have difficulty with any aspects of communication. These difficulties may include: the way sounds are produced, the way language is understood, the way language is used, and how language is used for social interactions. These basic but essential skills can greatly impact a child’s developmental, academic, social and emotional success if interventions are not provided.

Teacher: Must have a Bachelor's or Master's Degree in the field of elementary and/or secondary education and obtain a Montana Teacher's Certificate/License. K-12 Special Education degree or endorsement is preferred. Individuals must demonstrate proficiency in working with students with mental illness, ability in initiating individual education programs, and identifying appropriate classroom interventions academically and behaviorally. Excellent oral, written and interpersonal skills are required.

Teacher’s Assistant: Must have a high school diploma with additional educational course work in the field of education preferred. The individual will demonstrate proficiency in working with students with mental illness. They will demonstrate the ability to follow oral and written directions, maintain effective relationships with patients and employees, maintain good oral and written communication skills and acquire computer literacy skills.

Staffing Coordinator: A Nursing Department employee who coordinates staffing for the Nursing Department, Allied Therapies and the Jack Casey Shodair Family Home. This position is responsible for posting daily unit schedules, logging call-offs and approving shifts trades and vacation requests.

Occupational/Physical Therapist assesses each patient's emotional, vocational, educational, physical and recreational abilities; and implements a program to prepare the patient for life after discharge from the hospital. These services are accessed through St. Peter’s hospital.

In addition to these unit staff, consultation may be provided by pharmacists, and dietitians, as well as a wide range of other allied health staff. These consultations are part of the accurate assessment, diagnosis and treatment of the problems that precipitated a patient's hospitalization.
Module 1: The Role of the Mental Health Technician

◆ LEARNING EXPERIENCE 1 ◆ Describe the roles, expectations, and functions of the Mental Health Technician (MHT).

The role of the MHT is to assist individuals who are living with mental illness to maintain the highest level of independence possible. You will support them as they develop and maintain their skills of daily living and progress toward mental health recovery. You will provide this support to individuals on The Grasslands (acute unit) or on one of the three Residential Treatment Units (High Desert, Yellowstone or Glacier).

The following list includes some, but not all, of the duties you will perform as part of your work as an MHT. You will support individuals who are working on:

- Being part of their community
- Recreation
- Communication skills
- Exploration of meaningful activities including leisure, education, or other interests
- Personal Hygiene
- Interpersonal relationships
- Health maintenance
- Maintaining safety
- Basic academic skills
- Problem solving and decision making
- Developing and using self-awareness
- Emotional regulation

In order to complete this MHT workbook successfully, you will need to work with coworkers, supervisors and the people you support to practice some of these duties and skills.

Let's take a closer look at some of these life areas. Keep in mind that your role as an MHT is not just to support someone in achieving these tasks; it is also to help them develop the skills to accomplish these tasks without your help in the future.

Being Part of Their Community
Supporting a child in learning how to be successful in family and peer relationships at home, school and in their community is a major purpose in your role as an MHT. Feeling connected to others, and leading a life that has meaning to an individual regardless of their age or functioning level, is an essential foundation of mental health recovery. Making connections to community beyond those people paid to be with them is critical to community integration. As you read through the rest of this list of life areas, keep in mind how they relate to the overall goal of being part of one’s community.

Developing and Using Self-Awareness
Having positive relationships with adults may be a new experience for some of the children you support. They may have experienced trauma or personal loss. They may have been placed in foster care or group homes or experienced multiple hospitalizations. They may struggle with
having a sense of security or safety. They may have experienced a chaotic home life which didn’t allow them to learn how to manage the activities of daily living such as bathing/showering, doing laundry or cleaning their room. They may have little to no awareness or skills in recognizing or managing their emotions. As they learn more about what is helpful for them, the more they will be able to maintain their own health and sense of safety, even during stressful times.

**Exploration of Meaningful Activities**

Exploration of meaningful activities would include play/leisure activities, education, or other interests. The children you support may have “learned” that it's not possible for them to have fun or be a successful learner. With your support the child can discover where their interests or strengths lie. Ask if they once had a hobby they enjoyed. Do they have dreams or wishes about things they would like to do?

**Recreation**

Does the person you support enjoy physical activity? Do they like to read books? Are they interested in sports? Do they like to draw or play an instrument?

**Communication Skills**

Remember that having healthy and safe relationships may be new to the child you are caring for - speaking and relating to people they don't know may be a frightening idea to them. You can help by modeling good communication skills and coaching them as they try it themselves.

**Basic Academic Skills**

For many of the children at Shodair, school has been a stressful experience. Talk to them about academic skills they would like to improve. Be sensitive when you discuss this topic, because some children feel a lot of shame about “not knowing.” However, it is essential to be able to read, write and do basic math. They need to be encouraged to attend school while they are at Shodair.

**Problem Solving and Decision-Making**

Keep in mind that you might often be inclined to tell someone how to solve a particular problem. However, while your advice might be helpful over the short run, it is very important to encourage children and adolescents to learn how to make good choices. When we’re able to make our own good and healthy decisions it allows us to truly feel the success of the choice. It also creates the opportunity to take responsibility for a decision whether the outcome is positive or not.

**Supporting Children in Managing Their Lives**

This type of work may consist of:

- Activities of daily living (laundry, bathing, brushing teeth, cleaning toys or room, making their bed, etc.)
- Attending school, activities, and groups

**SUGGESTED ASSIGNMENTS:**

- Find and review the expectations applicable to your program.
- Are there any that are not discussed here?
Maintaining Safety
In addition to the health and cleanliness tasks listed previously, in a hospital environment certain activities are required to be performed by the hospital and its staff. You will learn about these in orientation:

- What to do during fire drills
- Assess and report unsafe conditions (fraying carpets, overloaded electrical outlets, ice on walkways, etc.)
- Make sure cleaning solutions are in a secure place.

**LEARNING EXPERIENCE 2**

Explain some of the important aspects of the MHT job.

The Mental Health Technician job can be complex and challenging, as well as rewarding. It can be an opportunity for personal and professional growth and a vehicle for developing core skills that will last you a lifetime.

**Let’s take a look at some of the skills you will learn and develop in your work:**

**Working as part of a team**
You are starting out as a new member of a team. The other members of the team are looking forward to meeting you and to the skills that you bring to the job. Each time a new member joins; the team adjusts to that person’s entry. Please take the time to observe some of the following courtesies:

- Show up on time, do what people request you to do, ask for help when you need it.
- Communicate clearly and directly.
- If you don’t understand something, ask for clarification.
- Participate in staff meetings and clinical supervision. New input is always valuable, when given respectfully.
- If you sense that there is disagreement and tension within the team, don’t take sides. Do what you can to resolve it. Don’t engage in gossip. If you are uncomfortable - ask your supervisor for help.
- Pay attention to yourself. Use supervision to identify things that may be stressing you out, and come up with a plan to deal with it.

**Using supervision:**
Your supervisor has skills and expertise to share. You will meet with him or her on a regular basis usually in a group setting that are called “Milieu Meetings”. However, for the first few weeks you will have the opportunity to meet with your supervisor individually. If you prepare ahead of time, you will make the best use of supervision.
Treating others with respect and dignity:
It is important to remember that you are a guest in the life of the child or adolescent you are assigned to care for. It may seem easier to read the person’s chart and make up your mind about what they need, but that will not help an individual in pursuing their own recovery. We sometimes come to this work with ideas about how we think people should be, or should live. That isn’t for us to decide. The work of a MHT is to support a child or adolescent to live the best life they can. What that life encompasses depends on the unique preferences of each child you care for.

Attending to boundaries:
Establishing and maintaining healthy personal and professional boundaries is an essential aspect of your work as an MHT. The nature of your role as paid staff creates a power differential between yourself and the person you are supporting. You need to be aware of how that power affects the relationship and be careful not to misuse it. Because you are in the paid role the people you support may assume you know what is best for them. It will be important to encourage them to make their own decisions. Be mindful of the suggestions you give.

You will also need to determine how much and what type of personal information to share with the individuals you support and give thought to the reason to disclose or not disclose. For example, if you are asked where you grew up or if you have a dog, why wouldn’t you answer that? If you are thinking about sharing personal stories about past or present struggles, remember that the goal should be to help individuals believe in themselves. The focus of any interaction with a patient should be on the patient, not on you. Be mindful of whether your sharing will benefit the other person, or is simply filling your need to share.

SUGGESTED ASSIGNMENTS:
- Name four activities prohibited when working with clients.
- Observe interactions between coworkers and the children they care for.
- Is there evidence that children are treated with respect and dignity? If not, think how you will address this with a supervisor.
- Discuss with your supervisor what information you will and won’t share with the people you support.

Problem solving
Humans are unique and so too are the issues and problems we confront. As a result, there won’t always be rules or black and white answers to many questions that arise during the day.

We suggest that you spend some time practicing your problem solving skills. Listed below is one example of a problem-solving model you could practice:

1 Fact-finding: What is the problem, and whose problem is it? What facts do I understand about the problem? Are there other things I need to know?
2 Brainstorming: Discuss the problem with other members of the team or the child with whom you are working and brainstorm, that is, set time aside to consider just this problem and begin to think of possible courses of action. The most unusual idea may hold the key to the resolution of the problem. The more ideas, the more possibilities you will have to choose from.

3 Proposing a possible solution: Make a prioritized list of possible actions. Review the risks and benefits of your choices. Make a choice.

4 Implement the solution and then evaluate the outcome.

5 Repeat the process as needed.

SUGGESTED ASSIGNMENT: Choose a problem you have solved, or are dealing with now (it helps to start with a small one). Ask your coworkers or supervisor to schedule some time to practice the above problem solving technique.

Resolving conflict
In everyday life, conflict will occur periodically. As an MHT, you may experience conflict among members of your team, between yourself and the people you support, and among various people you support. In any of these situations, it is essential for you to model healthy ways of dealing with conflict. In dealing with conflict, it is important to:

- Be respectful
- Seek to understand and help others understand the points of view of those involved in the conflict
- Focus on win-win solutions
- Work to create long-lasting solutions
- Acknowledge your own and other people’s feelings
- Be direct, keep the issue between you and the other person and avoid creating “sides”

Most of us find dealing with conflict difficult and sometimes frightening. We all come together with our various experiences of conflict. Think about how you learned what conflict looked like. Was it safe for you to share your concerns? Was conflict always resolved, or left hanging with no results? Many people have unhealthy methods of resolving conflict. It will be very important for you to stay calm and examine what is going on for you in the situation and to model this for the children you support. Use your supervision time to review and discuss conflict resolution strategies, as needed.

Dealing with stress
Being an MHT can be a stressful job. Stress is our internal response to situations that we find difficult. We become burned out when we believe that we can’t do anything about the stress we are feeling. We can’t eliminate stress from our lives, but we can choose to manage the stress in positive, proactive ways.
It is critical that you take care of yourself in order to have the patience and energy you need to do this work well. Some strategies for dealing with the moment-to-moment stress of your job may include:

- Being aware of what is causing you stress -
  - Taking a break -
  - Drinking a glass of water -
  - Taking deep breaths –
    - Going for a walk -
    - Counting to 10 -

Avoiding becoming overwhelmed with your job by using the following strategies:

- Talking with your supervisor for advice and support.
- Developing techniques for “leaving work at work.”
- Paying attention to having a satisfying life outside of work.
- Using your milieu meetings as a way of getting re-energized.

Maintaining a healthy lifestyle will also reduce stress. Try to exercise every day, get enough sleep, cut down on caffeine, nicotine, and sugar; talk to friends, and pursue a hobby. These simple steps can help keep stress down and resilience up. If you feel that you are getting too stressed at work, talk to your supervisor. Perhaps he or she can help you devise some coping strategies beyond what is listed here.

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**LEARNING EXPERIENCE 3**

Identify ways of supporting different learning styles in providing daily support.

Each of us processes information in ways that make sense to us. There are a variety of typical ways that people learn. These include:

- **Visual** – Visual learners acquire new information by looking at or making their own pictures, videos, diagrams, or other visual images. Seeing a demonstration of the skill being taught may be critical to the success of the visual learner.
- **Auditory** – Auditory learners need to hear instructions and information. Sometimes auditory learners may not appear to be paying attention when spoken to because they are processing what has just been said.
- **Kinesthetic (tactile, hands-on)** – Kinesthetic learners learn by moving, doing, and touching. They learn best when engaging in hands-on instruction. Kinesthetic learners may display impatience with instructions and demonstrations, because they need to be in direct contact with the task or skill. They may find it hard to sit still for long periods and may become distracted by their need for activity and exploration.
- Some people **combine** one or more of these learning styles.

There are other variables to take into consideration when teaching skills or supporting children in maintaining skills. Ask the child how they learn best. The following questions may be useful to ask yourself and the children you work with:
› How big or small do the learning steps need to be?
› Are there times of the day when you are more or less alert?
› Are you a morning or an evening person?
› What frustrates you when learning a new skill?
› What motivates you to learn a new skill?
› What have previous learning experiences been like?
› Do you get mixed up or frustrated with lots of directions?
› Can you stay on task when there are disruptions or distractions?
› Would it help if you had things written down for you?
› Do you need reminders from staff?

SUGGESTED ASSIGNMENTS:

- Do you know your own learning style? Think about how you’ve been working through this handbook. If interested, ask your supervisor about taking a learning styles inventory.
- Read an Occupational Therapy evaluation and pay attention to the description of how that person processes information.

◆ LEARNING EXPERIENCE 4 ◆ Explain Maslow’s Hierarchy of Needs

Abraham Maslow was a psychologist who developed the now famous *Hierarchy of Needs*. His theory is that we can’t focus on the higher needs in this pyramid until the needs that are lower down in the pyramid are met:
Maslow believed that all of us need to have basic needs satisfied, such as air to breathe, food, water, and shelter, before we can focus on the next highest level of needs such as security and belonging, love, family, and friends. Once those needs are met, we can then work on self-esteem needs such as the need for status, societal approval, and a good job. And once these are met, people can then move on to the highest level of the pyramid where human beings can reach their full potential through activities such as intellectual pursuits, creative expression, and appreciation of the arts and beauty.

Maslow believed that people are motivated to fulfill the needs in the hierarchy that have not yet been satisfied and that this motivation guides much of human behavior. Once a need is satisfied, and only when it is satisfied, people can move to the next level of the pyramid.

According to this theory, if you are worried about getting enough to eat, you won’t be thinking much about self-esteem. Maslow also believed that if people have experienced abuse or neglect, they are at risk of spending the rest of their lives trying to get the basic needs of safety and security fulfilled. The children you care for may have difficulty being motivated to go to school or groups if their families have no place to live or if they have experienced trauma in their lives.

**SUGGESTED ASSIGNMENT:**

- Think about a time in your life when you had difficulty having your needs on the lower level of the pyramid met. You may have lost a job or had a spouse/parent die, or experienced a natural disaster such as flood or fire. Think about how this experience affected you at the time. What were you mostly worried about? What kind of need did you seek to have fulfilled?
- Then think about the children you care for. What needs do you see them trying to fulfill? Discuss your observations with your supervisor.
Abuse, mistreatment, and exploitation — your role as a mandatory reporter

It is the responsibility of those working in the mental health system to report mistreatment. Unfortunately, there will be times when staff or family members may abuse, neglect, or exploit individuals receiving mental health services. In addition, some residential mental health facilities have experienced problems with residents abusing one another. Because you work closely with people, you may be in a position to witness these occurrences.

In your role as an MHT you are considered a mandatory reporter. If you observe abuse, neglect, or exploitation in the course of your work you are obligated to report it to your supervisor. You supervisor will see that the information is passed on to the treatment team and reported through the proper channels. Document any observations on an Incident Report.

As an MHT you may also be in the position to hear disclosures of abuse or neglect from a child. If this should happen — listen calmly and non-judgmentally. Be empathic. Do not press the child for details or ask probing questions. Assure them they did the right thing by telling you and reassure them they are safe. DO NOT promise to keep their disclosure secret. Document any observations you make of their behavior and any information they share using direct quotes when possible. ALWAYS inform the charge nurse on your assigned unit of what occurred.

Health and Safety

As an MHT, you are on the front line of safety. There are general environmental hazards (such as the possibility of fire) and specific hazards (such as blocked doorways) that you should be aware of as you go about your work. We give more specific examples of these hazards below. Remember to not only check for safety hazards but also teach the people you support to be aware of safety concerns and take proper precautions.

MHT’s are responsible for protecting the health and safety of the children they care for. Your watchfulness will help to prevent children from being needlessly injured. You are expected to be alert to possible hazards and to carry out periodic inspections of living spaces during your work shift. This section identifies the safety categories that you must evaluate.

During orientation, you will also be educated on the “Monitoring Policy” and “Special Precautions Policy”. These policies provide strict guidelines you must familiarize yourself with in order to fulfill your primary responsibility as an MHT—the safety of our children.
Fire

Fire presents the most serious potential problem, regardless of the setting you work in. Fire is rapidly destructive and difficult to escape from unless there are regularly scheduled inspections, plans for evacuation, and practice drills.

Hazards that may cause fire:

- **Improperly discarded smoking materials**
  Imposing no smoking and no open flame policies within any facility can help prevent fires from starting. Know what policies apply to the settings in which you work. For example, Shodair does not allow candles, incense or smoking.

- **Clutter** Help people to keep their space clean and free of clutter. Encourage proper disposal of trash, etc.

- **Contraband** Be alert to any contraband (sharps, strings longer than 6 inches, aerosol sprays, weapons, drugs, etc.)

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**LEARNING EXPERIENCE 3**

- Identify some preventive safety measures be familiar with Monitoring Policy and Contraband Policy

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Smoke detectors and hard-wired connections to the fire department

Maintenance Staff will test this equipment regularly as part of fire drills.

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Fire drills must be done regularly

Practicing how to get out in the case of a fire assures that children and staff know what to do when a real fire occurs. Ask your supervisor about fire drill policies and procedures if you have questions.

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Evacuation Plans

Evacuation plans clearly show the location of all exits from each room. These should be posted in each unit and public space within Shodair.

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Fire safety policies

Fire protection procedures need to ensure the safety of all children and staff. You will be inserviced on all policies associated with fire and fire prevention as part of your orientation.

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**LEARNING EXPERIENCE 4**

- Explain some important considerations regarding food storage and preparation.

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Food handling

Food handling is a common role of an MHT. You will be expected to adhere to the following standards and regulations. While we may choose to take some risk in food preparation in our own
homes, to do so at work could potentially expose others to the risk of sudden and life-threatening illness. Employees must wear gloves when handling food.

Employee cleanliness: All employees are expected to maintain a high degree of personal cleanliness and conform to good hygienic practices.

Hand washing: All staff are required to thoroughly wash their hands with soap and warm water before starting work and as often as may be required to remove soil and contamination; and immediately after using the restroom. Employees must also keep fingernails clean, short and free of gel polish or artificial nails.

Discuss this assignment with your supervisor prior to completing it. Also enlist the help of other staff members to locate these items. If you support someone living independently you can encourage him or her to help with this assignment. When you complete this form, bring it back to your supervisor for discussion and to answer any questions you may have. If important safety issues are identified as a result of this assignment, you and your supervisor will make and carry out a written plan to make sure that they are reported and addressed properly.

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<tr>
<th>What am I looking for?</th>
<th>What did I find?</th>
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<td>OSHA and Dept. of Labor notices</td>
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<td>MSDS book(s)</td>
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<td>Fire extinguishers</td>
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<td>How many?</td>
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<td>Where are they?</td>
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<td>What kind are they?</td>
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<td>What date will they expire?</td>
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<td>Where is the last Fire Marshal’s report?</td>
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<tr>
<td>Read it and summarize the findings.</td>
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<td>Was everything fixed that was mentioned in the report?</td>
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<tr>
<td>Are there maps showing escape routes and alternates in each room?</td>
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<tr>
<td>Where do people go if they have to leave the building during a fire drill?</td>
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<tr>
<td>Find the first aid kit. Has anything in it expired? Are all necessary items there?</td>
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<tr>
<td>Find the thermometer in a refrigerator or freezer. What is the temperature?</td>
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<tr>
<td>Identify unsafe conditions. What would you do to fix them?</td>
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Module 2: Understanding Mental Health and Mental Illness

LEARNING EXPERIENCE 1

Explore some of the characteristics of mental health and mental illness.

What is mental health?

The 1999 Surgeon General's Report on Mental Health defined mental health as the state of successful performance of mental function resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity. It went on to say that mental health is indispensable to personal wellbeing, family and interpersonal relations, and contribution to community or society. It is the springboard of effective thinking and communication, skills, learning, emotional growth, resilience, and self-esteem.

The Surgeon General's Report also noted that it is easy to overlook the value of mental health until problems surface. Mental health difficulties occur for almost everyone during times of crisis, major life transitions, losses, hormonal or physiological changes, and other events. According to the Report, "mental health" and "mental illness" are not polar opposites, but can be thought of as points on a continuum, or line.

What is mental illness?

Mental Illnesses are medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are a medical condition that often results in a diminished capacity for coping with the ordinary demands of life.

Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder and borderline personality disorder.

Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are not the result of personal weaknesses, lack of character or poor upbringing. Mental illnesses are treatable. Most people diagnosed with a major mental illness can experience relief from their symptoms by actively participating in an individual treatment plan.

A treatment plan may consist of medication(s), individual therapy, group therapy educational groups, therapeutic recreation, music therapy and leisure activity groups.

Historically, serious mental illness has been seen as a chronic and deteriorating condition. More recent research indicates that most people diagnosed with serious mental illnesses can and do recover. For example, the diagnosis of schizophrenia was once considered a lifelong condition; however, one third of people diagnosed with this illness will recover completely; one third will cope
well with the illness if they are given various forms of support; and one third will continue to experience acute episodes of their illness throughout their lives.

Mental Health care now focuses on recovery, learning, practice, and self-mastery for individuals suffering from mental illnesses.

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**LEARNING EXPERIENCE 2**

**What is the prevalence of mental illness and what causes mental illness?**

Mental illnesses affect almost every American family. Mental illness can occur at any stage of life, from childhood to old age. The federal government estimates that 5 to 7 percent of American adults live with a mental illness every year. That means millions of Americans are coping with a mental illness each year. Mental illnesses rank first among illnesses that cause disability in the U.S., Canada, and Western Europe (New Freedom Commission, 2003).

