

## SLIDE 1 TITLE SLIDE

# MENTAL ILLNESSES IN CHILDREN AND ADOLESCENTS: Expanded CRIT Content

**Time:** 40 minutes

**Slides:** 13

**Purpose:** This module provides additional instruction on mental illnesses in children and adolescents. It builds upon the information presented within *CRIT Module 4. Understanding Mental Health Conditions and Mental Illnesses*. Participants will be introduced to information on mental illnesses in children and adolescents, with a particular focus on disruptive, impulse-control, and conduct disorders and considerations for law enforcement when responding to children and adolescents living with a mental health condition.

### **Instructor:**

This module should be taught by a mental health expert with experience in working with children and adolescents and be supported by a law enforcement co-trainer.

### **Learning Objectives:**

Upon completing this module, participants should be able to:

1. Recognize that many mental health conditions begin in childhood;
2. Describe symptoms or characteristics of disruptive, impulse control, and conduct disorders; and
3. Identify at least three useful tips for responding to a youth experiencing a mental health crisis.


### **Activities:**

- Case Scenario


### **Additional Materials:**

- None

### Module Overview



- Mental Illnesses in Children and Adolescents
- Disruptive, Impulse-Control, and Conduct Disorders
- Tips for Responding



## SLIDE 2

### MODULE OVERVIEW



**Trainer Note:** Use this slide to outline the topics that will be discussed in this module and lead a brief discussion about the distinctions between mental health conditions and mental illnesses, referencing the note below. Note that we will use the term “mental illness” when discussing specific mental illnesses and “mental health conditions” when talking generally about living with mental health conditions (e.g., schizophrenia) and experiencing a mental health crisis.


**NOTE:** The terms “mental health condition” and “mental illness” are often used interchangeably. However, there is a distinction. “Mental health condition” is more inclusive than the term “mental illness,” as individuals living with a mental health condition may not necessarily be diagnosed with a mental illness. However, these conditions do impact one’s mental health and may cause some temporary impairment in daily functions. “Mental illnesses” are a range of mental health conditions that are diagnosable and often cause significant impairment in daily functioning. A mental illness is also referred to as a mental health disorder. A person may have a mental illness but has not been formally diagnosed and yet experiences symptoms that are debilitating to their functioning, such as suicidal thoughts, hallucinations, or delusions. It is also important to recognize that not all presentations of mental health conditions or mental illnesses are the same and everyone experiences them differently.

**Emphasize that it is not the intent of this training to make officers diagnosticians or clinicians.** However, officers often respond to people who exhibit various signs and symptoms associated with mental illness. The information that officers learn about mental illnesses can help inform their responses to people who experience mental health crises in the community. It can be helpful to remind participants that people can have more than one condition or co-occurring conditions (e.g., a person may have a mental health condition and a substance use disorder, more than one mental health condition, or an intellectual and developmental disability and a mental health condition and/or substance use disorder).

### Mental Illnesses in Children and Adolescents

- **Mental illnesses** in children can be described as serious changes in how they typically **learn, behave, and manage their emotions**, leading to **distress** and **problems with their functioning** at school and home.
- Children and adolescents can develop the same mental illnesses as adults, but some of the signs and symptoms may be different.

*About 50% of adult mental health conditions begin before age 18*



## SLIDE 3

# MENTAL ILLNESSES IN CHILDREN AND ADOLESCENTS



**Trainer Note:** Review the content on the slide and use the content note below as a reference.



**Content Note:** Mental illnesses in children can be described as serious changes in how they typically learn, behave, and manage their emotions, leading to distress and problems with their functioning at school and home. Many adult mental health conditions begin in childhood or adolescence—about 50% begin before age 18. Adults who experience mental health conditions may look back at their childhood and begin to identify signs and symptoms they had as a child. Young children and adolescents can develop the same mental illnesses (e.g., anxiety disorders, major depressive disorder, post-traumatic stress disorder) as adults, but their signs and symptoms may be different. Symptoms of a mental illness in children and adolescents can include the following:

Young children:

- Frequent tantrums or irritability
- Frequent talk about fears or worries
- Frequent physical complaints with no known medical cause (e.g., headaches)
- Difficulty sitting quietly and in constant motion
- Sleep challenges (e.g., sleeping too much or too little) or persistent nightmares
- Changes in eating habits
- Difficulty making friends or no interest in playing with other children
- Academic challenges or recent decline in grades
- Being overly clingy

Older children and adolescents:

- Loss of interest in the things they used to enjoy



- Low energy or periods of excessive energy
- Sleep challenges
- Withdrawing from social activities
- Self-harm behaviors
- Substance use
- Suicidal thoughts
- Frequent outbursts of anger
- Prolonged negative mood

Sources:

Centers for Disease Control and Prevention, July 26, 2023 [Last Reviewed], “What is Children’s Mental Health,” <https://www.cdc.gov/childrensmentalhealth/basics.html>.

