Children’s Mental Health Rule 79 Targeted Case Management Training
Part 1: Mission, Philosophy and Structure
June 24 – June 25, 2019
Welcome

Getting to know your trainer

Housekeeping

• Restrooms/Breaks
• Cell Phones
• Orientation on training Materials (e.g. handouts, Idea Catcher, parking lot)
• Schedule for the day, policy on breaks
Part 1 – Case Management Mission, Philosophy and Structure

Day One:

- Introduction: 0.5 hours
- Historical Perspective: 1.5 hours
- Integrated Care: 1.0 hours
- Service Requirements: 2.5 hours
- Wrap Up (check parking lot, other questions, plan for tomorrow): 0.5 hours
New Children’s Mental Health County Case Managers

• To meet the training requirements for Rules 9520.0912 Subp 4
• Case managers who do NOT have 2,000 hours of supervised experience in the delivery of services to children with severe emotional disturbance
• This includes persons with a bachelor’s degree without 2,000 hours of experience as well as persons qualifying as case manager associates and certain immigrants as defined under MS 245.472, Subd. 4 (h) 2.
Ice Breaker

Share your name, where you work, at least one thing you are hoping to gain from this training

Pick one:

1) Share a fact about yourself (not too controversial or incriminating) that others might find surprising.

2) Describe the aspect of working with children and families that you find most satisfying
Terms of participation

• Respect others
• Take risks
• Be open and honest
• Listen actively
• Be accountable
• Maintain confidentiality
Training Philosophy

• Disclaimer: Not “everything you need to know”

• Adult learning
  • To “educe” or draw out
  • Experiential, “hands-on” activities

• Breadth over depth
  • The “4 As”
Goal:

Understand the values, principles and legislation that serve as the foundation for children’s mental health case management.

Objectives:

• Identify the responsibilities held by counties as local mental health authorities

• Define the continuum of mental health services established by the Children’s Mental Health Act

• Describe components of a system of care
• The “Minnesota Miracle”

• Minnesota Rankings of Child Health and Well-being
Significance of Child Poverty

• One in three Latino babies and one in two black babies are born into poverty

• Increased vulnerability to physical health, mental health and developmental problems; limited access to care

• Undiagnosed physical health, mental health and developmental problems closely linked to school failure, chemical use and criminal activity
A Call to Action to Dismantle the Cradle to Prison Pipeline

“A CALL TO ACTION TO DISMANTLE THE CRADLE TO PRISON PIPELINE”

By Marian Wright Edelman
Founder and President Emerita

The Children’s Defense Fund convened a national Summit on America’s Cradle to Prison Pipeline® Crisis at Howard University to focus on the looming national catastrophe for all Americans but especially for the African American and Latino communities.

2007 study: A child’s future is determined by age 6

<table>
<thead>
<tr>
<th>Race</th>
<th>Sex</th>
<th>Chance of going to prison in their lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>Boy</td>
<td>1 in 3</td>
</tr>
<tr>
<td>Black</td>
<td>Girl</td>
<td>1 in 17</td>
</tr>
<tr>
<td>Latino</td>
<td>Boy</td>
<td>1 in 6</td>
</tr>
<tr>
<td>Latina</td>
<td>Girl</td>
<td>1 in 45</td>
</tr>
</tbody>
</table>

Childrensdefense.org
Discuss

• Describe your reactions to the child well-being statistics shared in this section. What did you find most surprising? Most encouraging? Most discouraging?

• How optimistic are you feeling about the future of children in Minnesota?

• If you had the power to make immediate changes in policies affecting children and families, what would you change and why?
• 1968: First comprehensive review of state’s Children’s Mental Health System

• 1989: Passage of Children’s Mental Health Act
  • Established a mission
  • Defined counties as local mental health authorities
  • Mandated a full continuum of services
  • Endorsed a System of Care Philosophy
Mission of children's mental health service system.