Mental illness stems from a variety of causes too numerous to include in this handbook. You will have an opportunity to learn about these factors in the course of your work as an MHT. You are also encouraged to read and keep abreast of current research and theory, much of which is being generated by university research, pharmaceutical companies, and the medical community. While most experts believe there is a genetic component to mental illness, mental distress and disease can also be also caused by exposure to stress, poverty, or trauma.

While medications have an important impact, research has clearly shown that healthy and supportive relationships make an important contribution to many individuals’ mental health recovery. Be sure to remember that when you are relating to the children you care for. The quality of your interactions can do much to repair the damage that has been done to them. A regular schedule, a safe place in which to live, friends, opportunities to participate in meaningful activities, and a chance to be successful, along with the right medication, can make an immense difference for the children we treat.

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**LEARNING EXPERIENCE 3**

**What does mental illness "look like"?**

When you are working with people with severe mental illness, they may show some signs of their specific disorder. Mental illness can cause changes in thinking, mood, and behavior. Children may be sad and feeling hopeless if they are depressed. They may experience hallucinations (seeing and/or hearing things others don’t see and hear), delusions (holding beliefs that no one else believes), and/or difficulty organizing themselves. They may be angry and frustrated because they have mental illness or they may deny that they have an illness at all. While an accurate diagnosis is important to establish medication management, and to establish eligibility for certain types of support, we encourage you to focus more on the individual and less on the diagnosis.

Some important facts about Mental illness:

- Mental illnesses are serious medical illnesses. They cannot be overcome through “will power” and are not related to a person’s character or intelligence. Mental illness falls along a continuum of severity. Even though mental illness is widespread in our population, the main burden of illness is concentrated in a much smaller population –about 6 percent or 1 in 17
Americans live with a serious mental illness. The National Institute of Mental Health reports that one in four adults, (approximately 57.7 million), in America experience a mental disorder in any given year.

- The U.S. Surgeon General reports that 10 percent of children and adolescents in the U.S. suffer from serious emotional and mental disorders that cause significant functional impairment in their day to day lives at home, in school and with peers.
- The World Health Organization has reported that four of the 10 leading causes of disability in the U.S. and other developed countries are mental disorders. By 2020, Major Depression will be the leading cause of disability in the world for women and children.
- Mental illness usually strikes individuals in the prime of their lives, often during adolescence and young adulthood. All ages are susceptible, but the young and old are especially vulnerable.
- Without treatment the consequences of mental illness for the individual their family and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives; The economic cost of untreated mental illness is more than 100 billion dollars each year in the United States.
- The best treatments for mental illness today are highly effective; between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports.
- With appropriate effective medication and a wide range of services tailored to their needs, most people who live with serious mental illness can significantly reduce the impact of their illness and find a satisfying measure of achievement and independence. A key concept is to develop expertise in developing strategies to manage the illness process.
- Early identification is a vital importance; By ensuring access to the treatment and recovery supports that are proven effective, recovery is accelerated and the further harm related to the course of illness is minimized.
- Stigma erodes confidence that mental disorders are real, treatable conditions. We have allowed stigma and now unwarranted sense of hopelessness to erect attitudinal, structural and financial barriers to effective treatment and recovery.

Mental Health Disorders Categories: (According to DSM -5)

Definition of DSM – the Diagnostic and Statistical Manual of Mental Disorders

Is the classification of mental disorders used by mental health professionals in the U.S.. It is intended to be applicable in in a wide array of contexts and used by clinicians and researchers of many different orientations. All patients at Shodair will have at least one psychiatric diagnosis from the DSM -5.

SUGGESTED ASSIGNMENT: Interview one person you will be caring for, before you read their records. Ask them to think about times in their lives when they felt successful, or fulfilled. You could ask them to tell you what they want to do in their lives, or the kinds of activities they enjoy. If they seem comfortable talking with you about their past, find out where they came from, what they did when they were growing up, and what they wish they could do next. Notice what it was like to explore with someone their story and see how the conversation opens up as they share that story. Then read this person's record and imagine how your initial impression may have differed if you hadn't first met and talked with the individual. Discuss your experience with your supervisor.
Module 3: Health and Recovery

◆ LEARNING EXPERIENCE 1 ◆ Define the principles of recovery.

In this module you will learn about the possibilities for people to recover from the effects of mental illness. You will read what some of the leading experts in mental health hold to be true. This module will also serve to debunk various myths that exist about mental illness. When you complete your work with this module you should have a foundational knowledge of recovery and understand your role in supporting the people you work with as they transform their lives.

What do people say about recovery?
The concept of recovery was adapted and expanded to apply to mental illness in the late 1980s—most eloquently by Patricia Deegan, Ph.D., herself a survivor of mental illness. In 1988 she said: "Disabled persons are not passive recipients of rehabilitation services. Rather, they experience themselves recovering a new sense of self and purpose within and beyond the limits of the disability."

In 1999, Mary Ellen Copeland, a survivor of mental illness and developer of the Wellness Recovery Action Plan, (WRAP), said: “Recovery involves people having a personal vision of the life they want to live; seeing and changing patterns; discovering that symptoms can be managed and doing it; finding new ways and reasons; doing more of what works and less of what doesn't."

One state describes their recovery program as it: “helps the person to not only understand what his disorder is, but it also shows him how to manage it while using the tools of recovery. The tools can be medication, diet, therapy, and supportive relationships — any number of things to manage the illness. It is the consumer's choice, and they have to be part of the journey. It’s not us doing it for them; it’s us doing it with them.”

The mental health community is undergoing a profound shift from thinking of mental illness as permanent and debilitating to something from which it is possible to recover as one would recover from a physical illness. It is possible to be a valued member of society regardless of one’s disability.

What are people diagnosed with mental illness recovering from?

- Limited Expectations
- Illness
- Sense of Hopelessness
- Unemployment
- Poverty
- Institutionalization
- Discrimination
- Homelessness
- Histories of Substance Abuse
- Unhealthy or Dangerous Coping Skills
- Negative Treatment
- Shame
- Labels
- Effects of Trauma
- Stigma
- Internalized & Externalized Wounds of the Spirit
- Medication Side-Effects
- Poverty
- Homelessness
- Histories of Substance Abuse
- Unhealthy or Dangerous Coping Skills
**MYTHS** about people diagnosed with mental illnesses:

- You can tell someone has mental illness by looking at them.
- They will always need to be taken care of.
- Their illness is due to personal failure.
- They are so “crazy” that they don’t know how people respond to them.
- They are doomed to a life of suffering and pain and can’t change.
- They cannot be successful unless they can make their symptoms of mental illness go away.
- They cannot be productive citizens.
- They are dangerous.

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**LEARNING EXPERIENCE 2**

*Identify specific factors that help the recovery process.*

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**What are the components of a strong recovery-based program?**

- Strong recovery-based programs emphasize choice, self-management, personal freedom and the personal growth that results from that freedom.
- An understanding that mental health recovery is not an end product but rather a process or journey. All of our lives are constantly transforming, whether we have a mental illness or not. Recovery-based programs take a holistic approach. Using this approach, a mental illness is seen as only one part of a whole person.
- Recovery-based programs make an effort to involve a network of supportive individuals which could includes friends, family, professionals, peers who are also recovering from mental illness, and the community in general.
- Recovery-based programs strive for individualized, unique approaches to help people develop a sense of responsibility for their own lives.
- The individuals receiving services lead the planning of those services and give feedback on the quality and appropriateness of those services.
- Recovery isn’t focused on fixing what is wrong, rather it is focused on moving towards what someone wants to accomplish.

**How can MHT staff support recovery?**

The key is the formation of healthy, supportive relationships. Many of the children you care for may have never experienced a healthy or "real" relationship in their lives. Some children or adolescents may have only experienced relationships as being controlling and/or painful.

The way we interact with other people can have an impact (negative or positive) on their self-image. When you treat the children you care for with respect and dignity it reflects back to them a sense of their own value and importance. Over time people learn from healthy relationships how to accept themselves, trust themselves, give to others, and trust others. Relationships provide a “safe” place to learn new ways of being and to be accepted unconditionally. Healthy relationships provide healing.

It will be important for you to be patient with the children you support as they learn how to maintain a healthy relationship. It may be difficult for them to learn new ways of interacting, and to trust that relationships can be rewarding.
You can create an environment conducive to recovery by:

- Having positive expectations for the people you support
- Encouraging hopes and dreams
- Seeing yourself as a learning partner rather than the "expert"
- Avoiding unnecessary limits and preconceived judgments
- Teaching and modeling a healthy lifestyle
- Encouraging independence while honoring requests for support
- Seeing the value in small steps as well as big ones
- Allowing the people you care for to be in control whenever possible
- Encouraging some risk taking, as long as it doesn’t involve a threat to safety
- Listening, listening, listening….
- Seeing your work through the eyes of the children you support.
- Being clear about your limits
- Being open to the possibilities of each day
- Using any opportunity to help a child practice their decision-making skills

**SUGGESTED ASSIGNMENT:**

Your supervisor will assign you to work with an experienced co-worker. With the preceding list in mind, work on the action step task(s) for a period of time, identifying when and where you are able to use recovery principles. Document and discuss this with your supervisor, co-worker and the person you will be supporting.

**Suggested Process:**

1. Identify an action step— an example might be “I will try one new activity in the unit program.”
2. Talk with the person you will be caring for to find out what specific kinds of things he/she wants to do. Help him/her “brainstorm” ideas.
3. Encourage the person to choose the activity.
4. Give feedback and encouragement.
5. Upon completion, discuss what happened and how the person felt about it.
   - Document your observations and then discuss them with your supervisor. Think about what worked, what didn’t work, and how you felt.
Module 4: Boundaries

There are four types of boundaries that develop in human beings: physical, sexual, emotional and spiritual. Physical and sexual boundaries are external while emotional and spiritual boundaries are internal.

Boundaries may be visualized as bubble that exists around a person. It is flexible and permeable. For example if you hug someone you have entered their physical boundary and they have entered yours. If a child chooses to share their feeling with you, you have entered their emotional boundary.

Allowing a person access inside any of our boundaries is a gesture of trust. Boundaries offer protections from the emotional and physical assaults of others.

Healthy boundaries allow a person to experience a comfortable interdependence with other people, resulting in generally functional relationships and positive self regard.

Damaged boundaries operate inconsistently and often dysfunctionally. They are the result of mixed messages and abuse, and are usually related to abusive relationships in the individual’s family of origin and/or relationships of choice.

Walls protect the person who has constructed them but do not let anything in or out. This person lives is a state of loneliness possibly protected from the assaults of others, but also prevented from establishing trusting, close relationships. People with walled boundaries have generally been hurt by others and have erected barriers to prevent being hurt again by others actions, thoughts and feelings.

No boundaries is the opposite extreme from walled boundaries. A person with no boundaries is unable to prevent unwanted intrusions and may be unaware it is possible to do so.

Boundary Challenges or Testing Behaviors:

Not all therapeutic relationships run smoothly. Patients, like staff live through moments of fear and uncertainty. Patients may not recognize, understand or admit their misgivings. They may need to grapple with a number of threats to their self-image as they invest in a relationship that involves receiving help. Some of the behaviors displayed at these times are called testing behaviors. Underlying all testing behaviors is the issue of trust. Testing behavior challenges the staff to remain focused and goal oriented.

Examples:
- Attempting a social relationship
- Casting a staff into a parental role
- Judging whether the staff trusts them
- Attempting to take care of the staff
- Avoiding discussion of problems
- Asking for personal data about the staff
- Violating personal space of staff and others
- Seeking attention from staff
- Challenging the staff’s commitment to the patient’s treatment
- Revealing information that is shocking to the staff
• Touching the staff inappropriately

It is essential for the safety of the patients that all staff understand and are aware of behaviors displayed by children that indicate problems with boundaries and set appropriate limits on those behaviors. It is also imperative that staff maintain appropriate and professional boundaries regarding their own behavior to avoid violating the trust and safety of the children in our care.

Red Flags to be alert for (potential boundary problems):
- Attraction to a patient
- Over identification with a patient
- Doing special favors for a patient
- Trading assignments to get a certain patient
- Requesting the same assignment repeatedly
- Bringing in a item from home for a patient or his/her family
- Giving or accepting a gift from a patient
- Not setting limits when a patient crosses your boundaries
- Feeling that you are the only staff that can handle or understand a certain patient

How to Protect Yourself and Your patients:
- Review policy on Therapeutic Boundaries
- Set limits when a patient crosses your boundaries
- Alert your manager if a patient is admitted with whom you have a personal relationship
- Limit self-disclosure
- Don’t talk about your personal life where patients can hear
- Be aware of your own limitations, ask for help if overwhelmed or confused
- Maintain rational detachment (do not get over involved/invested in one child)
- Remember that treatment at Shodair is a Team approach
- Alert your manager for any of the above red flags with yourself or a peer

Zone of Helpfulness:

To provide the best care for the children at Shodair we all need to work at all times - in the "Zone of Helpfulness". What is the "Zone of Helpfulness"? It is the place where we are putting the needs of the children first. Working with and around emotionally disturbed children is a difficult and challenging job on the best of days. It is easy to become confused or lax about what our roles are and what appropriate boundaries we need to keep. At all times our behavior, when around the children, should be guided by the question -"Is this helpful to the child or children or not?", if it isn't - don't do it.
Some example of the "Zone of Helpfulness":

1. You want to cut through the Glacier Unit instead of going around to get to the employee lounge. Is this helpful? - No. Why not? You are entering the place they live, possibly disrupting a group or activity. You are not in the "Zone of Helpfulness" - you are under involved because you are thinking about your needs not theirs. It indicates disinterest in the needs of the children on Glacier.

2. You come into the cafeteria and you see a child you used to work with on the Grasslands unit that is eating with his new unit (Glacier). You loudly say "hello" and walk over and give him a hug. Are you in the "Zone of Helpfulness?" No. You have disrupted the meal and possibly caused jealousy among the other kids (and there is a "no touch" rule for all staff and kids on Glacier). You are in the "Over involved zone".

3. You need to speak to an employee or (deliver a chart or paperwork) on High Desert. You walk in without checking to see if it is safe or if there is a group or activity and proceed onto the unit. Are you in the "Zone of Helpfulness?" No. You are in the "Under involved Zone" because you did not consider the needs of the children only your need to enter the unit.

4. You have been called to CRT on Grasslands. You assist and begin to leave when the special procedure is over. On the way out you see your roommate - you stop to chat about her plans after work? Are you in the "Zone of Helpfulness"? - No. You are in the "Zone of Under involvement" because your discussion with her about her plans has nothing to do with your care of the children.

5. You pass by the Yellowstone classroom and go in without invitation to speak with one of the adolescents. Are you in the "Zone of Helpfulness"? No. You weren't thinking about the needs of the children - only your relationship with a particular child. This is in the "Over involved zone".

All of us - in every department at Shodair have an important part in the care of our kids. The children watch us and learn from us - all the time. So no matter where you go - if there are children around please commit to staying in the "Zone of Helpfulness".
Module 5: Diversity, Values and Cultural Competence

◆ LEARNING EXPERIENCE 1 ◆ Define culture and cultural competence.

As an MHT, you will be expected to recognize and respect the qualities of diversity and differences between and among human beings. In order to work effectively with people belonging to different cultures, you should learn about and be sensitive to those attributes that are shared by different cultural groups.

Culture may be defined as:

"The values, beliefs, attitudes, and customs that are shared by a group of people and passed from one generation to the next."

Culture also refers to the shared language, behavior, customs, symbols, knowledge, pattern of comprehending reality, and the ability to create or determine history (Priest 1991).

SUGGESTED ASSIGNMENT:
What cultural groups do you belong to? Make a list. How many did you identify? Consider any traditions you may have because of your culture. Is there something that makes you feel “different” or “other than?” This will be important to remember when you work with people.

There are many definitions of cultural competence—just as there are many definitions of mental health.

One definition is: Cultural competence is the willingness, commitment, effort, and ability to understand and appreciate the cultural differences of others with whom one comes in contact, and the use of this knowledge to provide effective services based on cultural identity (Baker, 1989; Roland, 1994).

Because we belong to different cultures, others do not always hold the personal values that we hold. We should not insist that the people we support hold our same values.

Listed below are five ways that individuals and systems can be culturally competent:

- Value diversity.
- Be aware of your own culture and how it impacts your view of the world.
- Be conscious of the dynamics that can occur when people from different cultures interact.
- Learn about different cultures, and share what you learn with your coworkers.
- Think about how you might need to adjust how you support an individual based on his/her cultural traditions and beliefs.

◆ LEARNING EXPERIENCE 2 ◆ Describe diversity between cultures and within cultures.
Valuing diversity means accepting and respecting differences. People come from very different backgrounds, and their customs, thoughts, ways of communicating, values, traditions, and institutions vary accordingly. The choices that we as individuals make are powerfully affected by our culture. Culture can influence choices that range from recreational activities to how one defines family.

Not only do we need to recognize diversity between cultures, we also need to recognize diversity within cultures. We are exposed to many different cultures through school, television, books, and other social activities. People generally assume a common culture is shared between members of racial, linguistic, and religious groups. That's not always the case. Some individual members of the culture may share nothing beyond similar physical appearance, language, or spiritual beliefs. Once again, while it is a good idea to learn about different cultures, you still need to treat each person you interact with as an individual and not assume anything about what they believe, think or feel.

You will be expected to be culturally competent and value diversity in your interactions with coworkers and the children in your care, as well as modeling that attitude in the community. It is easy for us to support people who hold similar beliefs to our own. It can be more challenging to support someone you disagree with. Think ahead of time about cultural beliefs that challenge you, then you can strategize how you would handle it if the situation arises.

*If you have concerns, be honest and discuss them with your supervisor.*

**LEARNING EXPERIENCE 3**  
*Ponder the values you hold and their sources.*

In addition to cultural competence, it is also important to reflect on the values you have about your work. Have you given some thought to how you feel about children with mental illness and behavioral problems?

When asked what values are most important to them, staff made the following list:

- Inclusion
- Understanding
- Respect
- Dignity
- Belief in the equality of others
- Freedom from intrusion, control, restraint
- Hope
- Equality
- Cultivating trust

**SUGGESTED ASSIGNMENT:**  
Do you agree with the above list? Do you have values to add? What do you think is the source of many of your values? Please discuss this with your supervisor.
We value diversity by
ACCEPTING
and
RESPECTING

DIFFERENCES
Module 6: Confidentiality

Confidentiality is the protection of personal information and is enforced through professional codes of ethics, regulations, and by state and federal laws.

Learning Experience 1: Give examples of “individually identifiable information” and define the General Rule of Confidentiality.

Any information that makes it possible to figure out who is being referred to is called “individually identifiable information.” Examples of individually identifiable information obviously includes a name or a social security number, but could also include information such as an address, a place of work, or a detailed description of an individual's appearance, personal history, family relations, etc. In a state as sparsely populated as Montana, we need to be particularly careful not to inadvertently reveal personal information about individuals we support.

The General Rule of Confidentiality

“Never acknowledge or disclose any confidential information to anyone without authorization.”

This general rule provides a basis for how you treat information and make decisions in situations when people inquire about individuals you currently support or have supported in the past. There will certainly be “grey areas;” but if you are in doubt, don’t share the information and consult with your supervisor.

The General Rule means that:

- You know nothing and you share nothing without an authorization.
- You do not admit knowing or not knowing the person in question without an authorization.
- You do not share information with coworkers, professionals, the person’s family, law enforcement, the Governor, or your friends and family without an authorization.
- A child’s family or legal guardian has the right to disclose any information they choose.

Learning Experience 2: Define informed consent.

Informed consent means that nothing should be shared without the family’s or legal guardian’s specific knowledge of what, when, with whom and why it will be shared.

To Release Information

Individuals (family/legal guardians) retain the right, except in certain emergency circumstances, to control their personal information. If an individual agrees to share his/her confidential information with others, s/he will complete a release of information form. This document specifies:

- Who will disclose or obtain information.
- What specific information will be disclosed (the more specific the better).
- How the information will be used (treatment planning, collaboration, etc.).
How long the information will be available (no longer than a year, ideally only as long as is necessary).

That the person in question can rescind the release at any time.

Exceptions to the General Rule of Confidentiality do exist. However, they are rare and should only occur in extraordinary circumstances. Two examples of extraordinary circumstances where the rule may be set aside include mandatory reporting and emergency situations where there is a clear and immediate danger to a person. Discuss this issue with your supervisor. If you are ever in doubt about whether a situation warrants an exception to the rule, check with your supervisor before taking any action.

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**LEARNING EXPERIENCE 3**  
*Explain the “Need to Know” concept.*

The “Need to Know” concept limits access to an individual’s confidential information to the information needed for employees to perform their job functions. For example, a person who provides transportation for a resident does not need to know the resident’s medical history if it does not affect the transportation. Note that some of what’s important about confidentiality is also what’s important about documentation. Consider how confidentiality is maintained in the process of documentation. Many of the guidelines in documentation are based on preserving confidentiality.

**What this means for you on a daily basis when sharing information:**

**Never…**

✗ Use analog cell phones to convey confidential information, as they are not secure lines.

✗ Leave confidential consumer information on answering machines that may be listened to by people other than the intended recipient of the message.

✗ Refer to other consumers by name when documenting in someone else’s record.

✗ Talk outside of work (except in a very general way) about the individuals you support. Don’t use their names or other individually identifiable information.

✗ Have confidential discussions where you can be overheard.

✗ Gossip about the children you care for.

✗ Send patient info in an email, that is not a Shodair email.

**Always…**

✓ Check the copier to make sure that you have removed all copies of consumer information.

✓ Share information in a way that is respectful of the dignity and privacy of the person.

✓ Keep individual records or other documents secured when not in use. Never leave an individual’s records unattended when they are not secured.

✓ Verify fax numbers before faxing any consumer information. The person receiving the fax must be aware that the fax is being sent. Always put a cover sheet on the fax specifying who the fax is intended for, and indicating that the faxed information is confidential.
Nothing About Us Without Us

"Nothing about us without us" is a phrase often used by people who have been disenfranchised or discriminated against. It basically means "Don't talk about me or make decisions about me without me present". You can compare it to "taxation without representation." Whenever possible the children you care for should participate in meetings that impact them. It will take effort and at times may seem like a lot of work, but it is the most respectful thing you can do. How would you feel if other people were making plans for your life without you present?

Are you documenting something in a person's record that you wouldn't want that person to read? Are you sharing someone's personal information with your co-worker that s/he doesn't "need to know"? The work you are doing is very personal and you must always be mindful of how you share your experiences of that work. In the next module you will learn more about what you should document in the permanent record.

