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Mentored Service Coordination for Children and Adolescents:

A Guide for Practitioners and Mentors

...sharing information and skills to foster growth

Part I: PERSPECTIVES TO HELP GET YOU STARTED

Chapter 1: Introduction

Importance of the Service Coordinator in Community Mental Health

A good service coordinator is probably the most important professional in the lives of children and teens with mental health diagnoses living and recovering in the community. Psychiatrists may prescribe medicine and counselors may provide therapy, but a good service coordinator creates the avenues to these people and helps clients to knit their work together. The service coordinator helps to reach out and coordinate all other services and insures that they are relevant to the needs and dreams of the individuals they work with. A service coordinator plays a vital role in helping parents and families discover resources for their children, and perhaps for themselves, as well. A service coordinator can literally be a lifesaver for children and families.

The value of community resources and the mental health system is dependent on a service coordinator who forms a trusting relationship with the individuals and families assigned to their care, is available when needed, and can facilitate their access to all the formal and informal resources that are needed by those individuals. This manual was created in recognition of the vital role of service coordinators, and their need for practical and systematic information and ongoing support for the important work they do. It is crucial that the few special people tasked with this job receive the training and support they need to excel at their work and make a *real* difference.

What am I doing here? Responsibilities and Logistics of Service Coordination

As a service coordinator your primary work will be to connect children and adolescents with serious emotional disorders to the services that they need. You will be charged with understanding the needs and facilitating services for children and adolescents who have been diagnosed with a serious behavioral health disorder. Part II of the manual provides an introduction to major disorders and treatment approaches.

The children and adolescents you work with will also be involved with a number of other systems – schools, the health care system, and perhaps other systems, such as child welfare, juvenile justice or other specialized services. Some or all of the services provided will be paid for in the public sector; that is, the local or federal government will assume some or all of the costs of services received through Medicaid, Medicare, or other means. The families you work with may also need other public support, such as help with income, housing, and obtaining groceries. Part III of the manual provides basic information about the major systems you are likely to be dealing with.

Your primary job as a service coordinator is ***resource brokering*** for children and adolescents with serious behavioral health disorders, that is, you will connect families with the services that they need to help them survive and thrive in the community.

The children and adolescents that you serve will all have been diagnosed with a serious behavioral health disorder. Your ability to assess your clients' mental health functioning will be an important part of your work. Part II of the manual provides basic information on the major categories of disorders and treatments that are the most likely to affect the people who you serve.

Sometimes children or adolescents you serve will need to be hospitalized, or will need residential care away from their families. Your goal is children and adolescents stay in the least restrictive setting in which they can succeed, and to be there to help families and other providers understand when higher-intensity services may be needed.

You will need to be able to do five things.

- *Develop a good relationship with your consumers and their families*- This includes fostering trust and open communication so that it is clear to the individual and their family you are there to help. It also means being non-judgmental, respectful, and compassionate;

- *Broker resources*- It's your job to link the individual and family to the necessary goods (e.g., housing, food stamps, transportation) and services (e.g., doctors, dentists, therapists); Because of this responsibility you need to learn about the availability of goods and services in the areas you serve;
- *Assess mental health functioning*- Being aware and regularly taking an inventory of your consumer's status can help prevent relapse and the need for more restrictive care. (e.g., be aware of your consumer is taking their medications, experiencing more symptoms than usual, acting out beyond regularly seen behaviors, partaking in risky behaviors such as crime, alcohol or drugs);
- *Assess life stresses and strains*- Everyone experiences stress and strains from time to time but these can build and provoke more serious problems. If you keep an eye out for what is stressful to your client in their living arrangements, family interactions, or school, you can help them problem solve to minimize their impact. And;
- *Facilitate recovery*- Ensuring that clients and families are empowered to do what they can on their own and giving your clients and families the hope and opportunity to achieve their life goals.

Basic responsibilities. As a service coordinator you will have many crucial tasks, but you are not alone in the process of facilitating the recovery of a child or adolescent with behavioral or developmental diagnosis. Your essential responsibilities are helping an individual stay out of hospitalization or higher levels of care, help get what the individual and their family needs to survive in the community, and help them live the fullest and most satisfying lives possible. To accomplish these tasks, first start by insuring the individuals and families you see have their basic needs for shelter/food met and basic supports in place to facilitate their recovery. To achieve this, you need to perform 5 primary tasks:

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Logistics. The logistics of being a service coordinator are straightforward, and highlight both the unique and challenging experience of providing coordination services. A good review of these logistics ahead of time will help you to know what is expected. For instance, it is important to be prepared for the fact that you will not spend much time in the office. The best service coordinators spend most of their time in the community meeting with their consumers and identifying and connecting services their clients need. You will most likely see your consumers where they live, however you may see them at their doctor's office, or even at their local Eat N Park. Because of this constant motion, a service coordinator must maintain a daily schedule that is incredibly flexible. You have to deal with whatever comes up in the life of the child, adolescent, or family you serve. Some clients may only need 15 minutes of your time, but they may need 15 minutes every day. Other times you may need to spend half a day with one individual helping him/her with a task.

The continuous need for flexibility. The activities listed above form the primary responsibilities of a service coordinator. There will be times when your help is needed more in one area than another. There will be times when one client's needs are more important, or more of an emergency than another's and you will need to shift your time you had planned that day. It is important to remember that as your day unfolds, new crises or problems can arise and you will need to adjust your plans. Being flexible and understanding that unexpected events will happen often, is a way to maintain calm and be able to give the best services to your consumers.

Paperwork. Another important logistic component of service coordination comes from the fact that these services you are providing to your consumer are not free-someone (usually the federal or state government) pays for the services. This means that you will have to do paperwork to document your work with the individuals you see. This allows your agency to keep track of the services you provide and collect from payers who are funding your wage. Paperwork can also be used to help you see how an individual and their services change over time.

Staying up to date on paperwork while continuing to provide effective services requires you learn good time management. A balance between spending time going out and seeing clients and spending time staying in and doing paperwork is a goal to achieve and one that can be met. Your supervisors and/or mentor will help you more with the format of paperwork; they will be prepared to answer any specific questions you have about documentation. Remember conquering paperwork will be critical to your success at any agency because the agency will have no way of knowing how much you are doing to help your consumers without telling them by documenting your services.

Why a Manual for a Service Coordinator?

Excellent service coordination requires knowledge, skill, and the exercise of plenty of independent judgment. Sometimes people who want to accept the special challenges of this work have specialized training or experience, but often, they do not. Many people enter a career of service coordination right out of college. College degree programs, while excellent, usually do not address the complex, systematic knowledge needed to be a service coordinator. Basic knowledge about categories of behavioral and developmental disorders children experience and the other systems they will interact with is essential to getting a good start as a service coordinator. This manual is meant to fill the gap on basic knowledge while you learn the ropes of this job.

This manual aims to present practical, accurate, hands-on information that new service coordinators will find useful. It is designed to be of pragmatic help to new service coordinators while they are being mentored to do their jobs with children and adolescents in the community. The contents of this manual were drafted by expert service coordinators and service coordination mentors, with consultation from expert scholars in the field of mental health. It is a combination of hard won “real world” information and basic state-of-the-art academic knowledge about illness, recovery, and service coordination. The focus is on practical “how to” information about the work.

How To Use This Manual

- <u>Scope of the Manual</u>. There are some excellent comprehensive resources of service coordination; this work is not one of them. The goal of this manual is to provide a brief overview and orientation to the basic content needed to be an excellent service coordinator. The manual covers a lot of ground, but is not a replacement for good supervision. It should be used in conjunction with whatever traditional service coordination supervision and hands-on peer mentoring is available. Both supervision and mentoring are essential in effectively applying what is covered in this text, not to mention in learning the many additional skills that will move you beyond the basic information covered here. Supervision and mentoring will also help you to maintain your morale and combat the isolation that can be a part of outreach community work. Finally, this manual is not intended to replace good clinical and practical judgment. What is provided in this text are guidelines and basic information, not hard and fast rules. It is up to the service coordinators and their mentors to adapt these general guidelines to make them relevant to the individuals and situations they encounter.

- <u>Service Coordinators</u>: If you are a beginning service coordinator, you can use a review of this manual to orient yourself to the populations you will be seeing and the job you will be doing. Over time, you can use it more like a cookbook, a resource where you might find more detailed information and specific suggestions on a variety of topics as you encounter them. A page listed table of contents has been provided so that you can look up specific issues and get ideas about how to address them. You are strongly encouraged to discuss any questions you have about the content you read with your mentor or your supervisor. While we have tried to provide basic and clear information, some ideas might be confusing or difficult to apply to the specific individuals you see. Be sure to use the information and guidelines presented here as springboards for discussion with other service coordinators, your mentor and your supervisors.
- <u>Supervisor/Mentor</u>: This manual is written so that it can be understood by new and inexperienced service coordinators, regardless of whether or not they have a mentor. Some beginners will come with knowledge and experience about mental illness or social services or

both, but in our experience many will be starting from scratch in one or both areas. As a supervisor, or if a mentor is available, this text can serve as a guide for what content should be covered with new workers. New service coordinators will differ in their knowledge and experience of the material covered here. Thus, some sections will be review for some people. We expect that supervisors and mentors will use their judgment about which sections are reviewed briefly, and which sections are gone over in detail. However, we recommend that all areas be covered in a systematic way, even those sections that can be covered quickly for people with significant experience. As a supervisor or mentor, you can point your service coordinators to chapters providing specific information, and then use your supervisory time to help them integrate and apply the concepts presented to “real world” situations. For example, when new service coordinators do not understand the behaviors of individuals receiving services , you can suggest that it may help them to review the chapter on the symptoms of behavior and developmental disorders, then provide them with the opportunity to discuss with you how these symptoms are influence their relationship with their clients, how they can understand these symptoms in a way that will increase their ability to help the individual reach his/her goals or how they can help their consumer better manage their symptoms. Many people learn most effectively through hands-on practice and face to face supervision. Becoming familiar with the contents of the manual is simply a first step that can help you ensure everyone on your team has the same basic knowledge, which can allow you to direct mentees to specific sections which might be helpful in deciding how to intervene at specific times.

Chapter 2: The Big Picture

Recovery Is Real

The philosophy of recovery is a widely followed model in the mental health field. The belief is that a person can recover from a mental diagnosis and live happy, successful, and fulfilling lives. This idea of recovery is founded in the fact that the possibility of recovery is very real. People who receive mental health services do get better and continue to move on with their lives. But recovery does not just mean that a person is "cured" from his or her illness. A person can be in recovery and a success if he or she is living independently, are active in his or her treatment, or currently partaking in meaningful activities. Each person's recovery is a personal and unique experience. If a person feels that he or she is living a satisfying and hopeful life even with limitations of a mental diagnosis, they can be in recovery.

It is important to have a strong belief in recovery when working with individuals and families. Working with a person or family with a model of recovery in mind can help you encourage, support, and empower the person or family to succeed in their own recovery. As a Service Coordinator it is important to give the family or person you work with hope, because sometimes when people are in a very dark and unpleasant place it is hard to believe that things can ever get better. Also, it is important to continue to empower the person and family to function at the highest level possible. By empowering the family you are giving them the belief that they can control their own lives. If a family or person has been empowered to take control and make decisions about their own lives they can take a very large step towards recovery.

Children are Members of Families: A Family Systems Primer

As a child and adolescent Service Coordinator, you will be working with families- a lot. This is because children are a part of families, whether that is with their biological parent or parents, adoptive parents, aunts or uncles, or grandparents. You will never work with a child and not encounter a family because a child cannot function without the support of their family. A family is a system, with parts that move and change. Each member of the family affects the others. When one individual in the family acts out, or helps another family member, all members of the family are affected positively or negatively. Even if the child you work with is progressing in therapy or school, but has a horrible relationship with his or her siblings at home there still may be stunted positive growth. Because of this family system you can never think about just the individual independently, but must take in the entire situation of the family.

Children Go to School

A child's and adolescent's job is to go to school and they are expected to attend school every day. Unfortunately, many individuals who receive mental health services struggle to keep up with their academic expectations and goals. Further, schools can be rough places for kids who are feeling anxious or sad. As a child and adolescent Service Coordinator, you will need to become very familiar with schools often times speaking with teachers, guidance counselors, and administration. Further, you will need to work with the child or adolescent to get them in the best situation in order for them to be able to complete their requirements for school. Schools are a complex system, and work differently from the mental health system. We will discuss later in the manual the services the school provides, and ways to support the child and family in them.

Children Need Their Friends: Peer groups and Stigma

In the life of a child his or her friends play a major role. Friends allow children to have fun, relax, and can be a support in bad or difficult times. For a child with a behavioral disorder, making or keeping friends can be difficult for a variety of reasons. A child's symptoms can deter other kids from wanting to spend time with them, leaving the child feeling sad or alone. Also, a child's diagnosis can keep his/her peers from wanting to be around them. Unfortunately, in our society there is a stigma against those who have a mental diagnosis. This stigma partially comes from being "different", and also comes from society's negative perceptions about people who receive mental health services. As a child grows up they will encounter this stigma in increasing levels. This can be very difficult for many individuals causing them to feel sad, depressed, and isolated.

Another consideration about friends is that they have a strong influence over young people. It is easy for a child to want to do something just because his or her friends are doing it. If a child or adolescent you work with has a group of peers that are getting into trouble by breaking the law, or mixing in with drugs or alcohol, you may see that child being pulled in that direction as well. Remember that even if you are putting in supports to deter substance use and delinquency, they may not match up to the power of peer groups.

Children Change! Developmental Issues

As a child and adolescent Service Coordinator the individuals you work with will span a wide range of ages. Working with younger individuals will be very different from working with teens transitioning into the adult system. Individuals at different ages and developmental stages will have varying needs, desires and goals. Further, the child's developmental stage will influence their actions, behaviors, reactions, and emotions. Understanding that an 8 year old, will handle stress differently than a 13 year old is important to remember. Further, an individual may act younger or older than their chronological age. This is important to consider because while you would not expect a 10 year old to make his or her own appointments, some very mature 10 year olds can call and schedule times to meet with you. Developmental stages and chronological ages can give you a guide on what to expect from a child and how to interact with them, but keep in mind that everyone is different and there is no hard and fast rules of understanding kids.