As part of the comprehensive children's mental health system established under sections 245.487 to 245.4889, the commissioner of human services shall create and ensure a unified, accountable, comprehensive children's mental health service system that is consistent with the provision of public social services for children and that:
(1) identifies children who are eligible for mental health services;

(2) makes preventive services available to all children;

(3) assures access to a continuum of services that:

(i) educate the community about the mental health needs of children;

(ii) address the unique physical, emotional, social, and educational needs of children;

(iii) are coordinated with the range of social and human services provided to children and their families by the Departments of Education, Human Services, Health, and Corrections;

(iv) are appropriate to the developmental needs of children; and

(v) are sensitive to cultural differences and special needs;
(4) includes early screening and prompt intervention to:

(i) identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs; and

(ii) prevent further deterioration;

(5) provides mental health services to children and their families in the context in which the children live and go to school;
Mission of Children’s Mental Health Act – cont.

(6) addresses the unique problems of paying for mental health services for children, including:

(i) access to private insurance coverage; and

(ii) public funding;

(7) includes the child and the child's family in planning the child's program of mental health services, unless clinically inappropriate to the child's needs; and

(8) when necessary, assures a smooth transition from mental health services appropriate for a child to mental health services needed by a person who is at least 18 years of age.
Mn. Stats. 245.4871, Subd. 6. Child with severe emotional disturbance.

For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or
Mn. Stats. 245.4871, subd. 6

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

(ii) risk of harming self or others as a result of an emotional disturbance; or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

(4) the child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.
Mn. Stats. 245.4871, Subd. 15 Emotional disturbance

"Emotional disturbance" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is detailed in a diagnostic codes list published by the commissioner; and

(2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

"Emotional disturbance" is a generic term and is intended to reflect all categories of disorder described in the clinical code list published by the commissioner as "usually first evident in childhood or adolescence."
System of Care Bubble Map

- Education
- Juvenile Justice
- Public Assistance
- Informal Support
- Mental Health
- Health Care
- Child Welfare
Integrated Care: Where we’re going?
Goal: Understand why case management is delivered with respect to the physical and mental needs of the client

Objectives:

1. Define the concept of prevention
2. Describe the advantages associated with integrating physical and mental health care
3. Identify key features of a comprehensive benefit set
4. Define how the case manager’s role has changed in light of the 2007 Mental Health Initiative
Ensuring all citizens have access to the right care, at the right time, in the right location

Based on deficiencies in state mental health system noted by the Minnesota Mental Health Action Group (MMHAG)
Deficiencies along three themes:

• Fragmentation
• Inefficiency
• Inequity
Consequences of Fragmentation

• Many singers, no chorus
• Unrecognized and/or untreated health problems
• Delayed care
• Primary care setting becoming the “de facto” provider of mental health services
Inefficiency:

• The “fatal flaw” of the US health system
• Gaps in coverage
• Financial disincentives
Inequity:

• Affordable care for some, medical debt for others

• Working poor at distinct disadvantage
Definition of integrated care:

• Prevention
• Optimal health
• Biopsychosocial perspective
Integrated Care Approach

Three levels of integration

• Practice
• Policy
• Legal
Integrated care programs in Minnesota

- Preferred Integrated Networks
- Health Care Homes
Integrated Care Approach

Comprehensive Benefit Set:

• Improve outcomes
• Ease access
• Expand choice
• Eliminate stigma
Evolving Role of the Case Manager: Working with the MCO’s

Two service tracks: fee-for-service and managed care

Guidance for working with the MCO’s

Case transitions

Mental Health Targeted Case Management Universal Transfer form
(updated 2015)

https://edocs.dhs.state.mn.us/lfsnwrk/Public/DHS-6063-ENG
Evolving Role of the Case Manager

Integrated Approach to Case Management

• Basic assessment of health problems and diseases
• Monitoring access to basic health services
• Helping clients manage health care information
• Facilitating communication among health care providers
Evidence-based practice

• Data-driven decisions

• Establishing necessity
Discussion:

What are your reactions to the way the case manager’s role is being defined by current policy?

