

**DSHS Community Mental Health and Substance Abuse Services
Resiliency and Disease Management
Fidelity Toolkit – January 2005**

**III.D Children’s Mental Health Programs – Skills Training for Children and Adolescents
with Externalizing Disorders and their Parents and Primary Caregivers**

This manual is a guide for administering the Fidelity Scale for Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers. This manual includes the following:

I. INTRODUCTION

- A. A program description of Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers
- B. An overview of the Fidelity Scale for Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers

II. PROTOCOL

Discussions of each of the Fidelity Scale sections with descriptions and scoring guidance for the fidelity items under each of the four sections.

- A. System Support for Skills Training for Children, Adolescents, Parents and Primary Caregivers
 - 1. Credentials
 - 2. Training
 - 3. Supervision
- B. Skills Training Strategies for Sessions with Children, Adolescents, Parents and Primary Caregivers
 - 4. Structured and Goal-Oriented Sessions
 - 5. In-Session Practice
 - 6. Homework Assignments
 - 7. Establishing Reward Systems for Children and Behavioral Contracts for Adolescents
 - 8. Established Educational Strategies
- C. Content of Skills Training for Children and Adolescents
 - 9. Positive Social Behavior Skills
 - 10. Assertiveness Skills
 - 11. Social and General Problem–Solving Skills
 - 12. Relaxation Skills
 - 13. Anger Management Skills
 - 14. Skills to Understand and Express Feelings
 - 15. Coping Self-Talk (Helpful Thinking)
- D. Content of Skills Training for Parents and Primary Caregivers
 - 16. Principles of Behavior Management

17. Developing Positive Attention
17. 18. Developing Parental and Primary Caregiver Positive Attending Skills and Giving Effective Commands
19. Discipline Strategies
20. Managing Future Behavior Problems (*Defiant Children* only)
21. Problem – Solving Skills and Graduated Problem – Solving Skills (*Defiant Teens* only)
22. Communication Skills (*Defiant Teens* only)
23. Unreasonable Beliefs and Expectations (*Defiant Teens* only)

III. SOURCES OF INFORMATION

The following information will be used to verify the Fidelity Scale sections A – D:

- A. Items under Fidelity Scale section A will be verified through Human Resources, Training and Supervision records.
- B. Items under Fidelity Scale sections B, C and D will be verified through Child Progress Notes.

IV. SCORING SHEET

One scoring sheet is completed during the Fidelity Review. It is as follows:

- The Summary Fidelity Review Scoring Sheet (SFRSS) contains the individual item scores for each record reviewed and the average of these scores to determine fidelity for the individual records. It also contains the total score for all records reviewed and the average of these scores yielding a site fidelity score. The information on the Summary Fidelity Review Scoring Sheet can be used for improvement and targeted training for each therapist providing CBT and can be used for comparison across multiple sites.

Additional information regarding Fidelity Reviews and scoring is provided under **I.B. An Overview of the Fidelity Scale for Skills Training.**

V. REFERENCES

INTRODUCTION

Program Description

Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers focuses on a group of children and adolescents who exhibit non-compliant, defiant and anti-social behaviors. These behaviors may become very serious and include threatening and aggressive behaviors. Diagnoses that are common among this group include Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Conduct Disorder. These children and adolescents are described as having externalizing disorders because they display behaviors that have a negative impact on individuals in their environments, such as their parents, primary caregivers, teachers and friends. It is critical to remember that these children and adolescents have serious emotional disturbances that strongly influence their behaviors and that they do not have the skills that they need to cope effectively with life. For example, children and adolescents who exhibit aggression think and behave differently from non-aggressive children and adolescents. They often see the world as a hostile place filled with people who act toward them in a hostile manner. Because of this misperception, they misinterpret the behavior of others and see them as “out to get them”. These children and adolescents often solve problems in an angry manner. Beneath the anger is fear that is unknown to the child and adolescent. This sometimes results in their lashing out at others before others can lash out at them.

Because these children and adolescents do not have the skills they need to cope effectively with life, it is necessary to teach them these skills. They must be taught, practice and finally generalize the following skills to natural settings in order to live full productive lives:

Positive Social Behavior Skills
Assertiveness Skills
Social and General Problem–Solving Skills

Relaxation Skills
Anger Management Skills
Skills to Understand and Express Feelings

Coping Self-Talk (Helpful Thinking)

Many parents and primary caregivers of children and adolescents with externalizing disorders feel overwhelmed and unprepared to deal with the problematic behaviors exhibited by their children and adolescents. These parents and primary caregivers may not have the skills they need to help their children and adolescents control the effects of their serious emotional disturbances. These parents and primary caregivers also need Skills Training to equip them with the essential skills needed to parent children and adolescents with externalizing disorders effectively. Parents and primary caregivers are taught, practice and finally generalize these skills to natural settings in order to help their children and adolescents control the effects of their serious emotional disturbances.

The components of Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers will be defined as the Fidelity Scale is described by item.

An Overview of the Fidelity Scale for Skills Training

The Fidelity Scale for Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers is divided into four sections:

- System Support for Skills Training for Children, Adolescents, Parents and Primary Caregivers
- Skills Training Strategies for Sessions with Children, Adolescents, Parents and Primary Caregivers
- Content of Skills Training for Children and Adolescents and
- Content of Skills Training for Parents and Primary Caregivers.

Each of these sections includes fidelity items as outlined under **Protocol**. During Fidelity Reviews, these fidelity items are scored for **each child record** randomly selected for the review. Individual scores are given for each fidelity item based on objective information sources appropriate to the item. The reviewer determines from the available information whether the fidelity item has been addressed and to what extent. Sound clinical judgment must be used in these determinations as well as a thorough knowledge of the department-approved models for Skills Training.