Another consideration is that as you progress in the case with a child they may change. As time passes, the individual may begin to embark on a new developmental stage before your eyes. A child that you begin to know at 11 years old can be very different by the time they reach 14 years old. You will have to adjust your relationship with them, and their needs may become very different as they enter high school. They may be more concerned about their peers, or they may begin to develop problems at school when academics become more difficult. While you know the history of the child, keep in mind that children are ever-evolving. Grow with them, and provide new resources and supports as they develop.

Trauma: There's a lot of it out there

Trauma is a difficult issue to discuss, as many do not like to think that many children experience times of trauma and abuse. Trauma may not always be from abuse. Trauma may stem from losing a family member or friend in an abrupt and disturbing way. Further, each individual perceives and handles his/her own trauma in a different way. Being aware that trauma and abuse does occur can keep you attentive that there is a possibility that the individuals you work with may have had these experiences. Further, being aware of this possibility can keep you on the lookout for signs of trauma or abuse in a child's life. As a Service Coordinator it is your role to keep the individual you work with safe, and in the best situation possible.

Children and adolescents who have had experiences of trauma or abuse in their lives may be expressing this hurtful and upsetting incident through their symptoms or their actions. They may angry, scared, anxious, or sad that these things have happened to them. Some children who have been victims of trauma and abuse may be distrustful and have a slow time warming up to you. As a Service Coordinator you can provide these individuals with a safe, supportive, and attentive adult who is willing to be patient and help.

Chapter 3: Getting Started As a Service Coordinator

The hardest times in the life of a service coordinator are the initial days on the job, especially if you are starting without experience working with children and adolescents who receive services and without clear instructions about how to help your consumers. Under these circumstances, it would not be surprising if you were uncomfortable with individuals who might behave strangely or ask you what you could do to possibly help them. You might also question exactly what your responsibilities are, and how you are supposed to fulfill them. Even if you have experience working in other settings with individuals who have behavioral and developmental disorders, you may find it initially uncomfortable to work with them in an unstructured environment without the comfort of an office or immediately available colleagues. These feelings can be compounded by your first encounters with consumers. Thankfully there some clear rules of thumb for getting for your first days on the job.

Seeing Children and Families for the First Time

As you set out to encounter your new clients remember that everyone has some insecurity about how effective they will be in a new job, even if they have been well-trained. If you do not have a mentor or peer who has offered to take you along on some of their visits to clients, ask someone to do this so you will not be completely green. You cannot prevent things from being rocky at first. In fact, it is perfectly fine for your first sessions with consumers to resemble a crash course with a lot of trial-and-error learning. When things don't go well, they are best taken as learning experiences so the next time things can go better.

One of the most important things you can do before you see your consumer is to prepare. This includes:

- Read up on your consumer's mental health and diagnostic assessment information, focusing on what might be the person's strengths and problems he/she may be experiencing.
- Talk with your mentor, supervisor or other service coordinators who have worked with this individual or individuals with similar problems; and
- Do some advance work to come to a clear understanding of the purpose of each of your contacts with the individual and the tasks to be accomplished.

Being prepared will help you make the most of your time with clients, help you to concentrate on establishing a good relationship, and help those first meetings to go smoothly.

During your first visit it is important to do all that you can to convey respect and your willingness to be genuinely helpful. This includes beginning with the basic social graces, smiling as you greet the client, just as you would when greeting anyone else for the first time. The importance of communicating warmth and caring cannot be overstated, although it must be genuine and overdone. Many individuals will be nervous about seeing you, and some will be distrustful about seeing a stranger at all. Remember with children, it may be good to start off asking them about things they like to do and things they enjoy. By asking them simple questions, about things they like to talk about you can encourage them to talk more freely with you. Also, if your first contact seems overly tense, it is perfectly reasonable to cut it short and assure the client that you will be back to see them.

Before you visit with your consumer it is likely that you will meet a member of their family, whether that is a mother, father, aunt or grandfather. As you introduce yourself to them, use the same basic social graces described before and convey to them you are here to be genuinely helpful to the child or adolescent as well as to them. These family members will most likely want to tell you about the problems and the needs of the child or adolescent they care for. Be open to listening to their interpretation of the situation, they can be one of your best resources of learning how to serve the individual. Because of their long term relationship with the child or adolescent they can most clearly identify some of the symptoms that might be occurring, also they can be good historians about the individual's treatment history. Information from families can give you some idea of what has worked in the past, or what things they have tried that has not been successful. Finally, since your consumers are children and adolescents they are highly dependent on those that take care of them. Having a good working relationship your client's care takers can ensure that the services you set them up with are more likely to be followed through.

While family information is crucial to understanding the big picture of your consumer's situation, in the initial visits it is important that you take the time to really listen to the individual and his/her own description of how things are going. When people meet they usually want to feel understood and have a chance to tell their stories. You will most likely come into every session with a specific agenda, even if this is just to reinforce your connection with the consumer, but remember this should also be driven by the consumer. That means listening to what the individual needs, and letting him/her know you are listening by repeating back to them or asking questions about what you have heard. Responding to the consumers expressed needs in the moment requires you to have the flexibility to change your agenda and plans for the session. If the individual describes problems that go beyond your realm of help, or things you cannot change for the consumer, it is important to convey some level of empathy and understanding of the hardship of the situation. For example, after a client tells you about a bad fight he had with his mother, you could empathize with him and provide support by saying "That must have been really difficult for you. I bet you were so upset after that fight." It's not your job to try to fix the relationship per se, but you can be there to support your client and show them that you understand what they are going through. This tends to be one of the best methods of building a good helping relationship.

Your Life as a Navigator: The Other Big Systems You Will Encounter

Children and adolescents with behavioral and developmental disorders often can be part of many systems. These individuals may be part of the mental health system by seeing a psychiatrist or therapist for a specific disorder. But they may also have an addiction, and therefore receive services by an addiction specialist or counselor. Further, these children and adolescents go to school so they have teachers, education specialists, aides and tutors to help them with their class work. If a child or adolescent committed a crime, they may be required to go to court and will have a probation officer. You may work with a family that is involved in the child welfare system, these families will have case workers and attend court proceedings to determine if the child is being well cared for in the family. A child and adolescent can also receive mental retardation services, which differ from the mental health system as they have their own funding streams and resources. Essentially, one child can be part of a myriad of systems at one time. As a service coordinator it is your job to navigate your consumer and their family through these systems, stopping at ones that would provide services for your individual. Being aware that a consumer may have to utilize more than one system is one of the best methods of ensuring their best chance of recovery.

Working with Other Professionals

Service coordination is like no other mental health profession, in that you must coordinate across many different disciplines and settings. This requires that you work with a variety of people, both in the mental health field and beyond. Whenever you work with other professionals or other agencies you are always representing not only your consumer and their family, but also your department, agency, and the profession of service coordination in general. Therefore, it is important that you be friendly and act professionally or you will not be able to do what you need to do to help your clients. Dress for the occasion. Dressing casually is fine for many of the tasks you do in service coordination, but you will be far less likely to be heard or taken seriously if you show up for meetings with psychiatrists or other social service professionals in jeans with holes in them. How you look and everything you do with these colleagues will influence how effective you will be in helping your consumer get what they need.

While the services you connect people to may be quite diverse, any local human service industry is a small world, which will treat you well and give more attention to your clients once you develop a reputation and have history of acting professionally. In addition, since service coordinators will frequently find themselves working on a team of professionals within an agency or treatment team, it is important to facilitate the effectiveness of this team by staying in touch with other team members and actively participating in team meetings on behalf of your consumers so that services can be effectively coordinated. When you are working as part of a team, every action you take with clients has the potential to affect the work of other members of the team. If important things happen with your client, you should relay this information to your fellow team members as soon as possible, so they can provide help on their end if needed. As the service coordinator, you should always try to be at the table when these decisions are made, but avoid acting as if you are the only person who has a valid opinion. It is entirely possible that you will know your consumer better than the other professionals, but it is best to avoid getting into a power struggle or telling them so. Remember to listen thoughtfully to the ideas of the other team members, and contribute any information you have that is appropriate. When big decisions are made about clients, contributing to norms of open communication and shared decision making will allow you to play a key role in ensuring the effectiveness of what your team does for clients.

Part II: Disorders and Treatments to Know

Chapter 1: People Are Not Their Symptoms - Using Person First Language

Before a discussion about the different diagnosis and disorders, it is important to note the language we use to discuss individuals with behavioral, developmental, and intellectual disorders. Language is powerful, and the language we use can shape perceptions of people and situations. No one is “autistic”, “schizophrenic” or “manic”, but there are people who experience symptoms of autism, schizophrenia, or mania. Using a disorder or a diagnosis as a label for a person is taking away their individuality. People are much more than their symptoms or their diagnoses. The individuals you will serve have dreams, desires, goals, strengths, likes, and dislikes just like you.

A way to respect the individuality of a person is to use person first language. Person first language prioritizes that people are, at the very foundation, individuals first. By placing the noun before the adjective that describes it, the individual is given ownership of the condition. For example, a “mentally ill child” becomes a “child with mental illness”. Practice using person first language when talking about the individuals you serve with your supervisor, mentor, and colleagues. Also, you can encourage the families of the individuals you serve to also utilize person first language in describing their family member receiving treatment. By changing the way the family speaks about the individual who receive services, it may change the perceptions the family has about them.

Chapter 2: Behavioral Health Disorders

As a service coordinator you will be working with a diverse population of individuals that may have varying disorders. Knowing a little about the illness the individual you serve may have will be helpful for you to understand why he or she may be acting in a certain way. Behavioral health, sometimes called mental health, discusses the health of a person's mind, feelings, actions, and behaviors. This manual has provided you with the most common diagnoses that you will see in this line of work. These diagnoses come from the Diagnostic and Statistical Manual (DSM) distributed by the American Psychiatric Association. The DSM has become the standard in the classification of behavioral and mental disorders. Also, remember that while we talk about each diagnosis separately, it is possible for a person to have multiple diagnoses. For example, a person may have ADHD but also suffer from a specific phobia or anxiety disorder. "Co-morbid-" is the word that is used to describe a person who has two or more disorders.

Attention- Deficit/ Hyperactivity Disorder (ADHD)

As a child and adolescent service coordinator, the diagnosis of ADHD will be a frequent identifier that you will hear regarding the children you serve. ADHD can affect all parts of a child's life, including interaction with parents or peers and performance at school. There are two dimensions to the ADHD diagnosis: Inattention and Hyperactivity-Impulsivity. Symptoms of the inattention dimension include forgetfulness, high distractibility, difficulty organizing, commonly losing or misplacing things, difficulty paying attention to directions, and often appearing not to be listening when spoken directly to. Symptoms of the hyperactivity-impulsivity dimension are fidgeting or squirming, leaving one's seat, running about or climbing excessively in appropriate situations, difficulty playing quietly, is often "on the go" or acts as if "driven by a motor", often talks excessively, often blurts out answers, has significant difficulty awaiting a turn, and often interrupts or intrudes others' spaces. Children may present symptoms on one or both of these dimensions. Because of this mental health professionals describe children with ADHD in three categories or types: combined, predominately inattentive, or predominately hyperactive impulsive.

Oppositional Defiant Disorder and Conduct Disorder

Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) are two diagnoses that often interfere with a child's relationships with their parents, school, or society. These two diagnoses differ only in the severity of inappropriate behavior. ODD is a pattern of negative, hostile, or defiant behavior. A child with ODD may often lose his/her temper, argue with adults, refuse to comply with rules or requests, deliberately annoy people, blame others for his or her mistakes, or present as angry, resentful, spiteful, or vindictive. It is important to consider a child's age with determining their defiant behavior and compare this behavior to other children at similar ages and developmental stages. For example, two year-olds are commonly unable to follow rules or requests by adults. However by the age of 8, children should be able to follow the requests and rules of authority figures.

Conduct Disorder (CD) is considered to be a more extreme diagnosis for inappropriate behavior. CD is described as being a pattern of behavior in which the basic rights of others and major age-appropriate societal norms and rules are violated. This can mean aggression towards people and animals, such as frequently bullying and threatening others, often initiating physical fights, using a weapon that can cause serious harm, or being physically cruel to animals. Further, individuals with CD are prone to deliberate destruction of property, fire setting, deceitfulness or theft, and are prone to serious violation of rules such as truancy and running away from home.

Mood Disorders

There are several types of mood disorders: major depression, bipolar disorder, dysthymic disorder, and cyclothymic disorder. These diagnoses are grouped together because they all affect a person's mood. A person's mood can range from a very low mood (i.e., depression) to a very high mood (i.e., mania or hypomania). Some mood disorders (i.e., bipolar, cyclothymia) fluctuate from one extreme in mood to the other. The two types of mood disorders you are most likely to encounter as a service coordinator are major depression and bipolar disorder. The primary symptoms of such disorders include:

- Depression- feeling sad, frequent crying, extreme irritability, inability to sleep, excessive sleepiness, feelings of extreme guilt or worthlessness, diminished interest in previously enjoyed activities, recurrent thoughts of death or suicide
- Mania- inflated self-esteem, grandiose plans, excess energy, decreased need for sleep, more talkative or pressured speech, racing thoughts or ideas, increased risk taking behaviors

Depression as a very serious illness can sometimes be difficult to understand because everyone can feel "blue" or sad from time to time. However, when a child or adolescent feels down and hopeless for weeks on end and these feelings are severe enough to disrupt biological functioning (e.g., sleep, appetite) or psychological functioning (e.g., school, peer and family relationships), it is a good indication that they may have major depression. When a low mood state goes on for prolonged periods of time, but is not severe enough to meet the criteria for major depression, the condition is called dysthymia. It is important to remember that some children that you encounter may be too young to verbalize their sad moods they may be feeling; they might not even realize they are experiencing a sad mood. Instead their mood may sometimes be characterized on their face as a sad appearance. Also, somatic concerns or concerns about physical pains (e.g., headaches, tummy aches) may be expressed instead of emotional pains. Finally, school age children may engage in disruptive and aggressive behavior that negatively affects their relationships and school work. As a child becomes older and moves into adulthood, their symptoms take on a more traditional view of depression. Children and adolescents experiencing depression may have suicidal thoughts and may be at a substantial risk for committing suicides. The feelings of intense sadness or unhappiness, combined with a lack of insight or lowered inhibition because of juvenile age can create this increased risk of suicide, especially for adolescent individuals. Assessing for this risk and coming up with a plan of action is discussed in detail in Part V- Chapter 2.