What do you find encouraging or discouraging about these changes?
Service Requirements
Mandated Responsibilities of a Case Manager

- **Monitoring and Coordination:**
  - Review of goal progress and effectiveness of services, resources & supports

- **Assessment:**
  - Review diagnostic assessment, review screening tools
  - PA, level of care, & Reassessment

- **Referral and Linkage:**
  - Implement IFSP, acquire Resources, services, & natural supports

- **Planning:**
  - Develop IFSP, transition plan & other plans as needed

**Working Relationship:**
- Person centered & recovery oriented
Goal: Apply Rule 79 standards to the practice of Children’s Mental Health case management

Objectives:

1. Define the core services of a case manager
2. Identify allowable mental health targeted case management activities
3. Describe the eligibility criteria for mental health targeted case management
Guiding principles

- Child Centered
- Family focused
- Culturally competent
- Community-based
• Relationship is the “anesthesia”

• “Ages and stages” perspective

• Questioning stance

• Strengths-based
• “It can’t be about us without us”

• “Inheritances” children receive from families
  • Symbolic
  • Behavioral
Culturally competent

• Definition

• Culture applies to all people, not just people of color

• A journey not a destination

• Culture reveals strengths and opportunities
• The need for a culturally competent Children’s Mental Health system:

  • “Failing to prepare is preparing to fail”

  • Minnesota youth population by 2030
    • Number of white children decreases by 1%
    • Number of racial and ethnic minority children increases by 72%

  • Children of color up to 50% less likely to receive needed mental health services

  • Research on what works for children of color lacking
Community-based

- Least restrictive setting

- Availability

- Accessibility

- Utilization
Bronfenbrenner’s Ecological Model: Placing the child/family into context
Exploring Influences

List examples of how the child/family domain can be impacted by each of the other domains
Purpose: to help the child with severe emotional disturbance (SED) and the child’s family obtain needed health, mental health, social, educational, vocational, and recreational services:

Core Services:

- Assessment
- Planning
- Referral and linkage
- Monitoring
Case Management Structure

- Monitoring and Coordination: Review of goal progress and effectiveness of services, resources & supports
- Assessment: Review diagnostic assessment, review assessing tools, FA, level of care & reassessment
- Referral and Linkage: Implement IF/CCSP, acquire resources, services & natural supports
- Planning: Develop IF/CCSP, transition plan & other plans as needed

Working Relationship:
Person centered & recovery oriented
What case management isn’t:

• Direct mental health services
• Skills training
• Transportation service
• Legal Services
Child Welfare Targeted Case Management (CW TCM) activities not allowable for Children’s Mental Health Targeted Case Management (CMH TCM)

- Research gathering and completion of documentation required by the foster care program
- Assessing adoption placements
- Recruiting or interviewing for potential foster care providers
- Serving legal papers
CW-TCM claimable activities but not CMH TCM continued….

- Home investigations
- Providing transportation
- Administering foster care subsidies
- Making placement arrangements
Clarifying “dual” case management

• Mental Health Targeted Case Management and Child Welfare Targeted Case Management

• Mental Health Targeted Case Management and Developmental Disabilities Case Management

• Mental Health Targeted Case Management and Rehabilitation Services
Group Activity:

Case Management or not case management
Case management process

1) Request or referral for CMH TCM services

2) Eligibility determination (see slides #18 - 20)
   • Diagnostic assessment requirements
   • Presumptive eligibility

3. Case Manager Assigned
4. Case manager completes Functional Assessment within 30 days of meeting the child.

5. Case manager completes Individual Family Community Support Plan (IFCSP) within 30 days of meeting the child.

6. Case manager refers and links child and family to services.

7. Case manager monitors and reviews child’s progress, coordinating and evaluating services.
## Children’s Mental Health Work Flow