How Items are Rated

The Skills Training fidelity review scale consists of 23 items which are rated individually on a five point scale with “1” denoting minimal implementation of the services, “3” being midpoint and in most cases adequate implementation and “5” reflecting a faithful and superior implementation. Anchor points for the five-point rating are usually defined in terms of the extent of the presence of the element/sub-elements. Some items or essential elements are rated “5” or a “1” based upon a “Yes/No” format when a more graduated approach seems unfeasible. The scale of 1 – 5 is broken down as follows:

- 1 equals poor fidelity
- 2 equals fair fidelity
- 3 equals good fidelity (meets minimal expectations)
- 4 equals very good fidelity
- 5 equals excellent or optimal fidelity

To determine the fidelity score for a record where the child and the parent or primary caregiver are in treatment, all of the scores achieved on the fidelity items are added together to obtain a total score for each record. Then this total score is divided by the number of items to determine the score for the individual record. At this point, all of the individual record scores are added together and divided by the number of records reviewed. This results in the overall fidelity score for the site. Some of the items refer to 95% - 100% of sessions, of children and of parents and primary caregivers. These percentages translate into the following:

- 1 equals poor fidelity (less than 50%)
- 2 equals fair fidelity (50% - 74%)
- 3 equals good fidelity (meets minimal expectations) (75% - 84%)
- 4 equals very good fidelity (85% - 94%)
- 5 equals excellent or optimal fidelity (95% - 100%)

Fidelity scores are expected to be at least “3” for Skills Training in the beginning of implementation. It is expected that fidelity scores will increase as Qualified Mental Health Professionals – Community Services (QMHP-CS) and Community Services Specialists (CSSPs) gain experience with implementation of the models.

The fidelity items represent the elements of the three selected models of skills training. There are 15 fidelity items on the Fidelity Scale for Skills Training for children and adolescents (Bloomquist). There are 16 fidelity items on the Fidelity Scale for parents and primary caregivers. Item 20 applies to the parents and primary caregivers of **Defiant Children**. This means that 13 items apply to the parents and primary caregivers of **Defiant Children**. Items 21, 22 and 23 apply to the parents and primary caregivers of **Defiant Teens** and the parents and primary caregivers are involved in these three sessions with their adolescents. These three sessions teach the parent, primary caregivers and their adolescents how to problem – solve together, how to communicate with each other and how to identify and change irrational beliefs and expectations. This means that 15 items apply to the parents and primary caregivers of **Defiant Teens**. When scores are given for the record of a child or adolescent, scores are given for the parent and primary caregiver items if they are also receiving Skills Training and vice versa. The progress notes for the parent and primary caregiver sessions should be in the child record. **EVERY** effort should be made to involve the parents and primary caregivers in Skills Training. If the parents and caregivers are not receiving Skills Training, the items for them should not be marked. The fidelity items for each group are clearly noted both on the Fidelity Scale and under Protocol.

During a fidelity review, child records that have been selected randomly are reviewed using a scoring sheet. Whenever possible, selected child records should be for children and adolescents and parents and primary caregivers who have completed treatment. If there are insufficient child records for children and adolescents and parents and primary caregivers who have completed treatment, child records for children and adolescents and parents and primary caregivers who have not completed treatment will be used. In such cases, the Summary Fidelity Review Scoring Sheet will be scored based on the number of completed sessions and the calculation of the fidelity score will be the same as outlined above based on the number of completed sessions. Uncompleted treatment sessions will be coded N/A.

The fidelity review may be initiated internally for self-assessment and quality improvement purposes. The review may be initiated externally for quality improvement and accountability purposes. Either a single reviewer or a team of reviewers may be used to complete the fidelity review. Ideally, providers and supervisors of skills training should conduct internal reviews as a team. The inclusion of parents and primary caregivers who have been recipients of skills training can strengthen the process. Quality management staff may be involved in coordinating the reviews and may serve as members of the review team.

Child and adolescent program staff, quality management staff and other department experts can conduct external reviews. External experts not associated with the department may be invited to conduct or participate in the external reviews.

Whether the fidelity reviews are completed internally or externally, individuals who have an in-depth knowledge of the models and the purpose of the reviews should complete the reviews. These reviewers should have the ability to be objective when presented with the data necessary to make a decision. They should also have the ability to apply sound clinical judgment during the reviews. The results of the reviews should be provided to and discussed with the providers of the models. Providers should develop Plans of Improvement that contain improvement strategies based on the results of the reviews.

PROTOCOL

The Fidelity Scale for Skills Training is completed for each individual child record reviewed during the Fidelity Review. Scores must be determined for the individual records before an overall site score (average) can be determined to indicate overall fidelity.

System Support for Skills Training for Children, Adolescents, Parents and Primary Caregivers

Rationales for Items 1 (Credentials), 2 (Training) and 3 (Supervision):

Effective implementation of Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers requires system support to ensure providers have the required qualifications and training. Only qualified professionals with the required education and training should provide Skills Training. In addition, training in the department-approved Skills Training models is critical. Three separate models of Skills Training have been selected for implementation. One of the models is for children and adolescents (6 – 16 years of age). Two of the models are for parents and primary caregivers. One of the parent and primary caregiver Skills Training curriculum is for the parents and primary caregivers of children (2 to 12 years of age). One of the parent and primary caregiver Skills Training curriculum is for the parents and primary caregivers of adolescents (13 – 17). Education and training are essential to fidelity.

Another area essential to fidelity is supervision of the providers of the selected models. Supervision of Skills Training needs to be provided by a Qualified Mental Health Professional – Community Services (QMHP-CS) who has been trained in and who has provided Skills Training to children and adolescents with externalizing disorders and their parents and primary caregivers according to the department-approved models.

Scoring of Items 1 through 3

Item 1: Credentials (Rapid Review)

All providers of Skills Training are Qualified Mental Health Professionals – Community Services (QMHP-CS) or Community Services Specialists (CSSPs).

Item 1 may be answered yes or no. The reviewer may answer yes if:

- Human Resources records indicate that the provider of skills training is a QMHP-CS or a CSSP.
- Otherwise, the answer is no.

Item 2: Training (Rapid Review)

All providers and supervisors of Skills Training are trained in the department-approved evidence-based models. Training in the evidence-based models must be completed before providers can provide Skills Training to children, adolescents, parents and primary caregivers and before a supervisor can provide supervision for providers.

Item 2 may be answered yes or no. The reviewer may answer yes if:

- Training records indicate that the provider and the supervisor have completed **all** training in the department-approved Skills Training models prior to the provision or supervision of Skills Training. Training records include the name of the trainer, the dates of training and **a statement that the center considers the provider or supervisor competent to provide or supervise the Skills Training models.**
- Otherwise, the answer is no.

Item 3: Supervision (Rapid Review)

The QMHP-CS and the CSSP who provide Skills Training are supervised at least once a month by a QMHP-CS trained in the department - approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using the department-approved models. Supervision may be provided either individually or in a group.