Marco Solmi, Joaquim Radua, Miriam Olivola, Enrico Croce, Livia Soardo, Gonzalo Salazar de Pablo, Jae Il Shin, et al., 2022, "Age at Onset of Mental Disorders Worldwide: Large-Scale Meta-Analysis of 192 Epidemiological Studies," *Molecular Psychiatry* 27(1): 281–295.

Mayo Clinic Staff, March 2, 2022, “Mental Illness in Children: Know the Signs,” <https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577>.

Mental Health America, n.d., “Mental Illness and the Family: Recognizing Warning Signs and How to Cope,” retrieved November 15, 2023 from <https://www.mhanational.org/recognizing-warning-signs>.

National Institute of Mental Health, March 2023 [Last Reviewed], “Child and Adolescent Mental Health,” <https://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health>.

Rebecca H. Bitsko, Angelika H. Claussen, Jesse Lichstein, et al., 2022, “Mental Health Surveillance Among Children – United States, 2013-2019,” *MMWR Supplements* 71(2): 1–42.

Most Common Mental Illnesses in Children and Adolescents	
<b>Attention-Deficit/Hyperactivity Disorder (ADHD)</b>	
• Inattention	• Hyperactivity • Impulsivity
<b>Anxiety</b>	
• Frequent fears or worries	• Trouble sleeping • Physical symptoms • Irritability
• Fatigue	• Low self-esteem • Overly clingy
<b>Depression</b>	
• Feeling sad or hopeless	• Feeling worthless • Suicidal thoughts • Trouble focusing
• Changes in sleep or eating	• Feeling tired • Not enjoying the things they used to
<b>Disruptive, Impulse-Control, and Conduct Disorders</b>	
• Serious rule violations	• Anger/irritability • Aggressive behavior • Defiant behavior

## SLIDE 4 MOST COMMON MENTAL ILLNESSES IN CHILDREN AND ADOLESCENTS



**Trainer Note:** Use the content note below to summarize the most common mental illnesses in children and adolescents. Note that attention-deficit/hyperactivity disorder (ADHD) and anxiety among children of all ages, and depression among adolescents, are the most common mental illnesses experienced by youth. Inform participants that this module will cover ADHD and disruptive, impulse-control, and conduct disorders in more detail.



**Content Note:** Many children experience worries and fears or may feel sad at times. It can be normal for fears to appear at different times during a child's development, such as when a toddler feels distressed when away from their parents. However, persistent or extreme fears, frequent feelings of hopelessness or sadness, or strong fears that are not developmentally appropriate could indicate an anxiety disorder or depression. Signs and symptoms of an anxiety disorder can include frequent worries or fears, difficulty sleeping, physical symptoms (e.g., headaches, stomachaches), irritability, anger, fatigue, fears of embarrassment, low self-esteem, and being overly clingy. About 9% of children and adolescents aged 3–17 experience an anxiety disorder.

Children and adolescents may avoid talking about how they are feeling or have trouble describing it. Common symptoms and behaviors of depression include frequently feeling sad, hopeless, or irritable; feeling worthless or guilty; having suicidal thoughts; having trouble focusing; experiencing changes in sleep, eating, and energy (e.g., feeling tired and sluggish or restless); and not enjoying the things they used to. Depression and risk of suicide are more common in older children and adolescents than younger children; though, young children can experience depression. About 21% of children and adolescents aged 12–17 have ever experienced a major depressive episode.



There is an increased risk of suicide in youth living with mood disorders. There is some evidence that suicide attempts in childhood can be more impulsive than in adults. It is important to sensitize officers to the increased risk of suicide in youth, even for those who do not have a plan. **Any talk of self-harm and suicide should be taken seriously.**

Children and adolescents can also experience other mental illnesses similar to adults, such as Post-Traumatic Stress Disorder (PTSD) and psychotic disorders. Some people are traumatized at early ages either due to abuse or living in an unstable environment where they may witness or be exposed to violence, family dysfunction, etc. When a person is traumatized at an early age, the development of the brain can be affected, which may result in the development of a mental health disorder such as anxiety, depression, and/or Post-Traumatic Stress Disorder (PTSD). Youth who experience traumatic events such as physical or sexual abuse may experience nightmares, irritability, or bedwetting, be easily startled, and engage in repetitive acting out of the trauma in play. They may also avoid places or people associated with the traumatic event. However, not every child who experiences trauma will be diagnosed with a mental illness.