Mania is a fairly uncommon experience of children; however, the possibility increases with age. Mania in children varies slightly from mania seen in adults. Children with mania may be explosively irritable, throwing tantrums or experiencing symptoms of extreme rage. Further, children may appear to be very excited and may seem to be speaking “a mile a minute”. They may have difficulty sitting still, staying on a single train of thought, having a need for little sleep, and set out unrealistic or grandiose plans and ideas. As children progress into adolescence, the symptoms of mania can look more like adult symptoms. Some symptoms include need for little sleep, being easily distracted or restless, talking fast and having racing thoughts, partaking in high risk pleasurable behaviors such as spending sprees and impulsive sexual encounters, and having unrealistic belief in one’s abilities.

As you may have noticed, some of the symptoms of bipolar disorder are similar to symptoms of ADHD. Bipolar disorder and ADHD are very different diagnoses, but can look similar in some aspects. A major difference is symptoms of ADHD are chronic and always present, while bipolar disorder comes in episodes. Further, individuals with ADHD will have emotional mood shifts that are reactions to events in their life. Individuals with bipolar disorder shift moods without connection to life events. Another distinction is that through medication treatment, a diagnosis can be found. If a person is prescribed ADHD medication their symptoms should subside. If they do not, bipolar disorder can be assessed by a psychiatrist.

Anxiety Disorders

Anxiety disorders are becoming more commonly diagnosed in children and adolescents. There are various forms of anxiety disorders but all are characterized by intense and persistent anxiety.

- Generalized Anxiety Disorder (GAD) is characterized by a generalized and excessive feeling of worry. This worry is not limited to one particular thing or situation, but tends to be spread out through a child or adolescent's life. Children and adolescents with GAD tend to worry or focus particularly on their competence and the quality of their performance in activities, such as in school or sports. They may feel that they are being evaluated even when they are not. Also, children and adolescents with GAD may worry excessively about catastrophes, such as natural disasters or war. Common symptoms are muscle tension, feeling shaky, stomachaches, nausea, diarrhea, nail biting, irritability, and feeling keyed up or on edge.
- Specific Phobia is a marked and persistent fear that is excessive or unreasonable caused by the presence or anticipation of an object or situation. Common fears of childhood include the dark, school, and dogs. Other common phobias are of heights, water, spiders, snakes, clowns, elevators, and storms. In children, if they encounter an object or situation for which they have a phobic reaction, they may start crying, throwing a tantrum, freezing, or clinging to parents. Most commonly, individuals with phobia avoid the situations and objects that cause them this anxiety and fear.
- Social phobia or social anxiety disorder is the fear that one will do something that will cause embarrassment or humiliation. This fear is much more extreme than the normal fear experienced by the majority of individuals. For instance, the anticipation of speaking in front of the class or reading aloud will cause the child or adolescent to sweat, feel nauseous, "turn red", have stomachaches or diarrhea, or shake.
- Separation Anxiety Disorder is the excessive anxiety over separation from people to whom the child is attached to, typically parents or caretakers. This is very common diagnosis in childhood and is sometimes confused with school phobia. Symptoms include persistent and excessive worry about losing or something harmful happening to a caretaker, reluctance to attend school

or go elsewhere because of separation, reluctance to be home without primary caretaker, repeated nightmares involving separation, reluctance or refusal to go to sleep without being near a major attachment figure or fear sleeping away from home.

- Obsessive-Compulsive Disorder (OCD) is a diagnosis that is not commonly thought to occur in childhood; however, it is possible to have this disorder earlier in life. OCD is made up of obsessions (intrusive ideas) and compulsions (behaviors individuals feel they cannot control). Obsessions generally involve fear of germs or contamination, fears of harm to self or others, and excessive religiosity. Another obsession is a phenomenon some individuals experience when they are trying to get something “just right”, and they will continue to fix whatever is off balance until it is balanced. The most common obsessions in young individuals include hand washing, repetitive checking (such as re-locking, re-closing, re-aligning), and a preoccupation with orderliness, and repeatedly counting to a particular number or touching objects a given number of times.
- Posttraumatic Stress Disorder (PTSD) occurs when an individual experiences a traumatic event and their reaction to that event is one of intense fear or helplessness, or horror, agitation, and disorganized behavior. Traumas that may be a pre-cursor to PTSD include car accidents, house fires, natural disasters, being a witness of a shooting, being a victim to abuse or maltreatment, or being in a situation where one’s life or the life of a loved one is threatened. After the traumatic event, children and adolescents may “re-experience” the event; this can look like flash-backs of images of the event, nightmares, and other psychological distress to cues that resemble some aspect of the traumatic event. Other symptoms of PTSD include hyper vigilance, exaggerated startle response, difficulty concentrating, difficulty falling asleep or staying asleep, diminished interest in participation of previously enjoyed activities, feeling of detachment from others, restricted range of feelings, irritability, and outbursts of anger.

Eating Disorders

The two types of eating disorders are anorexia nervosa and bulimia nervosa. Anorexia nervosa is considered to be at least a 15% loss of body weight through purging and/or voluntary restriction of food, with an active pursuit of thinness. People with anorexia nervosa have an intense fear of gaining weight, or becoming fat and have a distorted view of their own body weight and image. Individuals with bulimia nervosa vary in that their body weight is usually within the average range; however, these individuals use methods of binge eating (eating an extreme amount of food and calories) and then maintain their weight through purging (vomiting or using laxatives) or non-purging ways of weight loss (excessive exercise, fasting). During a binging time, the person will feel a sense of lack of control and usually attempts to hide their binging or purging habits from others.

Psychotic Disorders

While it will be rare for you to encounter a child with a psychotic disorder, it is important to know this classification because as age increases, the possibility of developing a psychotic disorder also increases. The two most common psychotic disorders are schizophrenia and schizoaffective disorder, but there are many others, such as brief psychotic disorder, delusional disorder, schizophreniform disorder, and shared psychotic disorder. These disorders are grouped together because they all experience episodes of psychosis, or moments where the person seems to be cut off from reality.

Psychotic disorders have a collection of general symptoms which may include:

- *Hallucinations*-hearing, seeing, smelling or feeling things that are not there. Individuals who are hallucinating appear to be reacting to something that is not there. This may look like they are being distracted by their thoughts, laughing inappropriately, engaging in conversations with themselves, or telling you about uncomfortable feelings they may be having (bugs crawling on them, person tapping their shoulder). Hallucinations are the most common symptoms experienced.

- *Delusions*- firmly held irrational beliefs that persist in spite of contradictory evidence. These delusions can take a paranoid spin, giving the individual a fear of being poisoned, that certain people are out to get them, or that others want to harm him or her for some reason. Delusions also can be ones of grandeur, giving them beliefs that they are more powerful or important than they are (i.e. they are the son of God, their family is a well-known name, they're marrying a Prince).
- *Disorganized speech*-speech that does not make sense or frequently jumps from one idea to another. This symptom is easily identified through conversation. The person may appear to be speaking gibberish or jumping quickly from topic to topic with very loose associations (i.e. My dad has a car). I hate carrots. Do you know how to play baseball?).
- *Restricted affect/and or speech*-showing little emotion and/or speaking in only one or two word answers. While some symptoms are very obvious, this symptom at first may appear that the individual is shy, depressed, or sullen

Schizoaffective disorder exhibits many of the symptoms of psychotic disorder but is also combined with a mood disorder and experiences periods of mania, depression, or both.

Personality Disorders

Personality disorders are inflexible and enduring patterns of behavior and thought that deviate significantly from social expectations and lead to the individual's distress or impairment. Usually, individuals with this diagnosis do not comprehend that they have maladaptive behaviors and tend to look outward for causes of their distress and impairment. Further, this inflexible behavior and thought pattern makes people with this diagnosis have rough and sometimes tumultuous relationships with their peers and family. The onset is seen in adolescence and young adulthood; however, the diagnosis is very rarely applied to individuals under 18 because it is commonly believed their personalities are not fully developed yet.

One of the most commonly diagnosed personality disorders is Borderline Personality Disorder. Borderline Personality Disorder involves intensity and a pervasive instability in interpersonal relationships, self image, and mood. A person may have fluctuating relationships with peers, alternating between loving and hating a person. A person with Borderline Personality Disorder may have episodes of impulsive aggression, self-injury and drug or alcohol problems and tends to try to avoid feeling abandoned or alone.

Substance Abuse and Dependence

Children and adolescents are using drugs and alcohol at earlier ages than ever before. It is important to know that it is possible for a child or adolescent you serve to be using and abusing alcohol and/or drugs. While to some families the use of drugs and alcohol are “normal” for recreational use, these substances can be potentially harmful to a child and adolescent’s behavioral health. Substance abuse is defined in the DSM-IV TR as a pattern of substance use leading to clinically significant impairment or distress. This impairment or distress can be manifested in a failure to fulfill obligations, such as school, leading to poor attendance and declining grades. Further, this distress can be seen when an individual becomes aggressive or argumentative when under the influence of drugs and alcohol, causing fights at school, at home, or in the community. Also, keep in mind that the use of substances can interfere with an individual’s mental health, causing them to become more depressed, or it may flare psychosis symptoms. It is possible for children and adolescents to receive drug and alcohol rehabilitation; a person is never too young to receive help for substance abuse.

Chapter 3: Developmental Disabilities, Intellectual Disabilities, and Learning Disorders

Pervasive Developmental Disorders

Pervasive Developmental Disorders (PDD) are a group of conditions that involve significant delays in the development of socialization and communication with others. While symptoms of PDD can usually be seen in infancy, most children are not diagnosed until age 3 when delays in language and unusual play development are observed. There are 5 types of PDD: Childhood disintegrative disorder, Rett's syndrome, PDD not otherwise specified, and the most commonly heard of autism and Asperger's syndrome.

This section will be focused on autism and Asperger's, as these are the most common PDDs seen. Autism is a spectrum disorder, meaning that individuals with this disorder range from mild to severe. Individuals with autism will have impairment in social interaction. This impairment can look like social isolation and an inability to relate to people. A person with autism will have a difficult time with eye contact, and may appear to not be aware of an outsider's presence. Many children with autism do not react to the physical contact of hugging or sitting on their parents. Other children with autism may seem rude, as they will ask inappropriate questions or grab things out of people's hands without asking. Another impairment individuals with autism have is impairments in communication. Some children with autism are mute and do not speak. Many are non-verbal about their needs and wants and may throw tantrums or make loud noises to display they are unhappy but cannot inform their caregivers what they are upset about. Another communication impairment is non-communicative speech. Instead of having a conversation, a person with autism may repeat words or phrases. Individuals with autism also exhibit restricted and stereotyped interests and behavior. With autism, there is a strong need for sameness in environment and one's own behavior. Many children with autism do repeated motions, like hair-twirling, rocking back and forth, and stacking the same block repeatedly. The need for sameness tends to dominate all objects an individual encounters such as clothes, blankets, utensils, plates, cups, food, and even the location of furniture in a home. If any of this is changed, a child with autism may panic or throw a tantrum.

Asperger's is often considered a less severe form of autism, but is classified as a different diagnosis in the DSM. Asperger's is also different from autism in that individuals with Asperger's show no delays in language development and no significant cognitive deficits. Individuals with Asperger’s have impairment with non-verbal communication, such as lack of eye contact, lowered facial expression, and lack of understanding of others’ facial expressions. Many individuals with Asperger’s have a difficult time understanding how others feel and may not be able to pick up or sense others’ emotions. Some individuals with Asperger’s do not pick up on social cues, not knowing when someone is angry or frustrated with them. Further individuals with Asperger’s have a desire for sameness and routine in their life. Another common characteristic of people with Asperger’s is focused attention and interest in one topic or area. This topic or area of interest may consume the individual’s entire life, and they may know many facts about it, as well as wanting to discuss and talk about their interest all the time. Many individuals with Asperger’s fail to develop strong peer relationships because of the social impairments they exhibit.

Intellectual Disabilities

Intellectual disability, sometimes referred to as mental retardation or cognitive disability, is characterized by a significantly below average intelligence, as measured by a standardized intelligence test and limitations in the ability to function in areas of daily life such as communication, self-care, and social interactions. It is important to remember that simply a lower intelligence quotient (IQ) score does not determine intellectual disability; however, it is only classified as an intellectual disability when it is combined with an inability to accomplish basic life functions. According to the DSM, an IQ of 70 is the cut off for the intellectual disability range. There are different degrees of intellectual disability ranging from mild (70 IQ) to profound (20 IQ and below). Individuals will need varying levels of support and resources based on their degree of intellectual disability. People with intellectual disability can learn and do new skills; they just learn and develop more slowly than people of average intelligence. There are many resources for people with intellectual disabilities, including housing supports, peer/recreational supports, and vocational opportunities.