<table>
<thead>
<tr>
<th>Document</th>
<th>Responsible party</th>
<th>Timelines</th>
<th>Legal Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Assessment</td>
<td>Case Manager</td>
<td>Within 30 days of the first meeting with the child and at least every 180 days after the development of the ICSP</td>
<td>MN. Stats. 245.4871, Sub. 18a</td>
</tr>
<tr>
<td>Individual Family Community Support Plan (IFCSP)</td>
<td>Case Manager</td>
<td>Within 30 days of the first meeting with the child and at least every 180 days after the development of the IFCSP</td>
<td>MN. Rule 9520.0902, Sub 21</td>
</tr>
<tr>
<td>Transition Plan</td>
<td>Case Manager</td>
<td>For children between the ages of 17 and 21 before discontinuing case management services</td>
<td>MN. Stats. 245.4881, sub. 1</td>
</tr>
</tbody>
</table>
In-service Considerations

• Billing and reimbursement
• Caseload size
• Supervision
• Training
• Transition age youth
How do you support a child/youth and their family in making the decision whether they should continue to receive Children’s Mental Health case management services or be referred for Adult Mental Health case management services?
Wrap up
Welcome back!
Day Two:

- Child Development: 1.0 hours
- Diagnostic Assessment: 2.0 hours
- Treatment Approaches: 2.0 hours
- Psychiatric Medications: 0.5 hours

Wrap Up (check parking lot, other questions, plan for tomorrow)

0.5 hours
Child Development
Goal:

Apply knowledge of child development to case management service delivery
Objectives:

• Identify protective factors in the development of a child

• Define critical child development concepts including attachment, attunement, and mirroring

• Describe the notion of developmental trauma and its typical consequences
“Before I got married I had six theories about bringing up children. Now, I have six children and no theories.”

John Wilmot
Significance of child development for case managers

• Past informs the present
• Increase in number of children served under the age of 5
• Children are identified as meeting SED criteria with undetected developmental problems
• Contact with younger siblings
“Ages and Stages” Framework

• Cognitive
• Social-Emotional
• Speech and Language
• Fine Motor
• Gross Motor
Estimate the age at which each ability/skill typically emerges
Child Development

Start to understand danger 4 years
Show interest in other children 18 months
Often do the opposite of what is asked 2 years
Let the caregiver know what he/she wants 18 months
Speaking single words 16 months
Follow a 3-step direction 5 years
Understand common words like bye, all gone 9 months
Understand simple home rules 4 years
Use toilet during the day and stays dry at night 3 years
Thinks about others feelings of others 3 years
Red Flags

• Impairment in social interaction
• Impairment in communication
• Repetitive behaviors and restricted interests
Limitations of theories

Nature and Nurture

• Temperament
• Psychopathology

Risk and Protective Factors
Attachment: Ultimate protective factor

• A secure connection to a reliable, responsive, and nurturing caregiver
• Babies “hard-wired” to attach
• Attachment memory
• Effects of Maternal stress
Mirroring and Attunement

• Caregiver’s ability to read child’s emotional cues and respond appropriately to his/her needs
• The “glue” for interpersonal bonds
• Basis for self-regulation
Attachment in the real world

WCCO - Marshmallow Text reproduced by Dr. David Walsh

Discussion: What are the social-emotional competencies demonstrated by kids who are successful with the marshmallow challenge?
If there are current deficits, was there trauma/stress during timeframe?

Collecting a “brain history”
Developmental Trauma: Overwhelming level of stress experienced by children who experience a profound loss of control

Stress biology

• Positive
• Tolerable
• Toxic
Consequences of toxic stress

• Fight/flight
• Dissociation
• Insecure attachment
Group Discussion: Brainstorm some mental health conditions or diagnoses.

• Which conditions have symptoms similar to the fight/flight or dissociative responses?

• Why is it important to make the distinction between trauma and other mental health conditions?
Goal:
Apply knowledge of child mental health conditions to case management service delivery

Objectives:
• Define the concept of clinical significance
• Describe the cognitive basis for depression and anxiety
• Identify key considerations involved in accurately diagnosing Attention-Deficit Hyperactivity Disorder, and Bipolar Disorder
• Describe strategies for obtaining necessary diagnostic information from mental health professionals
Overview of Diagnostic and Statistical Manual:

Clinical Significance

- Onset
- Duration
- Impairment

Frequency
Pervasiveness
Group Activity:

- Label or not to label?