The first episode of psychosis often happens in the late teen years into the early twenties. Psychosis involves disruptions to an individual's thoughts and perceptions that make it challenging to recognize what is real and what is not. These disruptions are often experienced as seeing, hearing, and/or believing things that aren't real (i.e., hallucinations). They can also include experiencing persistent, strange emotions, thoughts, and behaviors (i.e., delusions). Some early signs of psychosis are withdrawal (the person spends increased time by themselves), a decline in personal hygiene, suspiciousness or paranoid ideas, sudden decline in grades or performance at work, trouble thinking clearly, and sleep disruptions.

**NOTE:** Emphasize the importance of evaluation/screening and linkage to services as early as possible. The sooner someone gets evaluated and receives treatment or services, the better their outcomes can be.

Sources:

American Academy of Child & Adolescent Psychiatry, October 2023 [Updated], "Anxiety and Children," *Factors for Families*, No. 47, [https://www.aacap.org/AACAP/Families\\_and\\_Youth/Facts\\_for\\_Families/FFF-Guide/The-Anxious-Child-047.aspx](https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Anxious-Child-047.aspx).

American Academy of Child & Adolescent Psychiatry, October 2018, "Depression in Children and Teens," *Facts for Families*, No. 4,



[https://www.aacap.org/AACAP/Families\\_and\\_Youth/Facts\\_for\\_Families/FFF-Guide/The-Depressed-Child-004.aspx](https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Depressed-Child-004.aspx).

American Academy of Child & Adolescent Psychiatry, June 2021, "Suicide in Children and Teens," *Facts for Families*, No. 10, retrieved from [https://www.aacap.org/AACAP/Families\\_and\\_Youth/Facts\\_for\\_Families/FFF-Guide/Teen-Suicide-010.aspx](https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx).

American Academy of Pediatrics, September 12, 2022 [Last Updated], "Depression in Children and Teens," <https://www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/childhood-depression-what-parents-can-do-to-help.aspx>.

Catherine M. McHugh, Rico Sze Chun Lee, Daniel F. Hermens, Amy Corderoy, Matthew Large, & Ian B. Hickie, 2019, "Impulsivity in the Self-Harm and Suicidal Behavior of Young People: A Systematic Review and Meta-Analysis," *Journal of Psychiatric Research* 116: 51–60.

National Center on Birth Defects and Developmental Disabilities, July 25, 2023 [Last Reviewed], "Anxiety and Depression in Children," Centers for Disease Control and Prevention, <https://www.cdc.gov/childrensmentalhealth/depression.html>.

National Center on Birth Defects and Developmental Disabilities, July 26, 2023 [Last Reviewed], "Post-traumatic Stress Disorder in Children," Centers for Disease Control and Prevention, <https://www.cdc.gov/childrensmentalhealth/ptsd.html>.

National Institute of Mental Health, 2023 [Revised], *Understanding Psychosis*, NIH Publication No. 23-MH-8110, Bethesda, MD: National Institutes of Health, <https://www.nimh.nih.gov/sites/default/files/documents/health/publications/understanding-psychosis/23-MH-8110-Understanding-Psychosis.pdf>.

Jessica Hamblen & Erin Barnett, n.d., "PTSD in Children and Adolescents," PTSD: National Center for PTSD, accessed December 6, 2023 from [https://www.ptsd.va.gov/professional/treat/specific/ptsd\\_child\\_teens.asp#three](https://www.ptsd.va.gov/professional/treat/specific/ptsd_child_teens.asp#three).

National Center on Birth Defects and Developmental Disabilities, March 8, 2023 [Last Reviewed], "Children's Mental Health: Understanding an Ongoing Public Health Concern," Centers for Disease Control and Prevention, <https://www.cdc.gov/childrensmentalhealth/features/understanding-public-health-concern.html>.

Rebecca H. Bitsko, Angelika H. Claussen, Jesse Lichstein, et al., 2022, "Mental Health Surveillance Among Children – United States, 2013-2019," *MMWR Supplements* 71(2): 1–42.



### Attention-Deficit/Hyperactivity Disorder (ADHD)

- Persistent pattern of inattention and/or hyperactivity and impulsivity that interferes with a person's functioning and development

Inattention	Hyperactivity and Impulsivity
Often fails to pay close attention to details	Often fidgets or squirms in seat
Has difficulty remaining focused in tasks or play	Has difficulty waiting their turn
Often does not seem to listen when spoken to directly	Often runs about in inappropriate situations (children) or feels restless (adolescents/adults)
Often starts tasks but fails to finish	Often interrupts others
Loses things easily and is often forgetful	Has difficulty playing or engaging in activities quietly
Often has difficulty organizing tasks and activities	Often talks excessively

5

## SLIDE 5

# ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)



**Trainer Note:** Use the content below to support a discussion on the symptoms or characteristics of Attention-Deficit/Hyperactivity Disorder (ADHD).