**SUGGESTED ASSIGNMENT:**

Your supervisor will assign you to review one person’s record. Find the releases section and examine the releases.

- Are any of them outdated?
- Are any of them good for an entire year?
- Is there a good reason for the length of time?
- Is the release specific as to the information that is being exchanged?
- Has the family declined to release information about their child’s mental illness?
- Is the documented information “need to know” only?

Discuss your findings with your supervisor.
Module 7: Documentation

“If it isn’t documented it isn’t done”

◆ LEARNING EXPERIENCE 1  ◆ Know the main purposes of documentation.

The State of Montana, in partnership with the federal government, spends millions of dollars every year to provide support to persons with disabilities. Agencies that create programs using Medicaid dollars or other public monies are obligated to assure the government and the taxpayers that the money is spent wisely.

That is one of the reasons why your responsibilities include writing about the services you’ve provided in the course of your work. Clear, concise documentation about what you do conveys to funding sources that the service is consistent with what the person wants, meets that person’s assessed needs, and has been done correctly.

Justifying the use of funds is of course not the only reason for documentation. A person’s record, (or "chart"), is also an important tool for planning and coordination of care.

What are the standards for documentation in your agency?

During your orientation, you will learn your employer’s specific expectations for documentation. You will be expected to provide written documentation at the conclusion of each day. You are expected to ask for help if you have questions about how to document. Your supervisor and other coworkers will rely in part on your documentation to write summary statements about a child’s progress. Sloppy, incorrect documentation isn’t acceptable, but you’re not expected to be Shakespeare either! Your documentation will improve with practice.

As always, remember to be respectful when writing your notes.

◆ LEARNING EXPERIENCE 2  ◆ Explain the guidelines that apply to documentation and records.

The following guidelines apply to all types of documentation and records:

- Records should be kept behind the nurses station or in a secure location—not left on the unit.
- Records should not leave the unit unless you are authorized to do so.
- Records are confidential. Only authorized personnel, on a “need to know” basis, should view an individual’s record.
- Keep separate records for each person.
- Be objective in your notes and record what you observe and experience. Do not include opinions or assumptions.
- Never mention the name of one person receiving services in someone else’s record—that would be violating their right to confidentiality. You may use initials.
- The original of all documents should be in the person’s file.
Use only black ink to write in the records--do not use red or blue ink, pencils, markers, etc.
• Never use liquid paper, erasable ink, or correction tape to reverse an error in the record.
• When you make an error, cross it out with a single line and place your initials over the line.
• Do not make an entry for a coworker.
• Do not document anything that you did not perform or witness.
• Use only abbreviations approved by your agency.
• Include the month, day, and year on all entries.
• Include the time that the entry is made, using a 24-hour clock.
• Do not write that you have done something until you have done it.
• Make sure that your notes are legible and signed, using your full name and title.
• Keep entries in chronological order.

Incident Reports

Sometimes people receiving services are injured, or other unusual events occur. At those times you will be expected to document what occurred, who responded, what treatment was provided, and the outcome.

Falls, injuries, fires, and automobile accidents that occur when you are driving agency vehicles are among the types of events that require Incident Reports.

General considerations include:

• Follow the reporting timelines. Finish the report before you leave work.
• Be as clear as you can about what happened.
• Include who you talked to, what they said to you, and the time.
• If you or a co-worker makes notes while the event is occurring, it will help your note to be accurate.
• If the Incident Report (IR) involves a patient, be sure to clearly document the incident in the patients chart without referencing the IR – which is an internal hospital document.
Module 8: Communication and Empathy

Effective communication is a big part of your work. Learning good communication skills early in your employment will limit misunderstandings and possible mistakes in the future.

As an MHT, communicating with people diagnosed with mental and emotional illnesses is a vital skill you will be practicing throughout your workday. Of course you are also expected to be a good communicator with your coworkers, other service providers, and families. At the same time you will be assisting the people you support by modeling and teaching them how best to make their wants and needs known.

The overarching principle that guides your communication with all people should be respect. Remember to recognize and honor people’s dignity in any verbal, non-verbal, and written communications. This curriculum module will explain the importance of non-verbal communication; assist you to effectively use words; and help you to be a better listener. If you learn these skills well, they are bound to improve your communication not only at work but in your personal life as well!

◆ LEARNING EXPERIENCE 1  ◆ Characterize verbal and non-verbal communication.

Communication: The giving and receiving of information, signals, or messages. Communication can include talking, writing, or gestures.

Nonverbal Communication

“It’s not just what you say, it’s also how you say it”

Nonverbal communication is defined as the parts of a message that are not conveyed by the literal meaning of words. Nonverbal communication includes body language, use of space, pacing of words, and tone. People notice both nonverbal and verbal messages. In fact, approximately 90 percent of messages are nonverbal and automatic. For example, in the first year of life, babies establish vivid nonverbal relationships with their mothers and close relatives. From this, you may conclude that when you are working with people, they will be gathering an opinion of you based entirely on how you present yourself. If your body language expresses disgust or impatience, what you say may not make a difference.

Often non-verbal communication can be misunderstood. So, it will be important for you to be mindful of how you carry yourself and to give the people you work with permission to question what they see. You can model this skill by "checking in" with the children you work with when you are unsure of the non-verbal messages you witness. For example, many people stand or sit with their arms crossed over their chests. This is often interpreted as someone being angry, or trying to create a barrier between themselves and the world. These are all assumptions until we ask what is going on for someone. You can say, "I notice you have your arms crossed. Sometimes when I do that I'm feeling bothered about something. Is that how you're feeling?" The person can then share what is going on for them. It may be that they are simply bored, or that holding themselves that way helps them to feel more comfortable. It is imperative that we not assume how someone is feeling.
Listed below are aspects of non-verbal communication. This list may be helpful to you as you try to be more mindful of what you are communicating non-verbally.

<table>
<thead>
<tr>
<th><strong>Body language</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>How is your posture? Are your arms crossed or open, down at your sides?</td>
</tr>
<tr>
<td>Do you use gestures when you are communicating?</td>
</tr>
<tr>
<td>Are you smiling? Frowning? What other facial expressions are you using?</td>
</tr>
<tr>
<td>Do you make eye contact?</td>
</tr>
<tr>
<td>Do you nod your head in response to others?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Use of Space</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you sitting or standing?</td>
</tr>
<tr>
<td>Where are your arms or legs?</td>
</tr>
<tr>
<td>How do you move around in the room?</td>
</tr>
<tr>
<td>Are you aware of where others are in the space?</td>
</tr>
<tr>
<td>Do you know how large your personal space is?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pacing and Tone</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>How fast or slowly do you speak?</td>
</tr>
<tr>
<td>How loudly or softly do you speak?</td>
</tr>
</tbody>
</table>

**Verbal Communication**

You’ll find that people communicate differently depending on their audience. When co-workers get together there are often inside jokes that need little explanation. With a good friend you may sit closer to them and speak more openly about your feelings. When you greet a neighbor at the supermarket you may smile and say hello and continue on your way or if you know them well you may stop and chat.

It is important to communicate with the people you support in a way that is comfortable for both of you. There is no formula for how to relate to people with mental illness, so it is important to not make assumptions and take the time to get to know each person as a unique individual.

**Barriers to Communication**

A number of things may limit a person’s ability to give and receive messages. As you read the following consider what it is like for you to attempt a conversation under these circumstances:

1. **Physical**
   - Hearing: Can the person hear you?
   - Seeing: Can the person see your body language?
   - Impairments: Can the person speak and understand?

   Also consider the impact of:

   - Traumatic brain injury
   - Thought disorders: If the person is experiencing hallucinations, he/she may not be able to distinguish between what you are saying and his/her own thoughts.
   - Verbal/nonverbal processing disorders
2. Past History and Experiences

- People may be distressed because of past trauma. If the person has a history of abuse, they may be fearful of relationships. While they appear to be listening, they may have fearful racing thoughts that get in the way of hearing you.
- People may have difficulty with eye contact if much of their experience is based in shame, trauma and low self-esteem.
- People may be "hyper vigilant" about their surroundings.

3. Structural

- Are you both using the same language?
- Are you viewed as a person who has "power over the other individual?"
- Are you trying to talk about something personal?

4. Emotional State

- Stress, anger, fear, distraction and grief can impact communication
- When any of us are experiencing a heightened emotion it can be difficult to engage with someone else.

**LEARNING EXPERIENCE 2**  Identify what constitutes respectful communication.

Communication is a complex human interaction. Consider all the potential barriers that we have identified in this section. One or more of them may be present in any interactions we have, but when we are respectful and honest more of our message is likely to get through to the other person. When we are unclear, impatient, rushed, or obviously stressed, the meaning of our message can become garbled and unclear and barriers to communication may become magnified.

Being honest about how you're feeling on any given day can go a long way in keeping the communication channels open. For example, if you're having a bad day, it may be a good idea to let people know. That is not to say that it is ok to go to work and be grumpy. However, you could begin your time with the person by saying something like "I've had sort of a rough time today, and I don't want it to get in the way of our work together. If I seem distracted or impatient, please let me know." Sometimes just saying it out loud helps you to feel better. You are also "owning" the fact that you may not be at the top of your game, and acknowledging that you have a responsibility to "be there" for the relationship and the work that you do. You haven't revealed personal information; you've just acknowledged what the person you support will probably sense anyway---that you're having a rough day.

**LEARNING EXPERIENCE 3**  Explore specific strategies that can improve communication, including listening skills and empathy.
The following list contains a number of strategies you can use to improve your communication:

- Be fully present and take time in a quiet place for your communications.
- Maintain eye contact (in a way that is comfortable for both of you)
- Notice the other person's non-verbal communication and check in with the person (don't make assumptions).
- Make sure your own body language matches your emotional tone.
- Let people finish what they are saying before you respond.
- Don't plan your response while you're listening to the other person.
- Focus your attention on the problem the other person is describing without giving advice.
- Acknowledge what people are saying by statements or body language.
- Use "I" statements that communicate to the person how you are feeling in response to his or her statements.
- Use phrases like "I wonder," and "I'm curious" when asking questions rather than saying "Why do you . . . " or "Why would you . . . ".
- Restate in a few words what you've heard to make sure you understood.
- If the person appears to be distressed, ask if they want to continue talking, or pick up the conversation at some future time.
- Get comfortable with silence. You don't have to fill in the silence with comments.

**Remember:**

You will be a more effective communicator if you are unfailingly respectful, even when you’re having a rough day. Always remember to introduce yourself and use the child’s name, (if you know it). If you don’t - ask! Never walk up to a child and just start talking or give directions. The children you support will be more likely to trust you and find you helpful if you remember these tips and you will feel better about yourself as well!

**SUGGESTED ASSIGNMENT #1:**

Ask your supervisor to arrange for you to sit in on a conversation between a coworker and one of the people s/he cares for. Observe your co-worker and note if you see him/her using any of the communication techniques in this module. Discuss this experience with your supervisor.

**SUGGESTED ASSIGNMENT #2:**

Think about how you were feeling when you came to work this morning. Were you happy? Sad? Worried? Tired? Full of energy? When you've identified how you are feeling, ask a coworker or your supervisor what they noticed about your body language. What were their assumptions about how you were feeling? Make a list of the nonverbal messages you sent.

**SUGGESTED ASSIGNMENT #3:**

Talk with a person you support about communication skills. Ask them what they know or understand about non-verbal communication. Demonstrate to them your understanding and explain what you've learned from this module.
Empathy vs Sympathy

What exactly is empathy?

Carl Rogers (1957), the founder of person-centered therapy, defined it as:

*to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the as if condition.*

All too often empathy and sympathy can be confused, but understanding the difference between the two can make us more effective communicators.

What is the difference between sympathy and empathy?

- To express sympathy is to make it known that you are aware of another’s distress and that you have compassion for them.

- To express empathy takes things a step further by not only expressing compassion but also showing a deeper level of understanding by entering into the other person’s experience.

Imagine being at the bottom of a deep, dark hole. Peer up to the top of the hole and you might see some of your friends and family waiting for you, offering words of support and encouragement. This is sympathy; they want to help you out of the pit you have found yourself in. This can assist, but not as much as the person who is standing beside you; the person who is in that hole with you and can see the world from your perspective; this is empathy.

On the surface, there is very little difference between empathy and sympathy, so why is it so important to distinguish the two?

Expressing sympathy can leave a person feeling that people have taken pity on them, or are feeling sorry for them, which can create a sense of inferiority and disempowerment.

A more effective approach would be to take a position that does not allow for a hierarchy to form, but that enables everyone to feel on the same emotional level. This more effective form of communication can only come with expressing empathy.

There are a number of ways in which empathy can be offered, including:

- Reflecting a person’s expressed feelings back to them
- Paraphrasing what a person has said to you to demonstrate an understanding.
Examples of sympathy versus empathy are shown in the box below. Empathy indicates your presence, conveys an understanding of the other person’s thoughts and feelings, and provides reassurance that no judgments are being made.

<table>
<thead>
<tr>
<th>Sympathy</th>
<th>Empathy</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am so sorry about your loss.</td>
<td>I feel your grief.</td>
</tr>
<tr>
<td>How awful. Poor you.</td>
<td>I understand this has been a great loss for you.</td>
</tr>
<tr>
<td>Let me do that for you.</td>
<td>Can I help you with that?</td>
</tr>
<tr>
<td>I feel so sad for you.</td>
<td>I feel and understanding your pain.</td>
</tr>
</tbody>
</table>

Empathy is not just useful as a tool to use when someone is in distress, it does have wider uses. For example, in our work and personal life we will meet many people with differing views and perspectives on life. People may express political or religious views that differ from our own and which can lead to barriers in communication. The use of empathic dialogue can serve to prevent such barriers.

Module 9: Major Psychiatric Disorders

Personality Disorders: Concepts
- Word derived from Greek Term –PERSONA. Used to describe mask worn by Greek actors
- Personality traits are enduring patterns of perceiving, relating to and thinking about the environment and oneself that are exhibited in a wide variety of social and personal contexts.
- Personality disorders are when personality traits are deeply engrained, inflexible maladaptive and cause significant functional impairment or subjective stress.

Common Personality Disorders:

Borderline Personality Disorder – is characterized as instability of self image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking and /or hostility.
- Borderline Personality Disorder is the most common type of personality disorder -1.6% of adults in the US suffer from this disorder.
- BPD is usually diagnosed in women, characterized by a pattern of intense and chaotic relationships, with affective instability and fluctuating attitudes towards other people.
- BPD is characterized by functional impairment- intense and chaotic relationships, (“I hate you/you are the only one that can help me”), inability to maintain employment or school performance, impulsive risky behavior.
- Treatment options that improve prognosis - Medications, Family Therapy, Psychotherapy, Cognitive Behavioral Therapy (CBT), Dialectical behavior Therapy (DBT).

Antisocial Personality Disorder – Pattern of socially irresponsible, exploitative, and guiltless behavior that reflects a disregard for the rights of others, inability to tell right from wrong, failure to conform to social norms, deceitful, reckless, staff splitting, LACK OF REMORSE.
- Usually men
- One of the oldest and most researched of the personality disorders

Interventions for personality disorders:
- Good nurse-patient relationships are necessary 24/7 for a unit to operate harmoniously. The following factors are important to remember:
  - Multidisciplinary team support and consistency
  - Build team consensus about approaches to manage difficult behaviors and interactions.
  - Self-awareness
  - Include all staff in decision making
  - Create an atmosphere of acceptance so staff can vent honest feelings
  - Choose battles carefully – prioritize
Psychotic Disorders

What is schizophrenia?
Schizophrenia is a challenging disorder that makes it difficult to distinguish between what is real and unreal, think clearly, manage emotions, and relate to others. These obstacles can get in the way of one’s ability to function normally and take care of oneself.

Terms:
- Greek Terms “schizein” means to split and “phren” means the mind. Swiss psychiatrist Eugene Bleuler coined the term “schizophrenia.” His belief was that a split occurred between the cognitive and emotional aspects of the personality. The intent was not to identify “split personalities”
- Psychosis — refers to the mental state of experiencing reality differently from others

Common Misconceptions about schizophrenia:

**Myth:** Schizophrenia refers to a “split personality or multiple personalities
**Fact:** Multiple personality is a different and much less common disorder than schizophrenia. People with schizophrenia are “split off” from reality — they do not have multiple personalities.

**Myth:** Schizophrenia is a rare condition.
**Fact:** Schizophrenia is not rare; the lifetime risk of developing schizophrenia is widely accepted to be about 1 in a 100.

**Myth:** People with schizophrenia are dangerous.
**Fact:** Although the delusional thoughts and hallucinations of schizophrenia sometimes lead to violent behaviors, most people with schizophrenia are neither violent or a danger to others.

**Myth:** People with schizophrenia can’t be helped.
**Fact:** While long-term treatment is required, the outlook for schizophrenia is not hopeless. When treated properly, many people with schizophrenia are able to function within their families and communities as well as lead productive lives.

Delusions vs Hallucinations

**Delusions:**
Delusions are beliefs which are not true to fact and cannot be corrected by an appeal of the person entertaining it.
- Delusions of reference or persecution – The person believe they are an object of negative attention.
- Delusions of grandeur – may be associated with elated or manic states such as delusions of great wealth and power.
- Somatic delusions – belief that the person is suffering from a terrible disease despite medical evidence to the contrary.
- Self-deprecation delusions- often seen in connection with severe depression. The person describes feelings of sinfulness, obnoxious odors ugliness etc.
Hallucinations:
Hallucinations are sounds or other sensations experienced by the individual as real when in reality they exist only in the person’s mind. While hallucinations can involve any of the five senses, auditory hallucinations, (e.g. hearing voices or some other sound), are most common in schizophrenia. Visual hallucinations are also relatively common. Types of hallucinations:

- **Auditory** – A false perception of sound. Most commonly they are voices, but the individual may report clicks, rushing noises or music.
- **Visual** – A false visual perception. It may consist of formed images, such as of images people, or of unformed images, such as flashes of light.
- **Tactile** – A false perception of the sense of touch, often of something on or under the skin. One specific hallucination is formication, the sense that something is crawling on or under the skin.
- **Gustatory** – A false perception of taste. Most commonly, gustatory hallucinations are described as an unpleasant taste.
- **Olfactory** – A false perception of the sense of smell.

Positive vs Negative symptoms

**Positive Symptoms** – An exaggeration of distorted normal function; usually responsive to traditional antipsychotic drugs.

1. **Delusions and / or hallucinations** – Thinking things that are not true or experiencing things that are not there.

2. **Disorganized speech** – Fragmented thinking is a characteristic of schizophrenia. Externally, it can be observed in the way a person speaks. Individuals who suffer from schizophrenia tend to have trouble concentrating and maintaining a train of thought. They may respond to questions with an unrelated answer, start sentences with one topic and end somewhere completely different, speak incoherently, or say illogical things.
   
   Common signs of disorganized speech in schizophrenia include:
   - Loose associations – rapidly shifting from topic to topic, with no connection between one thought and the next.
   - Neologisms – Made up words or phrases that only have meaning to the patient.
   - Perseveration – repetition of words and statements; saying the same thing over and over again.
   - Clang – Meaningless use of rhyming words (e.g. “I said the bread and read the shed and fed Ned at the head”).

3. **Disorganized Behavior** – Schizophrenia disrupts goal directed activity, causing impairments in a person’s ability to take care of him or herself, work or go to school or interact with others. Disorganized behavior appears as:
   - A decline in overall functioning
   - Unpredictable or inappropriate emotional responses
   - Behaviors that appear bizarre and have no purpose
   - Lack of inhibition and impulse control

**Negative Symptoms (4 A’s)** – A reduction or loss of normal function; usually unresponsive to traditional antipsychotic medication and more responsive to atypical antipsychotic medication:
- **Affective flattening or lack of emotional expression** – inexpressive face, including a flat voice, lack of eye contact, and a blank or restricted facial expression
- **Avolition/Apathy or lack of interest or enthusiasm** – Problems with motivation; lack of self-care (grooming and hygiene)
- **Anhedonia or seeming lack of interest in the world** – Apparent unawareness of the environment; social withdrawal
- **Alogia or speech difficulties and abnormalities** – Inability to carry on a conversation; short and sometimes disconnected replies to questions; speaking in a monotone

**Types of schizophrenia**

- Paranoid schizophrenia – absurd or suspicious ideas and beliefs
- Disorganized schizophrenia – disorganized speech and behavior and blunted or inappropriate emotions. Also have trouble taking care of themselves and may be unable to perform simple tasks, such as bathing or feeding themselves.
- Undifferentiated schizophrenia – Experience psychotic symptoms but are not paranoid or catatonic.
- Residual schizophrenia – symptoms are usually negative in nature.

**Other psychotic disorders**

- Schizoaffective Disorder – a Person has symptoms of both schizophrenia and a major mood disorder such as depression.
- Brief Psychotic Disorder – sudden onset of psychotic symptoms that may or may not be preceded by a major psychosocial stressor.
- Delusional Disorder – presence of one or more non-bizarre delusions that persist for at least one month.

**Effects of schizophrenia**

When the signs and symptoms of schizophrenia are ignored or improperly treated, the effects can be devastating to both the individual and those around him or her.

Some of the possible effects of schizophrenia can be:

- **Relationship problems** – Relationships suffer because people who suffer from schizophrenia often withdraw and isolate themselves. Paranoia can also cause a person with schizophrenia to be suspicious of family and friends.
- **Disruptions to normal daily activities** – schizophrenia causes significant disruptions to functioning, both because of social difficulties and because everyday tasks become hard, if not impossible to do. A person with schizophrenia’s delusions, hallucinations and disorganized thoughts typically prevent him or her from doing normal things. Like bathing eating or running errands.
- **Alcohol and drug use** – People with schizophrenia frequently develop problems with alcohol or drugs which are often used in an attempt to self-medicate, or relieve symptoms. In addition, they may also be heavy smokers, a complicating situation as cigarette smoke can interfere with the effectiveness of the medication prescribed to treat the disorder.
- **Increased suicide risk** – People with schizophrenia have a high risk of attempting suicide. Any suicidal talk, threats or gestures should be taken very seriously, no matter what.
with schizophrenia are at higher risk to commit suicide during psychotic episodes, during periods of depressions and in the first six months after they have started treatment.

Mood Disorders

Terms
- Mood – an individual’s sustained emotional tone.

What is Bipolar Disorder?