Learning Disorders

The basis of a learning disorder is a neurological variation that causes a person's brain to process information differently from others, making it more difficult for them to learn the same information. Further, these differences affect how an individual understands, remembers, and responds to new information. People with learning disorders have the same IQ's of their average peers, but perform more poorly academically than others. For this reason, an individual is usually first diagnosed in grade school, when differences among peers is more obvious. There are many types of learning disorders, such as reading disorder, mathematics disorder, and disorder of written expression. Children and adolescents with learning disorders will need special attention from teachers and will need to be taught different ways to learn and work with their differences. Early detection of a learning disorder is best so a child does not fall far behind peers.

Chapter 4: Managing and Treating the Major Disorders

Medication: A useful strategy that is here to stay

As a service coordinator, you will most certainly encounter children and adolescents that are taking medications to improve their mental health. Medications have become an important strategy in treating behavioral disorders. While medication is rarely the sole solution, it can be helpful in stabilizing behaviors and moods in order for other forms of therapy to be utilized. Although a service coordinator is not a psychiatrist, it is important that know something about the medications your consumers are taking. Service coordinators are often times the best people to inform the psychiatrist when a medication the individual is taking is not working or producing serious side-effects. This is because service coordinators are able to see the individuals taking the medication much more often than the psychiatrist.

The use of medication for children and adolescents with behavioral disorders is not as exact as we may like. Traditionally these medications have been made for, tested on, and marketed towards adults. Children and adolescents are not generally used in treatment trials of medication because of the possible harm it could cause. Unfortunately, the lack of research into the use of medications for behavioral health in children and adolescents has created a trial-and-error treatment style. Psychiatrists may often try several different medication combinations at varying levels of amounts until an effective blend is discovered. This can be a frustrating time for the individual taking the medications and the family who is expecting quick results. More often than not, the first combination of medications will not be the correct one. As a service coordinator, you can help support the family and individual by assuring them that this is a process that takes time, but the possible benefits are worth the time and effort. Keep the individual in tune with how they are feeling, and how their symptoms are changing or the lack of change. Encourage the family to report all these concerns to the psychiatrist.

As we mentioned, the service coordinator may fill the role of identifying side effects from the medications the individual is taking. It is important to know that all medications, behavioral health or not, cause side effects. Some of these side effects are life threatening, and some are annoying circumstances of the medication. Encourage the individual and family to discuss side effects with their psychiatrist, as there are some medications that can treat side effects. Also if you notice a significant side effect, have the individual see the doctor right away to help prevent a lasting problem. Further, encourage the family and individual to become knowledgeable in looking for side effects themselves.

Remember that even though the service coordinator plays a vital role in the individual’s medication management, you are not the doctor. You should never be responsible for making medical decisions about the medications people take. Keep an open dialogue with the psychiatrist if you see side-effects or other problems, but remember they are ultimately responsible for which medications the individual will take.

This manual has provided you brief descriptions of medications and potential side-effects to look for in the individuals taking them, as well as strategies to help the individual you serve maintain a medication regimen.

Attention Deficit/Hyperactive Disorder Medications

There are two major categories of medications prescribed for ADHD: Stimulant and non-stimulant. Stimulant medications, such as amphetamines and methylphenidate, are the traditional form of medication treatment and are considered highly effective treatments for ADHD. The only FDA approved stimulant medication is atomoxetine (Strattera). Non-stimulant medications are considered to be effective and commonly used when traditional stimulant medication is not effective. Below is a table of the ADHD medications approved for use from the FDA.

Table: ADHD Medications

Trade Name (All of these medications are stimulants except Strattera)	Generic Name
Adderall	amphetamine
Adderall XR	amphetamine (extended release)
Concerta	methylphenidate (long acting)
Daytrana	methylphenidate patch
Desoxyn	methamphetamine
Dexedrine	dextroamphetamine
Dextrostat	dextroamphetamine
Focalin	Dexmethylphenidate
Focalin XR	Dexmethylphenidate (extended release)
Metadate ER	methylphenidate (extended release)
Metadate CD	methylphenidate (extended release)
Methylin	methylphenidate (oral solution and chewable tablets)
Ritalin	methylphenidate
Ritalin SR	methylphenidate (extended release)
Ritalin LA	methylphenidate (long-acting)
Strattera	atomoxetine
Vyvanse	lisdexamfetamine dimesylate

Side-effects: For stimulant medications, the most common side effects are reduced appetite, weight loss, problems sleeping, headaches, stomach pain, and irritability. The most common side effects for non-stimulant medications are nausea, reduced appetite, weight loss, drowsiness, and irritability. These side effects for stimulant and non-stimulant medications are usually are not dangerous, but they should be reported to the individual's doctor. The more serious side effects are heart-related problems, hallucinations, voicing suicidal thoughts, liver problems, and worsening of pre-existing mental health conditions. Call the doctor immediately if the individual is feeling faint or dizzy, complains of unusual heart rhythms, chest pains, or shortness of breath as this could be a symptom of a heart problem. If the child or adolescent is taking the non-stimulant medication (Strattera) and is experiencing itching, upper belly pain, dark urine, yellow skin or eyes or unexplained flu-like symptoms, call the doctor immediately as these could be symptoms of liver problems.

Antidepressant Medications

Antidepressant medications can be helpful in the treatment of depression, as well as many other diagnoses, such as phobias, panic attacks, bedwetting, eating disorders, obsessive-compulsive disorder, posttraumatic stress disorder, other anxiety disorders, and attention deficit hyperactive disorder. These medications are in 4 categories: tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs) and atypical antidepressants. Tricyclic antidepressants (Elavil, Anafranil) and MAOIs (Nardil, Parnate), are older medications that are generally not the most common medications used in treatment. However, these older drugs are still prescribed if other, newer medications are not effective. The newer, more commonly prescribed antidepressants are SSRI's (Prozac, Zoloft, Paxil) and the atypical antidepressants (Wellbutrin, Remeron). These drugs are more favored because they work faster, and have fewer side effects.

It is important to remember that a person who is prescribed antidepressant medication must take it as prescribed for a minimum of two weeks before he or she may notice a change or start seeing the medication benefits. It is critical you inform and remind your consumers and their families how long it will take before they will see improvement from the antidepressants. Without this information, consumers may quit their medications before the drug has had time to take effect in the body. Below is a table that lists some of the most commonly prescribed antidepressant medications.

Table: Antidepressant Medications

Trade Name	**Generic Name**
SSRI's	
• Celexa	Citalopram
• Effexor	Venlafaxine
• Lexapro	Escitalopram
• Luvox	Fluvozamine
• Paxil	Paroxetine
• Prozac	Fluoxetine
• Sarafem	Fluoxetine
• Zoloft	Sertraline
Atypical	
• Remeron	Mirtazapine
• Serzone	Nefazodone
• Wellbutrin	Bupropion
Tricyclic	
• Anafranil	Clomipramine
• Elavil	Amitriptyline
• Pamelor	Nortriptyline
• Tofranil	Imipramine

MAOI’s • Nardil • Parnate	Phenelzine Tranylcypromine

Side effects: The majority of side effects for antidepressants are not serious; however, they can be considered a nuisance to those taking them. If your client is experiencing some of these side effects to a degree that they are not willing to take their medications, encourage them to speak to their doctor about alternative solutions. The most common side effects associated with SSRI’s and atypical antidepressants are headache, nausea, sleeplessness or drowsiness, agitation, and loss of libido. The most common side effects for tricyclic antidepressants are dry mouth, constipation, bladder problems, loss of libido, blurred vision, and drowsiness. People taking MAOIs need to be careful because the medication has a harmful reaction to the amino acid tyramine, causing an increase in blood pressure. Tyramine is found some foods such as certain types of cheese, wines and pickles.

A serious side effect of antidepressants in children and adolescents is an increased risk of suicide and suicidal thoughts. This side effect seems counter-intuitive; however, the FDA has a black-box warning label on all antidepressant medications. Research has shown that for a small group of children, adolescents, and young adults, antidepressants actually cause increased depression and suicidality. Because of this, your consumers will need to be watched closely, especially during the first few weeks they are taking the medication. Things to look out for are the depression getting worse, increased suicidal thinking or behavior, or any unusual changes in behavior such as trouble sleeping, agitation or social withdrawal. Encourage the family to watch out for these warning signs and inform their doctor if they do occur.

Mood Stabilizing Medications

Mood stabilizers are medications that may be helpful in treating bipolar disorder, severe mood symptoms, controlling mood swings, aggressive behavior, and impulse control disorders. Lithium was the first mood stabilizer approved by the FDA and has been shown to be effective in treating both manic and depressive episodes. Anticonvulsant medications (used to treat seizures) have been found to help control moods as well. The majority of mood stabilizers have not been thoroughly tested on children and adolescents. Because of this, the exact dosage and treatment schedule is still being discovered. It may take some time for the psychiatrist and the individual taking the medication to find the correct balance. Below is a list of the most common mood stabilizing medications approved for use by the FDA.

Table: Mood Stabalizers

Trade Name	Generic Name
Depakote	Divalproex sodium (valproic acid)
Eskalith	Lithium carbonate
Lamictal	Lamotrigine
Lithium citrate (generic only)	Lithium citrate
Lithobid	Lithium carbonate
Neurontin	Gabapentin
Tegretol	Carbamazepine
Topamax	topiramate
Trileptal	oxcarbazepine

Side Effects: Lithium can cause several side effects, and some of them can become serious. The most common are: Loss of coordination, excessive thirst, frequent urination, blackouts, seizures, slurred speech, irregular heart rhythm, hallucinations, changes in vision, itching, rash, and swelling of the eyes, face, lips, tongue, throat, hands, feet, ankles or legs. A person who is being treated with lithium should visit the doctor regularly to check the levels of lithium in the blood and make sure the kidneys and thyroid are working properly.

There are also several side effects with valproic acid/divalproex sodium. Some include changes in weight, nausea, stomach pain, vomiting, anorexia and loss of appetite. Valproic acid may cause damage to the liver or pancreas so people talking it should see their doctors regularly. Valproic acid may affect young girls and women differently than men. Sometimes, valproic acid may increase levels of testosterone, which can cause a condition called polycystic ovarian syndrome. Polycystic ovarian syndrome can affect fertility and make the menstrual cycle irregular, but symptoms tend to go away after valproic acid is stopped. Valproic acid may also cause birth defects in women who are pregnant.

Lamotrigine can cause a rare but serious skin rash that needs to be treated in a hospital. In some cases this rash can cause permanent disability or be life-threatening.

In addition, valproic acid, lamotrigine, carbamazepine, oxcarbazepine, and other anticonvulsant medications have a FDA black box warning. The warning states that the use of these medications may increase the risk of suicidal thoughts and behaviors. People taking anticonvulsant medication to treat their behavioral disorder should be closely monitored for new or worsening symptoms of depression, suicidal thoughts or behavior, or any unusual changes in mood or behavior.

Anti-Anxiety Medications

Anti-anxiety medications may be helpful in the treatment of severe anxiety. There are several types of anti-anxiety medications: benzodiazepines, antihistamines, and atypical anti-anxiety medications. Benzodiazepines can start working quickly to relieve feelings of anxiety. Common benzodiazepines include: Alprazolam (Xanax), Lorazepam (Ativan), Diazepam (Valium), and Clonazepam (Klonopin). Atypical anxiety medications include: Buspirone (BuSpar), and Zolpidem (Ambien). These medications are classified as atypical because they are not like traditional anti-anxiety medications. Buspirone (BuSpar) takes several weeks for it begins working, and is used to treat GAD. Also, Zolpidem (Ambien) is traditionally sold as a sleep aid. Below is a list of the most common anti-anxiety medications as determined by the FDA.

Table: Anti-Anxiety Medications

Trade Name	Generic Name
Benzodiazepines	
• Ativan	Lorazepam
• Klonopin	Clonazepam
• Librium	Chlordiazepoxide
• Oxazepam	Oxazepam
• Tranxene	Clorazepate
• Valium	Diazepam
• Xanax	Alprazolam
Atypicals	
• BuSpar	Buspirone

Side effects: The most common side effect for benzodiazepines is drowsiness and dizziness. Other possible side effects include: upset stomach, blurred vision, headache, confusion, grogginess, and nightmares.

Possible side effects from buspirone (BuSpar) include: dizziness, headaches, nausea, nervousness, lightheadedness, excitement, and trouble sleeping.

Anti-Psychotic Medication

Antipsychotic medications may be helpful in controlling psychotic symptoms (e.g., delusions, hallucinations) and/or disorganized thinking found most commonly in psychotic disorders like schizophrenia. Antipsychotic medications can help one's ability to think and cognitively appraise the world. While antipsychotic medication may not completely clear symptoms, they can make symptoms more tolerable, giving the person the ability to function in their day to day life. These medications are also occasionally used to treat severe anxiety and may help in reducing very aggressive behavior. Also, antipsychotics may be given to individuals with depression or bipolar disorder who also experience periods of psychosis. There are two categories of antipsychotic medication. The first, called first generation or traditional antipsychotics have been available since the mid 1950s. Some include: Chlorpromazine (Thorazine), Haloperidol (Haldol), Perphenazine (Trilafon), Fluphenazine (Prolixin). The second category of antipsychotic medications are called atypical, or second generation. Second generation or atypical antipsychotics were developed in the 1990's and are commonly the first prescribed medication for individuals with psychotic disorders because they typically have fewer long-standing side effects. Some atypical antipsychotics include: Aripiprazole (Abilify), Olanzapine (Zyprexa), Risperidone (Risperdal), Quetiapine (Seroquel). Below is a table with FDA approved antipsychotic medications.