**Content Note:** ADHD stands for Attention-Deficit/Hyperactivity Disorder. ADHD used to be called Attention Deficit Disorder (ADD); however, ADD is an outdated term and is no longer a diagnosis. A person with ADHD has differences in brain development and brain activity that affect attention, the ability to sit still, and self-control. ADHD is a neurodevelopmental disorder that is characterized as a persistent pattern of inattention and/or hyperactivity and impulsivity that interferes with a person's functioning and development. This disorder begins in childhood—a person diagnosed with ADHD must have several symptoms before age 12. ADHD can affect a person at school, at work, at home, and in relationships. Approximately 10% of children and adolescents are diagnosed with ADHD.

The behaviors of *inattention* can include wandering off task, difficulty staying focused, and having difficulty finishing activities. *Hyperactivity* refers to excessive motion during inappropriate times (e.g., running around), excessive fidgeting or talking, or extreme restlessness. *Impulsivity* refers to actions that occur in the moment without forethought that can potentially lead to harm to the individual. These behaviors can include interrupting others and making important decisions without considering the long-term consequences.

Some common symptoms or characteristics include:

### Inattention:

- Often fails to pay close attention to details or makes careless mistakes
- Has difficulty remaining focused on tasks or play (e.g., difficulty sustaining attention during lectures, reading, and conversations)





- Often does not seem to listen when spoken to directly
- Often starts tasks but fails to finish as they quickly lose focus
- Loses things easily (e.g., books, phone, wallet, keys) and is often forgetful in daily activities
- Often has difficulty organizing tasks and activities

### **Hyperactivity and Impulsivity:**

- Often fidgets with or taps hands or feet or squirms in seat
- Has difficulty waiting their turn (e.g., waiting in line)
- Often runs about in inappropriate situations (children) or feels restless (adolescents/adults)
- Often interrupts others and tends to blurt out answers instead of waiting to be called on
- Has difficulty playing or engaging in leisure activities quietly
- Often talks excessively

Children and adults living with ADHD may also have difficulty controlling their emotions and become easily frustrated and angry. The behavior and symptoms associated with ADHD can change as the person grows up. For instance, hyperactivity can decrease as children grow up, but difficulties with inattention and impulsivity remain. During adolescence, the prior signs of hyperactivity (e.g., running, climbing) may manifest as fidgetiness, impatience, or restlessness.

The term ADHD gets used liberally in our society when referencing a child who is overactive, acts oppositional, or is easily distracted and nervous/fidgety. Some symptoms of ADHD are also symptoms of other mental health conditions, such as anxiety, depression, and trauma-related disorders. Children living with ADHD can also have co-occurring mental health conditions. It is important that any child experiencing these symptoms get evaluated to determine the underlying causes of their behaviors and to get help to minimize the negative impact on their functioning.

Note that often the symptoms of ADHD may be what leads to law enforcement getting a call to respond. In some cases, if a youth responds to a teacher or parent redirection or behavior correction with aggression it could result in law enforcement being called.



**Ask officers if they know anyone living with ADHD. Ask what the experience is like, what they found difficult, and what they found helpful in responding or interacting with someone with ADHD.**



Sources:

American Academy of Child & Adolescent Psychiatry, February 2017, “ADHD & the Brain,” [https://www.aacap.org/AACAP/Families\\_and\\_Youth/Facts\\_for\\_Families/FFF-Guide/ADHD\\_and\\_the\\_Brain-121.aspx](https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/ADHD_and_the_Brain-121.aspx).

American Psychiatric Association, 2022, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR)*, Washington, DC: American Psychiatric Association.

Rebecca H. Bitsko, Angelika H. Claussen, Jesse Lichstein, et al., 2022, “Mental Health Surveillance Among Children – United States, 2013-2019,” *MMWR Supplements* 71(2): 1–42.

Disruptive, Impulse-Control, and Conduct Disorders

- Group of disorders characterized by problems in emotional and behavioral self-control/self-regulation
- Resulting behaviors violate the rights of others and/or societal norms
- First begin in childhood or adolescence

## SLIDE 6

### DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS



**Trainer Note:** Inform participants that the rest of the disorders discussed in this module are considered to be disruptive, impulse-control, and conduct disorders. This group of disorders is characterized by problems in emotional and behavioral self-control and self-regulation which often cause disruption in the functioning of a child’s or adolescent’s life as well as those around them. These disorders are unique in that resulting behaviors primarily impact others (e.g., aggressive behavior) and/or conflict with societal norms.