Bipolar Disorder (also known as manic depression) causes serious shifts in mood, energy, thinking, and behavior – from the highs of mania on the one extreme to the lows of depression on the other. More than just a fleeting good or bad mood, the cycles of bipolar disorder last for days, weeks, or months. Unlike the ordinary mood swings the mood changes of bipolar disorder are so intense that they interfere with a person’s ability to function in daily life.

Common misconceptions about Bipolar Disorder:

**Myth:** People with Bipolar Disorder can’t get better or lead a normal life.

**Fact:** Many people who suffer from bipolar disorder have successful careers, happy families, and satisfying relationships. Living with bipolar disorder is challenging. But with treatment and healthy coping skills and a solid support system, a person can live fully while managing their symptoms.

**Myth:** People who suffer from bipolar disorder swing back and forth between mania and depression.

**Fact:** Some people alternate between extreme episodes of mania and depression, but most are depressed more often than they are manic. Mania may also be so mild that it goes unrecognized. People who suffer from Bipolar disorder can also go for long periods without symptoms.

**Myth:** Bipolar Disorder only affects mood.

**Fact:** Bipolar Disorder also affects your energy level, judgment, memory, concentration, appetite, sleep patterns, sex drive, and self-esteem. Additionally, bipolar disorder has been linked to anxiety, substance abuse, and health problems such as diabetes, migraines and high blood pressure.

**Myth:** Aside from taking medication, there is nothing you can do to control bipolar disorder.

**Fact:** While medication is the foundation of the treatment of bipolar disorder, therapy and self-help strategies also play important roles. A person can help control their symptoms by exercising regularly, getting enough sleep, eating right, monitoring their moods, keeping stress to a minimum, and surrounding themselves with supportive people.

**Signs and Symptoms of Bipolar Disorder:**
Bipolar Disorder can look very different in different people. The symptoms vary widely in their pattern, severity and frequency. Some people are more prone to either mania or depression, while others alternate equally between the two types of episodes. Some have frequent mood disruptions, while others experience only a few over a lifetime.

**Common signs and symptoms of mania include:**
Feeling unusually “high” and optimistic OR extremely irritable

Unrealistic, grandiose beliefs about one’s abilities or powers

Sleeping very little, but feeling extremely energetic

Talking so rapidly that others can’t keep up

Racing thoughts; jumping quickly from one idea to the next

Highly distractible, unable to concentrate

Impaired judgment and impulsiveness

Acting recklessly without thinking about the consequences

Common symptoms of bipolar depression include:

- Feeling hopeless, sad or empty
- Irritability
- Inability to experience pleasure
- Fatigue or loss of energy
- Physical or mental sluggishness
- Appetite or weight changes
- Sleep problems
- Concentration or memory problems
- Feelings of worthlessness or guilt
- Thought of death or suicide

Treatment for Bipolar Disorder

Bipolar Disorder requires long-term treatment. Since bipolar disorder is a chronic, relapsing illness, it’s important to continue treatment even though the person may be feeling better. Most people who suffer from bipolar disorder need medication to prevent new episodes and stay symptom free.

There is more to treatment than medication. Medication alone is usually not enough to fully control the symptoms of bipolar disorder. The most effective treatment strategy for bipolar disorder involves a combination of medication, therapy, lifestyle changes and social support.

Other Mood Disorders

- Depressive Disorders
  - Major Depressive Disorder
  - Seasonal Affective Disorder
  - Postpartum Depression
• Cyclothymic Disorder and Dysthymia (persistent depressive disorder)

**Substance-related and Addictive Disorders**

**Substance Use Disorder:** A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by two or more of the DSM-5 criteria, occurring within a 12 month period. This disorder is measured on a continuum from mild to severe.

**Addictive Disorder:** Addiction is a primary chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use or other behaviors.

Addiction is characterized by an inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors, and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death. (American Society of Addictive Medicine definition)

**Co-occurring Disorders:** Co-occurring disorders are the presence of two or more disorders at the same time. For example, a person may suffer from substance abuse as well as bipolar disorder.

- Approximately 8.9 million adults have co-occurring disorders.
- Only 7.4 percent of individuals receive treatment for both conditions with 55.8 percent receiving no treatment at all.
- Compared to patients who have a mental health disorder or substance abuse disorder, patients with co-occurring disorders often experience more severe and chronic medical, social and emotional problems.
Module 10: Psychiatric Disorders and Mental Health Issues in Children

Hearing Voices and Seeing Things
Children often hear or see things that may scare or upset them. The wind at night, a creak in the house, or a shadow on the wall may feel frightening, especially for younger children. At times, children may imagine that they hear or see things as part of a game or as a result of their worries and fears. Younger children may even have an imaginary friend they want to sit next to at the table and have conversations with. These examples are usually just part of the normal growth of a child. They can most often be managed with understanding and gentle reassurance on the part of parents. Hallucinations are when one has heard, seen or experienced something that is not there. They can occur in any of our senses including sound, sight, touch, taste and smell. An auditory hallucination is when one has heard something that is not there. It is the most common type of hallucination. A visual hallucination is when one has seen something that is not there. Hallucinations may occur as part of normal development or may be a sign that a child is struggling with some type of emotional problems. This may be related to issues at home, school, with friends, or from experiencing upsetting thoughts and feelings.

In some cases hallucinations may occur as a sign of a psychiatric illness such as a psychosis, or other serious medical problems. Psychotic disorders in children, while not common, are serious and severely interfere with a child’s thinking and functioning. Children who are psychotic often appear confused and agitated. They also may have disorganized speech, thinking, emotional reactions, and behavior, sometimes accompanied by hallucinations or delusions (a fixed, false and often bizarre belief).

Hearing voices or seeing things that are not there can be a part of normal development but they may also happen as a result of the following:

- **When a youngster is under severe emotional stress**

  Children coping with the death of a parent or dealing with lots of stressors in their lives will sometimes hear voices or see things.

- **Certain physical illnesses**

  Examples may include migraines, seizures, infections, a very high fever, and problems with the thyroid or adrenal glands.

- **Adverse effects of medication**

  The use of certain medications, such as steroids or pain medicine, can cause hallucinations under rare circumstances. Many other medications can also lead to hallucinations when used in higher doses than prescribed or recommended. Illegal drugs such as alcohol, marijuana, amphetamines, cocaine and LSD are a frequent cause of hallucinations.
**Nonpsychotic psychiatric illnesses**

Children who hear voices telling them to do bad things often have behavior problems. Voices that refer to suicide or dying may occur in children who are depressed. The content of a hallucination may help us understand what type of illness a child is experiencing. Children who see things that are not there may be very anxious or depressed.

**Psychotic illnesses**

These include schizophrenia, major depressive disorder with psychotic features, and bipolar disorder. In addition to hallucinations, psychotic illnesses are characterized by delusions, disorganized and/or bizarre behavior and moods that don’t correspond with what is going on in someone’s life. Children may show social withdrawal, and inappropriate and unusual use of language.

From AACAP “Facts for Families” 2013
Conduct Disorder

Conduct disorder is a serious behavioral and emotional disorder that can occur in children and teens. A child with this disorder may display a pattern of disruptive and violent behavior and have problems following rules.

It is not uncommon for children and teens to have behavior-related problems at some time during their development. However, the behavior is considered to be a conduct disorder when it is long-lasting, violates the rights of others, goes against accepted norms of behavior and disrupts the child's or family's everyday life.

What Are the Symptoms of Conduct Disorder?

Symptoms of conduct disorder vary depending on the age of the child and whether the disorder is mild, moderate, or severe. In general, symptoms of conduct disorder fall into four general categories:

- **Aggressive behavior**: These are behaviors that threaten or cause physical harm and may include fighting, bullying, being cruel to others or animals, using weapons, and forcing another into sexual activity.
- **Destructive behavior**: This involves intentional destruction of property such as arson (deliberate fire-setting) and vandalism (harming another person's property).
- **Deceitful behavior**: This may include repeated lying, shoplifting, or breaking into homes or cars in order to steal.
- **Violation of rules**: This involves going against accepted rules of society or engaging in behavior that is not appropriate for the person's age. These behaviors may include running away, skipping school, playing pranks, or being sexually active at a very young age.

In addition, many children with conduct disorder are irritable, have low self-esteem, and tend to throw frequent temper tantrums. Some may abuse drugs and alcohol. Children with conduct disorder often are unable to appreciate how their behavior can hurt others and generally have little guilt or remorse about hurting others.

What Causes Conduct Disorder?

The exact cause of conduct disorder is not known, but it is believed that a combination of biological, genetic, environmental, psychological, and social factors play a role.

- **Biological**: Some studies suggest that defects or injuries to certain areas of the brain can lead to behavior disorders. In addition, conduct disorder has been linked to particular brain chemicals called neurotransmitters. Neurotransmitters help nerve cells in the brain communicate with each other. If these chemicals are out of balance or not working properly, messages may not make it through the brain correctly, leading to symptoms. Further, many children and teens with conduct disorder also have other mental illnesses, such as attention-deficit/hyperactivity disorder (ADHD), learning disorders, depression, substance abuse, or an anxiety disorder, which may contribute to the conduct disorder.
- **Genetics**: Many children and teens with conduct disorder have close family members with mental illnesses, including mood disorders, anxiety disorders,
substance use disorders and personality disorders. This suggests that a vulnerability to conduct disorder may be inherited.

- **Environmental:** Factors such as a dysfunctional family life, childhood abuse, traumatic experiences, a family history of substance abuse, and inconsistent discipline by parents may contribute to the development of conduct disorder.
- **Psychological:** Some experts believe that conduct disorders can reflect problems with moral awareness (notably, lack of guilt and remorse) and deficits in cognitive processing.
- **Social:** Low socioeconomic status and not being accepted by their peers appear to be risk factors for the development of conduct disorder.

**How Common Is Conduct Disorder?**

It is estimated that 2%-16% of children in the U.S. have conduct disorder. It is more common in boys than in girls and most often occurs in late childhood or the early teen years.

**How Is Conduct Disorder Diagnosed?**

As with adults, mental illnesses in children are diagnosed based on signs and symptoms that suggest a particular problem. If symptoms of conduct disorder are present, the doctor may begin an evaluation by performing a complete medical history and psychiatric history. A physical exam and laboratory tests (for example, neuroimaging studies, blood tests) may sometimes be appropriate if there is concern that a physical illness might be causing the symptoms. The doctor will also look for signs of other disorders that often occur along with conduct disorder, such as ADHD and depression.

If the doctor cannot find a physical cause for the symptoms, he or she will likely refer the child to a child and adolescent psychiatrist or psychologist, mental health professionals who are specially trained to diagnose and treat mental illnesses in children and teens. Psychiatrists and psychologists use specially designed interview and assessment tools to evaluate a child for a mental disorder. The doctor bases his or her diagnosis on reports of the child's symptoms and his or her observation of the child's attitudes and behavior. The doctor often must rely on reports from the child's parents, teachers, and other adults because children often have trouble explaining their problems or understanding their symptoms.

**How Is Conduct Disorder Treated?**

Treatment for conduct disorder is based on many factors, including the child's age, the severity of symptoms, as well as the child's ability to participate in and tolerate specific therapies. Treatment usually consists of a combination of the following:

- **Psychotherapy:** Psychotherapy (a type of counseling) is aimed at helping the child learn to express and control anger in more appropriate ways. A type of therapy called cognitive-behavioral therapy aims to reshape the child's thinking (cognition) to improve problem solving skills, anger management, moral reasoning skills, and impulse control. Family therapy may be used to help improve family interactions and communication among family members. A specialized therapy technique called parent management training (PMT) teaches parents ways to positively alter their child's behavior in the home.
- **Medication:** Although there is no medication formally approved to treat conduct disorder, various drugs may be used to treat some of its distressing symptoms, as well as any other mental illnesses that may be present, such as ADHD or major depression.
What Is the Outlook for Children With Conduct Disorder?

If your child is displaying symptoms of conduct disorder, it is very important that you seek help from a qualified doctor. A child or teen with conduct disorder is at risk for developing other mental disorders as an adult if left untreated. These include antisocial personality disorder, mood or anxiety disorders, and substance use disorders.

Children with conduct disorder are also at risk for school-related problems, such as failing or dropping out, substance abuse, legal problems, injuries to self or others due to violent behavior, sexually transmitted diseases, and suicide. Treatment outcomes can vary greatly, but early intervention may help to reduce the risk for incarcerations, mood disorders, and the development of other comorbidities such as substance abuse.

Can Conduct Disorder Be Prevented?

Although it may not be possible to prevent conduct disorder, recognizing and acting on symptoms when they appear can minimize distress to the child and family, and prevent many of the problems associated with the condition. In addition, providing a nurturing, supportive, and consistent home environment with a balance of love and discipline may help reduce symptoms and prevent episodes of disturbing behavior.

From: WebMD 2013
ADD / ADHD in Children

Signs and Symptoms of Attention Deficit Disorder in Kids

It’s normal for children to occasionally forget their homework, daydream during class, act without thinking, or get fidgety at the dinner table. But inattention, impulsivity, and hyperactivity are also signs of attention deficit disorder (ADD/ADHD), which can affect your child’s ability to learn and get along with others. The first step to addressing the problem is to recognize the signs and symptoms.

What is ADD / ADHD?

We all know kids who can’t sit still, who never seem to listen, who don’t follow instructions no matter how clearly you present them, or who blurt out inappropriate comments at inappropriate times. Sometimes these children are labeled as troublemakers, or criticized for being lazy and undisciplined. However, they may have ADD/ADHD.

Attention deficit hyperactivity disorder (ADHD) is a disorder that appears in early childhood. You may know it by the name attention deficit disorder, or ADD. ADD/ADHD makes it difficult for people to inhibit their spontaneous responses—responses that can involve everything from movement to speech to attentiveness.

Is it normal kid behavior or is it ADHD?

The signs and symptoms of ADD/ADHD typically appear before the age of seven. However, it can be difficult to distinguish between attention deficit disorder and normal “kid behavior.”

If you spot just a few signs, or the symptoms appear only in some situations, it’s probably not ADD/ADHD. On the other hand, if your child shows a number of ADD/ADHD signs and symptoms that are present across all situations—at home, at school, and at play—it’s time to take a closer look.

Once you understand the issues your child is struggling with, such as forgetfulness or difficulty paying attention in school, you can work together to find creative solutions and capitalize on strengths.

Myths about Attention Deficit Disorder:

Myth #1: All kids with ADD/ADHD are hyperactive.
Fact: Some children with ADD/ADHD are hyperactive, but many others with attention problems are not. Children with ADD/ADHD who are inattentive, but not overly active, may appear to be spacey and unmotivated.

Myth #2: Kids with ADD/ADHD can never pay attention.
Fact: Children with ADD/ADHD are often able to concentrate on activities they enjoy. But no matter how hard they try, they have trouble maintaining focus when the task at hand is boring or repetitive.

Myth #3: Kids with ADD/ADHD could behave better if they wanted to.
Fact: Children with ADD/ADHD may do their best to be good, but still be unable to sit still, stay quiet, or pay attention. They may appear disobedient, but that doesn’t mean they’re acting out on purpose.
Myths about Attention Deficit Disorder:

**Myth #4:** Kids will eventually grow out of ADD/ADHD.
**Fact:** ADD/ADHD often continues into adulthood, so don’t wait for your child to outgrow the problem. Treatment can help your child learn to manage and minimize the symptoms.

**Myth #5:** Medication is the best treatment option for ADD/ADHD.
**Fact:** Medication is often prescribed for attention deficit disorder, but it might not be the best option for your child. Effective treatment for ADD/ADHD also includes education, behavior therapy, support at home and school, exercise, and proper nutrition.

The primary characteristics of ADD / ADHD

When many people think of attention deficit disorder, they picture an out-of-control kid in constant motion, bouncing off the walls and disrupting everyone around. But this is not the only possible picture. Some children with ADD/ADHD are hyperactive, while others sit quietly—with their attention miles away. Some put too much focus on a task and have trouble shifting it to something else. Others are only mildly inattentive, but overly impulsive.

The three primary characteristics of ADD / ADHD

Which one of these children may have ADD/ADHD?

A. The hyperactive boy who talks nonstop and can’t sit still.
B. The quiet dreamer who sits at her desk and stares off into space.
C. Both A and B

The correct answer is “C.”

The three primary characteristics of ADD/ADHD are inattention, hyperactivity, and impulsivity. The signs and symptoms a child with attention deficit disorder has depends on which characteristics predominate.

Children with ADD/ADHD may be:

- Inattentive, but not hyperactive or impulsive.
- Hyperactive and impulsive, but able to pay attention.
- Inattentive, hyperactive, and impulsive (the most common form of ADD/ADHD).

Children who only have inattentive symptoms of ADD/ADHD are often overlooked, since they’re not disruptive. However, the symptoms of inattention have consequences: getting in hot water with parents and teachers for not following directions; underperforming in school; or clashing with other kids over not playing by the rules.

Spotting ADD / ADHD at different ages
Because we expect very young children to be easily distractible and hyperactive, it’s the impulsive behaviors—the dangerous climb, the blurted insult—that often stand out in preschoolers with ADD/ADHD.

By age four or five, though, most children have learned how to pay attention to others, to sit quietly when instructed to, and not to say everything that pops into their heads. So by the time children reach school age, those with ADD/ADHD stand out in all three behaviors: inattentiveness, hyperactivity, and impulsivity.

**Inattentive signs and symptoms of ADD/ADHD**

It isn’t that children with ADD/ADHD can’t pay attention: when they’re doing things they enjoy or hearing about topics in which they’re interested, they have no trouble focusing and staying on task. But when the task is repetitive or boring, they quickly tune out.

Staying on track is another common problem. Children with ADD/ADHD often bounce from task to task without completing any of them, or skip necessary steps in procedures. Organizing their schoolwork and their time is harder for them than it is for most children.

Kids with ADD/ADHD also have trouble concentrating if there are things going on around them; they usually need a calm, quiet environment in order to stay focused.

**Symptoms of inattention in children:**

- Doesn’t pay attention to details
- Makes careless mistakes
- Has trouble staying focused; is easily distracted
- Appears not to listen when spoken to
- Has difficulty remembering things and following instructions
- Has trouble staying organized, planning ahead, and finishing projects
- Gets bored with a task before it’s completed
- Frequently loses or misplaces homework, books, toys, or other items

**Hyperactive signs and symptoms of ADD/ADHD**

The most obvious sign of ADD/ADHD is hyperactivity. While many children are naturally quite active, kids with hyperactive symptoms of attention deficit disorder are always moving.

They may try to do several things at once, bouncing around from one activity to the next. Even when forced to sit still which can be very difficult for them their foot is tapping, their leg is shaking, or their fingers are drumming.

**Symptoms of hyperactivity in children:**

- Constantly fidgets and squirms
- Often leaves his or her seat in situations where sitting quietly is expected
- Moves around constantly, often runs or climbs inappropriately
- Talks excessively
- Has difficulty playing quietly or relaxing
- Is always “on the go,” as if driven by a motor
- May have a quick temper or a “short fuse”
Impulsive signs and symptoms of ADD/ADHD

The impulsivity of children with ADD/ADHD can cause problems with self-control. Because they censor themselves less than other kids do, they’ll interrupt conversations, invade other people’s space, ask irrelevant questions in class, make tactless observations, and ask overly personal questions.

Instructions like “Be patient” and “Just wait a little while” are twice as hard for children with ADD/ADHD to follow as they are for other youngsters.

Children with impulsive signs and symptoms of ADD/ADHD also tend to be moody and to overreact emotionally. As a result, others may start to view the child as disrespectful, weird, or needy.

Symptoms of impulsivity in children:

- Acts without thinking
- Blurs out answers in class without waiting to be called on or hear the whole question
- Can’t wait for his or her turn in line or in games
- Says the wrong thing at the wrong time
- Often interrupts others
- Intrudes on other people’s conversations or games
- Inability to keep powerful emotions in check, resulting in angry outbursts or temper tantrums
- Guesses, rather than taking time to solve a problem

Is it really ADD / ADHD?

Just because a child has symptoms of inattention, impulsivity, or hyperactivity does not mean that he or she has ADD or ADHD. Certain medical conditions, psychological disorders, and stressful life events can cause symptoms that look like ADD / ADHD.

Before an accurate diagnosis of ADD / ADHD can be made, it is important that you see a mental health professional to explore and rule out the following possibilities:

- **Learning disabilities** or problems with reading, writing, motor skills, or language.
- **Major life events** or traumatic experiences (e.g. a recent move, death of a loved one, bullying, divorce).
- **Psychological disorders** including anxiety, depression, and bipolar disorder.
- **Behavioral disorders** such as conduct disorder and oppositional defiant disorder.
- **Medical conditions**, including thyroid problems, neurological conditions, epilepsy, and sleep disorders.

A learning disability may be mistaken for ADHD

Sometimes, kids who are having trouble in school are incorrectly diagnosed with ADD/ADHD, when what they really have is a learning disability. Furthermore, many kids struggle with both ADD/ADHD and a learning disability.

Positive effects of ADD / ADHD in children
In addition to the challenges, there are also positive traits associated with people who have attention deficit disorder:

- **Creativity** – Children who have ADD/ADHD can be marvelously creative and imaginative. The child who daydreams and has ten different thoughts at once can become a master problem-solver, a fountain of ideas, or an inventive artist. Children with ADD/ADHD may be easily distracted, but sometimes they notice what others don’t see.

- **Flexibility** – Because children with ADD/ADHD consider a lot of options at once, they don’t become set on one alternative early on and are more open to different ideas.

- **Enthusiasm and spontaneity** – Children with ADD/ADHD are rarely boring! They’re interested in a lot of different things and have lively personalities. In short, if they’re not exasperating you (and sometimes even when they are), they’re a lot of fun to be with.

- **Energy and drive** – When kids with ADD/ADHD are motivated, they work or play hard and strive to succeed. It actually may be difficult to distract them from a task that interests them, especially if the activity is interactive or hands-on.

Keep in mind, too, that ADD/ADHD has nothing to do with intelligence or talent. Many children with ADD/ADHD are intellectually or artistically gifted.

**Helping a child with ADD / ADHD**

Whether or not a child’s symptoms of inattention, hyperactivity, and impulsivity are due to ADD/ADHD, they can cause many problems if left untreated. Children who can’t focus and control themselves may struggle in school, get into frequent trouble, and find it hard to get along with others or make friends. These frustrations and difficulties can lead to low self-esteem as well as friction and stress for the whole family.

But treatment can make a dramatic difference in a child’s symptoms. With the right support, a child can get on track for success in all areas of life.