Table: Antipsychotic Medications

Trade Name	Generic Name
First-Generation, Traditional	
• Haldol	Haloperidol
• Navane	Thiothixene
• Perphenazine(formerly Trilafon)	Perphenazine
• Prolixin	Fluphenazine
• Stelazine	Trifluoperazine
• Thioridazine(formerly Mellaril)	Thioridazine
• Thorazine	Chlorpromazine
Second-Generation, Atypical	
• Abilify	Aripiprazole
• Clozaril	Clozapine
• Geodon	Ziprasidone
• Risperdal	Risperidone
• Seroquel	Quetiapine
• Zyprexa	Olanzapine

Side-effects: It should be noted that the use of antipsychotic medications with children and adolescents is a controversial issue. While there are increasing amounts of treatment trials for children who take antipsychotic medications, there is still little known about long term effects of a child taking antipsychotic medication. Further, some of the serious and permanent side effects of antipsychotic medications deter many from using antipsychotics with young children. Sometimes the use is necessary as the child is greatly suffering from psychosis and would be greatly helped by these medications. It is important to attentively monitor the child taking antipsychotic medications, and inform the parents and the individual of the side effects before they begin treatment.

Some side effects of antipsychotics go away after a few days and often can be managed successfully through other medication to treat side effects. Most common side effects include: drowsiness, dizziness when changing positions, blurred vision, rapid heartbeat, sensitivity to the sun, skin rashes, and menstrual problems for women.

Typical or first generation antipsychotic medication can cause side effects related to physical movement. These side effects include: muscle rigidity, persistent muscle spasms, tremors, and restlessness. Long term use of first generation antipsychotic medication may lead to a condition called tardive dyskinesia. Tardive dyskinesia causes uncontrollable muscle movements primarily of the face, tongue, mouth and neck. Unfortunately, tardive dyskinesia is a side effect that can be permanent even when the person stops taking the medication.

Atypical, second generation antipsychotic medication can cause major weight gain and changes in a person’s metabolism. Major weight gain from the medication can cause obesity, diabetes, hypertension, high cholesterol, and abnormal levels of lipid and glucose levels. Unfortunately for children and adolescents who take atypical antipsychotic medication, abnormal levels of lipid and glucose levels predict adult obesity.

How to Help the Individuals Take Their Medication Properly

Medications need to be taken exactly as prescribed by the psychiatrist to insure they have the best chance to work properly and safely. Some medications need to be taken multiple times a day in varying amounts, some need to be taken only once, and some need to be taken with food or water. Also, it can be harmful to skip several doses of medicine or stop medication completely without gradually weaning an individual off of the medication. For a young person with a behavioral disorder this can be a very confusing situation. Also, parents who are unfamiliar with taking medications may not realize the need for their child to stick to a strict medicine regimen. As a service coordinator, there are several things you can do to help the individual you serve correctly take their medication.

- Educate the individual and their family about the important of sticking to a strict medicine regime. Tell them that they may not be seeing the exact results they want because they are not properly taking the medications. Further, explain that these medications can be unsafe if not used properly. Taking the medications as prescribed can insure the individual’s safety.
- Help the individual and their family to use concrete medication supports. If the individual and family are having a difficult time remembering to take the medication, suggest the use of a pill box where the medications can be pre-distributed for every day of the week.
- Help the individual and the family keep an updated list of the medications they are taking. This list should include the dosage amount and how many times it is taken per day. Have the family carry this list with them to doctors’ appointments so they will always be able to correctly report which medications the child is currently taking.
- Encourage the individual and family to speak with the psychiatrist about concerns and side effects. Some people stop the use of their medications because they cannot handle the side effects. If this is occurring, it is important that the individual tells their psychiatrist they do not

want to take the medication for this reason. The psychiatrist can try to adjust the medication to lessen side effects or prescribe an additional medication to treat the side effects.

Psychotherapy and other Treatments

Medication is a common form of treatment in today's age, but psychotherapy, also known as "talk therapy", is still a vital and effective treatment option. Sometimes medication and psychotherapy can be combined for the best fit of treatment to the child or adolescent. These therapies can be given by therapists, social workers, counselors, psychologists, and sometimes psychiatrists. Psychotherapy can be in an individual, family, or group format. There are many different frameworks and models for psychotherapy. Below we have listed commonly used types of therapy so you can be knowledgeable about the treatments the individual you work with is involved in.

- Behavior Modification- This treatment changes behaviors through a process called operant conditioning. Operant conditioning replaces undesirable behaviors with more desirable ones through positive or negative reinforcement. For example, if a child is able to sit in their seat during a class session, they will be given a reward such as a sticker. Behavior modification is commonly used in younger individuals.
- Parent Training-This model focuses on teaching parents techniques and skills to monitor and change their children's behaviors. By teaching the parent about behavior modification they can implement this practice at home.
- Cognitive-Behavioral Therapy (CBT) - CBT is a theory of therapy that is based on the idea that a person's thoughts cause feelings and behaviors. By changing the way a person thinks, they can change the way a person reacts and feels about situations.
- Play Therapy-This is an approach to therapy for young children, because most children under the age of 10 have not developed the reasoning skills or verbal ability to express their thoughts and

feelings through words. A therapist will use toys and play to assist a child in expressing his or her feelings.

- Systems Theory- This theory believes that individuals are always part of a larger system, including a family, friendships, school, work, community, etc. The individual's actions affect the system, and the parts of the system affect the individual. In order to create change, the individual's relationship with the system needs to be changed.

PART III: Systems Unpacked: Systems and Service Lines

Chapter 1: Understanding Children's Behavioral Health Service Lines

There are a wide range of treatment and services available for children and adolescents. These treatments and services available are on a continuum of care, meaning they range from the most intensive to less restrictive care settings. For example, some individuals only need to meet with a therapist once a week, while others may need 24 hour supervision in a hospital type setting. The goal is to have the individual at the least restrictive setting, as well as appropriately meeting the needs of the individual. As a child's needs change, he or she may also change what services they attend. An individual's diagnosis, how they are responding to treatment, and how they are doing in their social environment will determine the level of care they will receive. This chapter will discuss the behavioral health services available on the continuum of care.

Outpatient Services

Outpatient services are the least restrictive setting to receive treatment. These are community-based services that provide evaluation/diagnosis, treatment planning, medication management, and therapy. These services are provided by a variety of mental health professionals, including counselors, clinical social workers, psychologists and psychiatrists. *Outpatient therapy* can be in an individual or group format and is usually conducted once a week to once a month. An intermediate form of outpatient therapy is *Intensive-Outpatient Therapy (IOP)*. Instead of meeting with the mental health professional once a week, an individual in IOP will attend therapy 2-5 times a week. Further, the most restrictive outpatient therapy is a *Partial Hospitalization Program*. Partial Hospitalization Programs are intensive but still non-residential, meaning a person attends the program from 4-6 hours a day but sleep at home. Typically for children and adolescents in partial hospitalization will attend school for some period of the day on site, as well as receive treatment and participate in groups and individual therapy. Partial hospitalization may also serve as a step-down for individuals transitioning from inpatient hospitalization.

In-home Services

Beyond outpatient services, there are numerous in-home services for children, adolescents, and their families. *Service coordination* is an in-home service. Service coordination services provide monitoring, linking, advocating, and supporting are done in the home. The next level of in-home care is *Behavioral Health Rehabilitative Services (BHRS)*, it is also sometimes known as wrap-around. BHRS services are individualized per family to meet their needs. BHRS is designed develop stability; improve the individual's functioning in the family, at school, and within the community. Within BHRS there is a team of individuals who work together to provide services. They include a Behavioral Specialist Consultant (BSC) who writes the treatment plans and supervises the team, a Mobile Therapist (MT) who provides counseling services in the home, and a Therapeutic Staff Support (TSS) who works directly with the individual one-on-one, providing support and redirection. Beyond BHRS is *Family-Focused Solutions Based Services (FFSB)*. FFSB provides family and individual therapy to children diagnosed with a mental illness who are at risk for out of home placement. These services are provided in the home and can be utilized for the whole family, including other siblings. FFSB has available staff 24 hours a day, 7 days a week to provide support. Similar to FFSB is *Family Based Mental Health (FBMH)*, these are comprehensive services for the child and family designed to keep the child in the home, while allowing the child to receive the appropriate level of care. Services may include treatment for the child and other family members, service coordination and family support services. These services are available 24 hours a day, 7 days a week. For a child that is 16 years or older, there is another in-home service called *Community Treatment Team (CTT)*. CTT teams are made up of a psychiatrist, nurse, therapist, service coordinator, and vocational specialist to provide comprehensive and intensive services to a transitioning adolescent. CTT provides support for the individual to be able to live stably in the community.

Emergency Placement Services

There will be emergency situations when a child or adolescent will need to be immediately moved from the home. It is impossible to plan when these events are going to occur, but if an individual's symptoms are severe enough that the family cannot care for the child, if the child is at imminent risk of harm to himself/herself or others then the individual will need immediate shelter that can provide services to fit their needs. Calling a *crisis network* such as Re:solve, is the first step to emergency placement. This crisis network is trained to handle emergency situations. Re:solve is available 24 hours a day, 7 days a week. If an emergency situation takes place there are *Diversion and Stabilization Units (DAS)*. DAS is the least restrictive out-of-home placement used for children being diverted from a more restrictive inpatient unit. DAS is for short-term, emergency, or respite treatment and the stay should not extend past 28 days. Another option for emergency placement is WPIC's *diagnostic and evaluation center (DEC).* Before admission into WPIC an individual needs to be evaluated by a physician. This is completed at the DEC. Finally, *hospital emergency departments* are possible for emergency assessment if the individual is at immediate risk of harm to himself/herself or others while waiting for level of care determination.

In-patient Services

If it is determined that a child or adolescent will need care outside of the home for an extended period of time the individual will go to an in-patient facility. In-patient facilities are the most restrictive setting, but can provide a high level of care for an individual who is need of this type of facility. One kind of in-patient care is *Residential Treatment Facilities (RTF).* RTFs provide intensive, structured therapy for individuals who need constant supervision and treatment. The typical stay for a child at an RTF depends on their progress, but most children stay between 2-6 months. The other type of in-patient care is an *inpatient hospital*. Inpatient hospitals are for the individuals who remain in an imminent threat to themselves or others and cannot be cared for adequately in any less restrictive setting. The goal of inpatient facilities is to stabilize symptoms and to prepare the individual for a less restrictive facility.

Addiction Service Lines

Addiction service lines similarly work on a continuum of care model. However, the process tends to work in reverse with the majority of individuals first going through the most restrictive settings before they end in outpatient therapy. Also, addiction services are voluntarily services (unless court required) by individuals. This voluntary status means that individuals can leave therapy and treatment at any time if they so choose, unlike some behavioral health services. The age of the individual or the length or severity of the addiction will determine which level of care a person will need. An individual may want to first start at a *detoxification centers* if they are currently using drugs or alcohol. This is a place where an individual will go to remove the substances from the body and will be monitored and treated for withdrawal symptoms. Detoxification can take place in hospitals or in private agencies in the community. The detoxification process typically takes 5-7 days.

After detoxification, an individual will typically enter a *residential rehab center*. Again, some rehab centers are in hospitals and some are in private agencies in the communities. At the rehab center, the person will have limited contact with the outside world and will undergo intensive treatment through individual and group therapies. The length of stay at rehab centers will vary from agency to agency, and will be impacted by the individual’s progress. After residential rehab, some individuals will attend a *partial hospitalization program* that works similar to a behavioral partial hospitalization program, where an individual will spend the majority of the day in treatment but will sleep at home. When the individual and therapist feel confident in the individual's ability to stay sober with few reinforcements, *outpatient therapy* can take place. Outpatient therapy can be in individual or group format.

Many individuals will have both a behavioral health diagnosis and an addiction. This is called a dual-diagnosis. There are special treatment programs for individuals with a dual-diagnosis that combine behavioral health treatment and addiction rehab. There are very limited resources available for dual-diagnosis individuals, but it is worth inquiring if there is availability in a dual-diagnosis program in your area.

Chapter 2: Braiding as a Way of Life: Overview of the Other Big Systems

The children and adolescents you work with may be involved in several systems outside of the behavioral health system in which you reside. These systems may provide the individuals with services that are outside of your direct control, but you can still support the family and advocate for the individual you serve in these other systems. Understanding these diverse and complex systems will help you support the family you serve. This manual covers systems including schools, child welfare, juvenile justice, MR/Intellectual disability, and Autism.

The Schools

Understanding some of the workings and services of schools will be helpful, as the majority of the individuals you serve will be attending some sort of school. Unfortunately, sometimes school is where the child or adolescent suffers most. The individual's symptoms may be exacerbated by school, teachers, homework, peers, and the stress that comes from all of these. A child may have the most difficulty with maintaining appropriate behavior at school, frequently getting detentions or suspensions. Or a child may be having difficulties academically and may attempt to skip or cut class. As a service coordinator, it is not your responsibility to diagnose why a child is not succeeding in school, but you can be a valuable asset in helping the child’s guardians navigate this complex system. Your role in the schools is to be an informative support and advocate for the child or adolescent you serve.

If a child continues to have problems with school academically or behaviorally, there are a few options to assist the child in learning. Encourage the parent or guardian to speak with the child’s teacher or the school’s guidance counselor to see what the problems are. This is a time where the parents can also discuss their concerns over their child’s progress or difficulties. The teacher and guidance counselor may suggest alternative classroom settings or special education programs for the child or adolescent. Special education services can be an accommodating to children and adolescents who have difficulties learning in a traditional classroom. Special education classes are taught by teachers that have been specially trained to teach children with emotion and learning disabilities.

In order to be eligible to receive special education services, a child or adolescent will need to be evaluated. A parent or guardian can also request the principal to order an assessment. The evaluation consists of psychological testing and a review of the child’s academic progress. Based upon the results of the evaluation, an Individualized Service Plan (IEP) may be developed by the school. An IEP must be developed within 30 calendar days after the evaluation report is released. An IEP is a written contract between the child, the child’s guardians, and the school stating an educational plan that will be implemented. The IEP will include a description of the child’s current levels of academic and/or behavioral performance, description of the special education programs the child will be enrolled in, and yearly goals to be assessed. While the IEP is being written, there will be meetings with the child, guardians and school officials. The child’s parents must be at these meetings; if they are not, the meeting will be re-scheduled. As a service coordinator, you can attend these meetings to help advocate for the child or adolescent you serve, as well as support the family in this process. The IEP will be reviewed every year at another meeting, or more often if requested by any party.