Item 3 is scored 1 – 5. The reviewer may give a score of 5 if:

- Supervision records indicate the QMHP-CS and CSSP are supervised at least once a week by a QMHP-CS trained in the department - approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using department-approved models.

The reviewer may give a score of 4 if:

- Supervision records indicate the QMHP-CS and the CSSP are supervised at least every two weeks by a QMHP-CS trained in the department – approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using department-approved models.

The reviewer may give a score of 3 if:

- Supervision records indicate the QMHP-CS and the CSSP are supervised at least once a month by a QMHP-CS trained in the department – approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using department-approved models.

The reviewer may give a score of 2 if:

- Supervision records indicate the QMHP-CS and the CSSP are supervised at least every two months by a QMHP-CS trained in the department – approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using the department-approved models.

The reviewer may give a score of 1 if:

- Supervision records indicate the QMHP-CS and the CSSP are supervised less than every two months by a QMHP-CS trained in the department - approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using department-approved models.

Skills Training Strategies for Sessions with Children, Adolescents, Parents and Primary Caregivers

Rationales for Items 4 through 8 (Structured and Goal-Oriented Sessions, In-Session Practice, Homework Assignments, Establishing Reward Systems for Children and Behavioral Contracts for Adolescents and Established Educational Strategies):

The selected Skills Training models for **children, adolescents, parents and primary caregivers** contain highly structured, goal-oriented sessions that utilize established educational strategies. The sessions use interactive and practice-oriented strategies to teach and reinforce critical skills needed to cope effectively with life. The intent of each session is stated at the beginning of the session, and each session includes the **teaching of new skills that the children, adolescents, parents and primary caregivers** have an opportunity to practice. In-session practice provides an opportunity to try the new skills, to receive feedback on the practice and to practice until skills are demonstrated correctly (Items 4 and 5).

However, **in-session practice is not sufficient for children, adolescents, parents and primary caregivers** to generalize the new skills to natural settings. Specific homework assignments are given to **children, adolescents, parents and primary caregivers** to continue practice outside of the sessions for generalization to natural settings. To reinforce the correct use of the new skills by the children and adolescents and to promote positive behavior, the QMHP–CS or the CSSP teaches the parents and primary caregivers to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents. (Items 6 and 7) Reward Systems and Behavioral Contracts are critical to the outcome of treatment for children and adolescents with externalizing disorders. Reward Systems and Behavioral Contracts are used to reinforce the correct use of new skills, to reinforce generalization in natural settings for children and adolescents and to promote positive behavior.

Items 4, 5, 6, 7 and 8 (Structured and Goal-Oriented Sessions, In-Session Practice, Homework Assignments, Establishing Reward Systems for Children and Behavioral Contracts for Adolescents and Established Educational Strategies) are critical to ensure the greatest opportunity for children, adolescents, parents and primary caregivers to learn the new skills and to generalize them to natural settings.

Scoring of Items 4 – 8

Item 4: Structured and Goal-Oriented Sessions

The QMHP-CS and the CSSP conduct sessions that are structured and goal-oriented. Each of the three Skills Training models is structured and provides the QMHP-CS and the CSSP with the specifics of each individual session. If the QMHP-CS and the CSSP follow the outline for each session, the session will be

structured and goal-oriented. For purposes of scoring, it is the responsibility of the QMHP-CS and the CSSP to convey that sessions are structured and goal-oriented and that at least one specific content area is addressed per session.

Item 4 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that 95% - 100% sessions are structured and goal-oriented and teach a specific content area.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that 85% - 94% of sessions are structured and goal-oriented and teach a specific content area.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that 75% - 84% of sessions are structured and goal-oriented and teach a specific content area.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that 50% - 74% of sessions are structured and goal-oriented and teach a specific content area.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that less than 50% of sessions are structured and goal-oriented and teach a specific content area.

Item 5: In-Session Practice

The QMHP-CS and the CSSP use modeling, role playing, behavioral rehearsal, feedback and correction and interactive teaching to provide practice of new skills during the sessions. **Every session** must include the practice of new skills taught during the session. Each of the skills training models includes instructions on in-session practice of new skills. If the QMHP-CS and the CSSP follow the outline for each session, the in-session practice will be done as intended for the session. For purposes of scoring, it is the responsibility of the QMHP-CS and the CSSP to convey that in-session practice occurs as specified.

Item 5 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that in-session practice of new skills is present in 95% - 100% of sessions and that at least two of the methods noted above are implemented for the child, adolescent, parents and primary caregivers to practice during each session.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that in-session practice of new skills is present in 85% - 94% of sessions and that at least two of the methods noted above are implemented for the child, adolescent, parents and primary caregivers to practice during each session.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that in-session practice of new skills is present in 75% - 84% of sessions and that at least two of the methods noted above are implemented for the child, adolescent, parents and primary caregiver to practice during each session.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that in-session practice of new skills is present in 50% - 74% of sessions and that at least two of the methods noted above are implemented for the child, adolescent, parents and primary caregivers to practice during each session.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that in-session practice of new skills is present in less than 50% of sessions and that at least two of the methods noted above are implemented for the child, adolescent, parents and primary caregivers to practice during each session.

Item 6: Homework Assignments

The QMHP-CS and the CSSP use homework assignments to provide practice of new skills in natural settings outside of sessions. This strategy facilitates the generalization of the new skills to the natural settings. Every session must include homework assignments for this purpose. Each of the skills training models includes instructions on homework assignments. If the QMHP-CS and the CSSP follow the outline for each session, the homework assignments will be done as intended. For scoring purposes, it is the responsibility of the QMHP-CS and the CSSP to convey that homework assignments are assigned and explained as specified.

Item 6 is scored 1 – 5 based on the information provided by the QMHP-CS and CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that homework assignments for the practice and generalization of new skills to natural settings are assigned in 95% - 100% of sessions for the child, adolescent, parents and primary caregivers.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that homework assignments for the practice and generalization of new skills to natural settings are assigned in 85% - 94% of sessions for the child, adolescent, parents and primary caregivers.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that homework assignments for the practice and generalization of new skills to natural settings are assigned in 75% - 84% of sessions for the child, adolescent, parents and primary caregivers.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that homework assignments for the practice and generalization of new skills to natural settings are assigned in 50% - 74% of sessions for the child, adolescent, parents and primary caregivers.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that homework assignments for the practice and generalization of new skills to natural settings are assigned in less than 50% of sessions for the child, adolescent, parents and primary caregivers.