These disorders first begin in childhood or adolescence. It is important to note that youth brains are not fully developed. The part of the brain that is responsible for planning and reasoning is not fully developed until a person’s mid-to-late- 20s. Changes in an adolescent’s brain, along with other social, emotional, and physical changes can help explain why many mental health conditions begin in adolescence.

#### Sources:

American Psychiatric Association, September 2021, “What are Disruptive, Impulse Control, and Conduct Disorders,” <https://www.psychiatry.org/patients-families/disruptive-impulse-control-and-conduct-disorders/what-are-disruptive-impulse-control-and-conduct>

American Psychiatric Association, 2022, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR)*, Washington, DC: American Psychiatric Association.

National Institute of Mental Health, 2023 [Revised], *The Teen Brain: 7 Things to Know*, Bethesda, MD: U.S. Department of Health and Human Services, National Institute of Health, National Institute of Mental Health, retrieved from <https://www.nimh.nih.gov/health/publications/the-teen-brain-7-things-to-know/index.shtml>.

Intermittent Explosive Disorder (IED)

- Recurrent outbursts of anger and verbal or physical aggression in response to a minor provocation

Typically, the aggressive response or outburst...

- ...is much more intense than the situation or stressor.
- ...is not planned or premeditated. It is impulse- or anger-based.
- ...causes distress for the individual, impairs their functioning, or is associated with financial or legal consequences.
- ...does not last longer than 30 minutes.

Q&A

7

## SLIDE 7 INTERMITTENT EXPLOSIVE DISORDER (IED)



**Trainer Note:** Cover the information on the slide referencing the content below.



**Content Note:** Intermittent explosive disorder (IED) is an impulse-control disorder characterized by recurrent outbursts of anger and verbal or physical aggression in response to a minor provocation. The disorder is typified by hostility, impulsivity, and recurrent aggressive outbursts. People with IED essentially “explode” into a rage despite a lack of apparent provocation or reason. Individuals living with intermittent explosive disorder have described the feeling as though they lose control of their emotions and are overcome with anger. Symptoms of IED typically begin during late childhood or adolescence.

Outbursts due to a failure to control aggressive impulses can appear as the following behaviors:

- Verbal aggression (e.g., temper tantrums, tirades, verbal arguments, or fights)
- Physical aggression towards individuals, property, or animals (e.g., fighting)

Typically, the aggressive response or outburst...

- ...is much more intense (grossly out of proportion) than the situation or stressor.
- ...is not planned or premeditated. It is impulse- or anger-based.
- ...causes distress in the individual, impairs their occupational or interpersonal functioning, or is associated with financial or legal consequences.
- ...does not last longer than 30 minutes.
- ...is not committed to achieving some tangible objective (e.g., money, power, intimidation).
- ...is not better explained by another mental health condition.



If officers are called to a situation that sounds like intermittent explosive disorder, they should focus on staying safe and keeping the child safe. Often, efforts to use logic and reasoning with the child or youth can result in escalating the situation. Officers should use a calm voice when talking to these individuals. Allowing the child or youth to have space and time may also be helpful. Officers should consider whether a mobile crisis team with experience working with children and families should be contacted for support with the response, if that resource is available.



**Ask officers if they have seen or experienced encounters with youth that may have been related to intermittent explosive disorder. What was the encounter like? What was challenging and what worked well?**

Source: American Psychiatric Association, 2022, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5-TR), Washington, DC: American Psychiatric Association.

## Oppositional Defiant Disorder (ODD)

- Pattern of angry and irritable mood, argumentative and defiant behavior, or vindictiveness
- Symptoms can include:
  - Often losing their temper
  - Often becoming easily annoyed
  - Often arguing with adults or other authority figures
  - Often blaming others for their mistakes
  - Making frequent attempts to annoy or upset others
- Youth living with ODD may also be diagnosed with ADHD and/or have co-occurring mood disorders



## SLIDE 8 OPPOSITIONAL DEFIANT DISORDER (ODD)

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**Trainer Note:** Cover the information on the slide referencing the below content as needed.

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**Content Note:** Oppositional defiant disorder (ODD) is a childhood disorder that is defined by a pattern of angry and irritable mood, argumentative and defiant behavior, or vindictiveness directed at adults or other authority figures. While many children will display some type of defiant behavior throughout their growing years, children living with ODD will display such behaviors more often and more intensely. Children living with ODD will not only do things that cause conflict or annoy the people around them, but they will, oftentimes, place the blame on others. This behavior leads to distress in the child and others in their social context (e.g., family members, peers) or has a negative impact on their social, educational, and daily functioning. The symptoms usually begin during the preschool years.