Effective treatment for childhood ADD/ADHD involves behavioral therapy, parent education and training, social support, and assistance at school. Medication may also be used, however, it should never be the sole attention deficit disorder treatment.

**School tips for children with ADD / ADHD**

ADD/ADHD, obviously, gets in the way of learning. You can’t absorb information or get your work done if you’re running around the classroom or zoning out on what you’re supposed to be reading or listening to.

Think of what the school setting requires children to do: Sit still. Listen quietly. Pay attention. Follow instructions. Concentrate. These are the very things kids with ADD/ADHD have a hard time doing—not because they aren’t willing, but because their brains won’t let them.

But that doesn’t mean kids with ADD/ADHD can’t succeed at school. There are many things both parents and teachers can do to help children with ADD/ADHD thrive in the classroom. It starts with evaluating each child’s individual weaknesses and strengths, then coming up with creative strategies for helping the child focus, stay on task, and learn to his or her full capability.

From: Helpguide.org 2013
The Anxious Child

All children experience anxiety. Anxiety in children is expected and normal at specific times in development. For example, from approximately age 8 months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other persons with whom they are close. Young children may have short-lived fears, such as fear of the dark, storms, animals, or a fear of strangers. Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Parents should not dismiss a child’s fears. Because anxious children may also be quiet, compliant and eager to please, their difficulties may be missed. Parents should be alert to the signs of severe anxiety so they can intervene early to prevent complications. There are different types of anxiety in children.

Symptoms of separation anxiety include:

- constant thoughts and intense fears about the safety of parents and caretakers
- refusing to go to school
- frequent stomachaches and other physical complaints
- extreme worries about sleeping away from home
- being overly clingy
- panic or tantrums at times of separation from parents
- trouble sleeping or nightmares

Symptoms of phobia include:

- extreme fear about a specific thing or situation (ex. dogs, insects, or needles)
- the fears cause significant distress and interfere with usual activities

Symptoms of social anxiety include:

- fears of meeting or talking to people
- avoidance of social situations
- few friends outside the family

Other symptoms of anxious children include:

- many worries about things before they happen
- constant worries or concerns about family, school, friends, or activities
- repetitive, unwanted thoughts (obsessions) or actions (compulsions)
• fears of embarrassment or making mistakes
• low self-esteem and lack of self-confidence

Severe anxiety problems in children can be treated. Early treatment can prevent future difficulties, such as loss of friendships, failure to reach social and academic potential, and feelings of low self-esteem. Treatments may include a combination of the following: individual psychotherapy, family therapy, medications, behavioral treatments, and consultation to the school.

If anxieties become severe and begin to interfere with the child’s usual activities, (for example separating from parents, attending school and making friends) parents should consider seeking an evaluation from a qualified mental health professional or a child and adolescent psychiatrist.

From: AACAP Facts for Families 2013
**Bipolar Disorder In Children And Teens**

Bipolar disorder (formerly called manic depressive illness) is an illness of the brain that causes extreme changes in a person’s mood, energy, thinking, and behavior. Children with bipolar disorder have periods (or episodes) of mania and depression.

**Manic Episodes:** An episode of mania includes a period where someone’s mood has changed and it is elevated (overly happy), expansive, or very irritable and the person also has increased energy at the same time.

Other manic symptoms may include:

- Unrealistic highs in self-esteem - for example, a child or adolescent who feels all-powerful or like a superhero with special powers
- Great increase in energy
- Decreased need for sleep such as being able to go with little or no sleep for days without feeling tired
- Increase in talking - when the child or adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- Distractibility - the child's attention moves constantly from one thing to the next
- Thinking more quickly - for example, thoughts are on “fast forward”
- Repeated high risk-taking behavior, such as abusing alcohol and drugs, reckless driving, or sexual promiscuity

**Depressive Episodes:** People who have bipolar disorder may also experience periods of depression. An episode of depression includes low, depressed, or irritable mood.

Other symptoms of a depressive episode may include:

- Decreased enjoyment in favorite activities
- Low energy level or fatigue
- Major changes in sleeping patterns, such as oversleeping or difficulty falling asleep
- Poor concentration
- Complaints of boredom
• Major change in eating habits such as decreased appetite, failure to gain weight or overeating
• Frequent complaints of physical illnesses such as headaches or stomach aches
• Thoughts of death or suicide

Some of these signs are similar to those that occur in children and adolescents with other problems such as drug abuse, attention-deficit hyperactivity disorder, major depressive disorder, disruptive mood dysregulation disorder, or even schizophrenia.

Bipolar disorder can begin in childhood or during the teenage years. The illness can affect anyone. However, if one or both parents have bipolar disorder, the chances are greater that their children may develop the disorder.

The diagnosis of bipolar disorder in children and teens is complex and involves careful observation over an extended period of time. A comprehensive evaluation by a child and adolescent psychiatrist or trained mental health professional can help identify bipolar disorder and is the first step to starting treatment. Children and teenagers with bipolar disorder can be effectively treated. Treatment for bipolar disorder usually includes education of the patient and the family about the illness, mood stabilizing medications such as lithium, or atypical antipsychotics, and psychotherapy. Medications often reduce the number and severity of manic episodes, and may also help to prevent depression. Psychotherapy helps the child understand himself or herself, adapt to stresses, rebuild self-esteem, and improve relationships.

From: AACAP Facts for Families 2015
Posttraumatic Stress Disorder (PTSD)

All children and adolescents experience stressful events which can affect them both emotionally and physically. Their reactions to stress are usually brief, and they recover without further problems. A child or adolescent who experiences a catastrophic event may develop ongoing difficulties known as posttraumatic stress disorder (PTSD). The stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred (ex. they may be the victim or a witness of physical abuse, sexual abuse, violence in the home or in the community, automobile accidents, natural disasters (such as flood, fire, earthquakes), and being diagnosed with a life threatening illness). A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his/her relationship to the victim(s).

Following the trauma, children may initially show agitated or confused behavior. They also may show intense fear, helplessness, anger, sadness, horror or denial. Children who experience repeated trauma may develop a kind of emotional numbing to deaden or block the pain and trauma. This is called dissociation. Children with PTSD avoid situations or places that remind them of the trauma. They may also become less responsive emotionally, depressed, withdrawn, and more detached from their feelings.

A child with PTSD may also re-experience the traumatic event by:

- having frequent memories of the event, or in young children, play in which some or all of the trauma is repeated over and over
- having upsetting and frightening dreams
- acting or feeling like the experience is happening again
- developing repeated physical or emotional symptoms when the child is reminded of the event

Children with PTSD may also show the following symptoms:

- worry about dying at an early age
- losing interest in activities
- having physical symptoms such as headaches and stomachaches
- showing more sudden and extreme emotional reactions
- having problems falling or staying asleep
- showing irritability or angry outbursts
- having problems concentrating
- acting younger than their age (for example, clingy or whiny behavior, thumbsucking)
- showing increased alertness to the environment
- repeating behavior that reminds them of the trauma

The symptoms of PTSD may last from several months to many years. The best approach is prevention of the trauma. Once the trauma has occurred, however, early intervention is essential. Support from parents, school, and peers is important. Emphasis needs to be placed upon establishing a feeling of safety. Psychotherapy (individual, group, or family) which allows the child to speak, draw, play, or write about the event is helpful. Behavior modification techniques and cognitive therapy may help reduce fears and worries. Medication may also be useful to deal with agitation, anxiety, or depression.

With the sensitivity and support of families and professionals, youngsters with PTSD can learn to cope with the memories of the trauma and go on to lead healthy and productive lives.

From: AACAP Facts for Families 2014
Child Sexual Abuse

Child sexual abuse has been reported up to 80,000 times a year, but the number of unreported instances is far greater, because the children are afraid to tell anyone what has happened, and the legal process of reporting can be difficult. The problem should be identified, the abuse stopped, and the child should receive professional help. The long-term emotional damage of sexual abuse can be devastating to the child.

Child sexual abuse can take place within the family, by a parent, step-parent, sibling or other relative; or outside the home, for example, by a friend, neighbor, child care provider, teacher, or stranger. When sexual abuse has occurred, a child can develop many distressing feelings, thoughts and behaviors.

No child is prepared to cope with repeated sexual stimulation. Even a two or three year old, who cannot know that sexual activity is wrong, will develop problems resulting from problems coping with the overstimulation.

The child of five years or older who knows and cares for the abuser becomes trapped between affection or loyalty for the person, and the sense that the sexual activities are terribly wrong. If the child tries to break away from the sexual relationship, the abuser may threaten the child with violence or loss of love. When sexual abuse occurs within the family, the child may fear the anger, jealousy or shame of other family members, or be afraid the family will break up if the secret is told.

A child who is the victim of prolonged sexual abuse usually develops low self-esteem, a feeling of worthlessness and an abnormal or distorted view of sex. The child may become withdrawn and mistrustful of adults, and can become suicidal.

Some children who have been sexually abused have difficulty relating to others except on sexual terms. Some sexually abused children become child abusers or prostitutes, or have other serious problems when they reach adulthood.

Often there are no obvious external signs of child sexual abuse. Some signs can only be detected on physical exam by a physician. Sexual abuse can also include noncontact abuse, such as exposure, voyeurism, and child pornography.

Sexually abused children may also develop the following:

- unusual interest in or avoidance of all things of a sexual nature
- sleep problems or nightmares
- depression or withdrawal from friends or family
- seductiveness
statements that their bodies are dirty or damaged, or fear that there is something wrong with them in the genital area
refusal to go to school
delinquency/conduct problems
secretiveness
aspects of sexual molestation in drawings, games, fantasies
unusual aggressiveness, or
suicidal behavior

Child sexual abusers can make the child very worried about telling, and only when a special effort has helped the child to feel safe, can the child talk freely. If a child says that he or she has been molested, parents should try to remain calm and reassure the child that what happened was not their fault. Parents should seek a medical examination and psychiatric consultation.

Parents can prevent or lessen the chance of sexual abuse by:

- Telling children that if someone tries to touch your body and do things that make you feel funny, say NO to that person and tell me right away
- Teaching children that respect does not mean blind obedience to adults and to authority. For example, don't tell children to 'always do everything the teacher or baby-sitter tells you to do'

Sexually abused children and their families need immediate professional evaluation and treatment.

From: AACAP Facts for Families 2014
Children With Learning Disorders

Parents are often worried when their child has learning problems in school. There are many reasons for school failure, but a common one is a specific learning disorder. Children with learning disorders can have intelligence in the normal range, but the specific learning disorder may make teachers and parents concerned about their general intelligence. Often, these children may try very hard to follow instructions, concentrate, and "be good" at home and in school. Yet, despite this effort, he or she is not mastering school tasks and falls behind. Learning disorders affect at least 1 in 10 schoolchildren.

It is believed that learning disorders are caused by a difficulty with the nervous system that affects receiving, processing, or communicating information. They may also run in families. Some children with learning disorders are also hyperactive; unable to sit still, easily distracted, and have a short attention span.

Child and adolescent psychiatrists are aware that some of the long range consequence of learning disorders can be lessened with early intervention. However, if not detected and treated early, they can have a "snowballing" effect. For instance, a child who does not learn addition in elementary school cannot understand algebra in high school. The child, trying very hard to learn, becomes more and more frustrated, and develops emotional problems such as low self-esteem in the face of repeated failure. Some children with learning disorders misbehave in school because they would rather be seen as "bad" than "stupid."

Frequent signals of learning disorders, that parents should watch for in their child include the following:

- difficulty understanding and following instructions.
- trouble remembering what someone just told him or her.
- fails to master reading, spelling, writing, and/or math skills, and thus fails in school.
- difficulty distinguishing right from left; difficulty identifying words or a tendency to reverse letters, words, or numbers; (for example, confusing 25 with 52, "b" with "d," or "on" with "no").
- lacks coordination in walking, sports, or small activities such as holding a pencil or tying a shoelace.
- easily loses or misplaces homework, schoolbooks, or other items.
- difficulty understanding the concept of time; is confused by "yesterday, today, tomorrow."
Generally, an important first step is to understand the child's learning difficulties and consider how they will affect their communication, self-help skill, willingness to accept discipline, impact on play, and capacity for independence. Such problems deserve a comprehensive evaluation by an expert who can assess all of the different issues affecting the child. A child and adolescent psychiatrist can help coordinate the evaluation, and work with school professionals and others to have the evaluation and educational testing done to clarify if a learning disorder exists. This includes talking with the child and family, evaluating their situation, reviewing the educational testing, and consulting with the school. The child and adolescent psychiatrist will then make recommendations on appropriate school placement, the need for special help such as special educational services or speech-language therapy and help parents assist their child in maximizing his or her learning potential. Sometimes individual or family psychotherapy will be recommended. Medication may be prescribed for hyperactivity or distractibility. Parents need to consider the delicate balance between providing too much or too little assistance to their child to help them meet their educational goals. It is important to strengthen the child's self-confidence, which is vital for healthy development, and also help parents and other family members better understand and cope with the realities of living with a child with learning disorders.

From: AACAP Facts for Families 2013
The Depressed Child

Not only adults become depressed. Children and teenagers also may have depression, as well. The good news is that depression is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent's ability to function.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their youngsters.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Hopelessness
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self-esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self-destructive behavior
A child who used to play often with friends may now spend most of the time alone and without interests - things that were once, fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for completing suicide. Depressed adolescents may abuse alcohol or other drugs as a way of trying to feel better.

Children and adolescents who cause trouble at home or at school may also be suffering from depression. Because the youngster may not always seem sad, parents and teachers may not realize that troublesome behavior is a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

Early diagnosis and treatment are essential for depressed children. Depression is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. For example, cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are forms of individual therapy shown to be effective in treating depression. Treatment may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a qualified mental health professional, who can diagnose and treat depression in children and teenagers.

From AACAP Facts for Families 2013
Teen Suicide

Suicides among young people continue to be a serious problem. Each year in the U.S., thousands of teenagers complete suicide. Suicide is the third leading cause of death for 15-to-24-year-olds, and the sixth leading cause of death for 5-to-14-year-olds.

Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up. For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. For some teens, suicide may appear to be a solution to their problems and stress.

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. When parents are in doubt whether their child has a serious problem, a psychiatric examination can be very helpful.

Many of the signs and symptoms of suicidal feelings are similar to those of depression.

Parents should be aware of the following signs of adolescents who may try to kill themselves:

- change in eating and sleeping habits
- withdrawal from friends, family, and regular activities
- violent actions, rebellious behavior, or running away
- drug and alcohol use
- unusual neglect of personal appearance
- marked personality change
- persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- loss of interest in pleasurable activities
- not tolerating praise or rewards

A teenager who is planning to complete suicide may also:

- complain of being a bad person or feeling rotten inside
- give verbal hints with statements such as: I won’t be a problem for you much longer, Nothing matters, It’s no use, and I won’t see you again
• put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.

• become suddenly cheerful after a period of depression

• have signs of psychosis (hallucinations or bizarre thoughts)

If a child or adolescent says, I want to kill myself, or I'm going to commit suicide, always take the statement seriously and immediately seek assistance from a qualified mental health professional. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than putting thoughts in the child's head, such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems.

If one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help from a physician or a qualified mental health professional. With support from family and appropriate treatment, children and teenagers who are suicidal can heal and return to a more healthy path of development.

From: AACAP Facts for Families 2013
Self Injury

Why do people self-injure? :

Self-injury is a problem for an estimated 2 to 3 million people in the United States. The majority are between 13 and 30 years of age.

People who self-harm are not usually suicidal. They inflict injuries upon themselves as a result of trauma or severe emotional disturbances. Their injuries may vary from minor cuts that heal quickly to severe wounds that leave permanent scars.

Self-injury usually indicates that somewhere during development the person did not learn good ways of coping with overwhelming feelings or stress. Positive coping skills can be learned at any point in time but it can take years to learn new and healthier coping mechanisms.

Cutting seems to be the most common type of self-injury. Razors, utility knives, scissors or needles can be used to make repetitive cuts on various parts of the body. Some people burn themselves with lighters or rub their arms or legs raw with pencil erasers. Some pull out their own hair on their head, eyelashes or eyebrows. Others may swallow or insert sharp objects. The behavior is usually done secretly and privately. It may be planned and ritualistically performed or it may occur impulsively and without forethought.

Many people who self-harm state they do this because they feel numb and cutting helps them to “feel alive” or they get a “sense of control” over their overwhelming feelings of despair. Most agree it is triggered by stress and anxiety.

Often teens who hurt themselves are engaging in other forms of self-destructive behavior; such as reckless driving, shoplifting, substance abuse, sexual promiscuity, eating disorders.

Some Common Factors of Self Injury:

- Age of onset between 10 – 16 years old
- There was a major change in the teen’s life – parent’s divorce, death etc.
- There is a history of family violence, abuse or sexual abuse
- Intense feelings of fear, hurt, anger, rejection or abandonment
- Feelings of loss and or need for control

Some Common Reasons Why People Cut Themselves

1. They find it soothing:
   - To feel the pain on the outside instead of the inside (physical vs. emotional pain)
   - To cope with feelings
   - To express anger towards themselves
   - To feel alive and real

2. A way of communicating what they can’t say with words:
   - To tell people they need help
   - To get people attention
   - To tell people they should be in the hospital
3. An attempt to get people to react to their actions:
   - To get people to care for them
   - To make other people feel guilty
   - To drive people away
   - To get away from stress and responsibility
   - To gain a feeling of control over situations or people

4. Triggering Events Reported by Teens Who Self Injure
   - Being rejected by someone who is important to them
   - Being blamed for something over which they had no control
   - Feeling inadequate
   - Being wrong in some way

Interventions:

The goal of treatment is to provide alternative ways to communicate, self soothe and cope. It is essential to maintain an empathic, non-judgmental approach and assist the teen with:

1. Journaling –writing about feelings/fear
2. Art Therapy –drawing about feelings
3. Relaxation Techniques
4. Visualizations
5. Identifying cognitive distortions (negative self-talk)
6. Utilizing positive self-talk
7. Meditation
8. Physical exercise
9. Medication
**Aspergers Disorder**

Asperger’s Disorder was a term previously used to describe one of the pervasive developmental disorders. Children and adolescents diagnosed with Asperger’s Disorder had problems in the development of social skills, often experiencing difficulty interacting with peers. They also tended to display unusual, eccentric or repetitive behaviors.

Asperger’s Disorder was sometimes referred to “high functioning autism.” This is because many of the children diagnosed with the disorder had average or above average intelligence and near normal development of speech and language.

In 2013, the diagnosis of Asperger’s Disorder was removed from the newly revised Diagnostic and Statistical Manual (DSM-5). Children previously diagnosed with Asperger’s Disorder were included in the broader category of Autism Spectrum Disorder. The new definition covers children who display problems with communication and social interactions. For example, they may respond inappropriately in conversations or misread non-verbal cues. They may also have difficulty building friendships appropriate to their age. In addition, children with Autism Spectrum Disorder may be overly dependent on routines, unusually sensitive to changes in their environment, or intensely focused on specific items.

The decision to combine the categories grew out of research demonstrating that Asperger’s was not actually a separate “disorder.” Instead, children previously diagnosed with Asperger’s were better and more accurately described as having a disorder “on the autism spectrum.” Researchers also hope that the improved accuracy and consistency of the diagnosis will lead to enhanced research on the cause, treatment and ultimately prevention of Autism Spectrum Disorders.

Child and adolescent psychiatrists have the training and expertise to evaluate Autism Spectrum Disorders. They can also work with families to design appropriate and effective treatment programs. Currently, the most effective treatment for Autism Spectrum Disorder involves a combination of psychotherapy, special education, behavior modification, and support for families. Some children will also benefit from treatment with medication.

The outcome for children with Autism Spectrum Disorders is related to intellectual functioning and communication skills. Children with normal or above normal intelligence and normal or near normal speech and language often finish high school and attend college. Although difficulties with social interaction and awareness may persist, they can often do well in specific work settings and develop lasting relationships with family and friends. Access to ongoing counseling, support and assistance increases the likelihood of a positive and successful outcome.

From: AACAP Facts for Families 2013
Module 11: Psychiatric Medication

Psychiatric Medication For Children And Adolescents Part I –

How Medications Are Used

Medication can be an effective part of the treatment for several psychiatric disorders of childhood and adolescence. A doctor's recommendation to use medication often raises many concerns and questions in both the parents and the youngster. The physician who recommends medication should be experienced in treating psychiatric illnesses in children and adolescents. He or she should fully explain the reasons for medication use, what benefits the medication should provide, as well as possible risks, adverse effects and other treatment alternatives.

*Psychiatric medication should not be used alone.* The use of medication should be based on a comprehensive psychiatric evaluation and be one part of a comprehensive treatment plan.

Before recommending any medication, the child and adolescent psychiatrist interviews the youngster and makes a thorough diagnostic evaluation. In some cases, the evaluation may include a physical exam, psychological testing, laboratory tests, other medical tests such as an electrocardiogram (EKG) or electroencephalogram (EEG), and consultation with other medical specialists.

Medications which have beneficial effects may also have side effects, ranging from just annoying to very serious. As each youngster is different and may have individual reactions to medication, close contact with the treating physician is recommended. Do not stop or change a medication without speaking to the doctor. Psychiatric medication should be used as part of a comprehensive plan of treatment, with ongoing medical assessment and, in most cases, individual and/or family psychotherapy. When prescribed appropriately by a psychiatrist (preferably a child and adolescent psychiatrist), and taken as prescribed, medication may reduce or eliminate troubling symptoms and improve the daily functioning of children and adolescents with psychiatric disorders.

Medication may be prescribed for psychiatric symptoms and disorders, including, but not limited to:

1. **Bedwetting**-if it persists regularly after age 5 and causes serious problems in low self-esteem and social interaction.

2. **Anxiety** (school refusal, phobias, separation or social fears, generalized anxiety, or posttraumatic stress disorders)-if it keeps the youngster from normal daily activities.

3. **Attention deficit hyperactivity disorder (ADHD)**-marked by a short attention span, trouble concentrating and restlessness. The child is easily upset and frustrated, often has problems getting along with family and friends, and usually has trouble in school.
4. **Obsessive-compulsive disorder (OCD)** - recurring obsessions (troublesome and intrusive thoughts) and/or compulsions (repetitive behaviors or rituals such as handwashing, counting, or checking to see if doors are locked) which are often seen as senseless but that interfere with a youngster's daily functioning.

5. **Depression** - lasting feelings of sadness, helplessness, hopelessness, unworthiness, guilt, inability to feel pleasure, a decline in school work and changes in sleeping and eating habits.