Some children you work with may already have IEP and have their educational programs in progress. If so, you can continue to be a support to the family and child by attending the yearly IEP meetings, as well as monitoring progress of the child or adolescent. If you see that a child's behaviors or academics are not improving, you can suggest to the parents to make a request to review the IEP plan. Since there are so many children in the school systems, some kids can get lost in the wake. Be an advocate for the child you serve, and keep up with the program-making sure that they are receiving the best services for their needs.

As we mentioned, there are several options for children with academic and behavioral problems in schools. Below we have listed and describe some of the major options:

- One-on-one tutoring- Some children will be pulled out of the classroom for a short period of time to receive one-on-one support with a professional. Whatever the difficulty the student has, the tutor will supplement the in-class learning as well as monitor progress.
- Therapeutic Classrooms- These classrooms will have lower teacher to student ratios, with teachers specially trained to educate children with learning or emotional disabilities.
- Alternative Schools- These schools are for children who have not been successful in their community classrooms. If a child has been expelled from public schools or are involved in the juvenile justice system they are often enrolled in alternative schools. The classrooms have a lower class size, with a teacher and a behavioral specialist.

Child Welfare

The Child Welfare system, sometimes called Children, Youth and Families (CYF), is a state agency responsible for protecting children from abuse and neglect. A family may be involved if the parents are not able to care for their children as determined by the state. Parents may not be able to take care of their child due to financial reasons (e.g., having the electricity, heat, water turned off) or because they are dealing with a drug or alcohol addiction. Or parents may be suspected of physical, sexual, or emotional abuse or neglecting the child and leaving them alone without supervision. For any reason a family is involved with Child Welfare, the ultimate goal is to return the children to the parents, or an able family member. A child or adolescent you serve may simultaneously be involved in the Child Welfare system, as well as the in the behavioral health system. If the child is in the Child Welfare system they will have a case worker that will be monitoring the situation and the progress made. If a child you work with is involved with the Child Welfare system your role will be to continue to support the family and advocate for the child.

Since the Child Welfare system is responsible for the safety of children, there may be times when they require families to be involved in treatment or remove the child from the home. There are many services Child Welfare can utilize to achieve the optimal goal of making it possible and safe for the child to return home to their parents. A child may be receiving services through the behavioral health system that you are coordinating, but also are receiving services through the Child Welfare system. Some Child Welfare services include parenting classes, family counseling, assistance with housing and transportation, drug and alcohol rehabilitation, and financial assistance for food or clothing. The case worker will monitor the progress the family has made and determine if the needs of the children are being served. Unfortunately, there are times when the child needs to be removed from their parents' care. During these times, they will be placed in alternative housing. Most children are placed in foster homes. Foster homes provide a nurturing and safe environment for the child to stay. While foster homes are not permanent housing, they can be utilized for extended periods of time. If a child is having a difficult time adjusting to a foster home (e.g., arguing, throwing tantrums, fighting, becoming aggressive with other foster siblings), it may be determined that they live in a more therapeutic setting. There are therapeutic foster homes, which offer more one-on-one attention with families that are trained to handle children with behavioral disorders or emotional problems. If the child needs more therapy beyond a therapeutic foster home, they will be placed in a group home. A group home is a single-gendered residential facility designed to provide a therapeutic setting in a "home-like" environment. Children with reside in a group home until it is determined foster home is an appropriate setting, or the child is reunited with his/her family.

The Child Welfare system is operated through the family courts. Instead of a treatment team or psychiatrist determining services, a magistrate or judge decides what services or placements a family or child needs. Additionally, a judge or magistrate decides when a child can return home to the care of the parents. The family's case worker will report progress, or lack of progress, and the judge will hear testimony from the child, parents, agencies providing the services, and other parties. Court hearings are typically every 3 months. This process will continue until a child is returned home, or it is determined that it is in the child's best interest to be permanently removed from the home. This is not an easy decision, but a judge can terminate a parent's rights if after an extended period of time no progress has been made.

Juvenile Justice

Some individuals you work with may be involved in the Juvenile Justice System. The Juvenile Justice system is the court system for minors who break laws or commit delinquent acts. If the child is found guilty of a crime, they will receive consequences as determined by the judge. Some consequences may be a curfew, community service requirement, counseling, restitution, or placement in a day treatment program, a residential program (group home), or a state correctional facility. Further, the child will receive a probation officer that will monitor the child's progress and report results to the court. A child can be receiving services through the juvenile justice system, and be receiving services through the behavioral health system at the same time. Your role as a service coordinator is again to be a support for the family and an advocate for the child.

MR/Intellectual Disability

As we mentioned before a person with a behavioral disorder may also have an intellectual disability. If a child or adolescent you serve as an intellectual disability there is a wealth of opportunities, services, and supports available through the Office of Intellectual Disability (formerly called the Office of Mental Retardation). First, the individual must be registered with the local Office of Intellectual Disability. The person will be evaluated to determine eligibility. Once eligible, they will begin registering for services. The services are in several domains to cover all aspects of the person's life. Many of these services are for adults, but keep in mind the programs for adolescents transitioning into the adult system. As a service coordinator, you can support the family and the individual who you serve and help them utilize the services that are provided by the Office of Intellectual Disability.

All individuals involved in the Intellectual Disability system with receive a supports coordination services. This person has a similar role to a service coordinator. The supports coordinator will assist individuals in developing their individual support plans, choosing providers and informal supports and monitoring the administration of these services. Home and community services help individuals gain, maintain, and improve skills that allow them to live and participate in the community. These services vary in levels of support from group to individual help. Professionals can help assist individuals in finding housing, teach how to cook safely, teach to use public transportation independently, assist in social skills development, and much more. There are respite services that provide relief for primary caregivers. Respite can occur in the home or out of home. There are transportation services for individuals to gain access to the community to utilize services and informal supports. There are specialized therapies and clinical services provided by health care professionals, including physical therapy, occupational therapy, speech and language therapy, behavioral therapy, and nurse service. There are employment services to help find a job or develop vocational skills. Financial management services can be used to help individuals hire, pay, and manage their provider bills. There are even Family Support Services for the family members of individuals with intellectual disabilities.

Autism Services

Autism is an emerging topic that has garnered a lot of support and funding to help people with autism and their families. Similar to intellectual disability, autism services have their own funding separate from behavioral health. If a child or adolescent does not have insurance or insurance that will cover the entirety of costs for autism services, the family can apply for medical assistance. Medical assistance will cover the entirety of autism services. If the family you serve needs help applying for Medical assistance, skip to Resource Brokering for Families in Chapter 3 of this section.

With autism services, early intervention is the key to the best outcomes. Early intervention begins with early detection of autism or other pervasive developmental disabilities. There are several agencies that provide evaluation and screens for autism. If a family believes a child has autism or a pervasive developmental disability, encourage them to receive an evaluation. You can support them by finding an agency that conducts these services and help them in making a call to make an appointment for assessment.

There are many services and therapies for individuals with autism. One of the most popular and utilized treatments is Behavioral Health Rehabilitation Service (BHRS), also called wrap-around services. BHRS is composed of a treatment team of mental health professionals to provide services in a variety of settings such as home, school, and the community. Behavior Specialist Consultants (BSC) are Master's level or higher education staff that develop child-specific treatment plans, monitor the treatment team and the progress of the behavioral plan. BHRS also includes a Mobile Therapist (MT) that provides individual and family treatment in the community. Therapeutic Staff Support (TSS) provides direct services to the child with autism. From the treatment plan the TSS will implement interventions, skills and techniques.

Chapter 3: Resource Brokering for Children's Families

This manual has listed numerous types of services that can be utilized by the child or adolescent and family you serve. Unfortunately, many of these services can be very expensive. The costs of ongoing therapy, medication, treatment, and other services quickly add up. Brokering resources is one of the main functions of a service coordinator. While as a service coordinator you can apply for many resources on behalf of the child or adolescent you serve, having a guardian or parent available will make the process smoother and will empower the family to participate. It may help to explain to the parent or guardian that while this process may at first feel cumbersome, it can help to pay for the services needed and in the long-term be worth it financially. Further as a service coordinator, it is your role to encourage the family to complete this process as much as they can on their own with you providing guidance, support and advocacy. This section will discuss how to go about paying for services, as well as other methods to decrease the family's financial burden.

Private Health Insurance

If the child or adolescent you serve has private health insurance, you will need to have the guardian contact the insurance provider and obtain information about the mental health coverage plan (sometimes called behavioral health coverage) they receive. The guardian should request a list of the mental health professionals in their insurance "network". This means there are certain doctors, therapists, and other mental health professionals that are approved for re-imbursement from the insurance company. If a professional is outside of this network, their services will not be reimbursed by the insurance agency. It is important that the guardian inquires about the number of treatment visits to the mental health professionals and/or the number of days in an inpatient facility that is allowed by the plan. Most insurance companies set a limit of visits and days spent in inpatient facilities that can be used in one year. Also, receiving information about co-pays and deductibles will allow the family to plan how much the services will cost out of pocket.

If there are extending services that the child or adolescent you serve needs that will not be covered under private health insurance, these individuals can apply for public health insurance (medical assistance), regardless of parental income. This is called the PA "loophole" and can be very helpful in supplementing the expensive costs of services needed by individuals with severe disabilities, mental illness, and behavioral disorders, such as wrap-around services or extended stays in residential facilities. The family will need to present proof of disability, provided by a psychiatrist, and to apply for medical assistance for that child. The next section will discuss how to obtain medical assistance.

Public Health Insurance/Medical Assistance

Medical assistance is available for eligible low-income individuals and provides payment for necessary health care services. Medical assistance can offer payment for physical health and behavioral health services. Once a person is qualified to receive medical assistance, they are automatically part of a managed care organization (also known as a third-party payer) that is contracted by the government to be responsible for re-imbursement of services. There are managed care organizations for physical health and behavioral health. In Allegheny County the behavioral health managed care organization is Community Care Behavioral Health Organization (CCBHO). CCBHO is responsible for managing the delivery and quality of behavioral health services in this area. Similar to private health insurance networks, managed care organizations also have networks of providers that can be reimbursed for services. By contacting CCHBO or the managed care organization directly you can inquire about which mental health providers are available in the network and which services they will reimburse for.

There will be many individuals already enrolled in medical assistance that you will work with as a service coordinator. If an individual already has medical assistance, you can help remind the guardians to renew services and keep up with changes of address to allow for a smooth use of services. All of this can be done online at the Department of Public Welfare website, or you can call the department of public welfare offices.

If an individual or family does not have medical assistance you can help them apply for it. The family can apply online at the Department of Public Welfare's website by downloading an application, in person at the Department of Public Welfare local office or they can all the Department of Public Welfare Office and ask to speak to an "advocate" that can help the family through the application process.

Supplemental Security Income (SSI)/ Other Financial Resources

Depending on the child or adolescent's guardian's income, and family size, the individual may be eligible for Social Security Income (SSI). SSI is a federal income assistance program through the Social Security Administration for disabled individuals. The child or adolescent does not need to be permanently disabled to be eligible to receive help, but the individual will need documentation of disability by a psychiatrist. The application for SSI can be done online at Social Security Administration website or by calling the Social Security Administration office. After an application is complete, a phone or an in-person interview at the local social security office is usually requested to go over the disability information. Needed at this interview is documentation of diagnosis and current symptoms to display the need for supplemental income to care for the child or adolescent. After the interview, it may take several months for the request to be processed, and the family may be requested to submit more information. Have the family keep in regular contact with the social security caseworker assigned to the case to check on the progress of the application.

If the family is having a difficult time financially, you may also suggest they apply for food stamps to offset some of the living costs. The application for food stamps can be done with the application of medical assistance, but does not need to be. To apply for food stamps, a family can apply online at the Department of Public Welfare, download an application from the Department of Public Welfare website, or call the Department of Public Welfare office and ask to speak to an "advocate". If a family you work with is already on food stamps, remind them that this is a resource that needs to be renewed approximately every 6 months. If the family does not renew the food stamps, they will lose them and have to re-apply.

There are other financial resources that may be available in the area that families will qualify for but may not know about. Such programs could be cash assistance for families with young children with certain disabilities or diagnoses, or temporary grants that have been made available in the area. Ask your supervisor, mentors, or colleagues if they are aware of any assistance programs or grants and help the families apply to receive these supports.

Housing Resources

As a service coordinator, you may be involved with a family that has significant problems with their housing. Whether it is maintaining their current living arrangements or finding new ones, families with great financial stress seem to be constantly in a state of housing transition. As we have previously mentioned, constant transition can cause an unsettling feeling for many individuals and cause them to maintain a high level of stress. As the family service coordinator, it is your responsibility to help as best as you can to create a stable housing situation for the family.

Unfortunately, there are limited options for housing, and those resources available typically include long wait lists. The best option is to attempt to keep the family in their current residence, at least until another housing arrangement is secured. There are some programs that will help pay rent in order to avoid eviction, especially if the family has children. Also, if the family is having difficulties paying utilities there are some resources to cover the costs of heat and electricity. The Department of Public Welfare is a good place to start in looking for these resources. You will be able to contact your local Department of Public Welfare office through their website or by phone. You can also ask colleagues, supervisors, and mentors if they are aware of resources that your family can apply for.

If a family needs to move, you can look into getting them a Housing Choice Voucher (Section 8 housing) through the local housing authority. Section 8 housing provides a rental subsidy to low-income individuals and families. The families will only pay 30-40 percent of their monthly income towards rent. The waiting list for Section 8 housing can be extremely long (2 years long), and sometimes they do not even allow people to apply because of the wait. If the housing authority is accepting applications, contact the Housing Authority Occupancy Department through their website or by phone. Another option for more affordable housing is public housing. Public housing is funded through Department of Housing and Urban Development. Public housing has less stringent eligibility rules. To apply for public housing, you can contact the Housing Authority Occupancy Department through their websites or phone. Applications for public housing are made available online.