Common symptoms of ODD that persist as a pattern for six months or longer include:

- Often losing their temper/frequent temper tantrums
- Often becoming easily annoyed
- Often arguing with adults or other authority figures
- Often blaming others for their mistakes
- Making frequent attempts to annoy or upset others
- Often questioning rules
- Often refusing to comply with requests from authority figures or with rules
- Displaying vindictiveness
- Frequent anger and resentment



ODD is commonly diagnosed alongside ADHD and some children with ODD may also develop conduct disorder. They may also have co-occurring mood disorders like depression or anxiety disorders, especially with children who experience symptoms of anger and irritability. Professionals warn that ODD that goes unidentified early in life is often linked to other disorders later in life, including substance use disorder.

It is important for officers to recognize that children and youth with ODD have diminished capacity to regulate and control their behaviors. Their behaviors relate to more than stubbornness and disobedience. Rather than try to control situations with commands, officers might offer the child or adolescent choices to resolve the situation. The use of redirection in conversation (i.e., changing the topic) when at an impasse can also be helpful. These methods can allow youth to feel “in control” and to “save face.” Additional tips for responding are provided later in the module on Slide 11.

#### Sources:

American Psychiatric Association, 2022, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR)*, Washington, DC: American Psychiatric Association.

American Academy of Child & Adolescent Psychiatry, January 2019, “Oppositional Defiant Disorder,” *Facts for Families*, No. 72, retrieved from [https://www.aacap.org/aacap/families\\_and\\_youth/facts\\_for\\_families/fff-guide/Children-With-Oppositional-Defiant-Disorder-072.aspx](https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/Children-With-Oppositional-Defiant-Disorder-072.aspx).

Michele M. Martel, 2019, “Chapter 1 – Oppositional Defiant Disorder Dimensions and Prediction of Later Problems,” In *The Clinician’s Guide to Oppositional Defiant Disorder: Symptoms, Assessment, and Treatment* (pp. 1–15), San Diego, CA: Academic Press.



## Conduct Disorder

- Ongoing pattern of behavior that violates the rights of others, rules, or societal norms
- Behaviors can lead to problems in school, work or relationships; legal difficulties; and physical injuries from fights or accidents

## SLIDE 9 CONDUCT DISORDER



**Trainer Note:** Cover the information on the slide referencing the content below.



**Content Note:** It is not uncommon for children and youth to have behavior-related problems at some time during their development. However, behavior can be classified as a conduct disorder when it is long-lasting, severe, and disregards the rights of others. Youth living with conduct disorder display an ongoing pattern of behavior that violates rules, societal norms, or others' rights. These behaviors can lead to problems in school (e.g., suspension, expulsion), work, or relationships; legal difficulties; and physical injuries from accidents or fights.

Behavior of people living with this disorder can include the following:

- **Aggression to People and Animals**
  - Bullying, intimidating, or threatening others
  - Initiating physical fights
  - Physical cruelty to people or animals
- **Destruction of Property**
  - Can include fire setting
- **Deceitfulness or Theft**
  - Lying to obtain favors or avoid obligations
  - Breaking into someone's home or car
- **Serious Violations of Rules**
  - Often staying out at night despite being prohibited by their parents (before age 13)
  - Running away from home overnight
  - Truancy from school (before age 13)



Symptoms usually begin during middle childhood through middle adolescence. Living with conduct disorder is associated with an increased risk for later disorders, such as mood and anxiety disorders, post-traumatic stress disorder (PTSD), and substance-related disorders. Conduct disorder can be a precursor to antisocial personality disorder. Some warning signs include bullying (including cyberbullying) and cruelty to animals or early sexual activity. If this behavior continues past 18 years of age, it can develop into antisocial personality disorder. Emphasize that early treatment can help prevent these problems from continuing into adulthood.

Source: American Psychiatric Association, 2022, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5-TR), Washington, DC: American Psychiatric Association.

Engagement Tips

- Consider that trauma may be part of this child's life.
- Gather information from the adults on scene.
  - Duration of behavior? Receiving treatment services? Any use of alcohol or drugs?
- Consider if the child is exhibiting characteristics of a mental health condition and/or a developmental disability.
- Assess the need for mobile crisis response, referral to mental health services, or to be taken into custody for further evaluation.
- The goal is to build rapport.

QUICK TIPS

## SLIDE 10

### ENGAGEMENT TIPS



**Trainer Note:** Highlight the points on the slide as important things to consider and information to gather when responding to children and adolescents experiencing a crisis. Reference the below content as needed.