Item 7: Establishing Reward Systems for Children and Behavioral Contracts for Adolescents

The QMHP-CS and the CSSP teach each parent and primary caregiver to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents outside of sessions to promote positive behavior, reinforce the children and adolescents for the correct demonstration of new skills and for the generalization of these new skills to natural settings.

Defiant Children includes Reward Systems for Children and **Defiant Teens** includes Behavioral Contracts for Adolescents with instructions on the implementation of reward systems and behavioral contracts. These models as appropriate for children and adolescents can be used with **Skills Training for Children with Behavior Disorders** (ages 6 – 16) by Michael L. Bloomquist. There must be a reward system for every child and a behavioral contract for every adolescent. If the QMHP-CS and the CSSP follow the instructions, the QMHP-CS and the CSSP will be able to assist the parents and primary caregivers in establishing and implementing reward systems for children and behavioral contracts for adolescents. It is the responsibility of the QMHP-CS and the CSSP to convey that reward systems for children and behavioral contracts for adolescents are used with each Skills Training model. Step 4 and worksheets on pages 230 – 232 address

establishing and implementing Reward Systems for Children in **Defiant Children**. Step 5 and worksheets on pages 208 – 210 address establishing and implementing Behavioral Contracts for Adolescents in **Defiant Teens**.

Item 7 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that 95% - 100% of parents and primary caregivers are taught to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that 85% - 94% of parents and primary caregivers are taught to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that 75% - 84% of parents and primary caregivers are taught how to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that 50% - 74% of parents and primary caregivers are taught how to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that less than 50% of parents and primary caregivers are taught to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.

Item 8: Established Educational Strategies

Established educational strategies are used in teaching Skills Training to ensure that the children, adolescents, parents and primary caregivers have the greatest possibility of learning the presented materials. The following established educational strategies are used in teaching Skills Training:

- 1) Methods to ensure understanding
- 2) Breaking material down into its component parts
- 3) Material review and repetition
- 4) Interactive teaching
- 5) Modeling
- 6) Behavioral rehearsal
- 7) Role playing and
- 8) Worksheets.

Established educational strategies are used throughout Skills Training and should be evident in **each session**. It is the responsibility of the QMHP-CS and the CSSP to convey that established educational strategies are used to teach Skills Training.

Item 8 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that the QMHP-CS or the CSSP uses at least 5 of the established educational strategies to teach Skills Training in every session.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that the QMHP-CS or the CSSP uses at least 4 of the established educational strategies to teach Skills Training in every session.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that the QMHP-CS or the CSSP uses at least 3 of the established educational strategies to teach Skills Training in every session.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that the QMHP-CS or the CSSP uses at least 2 of the established educational strategies to teach Skills Training in every session.

The reviewer should give a score of 1 if:

- Child Progress Notes indicate that the QMHP-CS or the CSSP uses at least 1 of the established educational strategies to teach Skills Training in every session.

Content of Skills Training for Children and Adolescents

Rationale for Items 9 through 15 (Positive Social Behavior Skills, Assertiveness Skills, Social and General Problem-Solving Skills, Relaxation Skills, Anger Management Skills, Skills to Understand and Express Feelings and Coping Self-Talk (Helpful Thoughts))

It is evidence-based practice for skills training for children and adolescents with externalizing disorders to be taught individually, not in a group, because of the significant negative influence that children and adolescents with externalizing disorders have on each other.

Skills Training for Children and Adolescents with Externalizing Disorders has highly structured and goal-oriented sessions that cover content areas specifically related to skills needed to cope effectively with life. The sessions use interactive and practice-oriented strategies to teach and reinforce critical skills. Since each new session builds on previous sessions, the sessions must be taught in sequential order using the specified strategies across an episode of care unless specified otherwise by the model. The sessions teach and reinforce critical skills needed by children and adolescents with externalizing disorders.

Skills Training for Children and Adolescents with Externalizing Disorders is taught using **Skills Training for Children with Behavior Disorders** by Michael L. Bloomquist using chapters 9, 10 and 11 and chapters 13 and 14. This curriculum is used with children and adolescents ages 6 – 16. Other chapters may be taught if needed. **These skills are taught to all children and adolescents while their parents and primary caregivers are being taught either *Defiant Children* or *Defiant Teens*.** This Skills Training model includes instructions on teaching the content areas. If the QMHP-CS and the CSSP follow the selected Skills Training model, the QMHP-CS and the CSSP can ensure that the content areas are taught sequentially and as intended. It is the responsibility of the QMHP-CS and the CSSP to convey that the content areas are taught to and practiced by every child and adolescent. The content areas are:

- 9) Positive Social Behavior Skills
- 10) Assertiveness Skills
- 11) Social and General Problem-Solving Skills
- 12) Relaxation Skills
- 13) Anger Management Skills
- 14) Skills to Understand and Express Feelings
- 15) Coping Skills (Helpful Thoughts)

Additional information about each content area is provided as items 9 through 15 are discussed below.

Item 9: Positive Social Behavior Skills

Many children and adolescents with externalizing disorders who have difficulties in the social arena simply do not know how to behave in social situations. These children and adolescents often exhibit many negative social behaviors, such as hitting, interrupting, arguing and very few positive social behaviors, such as cooperating, sharing and expressing feelings. In order for children and adolescents to develop friendships, they need to eliminate negative behaviors and replace them with acceptable social behaviors. If positive social behavior skills are not taught, these children and adolescents with externalizing disorders are at high risk for social and emotional difficulties that continue into adulthood. Children and adolescents with externalizing disorders are taught positive social behavior skills to facilitate interactions with other individuals, such as parents, teachers and friends.

