

December 2005

IF YOU WISH TO RECEIVE CE CREDIT YOU MUST ARRIVE WITHING 15 MINUTES! THANK YOU

Bipolar Disorder in Children & Adolescents

QRTips

Presenter: Shane Gomes, Ph.D.

When: December 16, 2005 9:00 a.m. to 4:00 p.m.

Where: 405 W. 5th St., Ste. 433A

This is a REPEAT of the presentation on August 25, 2005

What is Bipolar Disorder? Is Bipolar Disorder the same as Manic-Depressive Disorder? What are the common symptoms in Bipolar Disorder? Do children and adolescents exhibit the same symptoms as adults? Isn't diagnosing Bipolar Disorder just the latest fad? How do you diagnosis Bipolar Disorder in children and adolescents and what are some effective tools? Is Bipolar Disorder different from Attention Deficit Hyperactivity Disorder (ADHD) or Asperger's Disorder or Tourette's Disorder? What is the Rage Cycle and what are the warning signs? Don't these kids just need to learn to calm down and control their anger? How do you manage Bipolar Rage in children/adolescents? What about medications for Bipolar Disorder? Aren't we giving our kids too many medicines? How do you effectively treat a child or adolescent with Bipolar Disorder? What can clinicians do to learn more about Bipolar Disorder? If you have heard any of these questions than this workshop on "Bipolar Disorder in Children and Adolescents" is for you! This workshop will look at how to define, properly diagnosis and effectively treat children and adolescents with Bipolar Disorder. We'll discuss diagnostic criteria, tools for diagnosing, the Rage Cycle and how to manage rage, medication concerns, and treatment strategies.

OBJECTIVES: As a result of attending this workshop, participants will be able to:

1. Define Bipolar Disorder and describe the common symptoms as exhibited by children and adolescents.
2. Differentiate between Bipolar Disorder, ADHD, Asperger's Disorder and Tourette's Disorder.
3. Define the stages of the Rage Cycle, warning signs and coping skills.
4. Describe effective treatment strategies for managing Bipolar Disorder.
5. Acquire effective resources for parents with children/adolescents with Bipolar Disorder.

Target Audience: Health and Mental Health practitioners and planners.

6 CE credits are available for psychologists, LCSWs and MFTs

This section provides monthly critical reminders in relation to documentation standards.

I. The results of some of the recent EPSDT audits for county and contract programs report the following:

- a) The completion of the Discharge Summary cannot be billed as case management fee.
- b) Assessment progress notes must document assessment activities. Medi-Cal's definition of Assessment is a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder, relevant cultural issues and history; diagnosis; and the use of testing procedures.
- c) The assessment summary, the diagnosis, the treatment plan and the progress notes must be connected.
- d) The date on the progress note must match the date of the ED.

II. If providing other than assessment services prior to completion of the assessment documents, including the treatment plan one must ;

- a) Complete the Treatment Plan for Non-Assessment Services Provided During the Assessment Period
- b) Medication Evaluation, Crisis Intervention, and Psychological Testing can be provided during the assessment period without the need of completing the Tx Plan for Non-Assessment Services.

Your Culture and Mine: A Monthly Column About Culture and Mental Health

Ethnicity and publicly funded health insurance (data from the Orange County Health Needs Assessment, Spring 2005)

Many of the children seen by CYS for mental health services are funded by MediCal, or to a lesser extent, the Healthy Families program. The number of children enrolled in these programs has increased by 50%-90% since 2001, but has leveled off in the last two years. In 2004 182,905 children in Orange County were enrolled in the MediCal program and 66,188 in the Healthy Families program.

Sixty-two percent of the children enrolled in publicly funded health insurance programs in the county are of Latino background; 21% of the children are Vietnamese-American, so more than four out of every five children covered by these programs are from the two largest ethnic minority groups in the county. Other Asian background children represent slightly over 5% of the children who are covered and only 1.3% are African-American. Non-Latino white children are just over 6% of those covered.

In addition to those covered by publicly funded health insurance, children who are uninsured are also eligible for county mental health services. The number of such children in 2004 was 38,380 a substantial drop from earlier years. The vast majority of such children (76%) are of Latino backgrounds, most of their families had incomes of less than 200% of the federal poverty level. The most likely reason for a child not being insured was lack of documentation to prove legal residency.

The percentage of children of Latino or Vietnamese background who are covered by publicly funded health insurance or not covered by any health insurance and thus are eligible for county mental health services is greater than the percentage of those children in the general population, which is why planning for the mental health needs of children in the county who will use public mental health services must include attention to issues of cultural and linguistic competence.