**Content Note:** Anything officers can use to relate to the child or adolescent will help de-escalate the situation. Work to build rapport.

Many children who may exhibit “acting out” or oppositional behaviors may have been exposed to trauma. These behaviors are often a response to their inability to express their emotions and sometimes feeling out of control in their life. Start from a place of listening, showing empathy, and building rapport. Officers should assess if the child is intentionally engaging in harmful or unlawful behavior or if they are exhibiting signs of a mental health condition. Calm the situation to get as much information as possible. Ask those who know the child, such as a teacher or parent, how long this behavior has been occurring. The longer the behavior has been occurring, the more serious. Ask if the child is already receiving treatment services. Getting help as soon as possible can help prevent the symptoms from worsening and leading to greater consequences.

Consider if the child is exhibiting characteristics of a mental health condition and/or a developmental disability. Mental health conditions are a wide range of conditions that can affect mood, thinking, and/or behavior. Developmental disabilities are physical and/or mental impairments that begin before age 22, are likely to continue indefinitely, and result in substantial functional limitations in at least three of the following: self-care (dressing, bathing, eating, and other daily tasks), walking/moving around, self-direction, independent living, economic self-sufficiency, and language. Mental health conditions and developmental disabilities can have some characteristics in common, such as the fact that they both may not be readily observable or may come with corresponding behavioral manifestations. However,



there are important differences between the two, including how they develop, timing implications, and whether or not they impact a person's intellectual functioning.

Mental health conditions can begin at any age, while developmental disabilities begin before age 22. The symptoms of mental health conditions may be episodic or temporary, while the symptoms of developmental disabilities can be life-long. Mental health conditions may affect perceptions, emotions, or thought processes; developmental disabilities may affect cognition, learning, language, or physical movement. Recognizing the basic characteristics of mental health conditions and developmental disabilities can help the officer decide where to seek additional assistance or where to make referrals.

Know the resources that are at your disposal for helping the child, such as mobile crisis teams with experience working with youth who can help de-escalate the situation and/or help link the child and family to longer-term services and supports. Officers should encourage parents to call a crisis center or seek mental health treatment or services if the current situation does not require involuntary custody for evaluation, stabilization, treatment, and/or services. If a mentorship program exists in your community, consider making referrals.



**Ask officers to share how they can build rapport with a child or adolescent. What strategies have they used?**

Source: Bureau of Justice Assistance, August 2021, *Style Guide for Using the Sequential Intercept Model: Behavioral Health and Intellectual and Developmental Disability Considerations*, retrieved from [https://www.informedpoliceresponses.com/files/ugd/e7007a\\_6febdbef767f4ff4b53d799dba64ce9c.pdf](https://www.informedpoliceresponses.com/files/ugd/e7007a_6febdbef767f4ff4b53d799dba64ce9c.pdf).


### Tips for Responding

- Slow things down; repeat as needed.
- Listen and show interest.
- Refrain from arguing.
- Explain what you are doing.
- Set clear expectations/firm limits.

- Empower youth through choices (let them have some wins).
- Use age-appropriate language; use affirmative words vs. negative words (i.e., instead of "Don't do," say "Please do...").
- Be aware of your body language; use an even, less authoritative tone.

**REMEMBER: kids' brains are different**

**QUICK TIPS**



## SLIDE 11

### TIPS FOR RESPONDING



**Trainer Note:** Highlight the points on the slide that provide strategies for de-escalation, referencing the below content as needed. Give practical examples.



**Content Note:** When a child or adolescent is having difficulty controlling their emotions, it is necessary for the responding officer to slow things down to de-escalate the situation. This is often done by the officer taking their time, having a calm tone of voice, taking time to listen, and showing interest in the youth to develop rapport. It is important to know that arguing may only worsen the behavior and agreeing with the child, when possible, can be disarming.

Children and adolescents who are having difficulty managing their emotions can have difficulty comprehending directives and instructions. Be as clear and simple as possible and explain all the things you are or may be doing to get them help or to resolve the crisis. It is equally important to set clear expectations and firm limits, as this will help them regain some control and can promote safety. Using more affirmative language such as "I would like you to do this..." or "Please do..." again can help to diffuse the intensity of the situation as many kids experience being told what NOT to do.

Adolescents need to feel they have choices and control over their thoughts and actions. They can be sensitive to external influence and be likely to feel coerced, even when there is no explicit effort to coerce them. Yet, they rely on others to validate their decisions. Provide them with a range of options and explain their choices in simple terms. Give them a chance to ask questions and give them a chance to have some wins.