Promoting positive social behavior skills is a good place to start with both children and adolescents. The following are essential positive social behavior skills that need to be taught and practiced by every child and adolescent **across several sessions**:

- | | | |
|---------------------------|-------------------------------|---|
| 1) Taking turns | 7) Playing fair | 13) Making eye contact |
| 2) Sharing | 8) Following the rules | 14) Telling others about self |
| 3) Cooperating | 9) Ignoring when appropriate | 15) Inquiring about other's interests and desires |
| 4) Starting conversations | 10) Listening to others | 16) Complimenting others |
| 5) Apologizing to others | 11) Talking in a brief manner | 17) Accepting compliments |
| 6) Asking questions | 12) Helping others | |

The Skills Training model for children and adolescents with externalizing disorders teaches positive social behavior skills. If the QMHP-CS and the CSSP follow the selected Skills Training model, positive social behavior skills can be taught as intended. It is the responsibility of the QMHP-CS and the CSSP to convey that positive social behavior skills are taught and practiced by every child and adolescent **across several sessions**. Worksheets are on pages 129 – 132. You may create your own and obtain approval for the worksheets from your supervisor.

Item 9 is scored 1 – 5 based on the information provided by the QMHP-CS and CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that at least 15 of the positive social behavior skills noted above are taught to and practiced by every child and adolescent in Skills Training across several sessions.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that at least 13 of the positive social behavior skills noted above are taught to and practiced by every child and adolescent in Skills Training across several sessions.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that at least 11 of the positive social behavior skills noted above are taught to and practiced by every child and adolescent in Skills Training across several sessions.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that at least 9 of the positive social behavior skills noted above are taught to and practiced by every child and adolescent in Skills Training across several sessions.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that less than 9 of the positive social behavior skills noted above are taught to and practiced by every child and adolescent in Skills Training across several sessions.

Item 10: Assertiveness Skills

Children and adolescents with externalizing disorders are taught and practice assertiveness skills. These children and adolescents are easily influenced by their peers to violate rules and exhibit other problem behaviors. They often have poor impulse control and have a hostile view of the world that can make it easy for them to get into trouble. Peer influences have much to do with children and adolescents with externalizing disorders using drugs, engaging in sex, skipping school, vandalizing, and committing other crimes. Assertiveness skills help children and adolescents resist the pressure their peers put on them. The Assertiveness Skills that are taught and practiced **across several sessions** are as follows:

1. Thinking ahead and planning
2. Saying “no” to peers
3. Refusing to cooperate with peers’ negative behaviors
4. Refusing to do negative things peers ask you to do
5. Asking for what you need and want
6. Apologizing when you are wrong or hurtful
7. Stating your opinion
8. Standing up for what you believe.

The Skills Training model includes the teaching of Assertiveness Skills. If the QMHP-CS and the CSSP follow the selected Skills Training model, Assertiveness Skills can be taught as intended. It is the responsibility of the QMHP-CS and the CSSP to convey that these skills are taught and practiced by every child and adolescent **across several sessions**. Worksheets are on pages 129 – 132 and may be adapted for teaching Assertiveness Skills. You may create your own and obtain approval for the worksheets from your supervisor.

Item 10 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that all 8 Assertiveness Skills noted above are taught to and practiced by every child and adolescent.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that 7 of the Assertiveness Skills noted above are taught to and practiced by every child and adolescent.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that 6 of the Assertiveness Skills noted above are taught to and practiced by every child and adolescent.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that 5 of the Assertiveness Skills noted above are taught to and practiced by every child and adolescent.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that less than 5 of the Assertiveness Skills noted above are taught to and practiced by every child and adolescent.

Item 11: Social and General Problem-Solving Skills_

Being able to solve problems and think about what we are doing is essential in life. Social and General Problem–Solving involves stopping to think about what the problem actually is and going through a specific process to develop a solution to the problem. Social and General Problem-Solving are important in social

relationships. Children and adolescents must be able to handle interpersonal problems in order to have good relationships. Many children and adolescents with behavior problems are impulsive and poor problem solvers. They may not even recognize when a problem exists. Children and adolescents with social problems, especially aggressive ones, usually do not solve interpersonal problems effectively. These children and adolescents are prone to make “mistakes” in how they perceive problems that may cause them to solve the problem in unhelpful ways.

The following are the steps that are used in Social and General Problem-Solving that need to be taught to and practiced by all children and adolescents with externalizing disorders **across several sessions**:

1. Stop! What is the problem?
2. Who or what caused the problem?
3. What does each person think and feel?
4. What are some plans?
5. What is the best plan?
6. Do the plan.
7. Did the plan work?

The Skills Training model includes the steps for Social and General Problem-Solving. If the QMHP-CS and the CSSP follow the specific model, teaching the steps for Social and General Problem-Solving Skills will be approached as intended. It is the responsibility of the QMHP-CS and the CSSP to convey that the steps for Social and General Problem-Solving are taught to and practiced by every child and adolescent. Worksheets are on pages 145 – 152.

Item 11 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that all 7 steps for Social and General Problem-Solving are taught to and practiced by 95% - 100% of children and adolescents.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that all 7 steps for Social and General Problem-Solving are taught to and practiced by 85% - 94% of children and adolescents.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that all 7 steps for Social and General Problem-Solving are taught to and practiced by 75% - 84% of children and adolescents.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that all 7 steps for Social and General Problem-Solving are taught to and practiced by 50% - 74% of children and adolescents.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that all 7 steps for Social and General Problem-Solving are taught to and practiced by less than 50% of children and adolescents.

Item 12: Relaxation Skills

The QMHP-CS and the CSSP teach Relaxation Skills to induce relaxation and to reduce tension in children and adolescents with externalizing disorders. Relaxation Skills are easy to implement and can have immediate effect on reducing the frequency and intensity of tension. Relaxation Skills are interventions that induce physiological calming during anger, in tense situations and when uptight. Relaxation Skills have been found to be very effective in the management of anger and tension. **The QMHP- CS and the CSSP may need to help the child and adolescent find the Relaxation Skills that work best for them.** Relaxation Skills that are generally helpful include:

1. Progressive Muscle Relaxation (The Jacobsen Relaxation Technique in *Adolescent Coping with Depression Course* is on pages 92 – 95.)
2. Deep Breathing Exercises
3. Guided Imagery (selected by the therapist)
4. Meditation (mantra) (The Benson Relaxation Technique and the “Quick” Benson Relaxation Technique in *Adolescent Coping with Depression Course* are on pages 170 – 173.)
5. Pleasant Visualizations (selected by the child or adolescent)
6. Robot/Rag Doll Techniques (Bloomquist: *Skills Training for Children with Behavior Disorders*, Chapter 11, page 156 describes the Robot/Rag Doll Techniques that can also be used with children with depression receiving *Taking Action*.)