If the family is without a home or shelter, you may need to connect them with local shelter resources. Some shelter facilities are for singles only. Assuming the individual you work with is part of a family and is under the age of 18, you will need to find a shelter that accepts families or adults with children. This is a serious situation; if this happens, make sure you inform your supervisor and mentor. They may be able you find emergency shelter, or suggest agencies that can assist the family.

Part IV: Children Grow Up, Transition from the Child to Adult Mental Health System

All children will eventually grow up and grow out of the supports provided in the children's mental health system. Once children reach the age of 18 or 21 (depending on the service) they may no longer qualify to receive resources and services, forcing them into looking for new supports and resources. The child will need new providers, a plan for his/her future, and think about what his/her goals are in life. This can be a very scary and confusing time for the individuals you work with. This transition is not an easy one and the Service Coordinator plays a large role in helping the individual make a smooth transition.

As the Service Coordinator, you will begin planning for long term goals and begin transitioning the child into the adult system around 16 years old. The transition process is not all about financial supports, housing supports, and mental health supports. A transitioning youth will need to be helped with education or career planning, gaining independent living skills, and developing relationships with family and friends to provide a safety net in the community. Around the age of 16 begin asking the teen to think about what goals or hopes they have about the future. Is he/she interested in continuing school? Or does he/she want to have more training in electronics, computers, or landscaping? Plant the seed in the individual's mind, and give him/her time to think about what they want for him or herself in the future. If a person is interested in continuing with school after 12th grade, encourage him or her to see an academic advisor. An academic advisor can give the individual a clear picture of what the options of education are available. If an individual is interested in a technical school or training program, encourage him/her to meet with the advisors at that school. It may take some time for the teen to develop a sense of what they see for their future. Keep supporting the individual, and continue looking into options that spark his or her interests.

Independent living skills are extremely important, especially if an individual no longer wishes to live with parents or guardians. There are several agencies that provide independent living skill groups for teens. These groups can teach teens how to do the laundry, how to cook, how to balance a check-book, how to grocery shop etc. Developing independent living skills in a teen will provide them with a large advantage when they begin living on their own. If they have the skills to manage living on their own, they will be less likely to become stressed, worried, or anxious.

Finally, encourage the individual to develop a safety net of relationships. Relationships can be with family members, friends, support groups, religious clergy-whomever the individual feels like they are supported by. Sometimes the world can be a pretty lonely place. If an individual has a developed support network, he/she will have the ability to call on these individuals for help if problems arise, or someone to talk to on a down day. Further, when individuals turn 18 they can begin attending drop-in centers or clubhouses. These activities provide the person to be with people who also receive mental health services, and are in a safe environment. Encourage the individual to check out the closest drop-in center or clubhouse.

There are some concrete supports that you will need to help the individual set up while transitioning into the adult system. As a child and adolescent service coordinator, you may not always be aware of the services, resources, and supports that are in the adult system. Being aware of what the adult system provides is an important step in helping the individual explore his/her options. Once you begin to become aware of the options in the adult system, begin making contacts and inquiring about services within the agency. Also, you can ask for guidance and support from your colleagues (maybe some adult service coordinators), mentor, or supervisors about the availability of services in the adult sector. Always keep in mind to respect the individual's wishes about what he/she wants, and support him/her in making his/her own decisions about the future. Encourage the individual to search for independence by planning his/her futures.

- Housing- If the transitioning youth is moving out of the home of the parents or caregivers, a discussion about housing needs to happen. If the child cannot live independently, and needs a high level of supervision or care looking into a group home or supportive housing may be an option. If you are unaware of the housing options for adults with mental diagnoses you can ask your mentor or supervisors for more information. If a transitioning youth wants to live independently, you can help them find affordable housing or help them apply for public housing or Section 8 vouchers. More details about applying for Public Housing and Section 8 vouchers can be found in Part III, Chapter 3: Resource Brokering.
- Financing- Financial independence is an issue for everyone. For youth transitioning into the adult system, money can be a great concern for them. Worrying about how to pay for housing,

groceries, leisure activities, mental health services and so on can cause great stress. As the Service Coordinator you can help the individual find and utilize the financial supports necessary for him/her. The individual will have to re-apply for Supplemental Security Income (SSI) when they transition into adulthood. If the individual received food stamps through his or her parents, he/she will need to re-apply individually when he/she becomes an adult. As you may know, applying to receive these two benefits is a lengthy process. Begin thinking about these resources and asking the individual if they want to partake in these services as adults. Also, health and mental health insurance is another concern when transitioning into adulthood. An individual will typically go off his/her parents' health insurance when they are over the age of 18 and are no longer in school. If this is the case and the transitioning youth does not receive private insurance from employment, they will need to apply for Medical Assistance (MA). If the individual was on Medical Assistance (MA) as a child, they will need to re-apply as an adult.

- Mental Health Services- Many agencies have separate therapists, psychiatrist, behavioral specialists, social groups etc. for youth and adults. An individual making a transition into adulthood may need to move from child providers to adult providers. Ask the agency where the individual receives services when the individual will be required to transition to adult providers. Some agencies will allow the individual to stay until he or she is 21-24 years old. Other agencies will want to close the case when the child graduates high school. If a transitioning youth needs new adult providers it is first important to find out what his/her insurance will allow. Also, have the individual set up appointments with new providers and see if the person likes or feels comfortable with the new services. If an individual does not have a good bond with his/her provider, it is less likely he or she will continue with services. For this reason, ensure that a transitioning youth finds providers they feel comfortable with and trust. Also, your services as the Service Coordinator may be transitioned as well to an adult Service Coordinator. Each agency handles transitioning youth differently. Speak with your mentor or supervisor to find more details about the steps of transitioning in your agency.

Part V: First Things Last: Back to the Big Picture

Chapter 1: The Whole Person: Healthy Activities

This manual has addressed many of the services a child or adolescent you serve will receive in school, the mental health and child welfare systems. This section will focus on the physical-bodily health, as well as being a part of the community and engaging with peer groups.

Physical Activity

Taking care of one's behavioral and mental health is just as important as taking care of one's physical health. Individuals who receive mental health services tend to live shorter lives. A large part of this is because of the sedentary and limiting lifestyle caused by peer isolation, medication side effects, and sometimes the actual symptoms themselves (depression, anxiety, anger etc). As an individual's service coordinator you are not required to be their personal trainer; however, you should serve as a support, informing them of the risks of becoming overweight and sedentary. Significant weight gain contributes to a myriad of serious physical health problems. Children and adolescents who are overweight have an increased risk of heart disease, high blood pressure, diabetes, breathing problems and sleep disorders (i.e. sleep apnea). Teens who are obese tend to have much lower self-esteem, which is an additional risk factor for a sedentary lifestyle. Furthermore, habits that are formed in childhood and adolescence can lead to lifelong issues with weight.

As a service coordinator, you should inform the individual and the family you are serving that many psychiatric medications can cause weight gain. Weight gain is an unfortunate side effect of some medications. However, this side effect may be counteracted by a healthy diet and increased physical activity. If weight gain is an issue, encourage the individual and family to seek help by speaking with their family physician.

Community Activities

Social and community supports are just as necessary, as the supports from mental health professionals. There are many opportunities in the community for children and adolescents to make friends and be around peers; it is just about finding them and initiating participation. A quick internet search can provide you with numerous options in the area. If you need help narrowing your search, we suggest trying humanservices.net, the United Way, the Boys and Girls Club, Big Brothers/Big Sisters and the YMCA. A child or adolescent can participate in after school programs or summer camps, or if they have specific areas of interest they can participate in sports or art classes.

Sometimes you will need to encourage the children and adolescents you serve to participate in these activities. Their fear of rejection or anxiety from partaking in a new activity may deter them from trying to get out and participate in community activities. Volunteer to go with them to check it out and see if they like it. Encourage them to give these activities a chance before they make a decision if they want to continue. If the activity is not a good fit for the individual you serve, support him/her in finding something else he/she would like to participate in that would more suit his/her individual interests and needs.

Chapter 2: Crises Happen: Helping Families Prepare and Cope

Crises are an inevitable part of the job of a service coordinator. Individuals and families experience a crisis when they encounter stress beyond their coping abilities, and it begins to affect their safety. Encountering stressors and stressful situations are unavoidable, and unfortunately not being able to deal with these problems can create a crisis. Crises may be caused by many things, but are almost always marked by a substantial increase of symptoms of the individual’s behavioral disorder because often times stress provokes the flaring of symptoms. For example, an individual with severe depression may respond to a fight with a parent or sibling by seriously considering or even acting upon thoughts of suicide. Or, an adolescent with schizophrenia may be hearing an increasing number of voices when there are changes to their living arrangements. In both situations, a stressful situation caused an increase of symptoms which led to a crisis. When an individual is in crisis, the service coordinator must act quickly, intelligently, and compassionately to minimize the impact of the crisis, prevent its escalation, and help resolve the crisis and/or ensure the person's safety until the crisis is over. This section will provide an overview of the basics for how to manage crises, so that you know will know what to do when a crisis occurs and be able to act in a way that ensures the safety of everyone involved.

Preventing Crises

The single best method of managing crises is to prevent them from happening. It is possible to set things up in a way that will help the individual make plans for dealing with stressors before they escalate into a crisis. Talk with the individual to learn what kind of stress is most difficult for them to manage and will likely produce a crisis. Also, speak with family members about what caused previous crises. Identifying these stressors can help alert you to what to look out for in the future.

Of course there will be stressful events that are not predictable, even if you are aware of the individual's past stressors. In these unpredictable situations, it is important that the individual learns to better cope with stress. Work with the individual's therapist to develop coping strategies for the individual. If you are aware of these coping strategies, you can help implement and reinforce them when the individual is not seeing their therapist. Also, encourage family members and care givers to be aware of these coping strategies and to use them during the times you are immediately unavailable.

Psychological stressors are increased when a person's basic needs are not being met. A family's financial strain can easily create stress that a child or adolescent can feel. A parent's stress or worry about buying groceries or paying the bills can manifest in a child's anxiety. The best way to manage this type of stress is to use all your connections to help get the individual or family resources they need, as soon as you are aware of the need. Finding temporary solutions and mobilizing resources quickly can help avoid a serious crisis.

An individual's environment can also produce stress that may lead to a crisis. When an individual is living in or frequently encountering a social environment that is chaotic, critical, or negative, it can take an emotional toll. This could include living in a dangerous neighborhood in which they feel unsafe or when a negative psychological environment develops among friends, family, and even treatment professionals. Modifying some stressful environments is beyond the control of the service coordinator, but finding services to lessen the impact of these negative environments can help. If a child feels unsafe in their neighborhood, find an after-school program so they can play and participate in activities in a safe environment. If the individual's family has a negative communication style, suggest family therapy to the adults to help create a calmer environment for everyone. You may feel there is much you cannot change, but by getting creative with services you may be able to develop a plan to combat negative environments.

Developing a Crisis Plan

There are many strategies you can use to help prevent a situation from developing into a crisis; unfortunately, there will also be times when a crisis cannot be prevented or avoided. In these times, it is important to have a plan set out before the event to help minimize the effect of the crisis and to ensure that the individual in crisis maintains their respect and dignity in this vulnerable time. Crisis plans come in many different forms and can vary widely, but they all have the same goal. The goal is to specify ahead of time how an individual and family would like to be treated during the crisis. For example, specifying ahead of time which treatment is preferred (e.g., medication, increased physical restraint) or specifying where the treatment should take place (e.g., certain hospital or agency) can ensure that the family's and individual's wishes can be met during this hectic time. Giving the individual choices about their treatment can be very empowering and will help minimize the discomfort felt in a seemingly uncontrollable time. Your agency will have a formal form for the crisis plan, and you will write the plan together with the individual and family you serve. Of course, you need to make it clear that sometimes the plan cannot be followed exactly the way it was written. For instance, there may be overcrowding at the hospital selected for treatment and the individual will have to go elsewhere, or the individual's plan may not be working and a doctor needs to step in to help the person from hurting himself/herself or others. Certainly the crisis plan should never be completely dismissed, and it should always be followed as closely as possible.

Assessing the Risk of Suicide

As we mentioned crises can involve several different events, but one of the most serious crises to be aware of and prepared for is an individual's possible suicide. When an individual is experiencing unrelenting feelings of sadness and believes that there is no other way to solve their problems, they may feel that this life is not worth living. Further, children and adolescents have not developed the capacity to for critical thinking about the long term consequences of their actions and may make impulsive decisions that end with an attempted suicide. Because of the risk of suicide it is important for a service coordinator to know how to assess the risk to ensure the safety of the individual.

Suicide can be assessed by its 4 critical components. These include: Specificity, Lethality, Access, and Proximity (see table below). These components can be easily remembered by using the acronym SLAP. *Specificity* refers to how specific of a plan a person has made. There is less of a concern if a person has just been thinking about death than if they have a specific method or time period when they are going to kill themselves. For example, you would consider a person at greater risk of suicide if they said they wanted to kill themselves tomorrow after school with a gun they can get from their family's attic versus the person saying they were wishing they were dead. *Lethality* refers to how fatal the plans for suicide are. There would be a greater risk of suicide if a person was planning to use a gun or swallow several pills than a person cutting their legs with a sharp object or burning themselves with a cigarette. These behaviors are serious, but not as immediately concerning. *Access* refers to the ability of a person to access the means by which they plan to commit suicide. A person who is planning to commit suicide by using a gun who has a gun in the house is at much greater risk for suicide than someone who has plans to use a gun but does not have the real ability to obtain one. Finally, *proximity* refers to how close the person is to others who might reasonably help to prevent a suicide attempt. Fortunately, when working with children and adolescents, informing their parents or guardians of your concern with suicide can help deter the problem with proximity. However, older children are not always watched closely and sometimes children will be by themselves after school or when their parents are out of the house.