Benefits

Disadvantages
Assessment of Intellectual Ability

• What IQ tells us:
  
  POUR: process, organize, understand, and retain

• IQ “genetically based?”

• Emotional Intelligence
What IQ doesn’t tell us may be more important:

Enrichment opportunities

• 10,000-hour Rule
• Concerted Cultivation
Other enrichment factors

• Unintentional Cultivation
• Premature Structuring
• Alternative Elaboration
• Multiple Intelligences (see handout)
• Scaffolding
• Expectations
Emotional Intelligence turns IQ on its head:

- **Self-awareness**: Recognizing one’s own emotions, values, strengths, and limitations
- **Self-management**: Managing one’s behavior and emotions to achieve goals
- **Social awareness**: Showing understanding and empathy to others
- **Relationship skills**: Forming positive relationships, working in teams, effectively dealing with conflict
- **Responsible decision making**: Making ethical, constructive decisions about personal and social behaviors
Emotional Intelligence

Bell Labs Story
Components of a high quality Diagnostic Assessment

What to look for: features of a good Diagnostic Assessment

(refer to handout here)

• DHS recommended template
  • Child/Adolescent Diagnostic Assessment - DHS 5704A (completed by parent/caregiver)
  • Child/Adolescent Diagnostic Assessment - DHS 5704B (completed by clinician)
Tips for Case Managers

• Don’t hesitate to ask questions

• Be persistent
Components of a comprehensive assessment

• Evidence of core symptoms

• Clinical significance

• History
  Developmental  Educational
  Family  Cultural
  Mental Health  Physical health
  Chemical Health

• Giftedness?
Major symptoms of depression:

- Feelings of powerlessness and hopelessness (including suicidal thoughts)
- Loss of interest in previously enjoyed activities
- Agitation or slowing of behavioral
- Loss of energy
- Impaired concentration and short-term memory
- Changes in sleep, appetite, weight
- Crying spells
- Young people - irritability
Over diagnosed, underdiagnosed or misdiagnosed?

• Fastest growing mood diagnosis among children

• Minimal evidence that actual rates of Bipolar has increased

• Explanations for increased frequency of diagnosis

• Disruptive Mood Dysregulation
Symptoms of Manic Mood

- Abnormally and persistently elevated, expansive or irritable mood for at least one week.
- Increased engagement in goal-directed activities
- Excessive involvement in pleasurable activities that have high potential for painful consequences
- Irritability and/or anger
- Distractibility
- Decreased need for sleep
- Pressured thoughts and speech (racing thoughts)
- Grandiosity
Diagnostic Criteria of Bipolar

• Unusual to find mania without subsequent or preceding period of depression

• Distinguish from ADHD. Manic state triggered by steroid medications, stimulant medication, acute stress or trauma

• Antidepressant induced mania ("affective switch"). Non-response to 3 or more antidepressant trials

• Family history

• Phases often less discrete among children than adults
Diagnostic Assessment- Disruptive Mood Dysregulation Disorder

- Severe temper outbursts at least three times per week
- Sad, irritable or angry mood almost every day
- Reaction is bigger than expected
- Child must be at least six years old
- Symptoms begin before age ten
- Symptoms are present for at least a year
- Child has trouble functioning in more than one place (e.g. home, school and/or with friends)
Major symptoms of anxiety:

• Extreme worry, nervousness child finds difficult to control
• Fear out of proportion to actual threat
• Going to great lengths to avoid source of fear
• Often accompanied by physical distress (sleep problems, stomach aches, headaches, muscle tension). If individual can’t escape from anxiety, it can convert to physical symptoms.
Types of Anxiety

• Generalized Anxiety Disorder
• Phobias
• Panic Attack
• Obsessive-Compulsive Disorder
Depression and Anxiety