Working with Children and Adolescents in Blended Families

Presenter: Michael T. Griffin, J.D., LCSW
When: December 20, 2005, 9:00 a.m. – 12:00 p.m.
Where: **744 N. Eckhoff, Orange, CA (Auditorium)**

Many CYS clients live in blended families, in which each parent has children from a previous marriage. These families present particular difficulties for children and parents alike. This workshop will focus on clinical assessment of the children in the family and how to determine their individual needs as well as assessment of the whole family and determination of its need. Treatment strategies will be addressed, including how to make recommendations for treatment that frame therapy in a way it will be accepted, how to develop an effective treatment plan and how to avoid the common pitfall involved in working with such complex family situations.

Michael T. Griffin has a law degree from Chapman University and a MSW from USC. He is licensed by the California State Bar and the BBS. He was formerly Director of Clinical Operations for Western Youth Services and a program coordinator for Children's Hospital in San Diego. He currently is in private practice of both law and social work.

Objectives: 1) To be able to assess the child's needs in the context of the family interaction pattern
2) To be able to formulate a treatment plan that takes into account the complex dynamics of a blended family

Target audience: Mental health professionals who work with children and families.

3 CE credits will be available for psychologists, social workers and MFTs.

**PLEASE REMEMBER TO CALL AND CANCEL
IF YOU HAVE SIGNED UP FOR A WORKSHOP
AND YOU ARE UNABLE TO ATTEND.
NO PHONE SIGNUP PLEASE!!**

Show Me The Evidence!

Cognitive therapy for schizophrenia?

Recently a number of articles and reviews have appeared related to the use of cognitive or cognitive-behavioral treatment (CBT) for schizophrenia. Since accepted wisdom has been that psychotherapeutic approaches, other than the offering of support and the training of social skills, were of little value in treating such a severe psychotic disorder such as schizophrenia, reports of successful interventions with CBT have received close scrutiny.

A 2003 review published in the Cochrane Reviews, probably the most respected source of reviews of the efficacy of medical treatments, was pessimistic regarding the utility of CBT. Although the review concluded that such therapy was promising, and some data suggested that hospital stays could be shortened and mental state improved, the lack of data indicating a reduction in rate of relapse and the failure of CBT to be superior to supportive therapy suggested a need for caution in accepting the utility of such treatment.

Since the Cochrane review, two more important reviews have been published, both with more positive conclusions. Gaudiano (2005) reviewed 19 studies and found that CBT plus medication administered to chronic clients was generally superior to pharmacotherapy alone and usually, but not always to pharmacotherapy plus supportive therapy. Several small studies that used random assignment found CBT to be superior to other supportive treatments in reducing hospitalization during the acute phase of the illness. A few studies addressing use of CBT with first-episode schizophrenia had mixed results in terms of reducing further episodes.

Zimmerman et al (2005) published a meta-analysis of the effectiveness of CBT on positive symptoms of schizophrenia. 15 studies with 1001 participants were included in their analysis and those not receiving CBT usually received either treatment as usual or supportive therapy. With regard to reduction in positive symptoms there was a modest overall superiority of CBT. "A typical patient in the CBT group improved more than 64% of the control patients and CBT increases the success rate of reducing positive symptoms from 41% to 59%." The effect of CBT was almost twice as large when only clients in an acute episode were considered. Furthermore, for 540 clients available for follow-up at 3 and 12 months, the results were not only maintained, but more strongly favored CBT.

CBT still needs more evaluation but its use in treating schizophrenic clients, perhaps particularly during acute psychotic episodes, appears promising as an adjunct to medication in reducing positive symptoms.

References:

- Cormac, I., Campbell, C., & Silveira da Mota Neto, J. (2003). Cognitive behaviour therapy for schizophrenia. *Cochrane Database Systematic Reviews*, 3, 14.
- Gaudiano, B. (2005). Cognitive behavior therapies for psychotic disorders: Current empirical status and future directions. *Clinical Psychology: Science and Practice*, 12, 33-50.
- Zimmerman, G., Favrod, J., Trieu, V.H., & Pomini, V. (2005). The effect of cognitive behavioral treatment on the positive symptoms of schizophrenia spectrum disorders: A meta-analysis. *Schizophrenia Research*, 77, 1-9.

HAPPY

HOLIDAYS

❖ Introducing- The Quality Review and Training Team

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All staff may be reached via county email as well.

The County of Orange Health Care Agency is an approved provider of continuing education credits for the California Board of Behavioral Sciences (provider no. PCE389), and is approved by the American Psychological Association to offer continuing education for psychologists. The Orange County Health Care Agency maintains responsibility for the programs.