Table : Elements of Suicide Assessment (SLAP)

1. **S**pecificity - Is there a clear suicide plan? Is there a specific time, method, location?
2. **L**ethality - How deadly are the methods to be used? Are deadly pills, guns, knives, or other weapons to be used?
3. **A**ccess - How realistic are the methods given what is available? Are there guns or deadly pills in the house?
4. **P**roximity - Is there anyone around who could stop an attempt? Is the person living alone or with a caregiver?

When assessing the risk of suicide pay attention to individuals who have a clear and lethal plan that is achievable with little effort and who have no one around them to stop them. Even individuals without these high risk situations should also be taken very seriously. **Always take it seriously if someone tells you they want to hurt or kill themselves.** While you may feel that a person has threatened to commit suicide before, it is always a serious issue that needs to be addressed with the correct professionals. Do not make the decision to not act or not to act on your own. Your supervisor and mentor should always be informed of the situation. By following the SLAP risk assessment and always taking the possibility of suicide seriously, you will have the best chance of protecting the individual you serve.

Acting on Crises

Acting on a crisis is an inevitably stressful experience, but if you are prepared with the individual's crisis plan and know how the system works, you will be better equipped to manage the situation. There are three options during a crisis: hospitalization, respite/diversion program, or close and careful monitoring. Hospitalization is for the most serious crises. Respite or a diversion program is for a less serious crisis, but for one in which the individual cannot be on their own. Close and careful monitoring should be used if there is no immediate threat to the crisis situation. Choosing among these options is difficult and is never a decision you should make on your own; always request help from a supervisor and/or mentor. You can use the risk assessment to help determine the seriousness of the crisis, and the information in this section can help determine how to apply your options during a crisis situation.

Hospitalization- If an individual clearly presents as an immediate threat to him/herself or others, he/she will need to be hospitalized. Hospitalization is usually avoided for treatment, but if a person is imminently suicidal or homicidal, it is the correct option. Hospitalization can help prevent the individual from seriously hurting himself/herself/ others, or killing himself/herself/ others.

In these situations, the individual needs to be evaluated by a psychiatrist as soon as possible, usually in an emergency room. Notify your supervisor, mentor, and the individual's psychiatrist if at all possible. The best way to start is by calling ahead to the hospital chosen in the crisis plan. The individual can be taken in by a family member or can be taken in an ambulance, like any other medical emergency. If an ambulance is necessary, call 911 and report the situation. Stay with the individual and family until the ambulance arrives. Once at the hospital, provide the admissions staff with your information and information about the individual in crisis (e.g., medications, diagnosis, age, etc.). If an individual is unwilling to go the hospital, it will be necessary to call the police to take them to the hospital. Once the individual is admitted, you will need to stay in regular contact with the hospital staff to keep up-to-date on the person's progress and discharge plans. Hospitalizations are used for acute stabilization, and are often very brief, usually lasting not much longer than a week. For this reason, it is important you make contingency plans for post-discharge.

While hospitalizing a child or adolescent you serve may be an upsetting experience at the time, it is sometimes necessary to make difficult choices to potentially save a person’s life or keep them from hurting someone else. This is sometimes a very challenging for a service coordinator, especially when it has taken time to engage and build a trusting relationship. The process of hospitalization can be very traumatic for the individual. It is always important to remember to respect the dignity of the person, explaining what you are doing and why. Being kind, caring and sympathetic will go a long way in this scary and difficult time. Once an individual is hospitalized, continue to visit them and reassure the person that you are there to provide ongoing support.

Respite Care/Diversion: In a previous section in the manual, we discussed the possibility of a program that was less restrictive than a hospital, but was able to closely monitor an individual and provide frequent monitoring by a psychiatrist. This program is the Diversion and Stabilization (DAS) Unit. DAS units are usually less ominous and more “home-like” than a hospital. The approval of a psychiatrist is necessary to be admitted to a DAS unit. So, the first step is to call the psychiatrist and explain the crisis. Further, it is necessary to call the DAS unit and explain the need for admittance and inquire if there is an open bed. Sometimes the psychiatrist and DAS unit will have to speak before admitting the individual; other times the DAS unit will admit the individual provisionally, and a psychiatrist will come and evaluate the crisis to make sure this is an appropriate level of care. Similar to a hospital, individuals do not stay in DAS units very long. A stay is typically less than 28 days. You will need to stay in regular contact with the team at the DAS unite to be part of the discharge planning process.

Close Monitoring: There will be times when a crisis arises, but an individual is not likely to harm himself/herself or others and his/her symptoms are not severe enough to warrant hospitalization or respite care. These kinds of crises are still serious and could eventually evolve to the point where hospitalization or respite care is needed. During such times, all you can do is provide close and careful monitoring to help prevent further deterioration. Further, you can speak to the individual’s care givers about close monitoring and supervision. It may be necessary to visit these individuals every day and check their stability. Make sure the individual and the family are aware of the number to the crisis line if things get worse. As always, your supervisor, mentor, and the psychiatrist should be notified.

Chapter 3: Being an Ethical Service Coordinator

Beyond learning the basics of the services and resources available, it is important as a service coordinator that you understand the ethical guidelines that guide this important job. Like every other recognized profession that has standards that govern its practice in terms of the acceptable and unacceptable behaviors, so does the profession of service coordination. Service coordinators serve some of the most vulnerable individuals in our community, especially service coordinators that work with children and adolescents. Such individuals and their families can easily be taken advantage of or misled in these confusing and cumbersome times of their lives. As a service coordinator, you will be one of your consumer's most trusted advisors and guides in their treatment. For this reason, it is imperative that as a service coordinator you act in an ethical manner. This chapter will provide you with the basic information you need to know regarding the professional and ethical conduction of service coordination, as well as provide you with some suggestions for how to handle ethical dilemmas that do not have a clear solution.

Personal Practice Guidelines of Service Coordinators

The accepted standard code of ethics for mental health case managers comes from the "Personal Practice Guidelines" of the National Association of Case Management*. Below, we have provided a copy of these guidelines that includes 20 statements that reflect the need for service coordinators to respect the dignity of all human beings. As a service coordinator, you will be working with a diverse group of individuals and families. Part of respecting the dignity of all human beings includes accepting individuals regardless of gender, race, religion, sexual orientation, economic availability, and so on. Further, by respecting an individual's privacy and maintaining the confidentiality of the people you serve, you will develop an ethical and trusting relationship. *Above all, a service coordinator must strive to do no harm to those people who rely on his/her services.* By following these practice guidelines, you will not only succeed as an ethical service coordinator, but also represent the best of your profession.

Table: Personal Practice Guidelines of Case Management

As a case manager, I:

1. Am committed to respect the dignity and autonomy of all persons and to behave in a manner that communicates this respect.
2. Am committed to each individual's right to self-determination, and the rights of people to make their own life choices.
3. Am committed to fight stigma wherever I find it, to educate the community, and to promote community integration for the people I serve.
4. Do not allow my words or actions to reflect prejudice or discrimination regarding a person's race, culture, creed, gender or sexual orientation.
5. Strive to both seek and provide culturally-sensitive services for each person and to continually increase my cultural competence.
6. Am committed to helping persons find or acknowledge their strengths and to use these strengths to achieve their goals.
7. Am committed to helping persons achieve maximum self-responsibility and to find and use services that promote increased knowledge, skills and competencies.
8. Acknowledge the power of self-help and peer support and encourage participation in these activities with those I serve.
9. Am honest with myself, my colleagues, the people I serve, and others involved in their care.
10. Keep confidential all information entrusted to me by those I serve except when to do so puts the person or others at grave risk. I am obligated to explain the limits of confidentiality to the persons I serve at the beginning of our working together.
11. Am committed to a holistic perspective, seeing each person I serve in the context of their family, friends, other significant people in their lives, their community, and their culture, and working within the context of this natural support system.
12. Must strive to maintain healthy relationships with the people I serve, avoiding confusing or multiple relationships and keeping the relationship focused on the individual's needs, not my own.
13. Maintain a commitment to prevent crisis situations with the people I serve, to present and support crisis alternatives, to develop an advanced instruction crisis plan with the individual whenever possible, and to avoid forced treatment unless there is a clear and present danger to the person served or another.
14. Have an obligation to consult with my supervisor, obtain training, or refer to a more qualified case manager any individual with a need I do not feel capable of addressing.
15. Have an obligation to remain curious; learning, growing, developing, and using opportunities for continuing education in my field or profession.
16. Am committed to a regular assessment of my service recipients' expectations of me and to consistently improving my practice to meet their expectations.

17. Have an obligation to advocate for the people I serve, for their rights, for equal treatment and for resources to meet their needs.
18. Am obligated to learn the laws and regulations governing my practice and to abide by them, including the duty to warn anyone in danger of physical harm, and the duty to report physical, sexual, emotional and/or verbal abuse to the proper person or agency.
19. Am obligated to work supportively with my colleagues and to keep their confidences.
20. Am obligated to urge any colleague who appears impaired to seek help and, failing this, to discuss my concerns with the appropriate agency authority.

Big Ethical No No's

The practice guidelines provided above will give you a good foundation for being an ethical and effective service coordinator. These guidelines will cover nearly every major ethical dilemma you will face as a service coordinator. This section has been provided to highlight ethical issues that are important and common.

- *Never share information without permission*-Confidentiality is the #1 rule of any health care provider. This means that you can never share information about an individual you serve with anyone, unless the client gives you explicit permission. The exceptions to this is sharing information with other members of your agency who are directly involved in treating the individual. Friends, colleagues, family members, and personnel from other agencies, should never be told about the status, diagnosis, and/or treatment of a client without clear, written permission. Confidentiality is such a large issue that the United States government created the Health Insurance Portability and Accountability Act (HIPAA) to ensure the protection of privacy of Americans' personal health records. Breaking HIPAA is a federal offense and can get you and your agency into serious trouble. To ensure that this is not an issue, make sure you have written and signed copies of releases of information from the individuals you serve.
- *Never become intimate with the individuals you serve or their families*- Beyond the legal ramifications of becoming intimate with children and adolescents, it is extremely unethical to become intimate or have sex with the individuals and families you serve. Since you will play a

major role in an individual's and their family's lives, it is quite possible you will become extremely close. Some service coordinators and consumers have difficulty in developing such close relationships and still respecting the boundaries of a professional relationship. If you cross these boundaries you will not longer be helping the individual you serve, and will very likely begin to contribute to their problems. Remember once a client, always a client. Even after an individual's case is closed, a professional boundary exists.

- *Never lie to the individuals you serve*-New service coordinators are often tempted to mask their uncertainty with false information and advice. Usually they are only fooling themselves, and if the individuals you serve act on this false information, you will be very likely doing them a major disservice. If you do not know the answer to a question, be honest and say you need to get advice from a colleague, mentor, or supervisor. Also, never give a consumer false hope or promise them something that is not possible. At the time, it will seem like you are calming their anxieties, however in the long run you will be breaking their trust when their desired actions do not occur. Instead tell your client realistic expectations, and what you are capable of doing to help them.
- *Never encourage dependency*- Individuals who receive services are by nature at least minimally dependent upon service coordination services, otherwise you would not be needed. However, service coordinators often think that this means they should do everything they can for their consumers. It may feel that sometimes it is easier to just do everything for the individuals and families you serve, rather than teach them the skills they need to do things independently. In doing this though, you negate your core responsibility of encouraging as much independence and autonomy as possible, and make it increasingly likely that your clients will be dependent on you or another service coordinator forever. Because of this, you should always work to provide the individuals and families with the skills they need to do things independently.

Mandated Reporting

There are some situations that are so severe that the #1 rule of confidentiality can be broken. These situations include those where a person is a reasonable threat to themselves or others, or when you have evidence that abuse or neglect is occurring. In such situations, a service coordinator is a mandated reporter and is required by law to notify the police, psychiatrist, and/or child welfare agency of the problem. The idea behind mandated reporting is simple: confidentiality can be broken when people's lives are at stake. If an individual you serve is a threat to him or herself, it is acceptable to call the psychiatrist or hospital without obtaining permission from that person. Similarly, if you know an individual is about to harm someone else, it is also acceptable to call the police without asking permission. Working with children also adds another layer of responsibility. If there is evidence of abuse or neglect for the children and adolescents you serve, it is required by law that you notify the local child welfare department of the problem.

If you need to break confidentiality for one of the above reasons, it is always best for you to discuss with your consumer why you were forced to reveal the issues to the psychiatrist, police, or child welfare agency. While it is a non-negotiable to be a mandated reporter, you still need to be there to support the individual through the situation. Finally, you need to discuss any issue regarding mandated reporting with your supervisor/and or mentor prior to taking action. This is the time where you need to share responsibility with others, and allow those with more experience to guide you to the best decision.

What to Do When You Don't Know What to Do

This manual has provided you with some concrete guidelines about serious ethical dilemmas that frequently arise within service coordination. Nevertheless, there will be situations you encounter that will not be clear cut. More often than not, you will be put in situations where there is no clear guide for proceeding. For example, what do you do when an individual you serve gives you a generous gift? Do you accept it? Do you return it to the client? Or, what do you do when a child's father tries to hug you for all the help you have given? Do you refuse the hug? Is proceeding too intimate? Both of these situations illustrate ethical problems where your decision may depend on the context in which they occur.

First and foremost, you should always discuss situations that you think are ethically ambiguous with your supervisor and mentor; they will help you come to an objective and appropriate decision. You should never be out there making these decisions on your own, if you do not have to. Of course, there are times when decisions require quick responses, in which case you should remember your practice principles and try to act accordingly. While the practice principles are not hard and fast rules, they will help guide you in tough situations where there is no clear answer. When you have to act, think not only about the practice principles but also about the likely consequences of your behavior. Would accepting a hug from the father of the child you serve insinuate something more? Would returning the large gift cause irreparable damage to your relationship? Regardless of your decision, it will always be important to take a careful assessment of its impact on the individuals, and report on your behavior to your supervisor and/or mentor for feedback.