When implementing Relaxation Skills, the QMHP-CS and the CSSP need to be aware that some children and adolescents may become agitated during the relaxation. The relaxation may open up areas for them that they are not prepared to deal with at the moment. If this occurs, the QMHP-CS and the CSSP should stop the Relaxation Skill being implemented and assist the child and adolescent in calming down. The Skills Training model includes several methods for teaching Relaxation Skills. If the QMHP-CS and the CSSP follow the model, the Relaxation Skills will be implemented as intended. It is the responsibility of the QMHP-CS and the CSSP to convey that Relaxation Skills are taught to and practiced by every child and adolescent. **Relaxation Skills are taught prior to teaching Anger Management because Relaxation Skills are used in managing anger.**

Item 12 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that 5 of the Relaxation Skills noted above are taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that 4 of the Relaxation Skills noted above are taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that 3 of the Relaxation Skills noted above are taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that 2 of the Relaxation Skills noted above are taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that 1 of the Relaxation Skills noted above are taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.

Item 13: Anger Management

Children and adolescents with externalizing disorders often have difficulty controlling their anger. These children and adolescents may not know how to deal with strong emotions. If these children and adolescents do not learn to cope with this problem, it can lead to many future personal and social problems. When children and adolescents have habitual angry outbursts that seem out of proportion to the situations at hand, these behaviors need to be addressed. There is a real anger problem when a child or adolescent becomes too angry, too often and in too many settings, such as at home, in school and in the community.

Anger is generally a secondary emotion that covers up unknown feelings that are too painful for the child or adolescent to face. These feelings may include hurt, guilt, shame, disappointment, fear, worry or confusion. The child or adolescent may be much more comfortable expressing anger than fear. The child or adolescent is completely unaware the other feeling exists and covers it up so rapidly that it is never felt. "Anger" is defined as a negative emotion, a feeling of displeasure that occurs in response to a real or perceived situation that does not go as the child or adolescent would like it to. Everyone feels anger. It is how the child or adolescent handles it that determines whether or not it is a problem.

Every child and adolescent with an externalizing disorder is taught and practices the following Anger Management Skills so they can express their anger differently in the future:

- 1) How to recognize personal bodily signs of anger (breathing and heart rates increase, red face color, body feels "hot", sweating increases, tense muscles, etc.)
- 2) How to recognize personal action signals of anger (punching/hitting, yelling, crying, running away, threatening, fainting, fidgeting, withdrawing, trembling, etc.)
- 3) How to recognize personal thoughts that lead to anger ("I hate myself."; "I feel like hurting myself."; "I hate her."; "I'm going to hit him."; "I'm not going to take this anymore."; "I hate doing homework."; "I can't do anything right."; "I give up."; "I am dumb."; "I want to break something.")
- 4) Coping self-talk ("Take it easy."; "Stay cool."; "Chill out."; "It's ok if I'm not good at this."; "I'm getting tense. Relax!"; "Take some deep breaths."; "I'm not going to let him bug me."; "I'm sad Pedro doesn't want to play with my anymore, but many other kids like to play with me."; "I'm going to be OK."; "I'll just try my hardest."; "Try not to give up.")
- 5) Take effective action (expressing feelings, asking for a hug, going for a walk, relaxing, being assertive with someone, using social and general problem-solving skills, avoiding potentially explosive situations, taking care of yourself first)

The Skills Training model includes the teaching of Anger Management Skills. If the QMHP-CS and the CSSP follow the Skills Training model, Anger Management Skills will be taught and practiced as intended. It is the responsibility of the QMHP-CS and the CSSP to convey that Anger Management Skills are taught to and practiced by every child and adolescent **across several sessions**. Worksheets are on pages 163 – 167.

Item 13 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that all 5 Anger Management Skills are taught to and practiced by 95% - 100% of children and adolescents.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that all 5 Anger Management Skills are taught to and practiced by 85% - 94% of children and adolescents.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that all 5 Anger Management Skills are taught to and practiced by 75% - 94% of children and adolescents.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that all 5 Anger Management Skills are taught to and practiced by 50% - 74% of children and adolescents.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that all 5 Anger Management Skills are taught to and practiced by less than 50% of children and adolescents.

Item 14: Skills to Understand and Express Feelings

Children and adolescents with externalizing disorders find it difficult to understand and express their feelings. These children and adolescents often bottle up their feelings and at some point end up blowing up at someone or something. They are unable to express their feelings directly and must be taught to do so. Difficulties dealing with feelings can either be a result or a cause of behavior problems. Some children and adolescents experience a lot of negative feedback from

others and are less successful in everyday life because of behavior problems. Over time they learn to stuff their feelings because they find it too painful to face them. These children and adolescents can develop serious emotional problems.

Other children and adolescents become angry, frustrated and perhaps sad. Because they do not know how to express their feelings in words, they act out through defiance, aggression or other emotional outbursts. Helping children and adolescents with externalizing disorders with their feelings can both help them feel better and reduce behavior problems.

The Skills Training model includes skills to understand and express feelings. If the QMHP-CS and the CSSP follow the model, Skills to Understand and Express Feelings can be implemented as intended. It is the responsibility of the QMHP-CS and the CSSP to convey that Skills to Understand and Express Feelings are used with every child and adolescent **across several sessions**. Worksheets are on pages 191 – 193.

The QMHP-CS and the CSSP use the following interventions to teach every child and adolescent with an externalizing disorder to understand and express feelings:

- 1) Teach and increase feeling vocabulary
- 2) Model the expression of feelings
- 3) Ask questions that require the expression of feelings in the answers
- 4) Label the child's and adolescent's feelings if they are unable to verbalize them
- 5) Reinforce the child and adolescent for expressing their feelings
- 6) Ask every child and adolescent to keep a "feelings" diary

Item 14 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that all 6 interventions noted above are used to teach and to practice the understanding and expression of feelings with 95% - 100% of children and adolescents with an externalizing disorder.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that all 6 interventions noted above are used to teach and to practice the understanding and expression of feelings with 85% - 94% of children and adolescents with an externalizing disorder.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that all 6 interventions noted above are used to teach and to practice the understanding and expression of feelings with 75% - 84% of children and adolescents with an externalizing disorder.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that all 6 interventions noted above are used to teach and to practice the understanding and expression of feelings with 50% - 74% of children and adolescents with an externalizing disorder.