6. **Eating disorder** - either self-starvation (anorexia nervosa) or binge eating and vomiting (bulimia), or a combination of the two.

7. **Bipolar (manic-depressive) disorder** - periods of depression alternating with manic periods, which may include irritability, "high" or happy mood, excessive energy, behavior problems, staying up late at night, and grand plans.

8. **Psychosis** - symptoms include irrational beliefs, paranoia, hallucinations (seeing things or hearing sounds that don't exist) social withdrawal, clinging, strange behavior, extreme stubbornness, persistent rituals, and deterioration of personal habits. Psychosis may be seen in developmental disorders, severe depression, schizoaffective disorder, schizophrenia, and some forms of substance abuse.

9. **Autism** - (or other pervasive developmental disorder such as Asperger's Syndrome) - characterized by severe deficits in social interactions, language, and/or thinking or ability to learn, and usually diagnosed in early childhood.

10. **Severe aggression** - which may include assaultiveness, excessive property damage, or prolonged self-abuse, such as head-banging or cutting.

11. **Sleep problems** - symptoms can include insomnia, night terrors, sleep walking, fear of separation, or anxiety.
Psychiatric Medication For Children And Adolescents Part 2 - Types Of Medications

Psychiatric medications can be an effective part of the treatment for psychiatric disorders of childhood and adolescence. In recent years there have been an increasing number of new and different psychiatric medications used with children and adolescents. Research studies are underway to establish more clearly which medications are most helpful for specific disorders and presenting problems. Clinical practice and experience, as well as research studies, help physicians determine which medications are most effective for a particular child. Before recommending any medication, the prescriber should conduct a comprehensive psychiatric diagnostic evaluation of the child or adolescent. Parents will be informed about known risks and/or Food and Drug Administration (FDA) warnings before a child starts any psychiatric medication as well as whether the medication is being prescribed on-label or off-label (whether the medication has been approved for children and adolescents for the condition for which it is being prescribed). When prescribed appropriately by an experienced psychiatrist (preferably a child and adolescent psychiatrist) and taken as directed, medication may reduce or eliminate troubling symptoms and improve daily functioning of children and adolescents with psychiatric disorders.

ADHD Medications: Stimulant and non-stimulant medications may be helpful as part of the treatment for attention deficit hyperactive disorder (ADHD). They come in several different forms, such as pills, patches, and liquid forms. Examples of stimulants include: Dextroamphetamine (Dexedrine, Adderall, Vyanse, Procentra) and Methylphenidate (Ritalin, Metadate, Concerta, Daytrana, Focalin). Non-stimulant medications include Atomoxetine (Strattera), Guanfacine (Tenex, Intuniv) and Clonidine (Kapvay).

Antidepressant Medications: Antidepressant medications may be helpful in the treatment of depression, school phobias, panic attacks, and other anxiety disorders, bedwetting, eating disorders, obsessive-compulsive disorder, posttraumatic stress disorder, and attention deficit hyperactive disorder. There are several types of antidepressant medications. Examples of serotonin reuptake inhibitors (SRI's) include: Fluoxetine (Prozac), Sertraline (Zoloft), Paroxetine (Paxil), Fluvoxamine (Luvox), Venlafaxine (Effexor), Desvenlafaxine (Pristiq), Citalopram (Celexa) and Escitalopram (Lexapro). Examples of serotonin norepinephrine reuptake inhibitors (SNRIs) include Venlafaxine (Effexor, Pristiq), and Duloxetine (Cymbalta). Examples of atypical antidepressants include: Bupropion (Wellbutrin), Nefazodone (Serzone), Trazodone (Desyrel), and Mirtazapine (Remeron). Examples of tricyclic antidepressants (TCA's) include: Amitriptyline (Elavil), Clomipramine (Anafranil), Imipramine (Tofranil), and Nortriptyline (Pamelor). Examples of monoamine oxidase inhibitors (MAOI's) include: Phenerazine (Nardil), and Tranylcypromine (Parnate).

Antipsychotic Medications: These medications can be helpful in controlling psychotic symptoms (delusions, hallucinations) or disorganized thinking. These medications may also help muscle
twitches ("tics") or verbal outbursts as seen in Tourette's Syndrome. They are occasionally used to treat severe anxiety and may help in reducing very aggressive behavior. Examples of first generation antipsychotic medications include: Chlorpromazine (Thorazine), Thioridazine (Mellaril), Fluphenazine (Prolixin), Trifluoperazine (Stelazine), Thiothixene (Navane), and Haloperidol (Haldol). Second generation antipsychotic medications (also known as atypical or novel) include: Clozapine (Clozaril), Risperidone (Risperdal), Paliperidon (Invega), Quetiapine (Seroquel), Olanzapine (Zyprexa), Ziprasidone (Geodon) and Aripiprazole (Abilify) Iloperidone (Fanapt), Lurasidone (Latuda), and Asenapine (Saphris).

**Mood Stabilizers and Anticonvulsant Medications:** These medications may be helpful in treating bipolar disorder, severe mood symptoms and mood swings (manic and depressive), aggressive behavior and impulse control disorders. Examples include: Lithium (lithium carbonate, Eskalith), Valproic Acid (Depakote, Depakene), Carbamazepine (Tegretol), Lamotrigin (Lamictil), and Oxcarbazepine (Trileptal).

**Anti-anxiety Medications:** Selective serotonin reuptake inhibitors (SSRIs) are used to treat anxiety in children and adolescents and are described above in the antidepressant section. There are also other medications used to treat anxiety in adults. These medications are rarely used in children and adolescents, but may be helpful for brief treatment of severe anxiety. These include: benzodiazepines; antihistamines; and atypicals. Examples of benzodiazepines include: Alprazolam (Xanax), lorazepam (Ativan), Diazepam (Valium), and Clonazepam (Klonopin). Examples of antihistamines include: Diphenhydramine (Benadryl), and Hydroxyzine (Vistaril). Examples of atypical anti-anxiety medications include: Buspirone (BuSpar), and Zolpidem (Ambien).

**Sleep Medications:** A variety of medications may be used for a short period to help with sleep problems. Examples include: Trazodone (Desyrel), Zolpidem (Ambien), Zaleplon (Sonata), Eszopiclone (Lunesta), and Diphenhydramine (Benadryl).

**Miscellaneous Medications:** Other medications are also being used to treat a variety of symptoms. For example: clonidine (Catapres, Kapvay) and guanfacine (Tenex, Intuniv) may be used to treat the severe impulsiveness in some children with ADHD.

**Long-Acting Medications:** Many newer medications are taken once a day. These medications have the designation SR (sustained release), ER or XR (extended release), CR (controlled release) or LA (long-acting).

From: AACAP Facts for Families 2102
Module 12: Child Developmental Stages, Effects of Trauma and Age Specific Competencies

It is essential that nursing staff are aware of the different behaviors that are expected to be present at different stages in children’s lives. This helps us to understand the child and his or her needs and to have realistic expectations for their behaviors.

Three to Seven years:

The child’s major task is to develop a sense of reality that is distinct from fantasy.
- A primary concern of the child is sex differences, and it includes interest in pregnancy and birth.
- This is a period of high creativity
- There is a strong need to make distinctions between what is real and what is imagined

Seven to Twelve Years:

The child’s task is to develop a sense of values to guide decision making and interests, as well as capabilities that lay the foundation for future decisions.
- The needs of the child revolve around tasks, hobbies and skill-oriented activities.
- Friendships with peers, especially of the same sex are important.
- Competition is heightened, as is preoccupation with performance.

Twelve to Eighteen years:

The child has two main tasks:
- To create a personal identity based on the integration of values and a sense of self. The adolescent must establish an identity in relation to society, the opposite sex, ideas, the future, possible vocations, and the universe.
- The establishment of independence. This can create tension with the family over limits, values, responsibilities, friends and plans for the future.

Effects of Mental Illness and Trauma on Child Development

Many of the children you will care for at Shodair have experienced trauma or have a mental illness that can interfere with achieving the normal developmental milestones outlined in this module. Abuse and neglect or mental illness can cause profound changes and problems in a child’s growth or development:

Physical
- The children may show generalized physical developmental delays; may lack the skills and coordination for activities that require perceptual –motor,(eye-hand) coordination. The child may be sickly or chronically ill.
Cognitive

- The child may display thinking patterns that are typical of a younger child, including egocentric (awareness of self needs only) perspectives, lack of problem-solving ability, and inability to organize and structure thoughts.
- Speech and language may be delayed or inappropriate.
- The child may be unable to concentrate on school work, and may not be able to conform to the structure of a school setting. The child may not have developed basic problem-solving and may have considerable difficulty in academics.

Social

- The child may be suspicious and mistrustful of adults or overly solicitous, agreeable, and manipulative and may not turn to adults for comfort and help when in need.
- The child may talk in unrealistically glowing terms about her family; may exhibit “role reversal” and assume a “parenting” role with the parent.
- The child may not respond to positive praise and attention or may excessively seek adult approval and attention.
- The child may feel inferior, incapable, and unworthy around other children; may have difficulty making friends, feel overwhelmed by expectations for performance, may withdraw social contact and may be scapegoated by peers.

Emotional

- The child may experience damage to self-esteem from denigrating or punitive messages from an abusive parent or lack of positive attention in a neglectful environment.
- The child may behave impulsively, have frequent outbursts, and be unable to delay gratification.

Unit Specific Information on Developmental Stages: Each Unit at Shodair have different age groups and therefore different behaviors are displayed by the children according to their developmental stages and needs. The following is some information to help you know what to look for and how to intervene:
Age Specific Competencies – Grasslands Unit

Kids ages 3-18 who are in an acute crisis and need stabilization or evaluation.

Common Issues

- Kids of various age ranges
- Kids at various developmental levels
- Higher turnover rate
- Higher acuity level
- Quick stabilization
- Assessment of unsolved problems
- Assessment of lagging skills

How to Help

- Empathy
- Listen
- Spend time with the patients
- Reassurance
- Encourage use of support
- Remain calm

How to help: in general on all units

- Empathy
- Play
- Listen
- Allow time for child to respond
- Don’t be judgmental– use a positive or neutral manner
- Frontload
- Teach feeling words or phrases
- Role model
- Role play
- Praise
- Positive feedback
- Suggest appropriate behavior
- Small groups
- Individual coaching
- Break down tasks and directions
- Check for understanding of what was said
- Use your team
- Talk to your supervisor and/or team about how to handle situations that arise
- Always report any suspected abuse, suicidal thinking, patient sexual activity, etc. to your supervisor immediately
Age Specific Competencies – High Desert Unit

Kids range from preschoolers to kids who are in mid-elementary school, ages 4 to 10

**What’s typical at this age**

- Egocentrism
- Concrete, literal thinking
- Family is the center of their social world.
- Learning words to express basic feeling.
- High activity levels
- Short attention spans
- Solitary or parallel play

**Challenges: Executive Functions**

- Short attention spans.
- Easily distracted.
- Don’t finish things they start.
- Impulsive (act first and think later)
- Go with their 1st response
- Don’t consider a lot of options

**Challenges: Language Processing**

- Limited vocabulary
- Difficulty understand what is said
- Difficulty expressing what they have to say

**Challenges: Social Skills**

- Difficulty joining groups
- Don’t know how to make friends
- Don’t know how to start a conversation
- Difficulty playing cooperatively with their peers
- Difficulty reading social cues

**Challenges: Cognitive Flexibility**

- Literal or black and white
- Don’t understand sarcasm
- Difficulty with change or transitions
- Don’t like surprises
- Can have distortions and misperceive often

**Challenges: Emotion Regulation**

- May become extremely upset
- Can’t think clearly & rationally until calm
- Irritable and grouchy
- Difficulty problem solving
• Anxious

**Other Challenges:**

• Food
• School
• Don’t know what to do with themselves
• Family visits, family contact (or lack thereof)
• Other kids being discharged from the hospital

**How to help:**

• Remember, some of these kids are LITTLE!
• Some kids can be held & comforted
• Some kids can be given piggyback rides, etc.
• They may need naps or snacks.
• Don’t use big of words.
• Build relationships.
• Play.
• Listen.
• Have problem solving conversations
• Teach feeling words or phrases
• Distraction
• Talk to them at their height level (but be aware of how close you’re getting)
• Let them help
• Use timers, red wagon, sensory tools etc.

**How to help: in general on all units**

• Empathy
• Play
• Listen
• Allow time for child to respond
• Don’t be judgmental– use a positive or neutral manner
• Front load
• Teach feeling words or phrases
• Role model/Role Play
• Praise
• Positive feedback
• Suggest appropriate behavior
• Small groups
• Individual coaching
• Break down tasks and directions
• Check for understanding of what was said
• Use your team
• Talk to your supervisor and/or team about how to handle situations that arise
• **Always** report any suspected abuse, suicidal thinking, patient sexual activity, etc. to your supervisor immediately
Age Specific Competencies – Yellowstone Unit

Kids on this unit are in middle school, ages 11 to 13

What’s Typical at this Age

- Entering puberty
- Wide range of maturity levels
- Concrete thinking
- Increasing social interest
- Want to be like their peers; may fear/reject things that make them seem “different”

General Info about the Challenges

- More independence
- Increasing demands – for social involvement, organization, tracking schoolwork
- Many have experienced bulling or rejection and have difficulty “fitting in”

Challenges: Executive Functions

- Poor attention span
- Difficulty completing multiple tasks
- Impulsive
- Difficulty waiting

Challenges: Language Processing

- Difficulty expressing self in words
- Difficulty understanding what has been said
- Easily frustrated
- Swearing

Challenges: Social Skills

- Interest in “dating”
- Awkward socially
- Bullying
- Rejection by peers

Challenges: Cognitive Flexibility

- Rigid and inflexible
- Increased stress
- Cognitive distortions (no one likes me, this isn’t fair…)
- Literal (black & white thinking); limited ability to understand sarcasm
Challenges: Emotion Regulation

• Easily upset or frustrated
• Trouble calming down on their own
• Chronic irritability or anxiety

How to help

• FRONTLOAD as much as possible
• Help kids learn to express feelings
• Encourage positive peer relationships
• Encourage appropriate dress
• Teach healthy boundaries
• Groups
• Community meetings & “Circle Ups”
• Facilitate problem solving
• Allow for extra time and space when kids become frustrated

How to help in general on all units

• Empathy
• Play
• Listen
• Allow time for child to respond
• Don’t be judgmental– use a positive or neutral manner
• Front load
• Teach feeling words or phrases
• Role model
• Role play
• Praise
• Positive feedback
• Suggest appropriate behavior
• Small groups
• Individual coaching
• Break down tasks and directions
• Check for understanding of what was said
• Use your team
• Talk to your supervisor and/or team about how to handle situations that arise
• Always report any suspected abuse, suicidal thinking, patient sexual activity, etc. to your supervisor immediately
Age Specific Competencies – Glacier Unit

Adolescents in High School  Ages 14-18.

What’s typical at this Age

• Peers are very important
• Separate from parents and “individuate”
• Develop an identity
• Increased independence & responsibility
• MAY be capable of abstract thought
• May believe they are invincible
• Pubertal changes

What’s typical with Adolescents at Shodair

• Problems with school attendance
• Drug and alcohol abuse
• Risky sexual behavior
• Mood disorders are common
• Cutting or self-harm (can be “contagious”)
• MAY experience a psychotic “break.”

Challenges: Executive Functions

• Attention, concentration, and impulsivity
• Legal trouble, driving accidents, or unintended pregnancy
• Risky behavior, act first and think later

Challenges: Language Processing

• Some have never been identified or treated for language issues
• May avoid social situations or school
• Difficulty engaging in conversation

Challenges: Social Skills

• Haven’t found a social group or “clique”
• Relating face to face can be difficult
• Prefer social media
• Don’t know why their social attempts are rejected
• Seek attention in inappropriate ways:
  Create drama, harm themselves, become aggressive, or withdraw

Challenges: Cognitive Flexibility

• Problems with transitions, changes to schedules, rules
• Do bad in unfamiliar or unstructured situations
• Think they are invincible
• Desire not to seem different or unusual
• MAY reject treatment
• Believe that taking medicine will make them seem weird

**Challenges: Emotion Regulation**

• Mood instability
• Chronic anxiety or irritability
• Disrupted functioning in daily activities
• Difficulty managing frustration

**How to help**

• BUILD A THERAPEUTIC RELATIONSHIP (takes time)
• Listen, rephrase what you hear
• Drill down to find out “the real issue”
• Check for comprehension
• Talk through situations that don’t go well
• Model or role play
• “How else could you say that”
• “What could you do differently”
• Point out distorted thinking (gently)
• Don’t shame
• Don’t over pathologize behavior (like dating)
• Encourage a positive peer culture
• Help facilitate conflict resolutions
• Facilitate a “circle up” when there is drama/conflicts
• Set reasonable limits and remind patients of unit expectations
• Frontload: expectations, change in plan, upcoming activities.

**How to help in general on all units**

• Empathy
• Play
• Listen
• Allow time for child to respond
• Don’t be judgmental—use a positive or neutral manner
• Front load
• Teach feeling words or phrases
• Role model
• Role play
• Praise
• Positive feedback
• Suggest appropriate behavior
• Small groups
• Individual coaching
• Break down tasks and directions
• Check for understanding of what was said
• Use your team
• Talk to your supervisor and/or team about how to handle situations that arise
• **Always** report any suspected abuse, suicidal thinking, patient sexual activity, etc. to your supervisor immediately
Module 13: Managing Sexual Reactivity in Children

Some of the children at Shodair have been sexually abused. As a result their behavior may be reflective of this abuse. The following information is to assist you in managing their feelings and behavior.

Staff Interventions:

- Remember safety first.
- Supervise children closely.
- Encourage privacy in bathroom use, bathing, sleeping arrangements, getting dressed and changing clothing. "Private parts for private places."
- Teach children that no one can touch them without their express verbal permission. (Staff should always ask permission before touching/hugging a child.)
- No wrestling, tickling, roughhousing, or other forms of indiscriminate sexual contact. (This includes staff to staff…we need to role model appropriate behaviors in front of the children!)
- Have clear expectations and be consistent
- Clearly identify acceptable and unacceptable behaviors
- Provide opportunities (using empathy) for the children to express their feelings
- Talk with the children about how to be respectful of their own and other’s bodies.
- Encourage respectful body space (arms lengths apart.)
- Identify triggers/ circumstances that lead to sexual acting out and attempt to minimize exposure to these.

Possible Goals to Work Toward with a Child:

- Keep my hands to myself
- Respect my body parts
- Keep my body private
- Give other’s their space
- Respect other people’s body parts

What to Do if a Child Reports Abuse:

- Talk with the child calmly and matter of factly about the experience.
- Do not ask questions about the abuse or question the child’s truthfulness.
- Allow the child to talk but then guide the child back to an age appropriate activity as soon as possible.
- Reassure the child that the abuse was not their fault and that they have done nothing wrong.
- Tell the child "This sounds very important. I would like you to talk with your Therapist/Doctor about this."
- Document in the progress notes what the child tells you.
- Notify the charge nurse. The charge nurse will notify the therapist/MD
**Module 14: The Therapeutic Milieu**

**Milieu Therapy** is the systematic management of the socio-environment (or unit) as a treatment modality for the benefit of patients. A key concept in Milieu Therapy is that every interaction with the staff can be a potentially healing opportunity.

The MHT plays an important role in the management of the milieu which usually refers to the nursing unit. The nursing unit can be a chaotic and complicated environment. The needs of many children with emotional problems and behavioral challenges can be hard to meet. Creating and maintaining a safe, nurturing and healing environment requires a great deal of thoughtful attention and planning.

Many factors go into the creation of a therapeutic milieu which will be covered in this module, but one thing is most important to remember: This is our children’s temporary home during the time they are with us. We must strive to always be mindful and respectful of that and make our decisions about their “space” with care and consideration for their feelings.

**Concepts:**

- **Communication** occurs on two levels simultaneously. Both are equally important:
  1. **Content**—refers to what is actually being said or done with the patient
  2. **Process**—refers to the underlying dynamics of the communication, (posture, tone of voice, eye contact, attitude etc.)
- **Transference** refers to an unconscious process in which a patient perceives and relates to the staff as someone from his or her past.
- **Countertransference** is the unconscious process in which the staff perceives and relates to the patient as someone from the staffs past.
- **Re-enactment** of problematic issues from childhood may occur around areas such as power, response to authority, dependency, self-worth, identity and acceptance
- **Functions of the Milieu:**
  1. **Containment** refers to sustaining the physical wellbeing (safety) of patients and those around them. The objective of containment is to prevent assaults, self-harm or physical deterioration in patients who lack impulse control or good judgment. Examples of containment are: restraint and or seclusion, elopement and suicide policies, unit and/or building restriction and other patient monitoring policies.
  2. **Support** is the promotion of a sense of well-being and self-esteem in patients. In a supportive milieu, patients feel comfortable and secure and have lowered anxiety. Examples of a supportive milieu include encouragement, advice, reality testing, praise, positive reinforcement, and a communicated belief there is hope for them.
  3. **Structure** pertains to all aspects of a milieu that provide an organized, predictable treatment. Examples of structure include scheduling a patients time, maintaining a pleasing and uncluttered physical environment, providing unit programs and policies, classes, groups, and patient contracts. When unit order in the inpatient setting is poor, there may be an increase in social conflict. A poorly structured milieu may have too few activities, inconsistent application of a schedule or inconsistently applied limits for dysfunctional behavior.
  4. **Involvement** refers to mobilizing patients with activities that encourage attendance to and interaction with others. The staff actively seeks patient participation by being open
to the expression of feelings. Staff can assist patients by helping them achieve an awareness of how they interact on the unit and how their behavior affects others.

5. **Validation** refers to interventions that affirm a person’s uniqueness. Validation is an essential ingredient for healing when it is done with open acceptance and confirmation from the patient. When validation is high in the milieu, patients feel affirmed even when their behaviors are not okay.