• Depression and anxiety often co-occur

• The Cognitive Model
  • Activating event
  • Beliefs
  • Consequences

• Cognitive Distortion: catastrophizing and unrealistic appraisal
### Group Activity: Cognitive Distortion Grid

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Anxious Child</th>
<th>Non-Anxious Child</th>
<th>Anxious Child</th>
<th>Non-Anxious Child</th>
<th>Anxious Child</th>
<th>Non-Anxious Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher calling on student to share results of homework. Child not sure if she did it right.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child tried out for soccer team but wasn’t selected.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depressed Child</td>
<td>Non-Depressed Child</td>
<td>Depressed Child</td>
<td>Non-Depressed Child</td>
<td>Depressed Child</td>
<td>Non-Depressed Child</td>
</tr>
</tbody>
</table>
Diagnostic Assessment: Anxiety and Depression

**Blinders:** make you pay attention only to the negative things in a situation and keeps you from seeing the good things.

**Magnifying Glass:** blows things up to be much worse than they actually are or makes a big thing out of nothing.

**Quick Sand:** tries to get you to focus on the negative thought (get stuck) when it’s ok to move on.

**Crystal Ball:** predicts that things will not go well or will be bad before they happen.
Diagnostic Assessment: Oppositional Defiant Disorder

Group Activity

Think about the most challenging child with whom you have worked

• What was particularly difficult about working with him/her?
• What emotions did you experience during your efforts?
At least 4 of the following symptoms are present for 6 months or more:

- Often loses temper, frequent temper tantrums
- Often argues with adults
- Active defiance and refusal to comply with adult requests and rules
- Deliberately annoys others
- Blames others for his/her mistakes
- Often touchy or easily annoyed by others
- Often angry and resentful
- Often spiteful and vindictive
Common Assumptions

“He/she knows better”

“He/she is doing it on purpose”

“He/she is being manipulative”

“It’s my fault. I’m doing something wrong.”
Diagnostic Assessment: Oppositional Defiant Disorder

Common Strategies

- Yelling
- Threatening
- Explaining
- Punishing
- Rewarding
- Giving in
Alternative Concepts:

• Difficulty organizing stimulation
• Behavior communicating what child unable/unwilling to voice
• Child has experienced difficulty in the area of attachment and/or separation
• Child “stuck” in an ingrained response pattern
• Child seeking to control factors beyond his/her control
Alternative Concepts (continued)

- Child being asked to perform tasks beyond his/her ability
- Child does not understand the purpose of what he/she is being asked to do
- Child may not enjoy what he/she is being asked to do
- Child may lack confident in ability to perform tasks
- Child may have reached developmental stage of limit testing
- Child may not feel well
Symptoms:

• A persistent pattern of violating the rights of others and accepted social norms and rules
• At least three of the following criteria are met over a 12-month period
  • Aggression to people or animals
  • Destruction of property (intent to destroy)
  • Deceitfulness or theft
  • Serious violations of rules (out all night, running away, assaulting others)
Rigidity, restriction, repetition in three domains: social interaction, communication, and behavior

Social:

• Lack of social emotional reciprocity ("give and take")
• Inability to notice the needs or distress of others
• Absence of peer relationships
Diagnostic Assessment: Autism Spectrum Disorder

Communication:
- Inability to initiate or carry on conversations
- Stereotyped and/or repetitive use of language (echolalia)

Behavior:
- Lack of developmentally appropriate play
- Limited patterns of interest
- Inflexible adherence to purposeless routines and rituals
Diagnostic Assessment: Autism Spectrum Disorder

- Autism
- Asperger’s Disorder
- Rett’s Disorder
- Child Disintegrative Disorder
- Pervasive Developmental Disorder NOS
Discussion Points:

• Environmental factors
• Vaccinations
• Genetic factors
• Neurological factors
Discussion Point

Why increased incidence? In Minnesota, about 200 diagnosed cases in 1990 to 3500 currently

• New tools for early diagnosis
• Diagnosis often subjective
• Wider net, label needed to access services
• Vitamin D deficiency
Posttraumatic Stress Disorder symptoms:

Exposure to an extraordinary stressor followed by intense fear, helplessness, and horror

• Hypervigilance
• Avoidance
• Re-living (flashbacks, intrusive thoughts)
• Emotional numbness or detachment
Definitions of traumatic event

Simply put: “a profound loss of control”

Diagnosis often complex with children
Response to trauma shaped by many factors

Cumulative effects (i.e., bouncing ball losing resilience)

Source of trauma can predict response

- Intentional human
- Unintentional human
- Acts of nature
Diagnostic Assessment: Fetal Alcohol Spectrum

Definition:

• Fetal Alcohol Spectrum Disorder a term used to describe a group of birth defects that can result when a woman drinks alcohol when pregnant

Symptoms and physical features

Not in DSM. Public mental health system has no statutory responsibility to identify or treat it
Goal:

Apply knowledge of evidence-based treatment approaches to case management work

Objectives:

Define cognitive-behavioral approaches to treating depression and anxiety

Identify effective interventions for ADHD, oppositionality, trauma, and developmental disorders.
Purpose for case managers:

To be familiar with accepted intervention approaches and better able to assess if the service the child is receiving is appropriate for their needs
The Minnesota Model of Evidence-Based Practice

Important takeaways from the Minnesota Model

Therapy with best support for many problem areas is cognitive-behavioral therapy

Family involvement key component of effectiveness

Minimal support for “play” and “supportive” therapies

Known risks associated with group therapy

Relatively known about treating Autism Spectrum Disorder and Bipolar Disorder

Unanswered question about the effectiveness of indigenous or “alternative” healing methods
ADHD

• Psychoeducation
• Routine and structure
• Problem Solving
• Stimulus Control

Group Activity: Video (Dr. Sulik)
"People are not disturbed by events as much as they are by their interpretations of those events."

Cognitive-Behavioral Approach: Adding a “D” (dispute) to the A-B-C model

• De-catastrophizing

• Realistic appraisal

• Coping plan
Treatment Approaches

Depression and Anxiety

Group Activity: Video (Dr. Sulik)
Treatment approaches: Oppositionality
Treatment Approaches

Oppositionality

- The “3 C’s:” Choice, Control and Collaboration
- Precautions
Treatment Approaches

Oppositionality

Limitations of consequences and rewards:

• Child does not understand cause and effect

• Child cannot or does not distinguish between positive and negative experiences (The certainty of misery is better than the misery of uncertainty)

• Child des not prefer positive attention over negative attention
Oppositionality:

Limitations of consequences and rewards continued…

• Consequence or reward is not relevant to the child’s reality
• Consequence or reward is simply code for punishment
• Can activate traumatic experiences, produce intense reactions
Oppositionality

Effective use of consequences:

• Keep them logical, natural, timely, and proportional
• Calmly state and reinforce them
• Allow a reasonable amount of time for compliance
• Avoid coercive cycle (ie., power struggle)
• Move on without bearing a grudge
• Establish a system for addressing problems. Manage system, not child
Conduct Disorder

- Good Support: Multi-systemic Therapy (MST)
- Minimal Support: Juvenile Justice System
- Known Risks: Group Therapy (leads to “deviance training”)

Treatment Approaches
Pervasive Developmental Disorder

“Then and Now”

Characteristics of Effective Treatment

• Earlier the better
• Active parent involvement
• Home-based component
• Structured environment
• Generalization of new skills
• High intensity
Trauma

Initial Response

• Validate and normalize

• Plain talk
  • Permission to talk (or not talk)
  • Listen as long as child wants to talk
  • Provide simple, declarative statements

• Create a web of support
Cognitive-Behavioral Therapy is the gold standard in clinical treatment

• Systemic Desensitization

• Why it works:
  • Organizing memories keeps them from intruding
  • Integrating memory and emotion offers control
  • Exposure (making the tolerable more tolerable)
Evaluation
Questions regarding Part 1
Please fill out your course evaluation
Thank you!

For more information or ?’s
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