The reviewer may give a score 1 if:

- Child Progress Notes indicate that all 6 interventions noted above are used to teach and to practice the understanding and expression of feelings with less than 50% of children and adolescents with an externalizing disorder.

Item 15: Coping Self – Talk (Helpful Thoughts)

Children and adolescents with externalizing disorders often receive more negative feedback than positive feedback from parents, primary caregivers, siblings, teachers, neighbors, friends and others. Over time this can negatively affect how these children think and how they view the world. They may worry, think negative thoughts about themselves and the world and may think others do not like them.

The Skills Training model includes skills for recognizing negative (unhelpful) thoughts and changing them through Coping Self – Talk (Helpful Thoughts) to positive counter thoughts. If the QMHP-CS and the CSSP use the model, then recognizing negative (unhelpful) thoughts and changing them through Coping Self – Talk (Helpful Thoughts) to positive counter thoughts can be taught as intended. It is the responsibility of the QMHP-CS and the CSSP to convey that every child and adolescent is taught and practices Coping Self – Talk (Helpful Thoughts) **across several sessions**. Worksheets are on pages 201 – 209.

Every child and adolescent with an externalizing disorder is taught and practices Coping Self – Talk (Helpful Thoughts) to counter negative (unhelpful) thinking about self, others and the world. Coping Self – Talk (Helpful Thoughts) involves the following 3 skills:

- 1) Helping the child and adolescent learn to identify their own negative (unhelpful) thoughts
- 2) Helping the child and adolescent understand how these negative (unhelpful) thoughts negatively influence their emotions and
- 3) Helping the child and adolescent learn and practice positive counter thoughts (helpful) to change the negative (unhelpful) thoughts so they can experience more positive emotions.

Item 15 is scored 1 – 5 based on the information provided by the QMHP – CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that 95% - 100% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that 85% - 94% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that 75% - 84% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that 50% - 74% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that less than 50% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).

The Content of Skills Training for Parents and Primary Caregivers

Rationales for Items 16 through 23 (Principles of Behavior Management, Developing Positive Attention, Developing Parental and Primary Caregiver Positive Attending Skills and Giving Effective Commands, Discipline Strategies, Managing Future Behavior Problems, Problem–Solving Skills and Graduated Problem – Solving Skills, Communication Skills and Unreasonable Beliefs and Expectations)

It is evidence-based practice for skills training for parents and caregivers of children and adolescents with externalizing disorders to be taught individually, not in a group, because the parents and caregivers learn and generalize information more readily when using an individual format.

Many parents and primary caregivers of children and adolescents with externalizing disorders feel overwhelmed and unprepared to deal with the problematic behaviors exhibited by their children and adolescents. These parents and primary caregivers may not have the skills they need to help their children and adolescents control the effects of their serious emotional disturbances. These parents and primary caregivers also need skills training to equip them with the essential skills needed to parent children and adolescents with externalizing disorders effectively. Parents and primary caregivers are taught, practice and finally generalize these skills to natural settings in order to help their children and adolescents control the effects of their serious emotional disturbances.

Skills Training for Parents and Primary Caregivers of Children and Adolescents with Externalizing Disorders has highly structured and goal-oriented sessions that cover content areas specifically related to skills needed by parents and primary caregivers to help their children and adolescents control the effects of their serious emotional disturbances. The sessions also equip parents and primary caregivers with the essential skills needed to parent children and adolescents with externalizing disorders effectively. The sessions use interactive and practice-oriented strategies to teach and reinforce critical skills. Generally each new session builds on previous sessions; therefore, the sessions must be taught in sequential order using the designated strategies across an episode of care unless specified otherwise by the model. **If the child or adolescent is having difficulties in school, the QMHP – CS and the CSSP should incorporate Step 8: Improving School Behavior from Home: the Daily School Behavior Report Card and the Worksheets on pages 240 – 246 in *Defiant Children* and should incorporate Step 9: School Advocacy and the Worksheets on pages 212 – 218 in *Defiant Teens*.**

There are two Skills Training models for parents and primary caregivers. One Skills Training model is for the parents and primary caregivers of children, and one is for the parents and primary caregivers of adolescents. The skills training models selected for parents and primary caregivers of children and adolescents with externalizing disorders are ***Defiant Children*** by Russell A. Barkley and ***Defiant Teens*** by Russell A. Barkley, Gwenyth H. Edwards and Arthur L. Robin. Each Skills Training model includes the instructions for teaching the content areas. If the QMHP-CS and the CSSP follow the selected Skills Training models, the QMHP-CS and the CSSP can ensure that the content areas are taught sequentially and as intended. It is the responsibility of the QMHP-CS and the CSSP to convey that the content areas of the Skills Training models are taught and practiced by every parent and primary caregiver as applicable to children or adolescents. The content areas are:

- 16) Principles of Behavior Management
- 17) Developing Positive Attention
- 18) Developing Parental and Primary Caregiver Positive Attending Skills and Giving Effective Commands
- 19) Discipline Strategies
- 20) Managing Future Behavior Problems (***Defiant Children*** only)
- 21) Problem – Solving Skills and Graduated Problem – Solving Skills (***Defiant Teens*** only)
- 22) Communication Skills (***Defiant Teens*** only)
- 23) Unreasonable Beliefs and Expectations (***Defiant Teens*** only)

Item 16: Principles of Behavior Management

Certain Principles of Behavior Management are taught to and practiced by the parents and primary caregivers of children and adolescents with externalizing disorders. These Principles of Behavior Management are reinforced throughout Skills Training by routinely incorporating them into sessions. Parents and primary caregivers will be using these Principles of Behavior Management throughout these courses, in in-session practice, in homework assignments, in the use of reward and incentive systems and in dealing with misbehavior from their children and adolescents long after they have completed Skills Training. These concepts can be found in Chapter 4 of ***Defiant Children*** and in Step 2 of ***Defiant Teens***. Worksheet sheets are on pages 203 – 204. These same Worksheets may be used with Chapter 4 of ***Defiant Children***. **You may create your own and obtain supervisor approval for the worksheets.**

These 6 Principles of Behavior Management are as follows:

- 1) The connection between the antecedent to a misbehavior, the misbehavior itself and the consequence for the misbehavior
- 2) Anticipating and planning for misbehavior
- 3) Implementing incentive programs before punishment
- 4) The immediacy, specificity, predictability and consistency of consequences
- 5) The reciprocity of family interactions and
- 6) The coercive behavior cycle.