- **Examples of common milieu interventions**

  1. **Role Modeling** – *eg.* The staff keeps commitments made to the client
  2. **Confrontation** - *eg.* A staff explains to the client that his off unit privileges are revoked because he was overheard making plans to elope.
  3. **Seclusion** – *eg.* A patient is threatening to hurt another patient and is escorted to a quiet room until her behavior is under control (safety).
  4. **Suicide Precautions** – *eg.* The Charge nurse assigns an MHT to stay within arm’s reach of an actively suicidal patient
  5. **Positive reinforcement** – *eg.* The staff praises a patient’s efforts towards a goal, even if it was not achieved.
  6. **Structured interactions among patients** – *eg.* An MHT introduces and seats a withdrawn patient next to a more verbal patient during a community meeting.
  7. **Therapeutic schedule of activities** – *eg.* A staff develops and coordinates a monthly schedule of patient education topics.
  8. **Consistent expectations** – *eg.* The staff follows through on Expectations set with patients.
  9. **“circle up” meeting** – *eg.* There is an attempted suicide on the unit, so the nurse calls the patients and staff together for a meeting to process feelings related to the event.

**Points to Ponder and Remember:**

**Staff to patient**

- Safety First!
- Post Unit Expectations where all the kids can see them.
- Be aware of body language (posture, stance, facial expression) and para-verbal communication (tone, volume and rhythm of speech)
- Actively listen (use empathy).
- Follow through with expectations If you make a mistake, apologize.
- Be consistent with treatment interventions
- Be flexible in your approach
- Use praise liberally
- Remember – It’s all about the kids (all the time)

**Staff to staff**

- Shift report is essential for sharing pertinent/current information about treatment decisions/approaches from off-going to on-coming staff.
- Avoid undermining the prior staff’s decision/directions regarding a patient’s behavior.
• Ask the patient’s assigned staff first before making decisions regarding their patients.
• Pull staff aside to a private place before discussing differences of opinion.
• Be aware of Unit Expectations – consistently enforce.
• Be aware of how you speak about patients – negative comments are powerful – and tell more about us than the child.
• Remember that these children can generate powerful feelings in us as staff – work at being “self-aware”, so you can respond not react.
• Be understanding and supportive, (not judgmental), of yourself and your peers.
• We are all in this together.

**SUGGESTED ASSIGNMENTS:**

• Review the program schedule on your assigned unit.
• Can you identify the different functions of the milieu?
• Can you observe staff performing common milieu interventions?
Module 15: Behavioral Interventions

Acceptable Behavior Management Techniques

These interventions:

- Do not require a Physicians Order
- Do not have monitoring requirements
- Are documented in the progress notes or on the intervention sheet
- May be initiated by any staff within any discipline on or off the milieu

Empathy – can be described as the emotional appreciation of another’s feelings or the ability to “put oneself in another’s shoes”. Empathy assists in developing a therapeutic relationship by letting the child know he or she is being listened to and understood. Empathy is also about getting to a child’s true concern. Sometimes by asking more about what is bothering them or (when they can’t tell you), helping them figure it out. A statement that can facilitate empathy is “what’s up?”. Other examples of statements to facilitate empathy are – “Can you tell me more about that?” or, “I hear you” or “Let me see if I understand (and repeat back the child’s statement to them), or “Sounds like you are… (identify a feeling for them)”. Empathy with a child helps them from escalating and may allow them to engage in a problem solving conversation.

Relationship building – Is spending time building rapport with the child when the child is calm. Establishing a therapeutic, trusting relationship is the foundation of all treatment interventions at Shodair.

Verbal Redirection - This is a request by staff for the child to stop their current behavior or language and to return to the task at hand. This may result in focusing on the unitor getting an individual child to stop their current behaviors.

Cool Down Time (or Break Time) – This is a request by staff for a child to cease their current activity when they are having significant difficulty and need time to calm or regroup. Cool Down time may be completed anywhere the patient can be safe. During this time the goal for the patient is to show they are calm, safe and in control of their emotions or behavior. Patients may use any calming technique they find helpful, reading, journaling etc. The amount of time the child needs is negotiated with the staff and then is recorded/charted in the intervention sheet or in MHT charting.

Exclusionary Time out – Exclusionary time out is a break the staff asks a child to take in a specific place such as their room or an open Quiet Room. If the time is spent (voluntarily) in their room or a Quiet Room it should not exceed thirty minutes. After the child has calmed the staff may initiate a problem solving conversation and/or the child may return to regular unit activities. This must be documented in the patient’s chart.

Front Loading - Many of our children have difficulties with transitions in general. Front loading is a technique which staff use prior to an activity or schedule change. Staff use this knowledge of a child’s triggers and lacking skills to anticipate when a transition or activity might be hard for a child and help prepare them to do well. The child is given information about what is going to occur or about what the expected behaviors are before the actual event. The emphasis is on spending time with the kids in order to build the relationship when the child is calm and analyzing meltdowns to understand what led up to them. Unit “expectations” are frontloaded on a daily basis.
Re-do’s – Many of our children display unacceptable or inappropriate behaviors which require a long period of time to change. Children can become frustrated when they repeat these behaviors despite their efforts and staff support to stop. A “redo” gives the child an opportunity to be successful “in the moment”. Staff will point out the unacceptable behavior and ask the child if they would like to “redo” that. The child then has an opportunity to “turn back the clock and try again”, giving him or herself the chance to practice new healthy behaviors with staff guidance and support. This intervention is used when it is likely the child knows what a more appropriate behavior would be. Generally used with younger patients 4-10 years.

Friendship Coaches – Children at Shodair frequently have severe difficulty in forming friendships with other children. A friendship coach, (often the staff assigned to the child for that shift), discusses the ways to be a friend with the child and then involves a peer of their choosing in practicing these behaviors with the child in a safe and supportive time.

Role-plays – It is difficult to learn new behaviors and skills during times when task completion is also expected such as meals, school, etc. Role-playing allows the child to be free of the pressure of other expectations. The child is able to “pretend” and practice new behaviors with the support and guidance of staff, before trying the behaviors out in “real time”.

Diversion – “Meltdowns” occur when the child is triggered by an event and quickly begins to lose “IQ points” (diminished cognitive functioning) with accompanying out of control behaviors. Diversion, (also called distraction), turns the child’s attention quickly to another activity or topic unrelated to the triggering event.

“What Else” Game – Many of the children at Shodair experience cognitive distortions which cause them to attribute the worst interpretation to an upsetting event. The “what else” game teaches the child to move out of black and white thinking and gives them additional possibilities to consider when interpreting or understanding an upsetting event.

Boulder Technique or How Big Is It? – Children often experience all problems as equally difficult no matter how big or how small. This technique teaches the ability to discern and think of solutions based on a realistic assessment of how difficult something is and may begin with classifying problems as small, medium or large (perhaps using other terms chosen by the child) responding accordingly.

Divide and Conquer – Emotions can be contagious. The anger of one child can quickly spread to others in the group. Dividing children up into smaller groups allows for greater personal control resulting from decreased stimulation.

Communication Cards – This technique uses cards for children who lack verbal communication skills. These cards may include “feeling” cards, phrases to use, pictures that illustrate emotions, etc.

Staff Shadowing – children who display difficulty integrating into the milieu or children with high anxiety in negotiating their interactions with peers may benefit from being assigned a nursing staff member to “shadow” during a shift. This intervention allows the child to remain in close physical proximity to a staff for an extended period providing a “safety net” for social interactions that are threatening.

Check In’s – Children who are having difficulty managing their emotions or behaviors safely within program activities have their expectations for safe behaviors reviewed at the beginning of a shift and if necessary at regular intervals throughout a shift. The child then receives regular “check ins” from
staff to assess how successful the child is at meeting the expectations. If difficulties are identified at “check in” time, proactive problem solving occurs to help manage the behaviors.

**Time and Space** – When a child is displaying signs of a “meltdown” or increased agitation it can be helpful to give them a large amount of personal space and an extended period of time to regain a degree of control before staff attempts to intervene with verbal interventions or directions.

**Reassurance** – Another tool to help kids stay calm and remain available for problem-solving is Reassurance. Kids sometimes become so preoccupied by their own concerns and their fear that they will be told “no”, or become so worried that the reason staff are talking to them is because they are in trouble, that they may not be able to listen and participate adequately without some reassurance. Staff may need to let the child know “you’re not in trouble”, or “I’m not saying no”, in order to help them stick with the conversation. Note that Reassurance needs to be realistic, and that it is not helpful to make promises that cannot be kept.

**Circle Ups** – Circle Up’s are used as a problem solving tool for the entire milieu or for just a few children who may be having trouble getting a long or coping with tension on the unit. The purpose of a “circle up” is to inform the patients of a change, to re-focus and/or allow the milieu as a whole to reset or “re-do”. Staff will identify the children who are to be gathered into a group (or “circle”). Staff (with input from the kids involved), will state the problem or issue that is to be worked on, allowing everyone in the group to have input. The group will come to a consensus about how the problem is to be dealt with, and then group adjourns and returns to regular programming.

**Additional Interventions/Tools:**

Children with emotional and behavioral problems often have extreme difficulty in emotional regulation and verbal expression. Their ability to calm and self soothe is impaired. The following interventions or tools may be used in a variety of situations to help the child manage their emotions such as anxiety, frustration and anger before they escalate into a meltdown or aggressive or violent behaviors. The choice of interventions is based on age, developmental level, identified Pathways and lacking thinking skills.

These interventions
- may be used at staff’s discretion on the milieu or in the classroom if appropriate
- do not require a Physicians order
- do not have documentation requirements but may be documented in the progress notes or on intervention sheets

**Muscle Pressure:**
- Weighted vests or lap pads
- Weighted blankets
- Stress balls

**Tactile Stimulation:**
- Plastic skin brushes (RN’s only)
- Back massagers
- Modeling clay

**Diversion/Relaxation**
- Race to your room
Sack of Potatoes
Puppets
Books
Drawing
Puzzles/Board games
Being a “helper”
Journaling
Call to family
Boo Boo Buddies
Feeling faces/cards

**Time Management:**
Timers

**Physical Exercise:**
Push ups
Jumping Jacks
Sit ups
Taking a walk with staff

**Acceptable Behavior Management Programs**

These interventions:

- Have monitoring requirements
- Must be documented on Treatment plan and in progress notes
- May be initiated by charge nurse after consultation with staff/ treatment team

**Block to Block**

**Rationale:**

Children who are having significant difficulty attending activities or safely managing social or group settings may benefit from Block to Block programming. This is a graduated approach to participation in programming which assists the child in problem solving and developing solutions to safely attending regular programming.

A child on Block to Block Schedule is able to attend partial programming blocks for 15, 30 or 45 minutes at a time. The remainder of the time (45, 30 or 15 minutes) is spent on the unit in a designated place negotiated by the child and the staff where the child can be safe and in control. If some of the time is to be spent alone in the patient’s room or a quiet room, the time there should not exceed thirty (30) minutes (see Exclusionary Time Out).

While on the unit a child may:
- have comfort items (such as a blanket, pillow, book etc.), if allowed by the Treatment Team.
- do school work,
- do a specific action plan developed by the charge nurse or the treatment team.
If the child is achieving success during a scheduled block or activity while on this program, the unit charge nurse, teacher or therapist in charge of the block has the discretion to allow the child to stay for additional time or for the remainder of the block.

Procedure:

- The use of the Block to Block schedule is explained to the child as a means to help them to participate successfully in programming and is not meant as a punishment.
- Where the patient starts on the step program 45/15, 30/30 or 15/45 is determined by the charge nurse or treatment team in consultation with the physician.
- Monitoring is every fifteen minutes
- The child is re-evaluated by the unit charge nurse or treatment team regularly for safe, calm, controlled behaviors.
- The child can be advanced to the next step or the program can be discontinued if the child’s behavior is meeting these criteria.
- If the child continues to have difficulty problem solving and maintaining safe behaviors, the same step can be continued with ongoing re-evaluation every shift.

**SUGGESTED ASSIGNMENTS:**

› Observe the interactions of several staff on your assigned unit, how many behavioral interventions did you observe? Were they effective? Why or why not?
Module 16: Types of Groups and Community Meetings

Community Meetings

Community Meetings are an integral part of a therapeutic program for inpatient and residential psychiatric units. Patients examine how they are working together with the goal of creating a more gratifying environment. Community Meetings help patients decrease their sense of isolation by identifying with the community and gaining strength from that identity. The emphasis on the value of cooperation helps to make up for the loss of freedom in the treatment setting. When trust develops in the community, patients will express their feelings and reactions to each other, and staff can enter and influence this process.

Functions of the Community Meeting:
The Community Meeting becomes a mechanism for enculturation, which integrates new members, promotes the norms and ideology of the therapeutic culture and decreases deviant or anti-social behavior. Both new staff and patients learn what is expected of them. The meeting can reinforce the expectations of the unit and set the tone for the day. It can function as a “social barometer” to confront and analyze and understand the actual experience of those who live and work in the milieu.

Incorporating the Community Meeting into the Milieu:
The Community Meeting is always a means for exchanging information. It can be used as a way of introducing and establishing therapeutic values. At best it can discourage pathological behavior and encourage healthy behavior, using the staff as role models. Patients can begin to feel a sense of belonging and membership in the community. Patients can learn how they affect others and the unit living situation.

Structure in the Community Meeting:
Structure in the Community Meeting is vital. There should be an agenda for each meeting which is openly shared. Supportive beginnings and endings create a good climate. New members should be welcomed and introduced. Absent members should be acknowledged. Each issue discussed should be brought to closure, even if unresolved. Meetings that are highly structured assist in promoting reality testing, patient participation, patient self-worth and problem solving. Community Meetings are most successful when they can build staff and patient cohesiveness and develop a sense of community, cooperation and caring.

Staff Attendance:
Regular and predictable staff attendance from all members of the treatment team at Community Meetings is essential. Multi-disciplinary teams, while vital and required in in-patient and residential treatment programs, can be confusing to children and adolescents, since they rarely understand each member’s different roles and responsibilities. Opportunities for confusion, misunderstanding and “splitting” between patients and staff are abundant. Community Meetings offer a format to openly address and resolve these tension points in a healthy safe manner.
**Types of Therapy**

There are three main types of therapy for children and teens that are provided by the Primary Therapists at Shodair; individual, group, and family. Sometimes, people will do combinations of therapy, such as individual and group therapy. The type of therapy you have depends on the problem(s). Here are some details on each:

- **Individual Therapy.** In individual therapy, the child meets with a therapist alone to talk about his or her problems. Each session lasts about 30 -50 minutes. The therapist may ask the child to identify their feelings about problems. The child or teen might get "homework" that will help them work through their problems. Everything a child or teen says in therapy is confidential to the treatment team on a need to know basis (information that is considered important for members of the team to know is shared especially if the therapist has reason to believe the child might hurt him or herself or someone else). Sometimes, it can be helpful for the therapist to talk to parents or the school counselor about a problem, so it can be resolved outside treatment as well.

- **Group Therapy.** Group therapy allows children or teens to see how other children handle their problems. They can also practice new ways to handle stress. Usually, there are about 10 children or teens in each group with one or two leaders (therapists lead therapy groups). The group leaders will bring up topics and ask questions. Group therapy sessions usually last about 30 - 45 minutes.

- **Family Therapy.** In family therapy, the child and parents or (guardians, and sometimes brothers and sisters) go to therapy together. Because everybody is there, everyone can work on problems that affect the family. The therapist will discourage interrupting, and make sure everyone gets to voice their concerns. Because many of our families at Shodair live long distances away, many of these sessions are conducted over the phone or by using Telemedicine.

**Other Types of Therapy**

Shodair provides other types of Therapy to help children and teens learn to manage their emotions and build coping skills. These are:

- **Play Therapy**- utilized by a child’s primary therapist to help the child communicate feelings, and thoughts through play. Primarily used with children on the High Desert Unit ages 4-10.

- **Therapeutic Recreation**- Based on the specific needs of the patient, CTRS’s (Recreation Therapists) develop creative and instructive groups that are focused on building social and interpersonal skills and the management of emotion. These groups focus on: Cognitive Stimulation, Social Skills, Coping Skills, Symptom Management, Stress Management, Adventure Therapy, Problem Solving, Teambuilding, Exercise/Physical Fitness, Creative Arts, and Community Re-Integration.

- **Music Therapy**- An active treatment offered in both the group and individual setting that works to improve the health and well-being of children through music. Based on the specific needs of the patient, a highly trained MT-BC (Music Therapist) works with the children to facilitate self-awareness and self-expression while building lifelong skills.
- **Activity Groups** – Recreation Aides, under the direction of a recreation therapist (CTRS), provide diversional activities to reduce stress and provide leisure time.

- **Education Groups** – Nursing staff provide structured educational groups on a variety of health and mental health related issues to improve understanding and develop coping skills.
Module 17: Managing Aggression in Older Children

If you discover that the teen placed on your unit has a tendency towards aggressive behavior there are steps you can take to help them learn to deal more effectively with their feelings.

Document the Pattern

One of the most basic steps in dealing with aggressive teen behavior is to observe and document the pattern. Many teens become aggressive as a way of coping when they are stressed out or after they have suffered a disappointment. Observe the child looking for the pattern of aggressive behavior. Document in your progress notes:

• The time and date of aggressive behavior.
• The setting of the aggressive behavior.
• The type of aggressive behavior (for example, shouting, knocking items over, pushing others, threatening, etc.).
• How the teen acted immediately after the incident (within a half an hour) and several hours later.

Identify the Triggers

The pattern of aggressive behavior along with triggers to the behavior will emerge. It’s important to note that triggers may be external (things that happen to or are said) or internal (messages the child gives to his or her self - referred to as “self-talk” that gets them worked up). Often this “self-talk” is based on assumptions or incorrect information (cognitive distortions). Regardless of the origins of these triggers, the result is often the same, the child becomes aggressive. Common triggers of aggressive teen behavior include:

External Triggers:
• Teasing from others.
• Denial of a certain item/privilege.
• References to a certain event (such as an embarrassing situation in the past).

Internal Triggers:
• Feelings of inferiority (such as after losing a race or quiz).
• Feelings of stupidity (such as when unable to comprehend a subject).
• Feelings of frustration (such as when turned down for a date).

Addressing the Behavior

Often the child doesn’t understand their own behavior, so when you attempt to address angry, aggressive behavior with them directly don’t be surprised if they seem unaware of the patterns or triggers that you mention. Remember the aim here is not to control the child, the aim is to introduce, model and offer them a different way to deal with their emotional distress.

The following suggestions will strengthen your ability to nurture self-esteem in young people and reduce aggressive behaviors:

1. No child is always difficult. Catch the child behaving well, attend to, and praise these positive behaviors. Provide additional opportunities to act appropriately and give positive feedback. If you only notice inappropriate and aggressive behavior, these behaviors may be used as a way to get your attention.
2. Lead with Respect. Always let the child know that you care and respect him or her. Remind them that it’s the behavior (not them) that you do not like. Avoid falling into the; “You’ve got to give respect
to get respect" trap. This child may not have a point of reference for respect so expect to have to “model” respect for them before they're able to show respect for you.

3. Don’t ignore. Although ignoring minor disruptive behaviors (complaining) can be an effective way to decrease those behaviors, do not ignore inappropriate aggression.

4. Be positive. Remain calm and model positive problem solving for the child. Do not become angry in response to his or her anger.

5. Don’t rationalize. Do not try to rationalize about the aggressive behavior or why they are receiving consequences. *Avoid falling into the power struggle trap.

6. Effective directions. Use effective directions and questions. Directions should be clear, direct, positively stated, and given one at a time. Avoid “yes/no” questions (“Would you like to help me clean up your room?”) because the answer most often is “No!” Avoid saying “Let’s get this room cleaned up”, unless you actually plan to help with the task. Avoid being vague, (“I need you to do better.”).

7. Unit Expectations. Establish and even more important, communicate, in a clear consistent way unit expectations that must always be followed.

8. Limits. When the child does not follow instructions or other established expectations, breaks rules, or engages in aggressive behavior, provide prompt, reasonable limits.

9. Communication. Increase ongoing communication between yourself and the child. The child then will be more likely to come to you when a problem arises if they feel some sort of connection, (relationship) with you.

10. Problem solving. Model effective problem solving: identification of the problem is just the first step. Potential responses, both positive and negative should be generated; evaluating responses for an option ideally one which is mutually agreed upon; then plan how to carry out the response. Help the child to see problem solving in action and use opportunities to assist him or her in applying these skills to their own problems. It will likely feel uncomfortable or complicated in the beginning, the more these skills can be practiced the more comfortable they become.

11. Relaxation. Teach quick but effective relaxation techniques (deep breathing, counting to 10,) that can be used to calm down when the child gets very angry. Again the child might say it’s silly or even "stupid" in the beginning, but with repetition this skill becomes part of their natural response.

12. Perspective taking. Encourage the child to understand other people’s perspectives, like what others may be thinking and feeling. Be sure to practice perspective taking during times and in situations that don’t typically spark an aggressive response so the child can be better prepared when they are provoked.

13. Recognizing Triggers. Work with the child to identify what “triggers” an aggressive response – for some children its being called a name, or getting teased. Ask about what they say to themselves when someone does something that triggers aggression for example “He’s trying to make me look like a punk.”

14. Coping statements. Help the child to develop a list of coping statements to deal with anger. (Positive self-statements like: “Just stay calm. I don’t need to freak out over this.”) Practice these statements in advance, so that he or she will be more readily able to use these statements when in provoking social situations.

15. Negotiating. Teach the child skills for negotiating needs with peers, parents, and teachers, so that the teen will be less likely to use aggression or defiance as a means of getting what he or she wants.
16. **Autonomy.** Help the child develop autonomy by valuing his or her positive ideas and encouraging positive independent thinking and decision making. As experience with these positive decisions and behaviors develops, the child is less likely to respond in negative, aggressive ways.

17. **Monitoring.** Caring involvement is rarely seen as a violation of privacy (a major concern in the teen years.) When you have a genuine interest in the child, the child is less likely to engage in disruptive behavior.

18. **Skill Building.** Look for opportunities to focus on building new skills with the child that can help them be successful. This may be joining new, positive peer groups and avoiding harmful peer groups and negative peer pressure.

19. **Evaluation.** Whenever you are very concerned about ongoing inappropriate behavior, a discussion with the treatment team is important to evaluate the behavior and decide on a useful approach to deal with the behavior.

**Final thoughts**

Dealing with an aggressive, angry teen can be difficult for staff, especially if you have not established a therapeutic rapport with the child. Understanding the child in relation to the experiences they’ve had is the key to eliminating it. You must observe the child’s behavior and watch for triggers. If you are struggling in your ability to manage a child’s angry or aggressive behavior, or you feel unsafe when interacting with a child, get help and support from your team; your manager, your peers, the therapist or physician. Remember **YOU** can be an important person in this child’s life and can help this child learn another healthier and safer way to deal with their distress.
Module 18: De-escalation

What is de-escalation?
De-escalation refers to any activity that is meant to diffuse a conflict or intense situation. When children have “blow-ups” or “outbursts”, (behavioral issues that are disruptive to others), staff must respond in a way that diffuses the situation to ensure safety and calm the child.