Additional resources for information on responding to youth are the following:

- International Association of Chiefs of Police (IACP), n.d., *The Effects of Adolescent Development on Policing*, Alexandria, VA: International Association of Chiefs of Police, retrieved from <https://www.theiacp.org/sites/default/files/2018-08/IACPBriefEffectsofAdolescentDevelopmentonPolicing.pdf>
- International Association of Chiefs of Police and Yale Child Study Center, February 2017, *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement*, Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, retrieved from <https://www.theiacp.org/sites/default/files/2018-08/CEVToolkit.pdf>

### Putting it into Practice – Case Scenario



Officer gets a call to a family home in which the mother reports her adolescent son is out of control. He is throwing things around and yelling, cursing, and threatening to harm her and others. He stated that he has had enough with this world.

When the officer arrives, they are met by the mother who is outside the house.

When the officer encounters the adolescent, he is pacing, breathing hard, cursing, kicking things around the living room, and saying things aren't worth it anymore, he can never do anything right, and it's everyone else's fault.



12



## SLIDE 12

### PUTTING IT INTO PRACTICE – CASE SCENARIO



**Trainer Note:** Take the class through this case scenario as a tabletop discussion. This activity should be done in about 20 minutes. The instructor will need to be mindful of time. The main purpose of this activity is to get the officers to ask questions that go beyond the immediate behaviors and determine through strategic questioning various risk factors of harm to self and/or others as well as being able to think through ways to de-escalate the situation.



#### Class Activity:

**For Tabletop Discussion:** Read the case scenario to the class and then ask these questions as you walk the officers through their response. Also, add questions as you deem to be appropriate that will aid in the learning process for engagement, de-escalation, and facilitating an outcome.

#### Scenario:

Officer gets a call to a family home in which the mother reports her adolescent son is out of control. He is throwing things around and yelling, cursing, and threatening to harm her and others. He stated that he has had enough with this world.

When the officer arrives, they are met by the mother who is outside the house.

When the officer encounters the adolescent, he is pacing, breathing hard, cursing, kicking things around the living room, and saying things aren't worth it anymore, he can never do anything right, and it's everyone else's fault.





### Questions for the trainer to ask the class:

- Before going into the home, what information do you want to get from his mom?
- When you encounter the adolescent, what do you assess for?
- How might you approach this situation?
- What do you do to ensure safety for all?
- How might you slow him down to help him calm down?
- What might your tone of voice be to help with de-escalating?
- What might you listen for?
- What are some ways to build rapport?
- What type of choices can you give the adolescent?
- What resolution might you be thinking about?
- What information is shared that concerns you about the safety of this adolescent, his mother, and others?
- What behaviors concern you?
- Who might you pass that information on to?
- Ask the officers to also describe what it would look like to demonstrate several of the Tips for Responding.

### Backstory information that can be presented as the officers ask questions:

- He is a 14-year-old adolescent in his first year of high school.
- He has been suspended in the past for fighting with other kids, skipping school, and trying to light a trash can on fire one time in the bathroom, although he did not succeed.
- Mom said he was diagnosed with ADHD in grade school but didn't like taking medications so he struggled in school.
- Mom is a single parent who has been divorced from his father for the past eight years.
- The father visits infrequently.
- Mom has tried to get him into therapy but he doesn't want to go.
- The school has reported concerns to the mother that he spends time drawing pictures of dead animals, guns, and war-like scenes.
- Mom reports that at one time about a year ago, a cat was found dead in their yard, but he denied knowing how the cat died.
- Mom said he does play rough with their cat, but the cat is currently okay.
- Mom said he has experimented with marijuana and alcohol but doesn't seem to use it regularly—just sometimes when he goes out with his friend.
- Mom does not like his friends; they are older and a couple have dropped out of school.



**Adolescent (as the role-player):** This information comes out as the officers engage and ask questions:


- You pace a lot, curse, are angry, and kick some things around.
- You make veiled threats to self-harm.
- You don't want to listen to the officer at first and you state they do not care.
- You deny cheating, you blame the teacher and other kids for your problems.
- You have no future direction except to turn 18 and go live on your own.
- You are angry with the school and with other kids.
- You are angry with your mom because she works two jobs and isn't home much.

**NOTE:** As the trainer, you can also design this activity in a manner that fits your style of instruction or create another activity that engages the officers in interactive instruction.




Ask the class what strategies they have used when responding to children and youth that have been effective and what has been challenging. Ask officers what type of warning signs they look for that may be indicative of very serious problems that could be harmful to others and whom they provide that information.






## Module Wrap-Up

# Questions?



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## SLIDE 13

### MODULE WRAP-UP/Q&A



**Trainer Note:** Use this as an opportunity for participants to ask questions.