What causes a child to escalate?
Brain imaging studies show that when an individual is under stress or reminded of a past traumatic event, there are physical (biological) changes in their brain. Under stress, the inner regions of a child’s brain becomes more active, and there is less blood flowing to the outer regions of their brain. The outer region, also called the frontal cortex, is the area of the brain responsible for logical, rational thinking, planning and responding, as well as speech. The inner regions of the brain are responsible for instinctive responses, such as emotion, respiration, arousal and the fight-flight-freeze response.

Many behaviors children display during a severe tantrum or meltdown are a result of the child’s inner (emotional) region of the brain being “turned up” and their outer (rational) region of the brain being “turned down.” This causes the child to have controlling, aggressive, destructive, hyperactive and unreasonable behavior. These behaviors are mostly or completely automatic depending on the child’s level of distress. The way in which staff respond to these behaviors either escalates or de-escalates (calming response) these behaviors.

Severe tantrums, outbursts, and meltdowns occur when a stressor exceeds a child’s limit to cope. This limit is known as their “stress threshold”. Because of past trauma and abuse, many children can be categorized as “highly-strung” (see the diagram below). Since they operate at a higher arousal level, it takes very little stress to push them over their “stress threshold”.

Seven Phase Model of Acting Out Behavior
This diagram represents the level of intensity for the child’s behavior. Notice the child’s behavior starts as calm, then a trigger occurs, which upsets the child. The child is agitated and the behavior intensifies to the peak of the tantrum. After the peak, the child’s behavior settles down (de-escalates) and returns to a calm state.
What are some possible triggers for Shodair children?
- Speaking to birth family on phone
- Being told ‘no’
- A bad day at school
- Requests from the staff to stop doing an enjoyable activity
- Frustration from a learning disability
- Fights over possessions or territory with other patients
- Anything that makes children feel vulnerable or treated unfairly

At this stage, staff should focus on reducing anxiety or redirecting attention in an effort to avoid a tantrum.

What are some warning signs during the agitation and acceleration phases?
Children may exhibit physical warning signs that staff can observe during the agitation and acceleration phases of the melt down. These signs include clenched fist or teeth, a nervous twitch, rolling their eyes, glaring, frowning. This stage is another opportunity for staff to focus on reducing anxiety or redirecting attention in an effort to avoid the peak of the melt down.

What should staff do to de-escalate the melt down?

- **Focus on safety** – remove children and others from the area, remove any objects that can be unsafe if thrown.
- **Maintain calmness and speak in a soft, slow voice**—we often mirror the voice and tone of those we speak to, so this will help the children lower their voice and help them calm down.
- **Model emotional regulation** — don’t appear angry or raise your voice. The child will feed off of your anger because he or she is looking for an emotional response from you. Appearing angry is giving the child permission to get angrier.
- **Be prepared that they will keep trying to engage you**—you may need to remove yourself from the child to get rid of the “audience”.
- **Redirect the child with a new activity**—try to distract the child with a pleasurable safe activity.
- **Don’t bargain or bribe a child during an outburst**—children cannot use logic or reasoning skills during an outburst.
- **Communicate one thought or idea at a time**—children are not using rational thinking skills during an outburst, and you do not want to overwhelm the child with speaking in long sentences.
- **Don’t discipline**—by trying to discuss the melt down or give consequences, you will only escalate the child’s meltdown.
- **Try relaxation techniques**—encourage the child to count to 10 before speaking or take deep breaths.

What are some pointers for staff?
- Identify what typically sets the child off. It’s important to recognize patterns.
- Set up clear rules.
- Develop a safe, caring relationship.
- Communicate requests or directions to the child in ways that are the most calm and least provocative to the child.
• Recognize and acknowledge even the smallest steps toward good behavior.
• Note what a child has said or how he has reacted emotionally and verbally to learn the child's point of view.
• Don't try to solve the problem for the child, but work with the child to solve the problem and build awareness of the outburst.
• Help the child interpret the behavior, possibly by drawing pictures and translating them into words.
• Reward with praise for initial, tentative steps in the right direction.
• Avoid "I told you so" remarks or bring up past behaviors.
• Evaluate consequences to see if they make things better or worse.
• Debrief with the child during or after the consequences.
• Help the child generate options other than getting angry in order to peacefully achieve what he needs or wants.

**SUGGESTED ASSIGNMENTS:**

- Observe children who are becoming escalated in their behavior - Can you identify the different stages?
Ten tips for Crisis Prevention (from CPI)

A crisis can be defined as a moment in time when an individual in your charge loses rational, and at times even physical, control over his or her own behavior. This can be very challenging and anxiety producing for those responsible for intervening. Due to the chaotic, unpredictable nature of a crisis, it is vital that staff stay calm and proceed with a plan.

These crisis moments do not sprout into being without roots; there are almost always warning signs that let you know an individual’s behavior is escalating. By following the tips listed here, you can often intervene before the crisis becomes dangerous.

1. **Be empathic.**
   Try not to judge or discount the feelings of others. Whether or not you think their feelings are justified, those feelings are real to the other person. Pay attention to them.

2. **Clarify messages.**
   Listen for the person’s real message. What are the feelings behind the facts? Ask reflective questions and use both silence and restatements.

3. **Respect personal space.**
   Stand at least 1.5 to 3 feet or more from an acting-out person. Invading personal space tends to increase the individual’s anxiety and may lead to acting-out behavior.

4. **Be aware of your body position.**
   Standing eye-to-eye and toe-to-toe with a person in your charge sends a challenging message. Standing one leg-length away and at an angle off to the side is less likely to escalate the individual.

5. **Ignore challenging questions.**
   When a person in your charge challenges your authority or a facility policy, redirect the individual’s attention to the issue at hand. Answering challenging questions often results in a power struggle.

6. **Permit verbal venting when possible.**
   Allow the individual to release as much energy as possible by venting verbally. If you cannot allow this, state directives and reasonable limits during lulls in the venting process.

7. **Set and enforce reasonable limits.**
   If the person becomes belligerent, defensive, or disruptive, state limits and directives clearly and concisely. When setting limits, offer choices and consequences to the acting-out individual.

8. **Keep your nonverbal cues nonthreatening.**
   The more an individual loses control, the less that individual listens to your actual words. More attention is paid to your nonverbal communication. Be aware of your gestures, facial expressions, movements, and tone of voice.

9. **Avoid overreacting.**
   Remain calm, rational, and professional. Your response will directly affect the person’s behavior.

10. **Use physical techniques only as a last resort.**
    Use the least restrictive method of intervention possible. Physical techniques should be used only when individuals are a danger to themselves or others. Physical interventions should be used only by competent/trained staff. Any physical intervention may be dangerous.

**SUGGESTED ASSIGNMENTS:**
- Observe a Restraint and/or Seclusion
- Are there any techniques used that are discussed here?
- Are there staff behaviors you question?
Module 19: The Sensory Diet and Sensory integration Disorders

What on earth is a “sensory diet”? No, this is not a diet of only certain foods or certain calories. A sensory diet is a term used to describe sensory activities that are used to treat kids with Sensory Integration Disorder. A “menu” of activities to do with a child is created and you perform these activities in order to create a sensory “meal” or “snack”. Just like nutritional diets, the sensory diet is designed for a child’s sensory needs. The Treatment Team, therapist or Unit Manager will create a plan of activities for you to do with the child throughout the day.

Proprioception activities- Proprioception has to do with body awareness (being aware of where your body is positioned in relation to other parts of your body). Receptors in the muscles and joints help to coordinate movements even without vision. Proprioception activities would include things like

- Pushing and pulling activities
- Squeezing toys or popping bubble wrap
- Wrapping the child in a “burrito” by rolling him up in a blanket
- Weighted blankets and animals

Vestibular activities- Vestibular input has to do with the sense of movement and balance that is processed in the inner ear. Vestibular activities include:

- Rocking in a rocking chair
- Swinging on a swing at the park
- Running, jumping or skipping

Tactile activities- Tactile activities involve the sense of touch, texture or temperature.

Examples of some tactile activities are:

- Messy play such as playing with shaving cream, finger paint, or play dough
- Reading and touching textured books
- Tracing shapes on to your child’s back and letting him guess what shape
- Sensory brushing (RN’s only)

Auditory activities- Auditory activities include hearing and listening. Some auditory activities might include:

- Playing with instruments, such as imitating a rhythm with a drum or tambourine
- Playing listening games to see if the child can guess the sound
- Listening to music or songs

Visual activities: Visual activities involve making eye contact, processing what is seen with the eyes and interpreting visual input. Some visual activities might be:

- Fusion beads
- Matching games such as matching cards or matching words to cards
- Picture games, finding pictures in a picture book like the “eye spy” books
Smelling and tasting activities - Smelling and tasting activities use the nose and the mouth to stimulate interest in different experiences.

- Play a guessing game with scratch and sniff stickers. See if the child can guess the smell without looking.
- Add a new texture to a food a child already likes. For example if the child likes yogurt, try adding some crunchy granola to his yogurt.

**SUGGESTED ASSIGNMENTS:**
- Locate sensory items on your assigned unit
- Are there any that are not discussed here?
Cognitive therapy traditionally identifies ten cognitive distortions or “faulty thinking patterns”, that maintain negative thinking. Reducing these distortions and resulting negative self-talk may improve depression and anxiety. The process of learning to refute these distortions is called “cognitive – restructuring”.

1. **Personalization** – Taking it on yourself – Being blamed and accepting blame for something not in your control. Your partner loses his job, your child has a fight, a doctor’s appointment was canceled and you are the one who feels totally responsible.

2. **Should statements** – You try to motivate yourself with shoulds and should not’s, as if you had to be punished before you could be expected to do anything - “I should have known what he wanted.” “I shouldn’t let it bother me.” “I should just keep quiet and take it.”

3. **Magnification (catastrophizing) /Minimization** – do you blow things out of proportion or shrink their importance? A co-worker fails to greet you on the morning and you conclude she hates you. Or “These bruises aren’t really so bad”

4. **Labeling and Mislabling** – Instead of describing an error you attached negative label to yourself or another; “I am a worthless person.” “Everyone in this town is ugly.”

5. **All or Nothing Thinking** – No gray areas exist. You see things in black– and-white categories, “I am nothing” “He has the answers to everything” “Nothing helps me.” “This is all beyond my ability to understand.”

6. **Overgeneralization** – You see one negative event as a never-ending pattern of defeat. He’s late coming home and automatically he has abandoned you.

7. **Disqualifying the Positive** – Upon receiving a compliment, the response is usually “Oh this is nothing!” Or a quality that you possess isn’t really worth that much; “He probably says that to everyone.”

8. **Emotional Reasoning** – You assume that your negative emotions necessarily reflect the way things really are - “I love him, so he would never hurt me.” “My partner is going to be so successful. When he realizes how I stuck by him he will treat me a lot better.”

9. **Mental filter** – Pessimistic, half empty glass, expect the worst possible outcome all of the time. You pick out a single negative detail and dwell on it exclusively so that the whole situation is negative; “I have ______, no one would ever want me.”

10. **Jumping to conclusions** – You make a negative interpretation even though there are no definite facts that convincingly support your conclusion:
    a. Mind reading – You arbitrarily conclude that someone is reacting to you negatively, and you don’t bother to check this out
    b. The Fortune Teller error – you anticipate that things will turn out badly and feel convinced this is an established fact
Defense mechanisms protect us from being consciously aware of a thought or feeling which we cannot tolerate. The defense only allows the unconscious thought or feeling to be expressed indirectly in a disguised form. Let’s say you are angry with a patient because he has been verbally abusive to you. Here’s how the various defenses might hide and/or transform that anger:

**Denial:** You completely reject the thought or feeling.

“I’m not angry with him!”

**Suppression:** You are vaguely aware of the thought or feeling, but try to hide it.

“I’m going to try to be nice to him.”

**Reaction Formation:** You turn the feeling into its opposite.

“I think he’s really great!”

**Projection:** You think someone else has your thought or feeling.

“That patient hates me.”

“That staff hates the patient.”

**Displacement:** You redirect your feelings to another target.

“I can’t stand that doctor.”

**Rationalization:** You come up with various explanations to justify the situation (while denying your feelings).

“He’s so abusive because he’s trying to forget about his own abuse.”

**Intellectualization:** A type of rationalization, only more intellectualized.

“He is acting out feelings of abandonment with his verbal abuse.”

**Undoing:** You try to reverse or undo your feeling by DOING something that indicates the opposite feeling. It may be an “apology” for the feeling you find unacceptable within yourself.

“I think I’ll burn a CD for that patient.”

**Isolation of affect:** You “think” the feeling but don’t really feel it.

“I guess I’m angry with him, sort of.”
Regression: You revert to an old, usually immature behavior to ventilate your feeling.

    “Let’s shoot spitballs at people!”

Sublimation: You redirect the feeling into a socially productive activity.

    “I’m going to write a poem about anger.”
**22. Appendix 3**  

**Psychiatric/Mental Health Glossary**

**ACEs:** Adverse Childhood experiences. A term coined by researchers to describe ten potentially damaging childhood experiences and the long-term relationship between these experiences and a wide array of adult medical issues

**Affect:** Emotions, facial expression of feelings

**Aggression:** harmful acts or words

**Ambivalence:** coexistence of contradictory feelings

**Bizarre:** grotesque, odd, peculiar

**Circumstantial:** irrelevant and redundant speech

**Compassion:** A feeling of deep empathy and respect for another who is stricken by misfortune and the strong desire to do something about it.

**Compulsion:** insistent, repetitive urges to act

**Conflict:** clash between emotions or thoughts

**Defense mechanism:** Unconscious, intrapsychic process to reduce conflict and anxiety

**Delusion:** false belief

**Denial:** rejection of reality

**Dissociation:** separation of thought and affect

**Distortion:** twist painful ideas

**Distractibility:** mind easily diverted

**Echolalia:** automatic repetition of what is heard

**Echopraxia:** mimics what is done

**Euphoria:** exaggerated sense of physical and emotional well-being

**Executive Functions:** The abilities to set and follow through on goals, develop plans, anticipate consequences, and reflect on the process of doing so. These abilities are often lacking in children affected by trauma who therefore tend to act instead of plan.

**Flight of ideas:** skipping from one idea to another

**Hallucination:** false sensory perception without external stimulus
Hypochondria: exaggerated somatic concerns

Hypomania: mild excitement

Ideation: organization of ideas

Idealization: overvaluation of loved ones

Incoherence: disorganized, illogically connected thoughts

Insight: understand behavior

Introjection: incorporate into self

Labile: unstable emotions

Narcissism: exaggerated self-love

Obsession: persistent thought

Panic: acute state of anxiety

Paranoia: fear of persecution

Phobia: morbid, unreal fear

Projection: blame others, not self

Rapport: harmonious accord as in therapeutic situation

Rationalization: excuses for behavior

Regression: reversion to past more immature behavior

Repression: submerge painful ideas unconsciously

Resilience: The ability of an individual, family or community to withstand and rebound from adversity.

Stress: Physical, emotional or mental strain or tension. Stress may be “acute” (brief and severe) or “chronic” (over a long duration); however, when it overwhelms an individual or community stress can become the source of trauma.

Tics: involuntary spasms

Transference: unconscious displacement of affects and attitudes

Trauma: An umbrella term denoting the inability of a community or individual to respond in a healthy way (physically, mentally and/or emotionally) to acute or chronic stress

Worry: anticipation of anxiety
Healthcare in general and Mental Healthcare in particular have numerous terms and acronyms that may be unfamiliar. In order to have the ability to fully understand and participate in discussions about patient care and understand information documented in the patients chart the following list and definitions are provided. This list is not all inclusive but serves as a general reference:

**BOV (Board of Visitors):** The Mental Disabilities Board of Visitors is an independent board of inquiry and review established to ensure that the treatment provided in Montana's public health system for people with developmental disabilities and people with mental illnesses is humane, is consistent with established clinical and other professional standards, and meets the standards set by state law. Shodair is reviewed by the Board of Visitors on a regular basis.

**CPS – (Child protective Services):** State Agency responsible for oversight of child welfare in Montana. Investigates report of neglect or abuse.

**CSCT (Comprehensive school and Community Treatment):** In-school Mental Health Services that are provided in numerous (but not all) school districts in Montana. Patients may be referred for CSCT services on discharge if indicated.

**CMS (Center for Medicare and Medicaid Services):** Federal government agency that provides health insurance through Medicare, Medicaid and Children’s Health Insurance Program (CHIP).

**CRT (Collaborative Response Team):** The CRT is an organized response to a crisis situation involving a child or children. Specific steps are followed by designated staff, (who have completed restraint and seclusion and CRT training), when they are called to help.

**CBT (Cognitive Behavioral Therapy):** Form of psychotherapy. It works t solve current problems, and change unhelpful thinking and behavior. Focuses on exploring relationships among a person’s thoughts, feelings and behaviors.

**DBT (Dialectical Behavioral Therapy):** A modified form of CBT designed specifically for individuals with self-harm behaviors to help them learn to change these behaviors

**DPHHS (Department of Health and Human Services):** Large State Agency which contains many services/agencies related to mental health and child welfare including CPS.

**DRM (Disability Rights Montana):** A federally mandated civil rights protection and advocacy system for the State of Montana.

**ED (Emergency Department) or ER (Emergency Room):** Shodair uses St. Peter’s hospital for any children who require emergency medical treatment.

**eMar (Electronic Medication Administration Record):** Medication for all patients is entered into the Meditech system. Nurse document all medication administered to patients in Meditech.

**EMR (Electronic Medical Record):** Any health care information that is access through Meditech is part of the EMR.
ERC (Exit Review Conference): a conference (usually on the phone), that is held with the Director of Education at Shodair, the child’s teacher and representatives from the school where the child will be returning prior to the child’s discharge from Shodair. The purpose of this conference is to discuss any special educational needs the child may have upon their return to their community school.

HIM (Health Information Management): The department also known as “Medical Records”. Patient Charts and all patient health information are managed and stored in this department.

IEP (Individual Education Plan): Written statement of the educational program designed to meet a child’s individual needs. Every child who receives special education must have an IEP. Parents are involved in the process. The IEP identifies a child’s strengths weaknesses and educational goals.

JDC (Juvenile Detention Center): Youth who commit a felony while at Shodair are transported to the Juvenile Detention Center in Great Falls.

Medication: There are three ways that the timing of medication is ordered at Shodair. The first is “scheduled” medication, given at specific time during the day. The second is “PRN” medication which is given on an “as needed” basis, depending on patient need and a nurse’s assessment of that need. The third is a “now”, or “STAT”, medication which indicates an urgent or emergent need for a medication. All of these require a physician’s order and administration by an LPN or RN.

Milieu: The physical and social surroundings and environment and everything that makes up the environment of a person or group of person’s. At Shodair we refer to the unit as the “Milieu”. We also refer to the “state/acuity or condition of the milieu”. This refers to the level of tension or activity or disruption on the unit.

Milieu Meetings: Milieu meeting are unit staff meetings. They are held on a weekly basis in the “couch room” at 1:30 PM. Monday (Grasslands), Tuesday (Glacier), Wednesday (High Desert), Thursday (Yellowstone). These meeting are informative, problem solving and educational. Attendance is not mandatory but is strongly encouraged.

NPO: Latin term for “nothing by mouth”. It is sometimes necessary for patients to have nothing by mouth (liquid or solid) the night before some medical procedures, usually procedures involving anesthesia. If this is necessary a doctor will write an order for nursing.

OPI (Office of Public Instruction): State Education Agency of Montana. Oversees all education activity, programs and schools.

P.O. (Probation Officer): Works with youth on probation to prevent them from committing another crime.

Precautions: All children are checked every fifteen minutes for safety. At times they must be monitored more closely and will be put on additional monitoring precautions.

TJC (The Joint Commission): An independent not-for-profit group that accredits more than 20,000 healthcare organizations and programs in the US. Shodair is accredited by TJC and is reviewed for compliance every three years.

*If you hear terms or words that you don’t understand, that are not included here –please ask!
**Conclusion**

You've finished the MHT Orientation Handbook training and are on your way to completing your probationary period. At this point you should have a foundational understanding of mental illness, what it means to live with mental illness, basic understanding of behavioral interventions and what your role is as a Mental Health Technician. Some essential points to remember:

- The children you will care for have not chosen this path in their lives.
- Many of the children you support have experienced trauma, and some may have spent a number of years in the mental health system.
- Just as recovery from physical illness is possible, it has been shown that children living with mental illness can recover and have full and meaningful lives. That is what you're working towards with these children.
- Mental illness is a disability you can't see, but is very real. Remember to believe in the children you care for and have compassion for their situation. Whenever possible try to put yourself in their shoes.
- Good communication is crucial in any relationship. In your role you will need to successfully communicate with your co-workers and the children you care for.
- The work you do is confidential. Always check the patient’s confidentiality number before sharing information with a parent or guardian, and share information with coworkers only on a "need to know" basis.
- Your documentation should be short and to the point and objective, not opinion. It should be something you'd be comfortable having the child you care for (or their families) read.
- Maintaining a safe and orderly living space for our children is a necessary and an important part of your job.
- Cultural competence is an expectation of anyone working in the mental health field. Sometimes different cultural beliefs can challenge your personal values. Think ahead of time about how best to handle that, should the situation arise.
- None of us can ever know all there is to know about this challenging and fascinating work we have chosen to do. It is vital to your success and growth in your job that you ask questions when you are unsure of what to do or are unsure of an answer.
- We are all in this together and it is all about the children – all the time.

Congratulations and good luck as you complete your probationary period! Please remember, if you mindfully participate as a learning partner with the children you care for and wholeheartedly champion their personal growth, you will find this work challenging yet incredibly gratifying.
Mental Health Technician Orientation Form

I,

____________________________________________________

Name & Title (*please print*)

of

____________________________________________________

Shodair Children’s Hospital

Do hereby certify that ___________________________________________

Name of Employee

Has completed the *Mental Health Technician Orientation Handbook*. The above named person is familiar with all the content of the handbook, and has demonstrated the ability and understanding to safely and competently perform his/her job assignments in this facility in accordance with the general instructions contained in the handbook. This qualifies said person to complete his/her probationary period.

Signed:

____________________________________________________

Name and Title of Shodair Supervisor Date

____________________________________________________

Employee Date

____________________________________________________

HR Director Date