Item 16 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that the QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into 95% - 100% of sessions.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that the QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into 85% - 94% of sessions.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that the QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into 75% - 84% of sessions.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that the QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into 50% - 74% of sessions.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that the QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into less than 50% of sessions.

Item 17: Developing Positive Attention

Parents and caregivers of children and adolescents with externalizing disorders are taught the importance of developing positive attention toward their children and adolescents. Parents and primary caregivers are taught and practice a specific strategy to develop positive attention toward their children and adolescents. Parents and primary caregivers are taught methods for attending to positive child and adolescent behavior while ignoring minor misbehaviors. It is important to begin with positive attending skills for three reasons. First, in many families who have experienced months or years of misbehavior, frustration and punishment, the overall family atmosphere becomes very negative. The child and adolescent may feel they are always in trouble. The parents and primary caregivers may feel depressed and demoralized because all they do is “yell” at their children and adolescents. Beginning with the positives helps lighten the tone and helps everyone feel more optimistic.

Second, exclusive use of negative strategies, even if they are excellent strategies, will not be sufficient to correct the negative situation. Research shows that exclusive and inconsistent use of punishment is insufficient. Adding positive strategies and becoming more consistent will result in the same punishment becoming more effective. Finally, adding positive strategies and consistency helps strike a balance between the number of positive interactions and the number of negative interactions the parents and primary caregivers have with their children and adolescents over the course of a day.

The first strategy parents and primary caregivers will practice in-session and as homework is spending one – on – one time with their child or adolescent. During a pleasant activity for the child and adolescent in a relaxed manner without criticizing, directing, asking intrusive questions, giving commands, being judgmental, giving instructions, or correcting, the parent and primary caregiver will give only positive, genuine input or will make neutral, descriptive comments. Minor misbehavior will be ignored. Worksheets for **Defiant Children** are on pages 223 – 225 and for **Defiant Teens** on pages 205 – 206.

Item 17 is scored 1 - 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that 95% - 100% of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that 85% - 94% of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that 75% - 84% of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that 50% - 74% of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that less than 50% of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.

Item 18: Developing Parental and Primary Caregiver Positive Attending Skills and Giving Effective Commands

Step 4 in **Defiant Teens** and the Worksheets on pages 205 - 207 and Step 3 in **Defiant Children** and the Worksheets on pages 226 – 229 are used to teach parent and primary caregivers additional skills for increasing positive interactions with their children and adolescents and how to give effective commands. The QMHP – CS and the CSSP may find it helpful to parents and primary caregivers to use the “Giving Effective Commands” from both **Defiant Children** and **Defiant Teens**. These positive behaviors on the part of parents and primary caregivers increase the likelihood that children and adolescents will internalize rules, routines and compliance for future situations. These exercises continue to build toward a balance of positive interactions and negative interactions between parents and primary caregivers and their children and adolescents. There is some variation between increasing positive interactions and giving commands to children versus adolescents. Basically the parent and primary caregiver are taught and practice the following:

- 1) Using opportunities when children and adolescents are demonstrating positive behaviors to pay attention to, state appreciation for and praise the compliant behaviors.
- 2) Providing particularly salient positive attention and rewards to children and adolescents who have complied with household rules or routine chores without having to be reminded.
- 3) Paying attention to, stating appreciation for and praising compliant behavior when children and adolescents comply with commands.
- 4) When giving a command, the parents and primary caregivers must make sure they mean it. Parents and primary caregivers should never give a command that they do not intend to see either completed or followed up with a consequence if not completed.
- 5) Do not present commands as a question or a favor.
- 6) Do not give too many commands at once.

- 7) Tell the child or adolescent what to do rather than what not to do.
- 8) Reduce all distractions before giving the command.
- 9) Be cautious of commands that involve the concept of time for children and adolescents. It is better to give commands that you want compliance with NOW.
- 10) For children, parents and primary caregivers need to make sure the children are paying attention to the command, ask the children to repeat the command and make up chore cards for the children.

Item 18 is scored 1 – 5 based on the information provided by the QMHP – CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate the parents and primary caregivers of children are taught and practice all 10 components for increasing positive attention and giving effective commands and the parents and primary caregivers of adolescents are taught and practice all 9 components for increasing positive attention and giving effective commands.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate the parents and primary caregivers of children are taught and practice 9 of the 10 components (including #10) for increasing positive attention and giving effective commands and that the parents and primary caregivers of adolescents are taught and practice 8 of 9 components for increasing positive attention and giving effective commands.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate the parents and primary caregivers of children are taught and practice 8 of the 10 components (including #10) for increasing positive attention and giving effective commands and that parents and primary caregivers of adolescents are taught and practice 7 of 9 components for increasing positive attention and giving effective commands.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate the parents and primary caregivers of children are taught and practice 7 of the 10 components (including #10) for increasing positive attention and giving effective commands and that of parents and primary caregivers of adolescents are taught and practice 6 of 9 components for increasing positive attention and giving effective commands.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate parents and primary caregivers of children are taught and practice 6 of the 10 components (including #10) for increasing positive attention and giving effective commands and that parents and primary caregivers of adolescents are taught and practice 5 of 9 components for increasing positive attention and giving effective commands.

Item 19: Discipline Strategies

The parents and caregivers of children and adolescents with externalizing disorders are taught and practice Discipline Strategies to use with their children and adolescents with externalizing disorders. In ***Defiant Children*** this includes Steps 5, 6 and 7 and the Worksheets on pages 233 – 239 and in ***Defiant Teens*** this includes Steps 6, 7 and 8 and the Worksheets on pages 208 – 211. Discipline Strategies include the following:

- 1) Time out procedures (children)
- 2) Response cost procedures (fines and penalties for non-compliance) (both)
- 3) Grounding (adolescents)
- 4) Behavioral contracts (adolescents)
- 5) Point systems (both)
- 6) Managing Children in Public Places (children)

Item 19 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that 95% - 100% of parents and primary caregivers of children are taught and practice all 4 of the Discipline Strategies for children and 95% - 100% of parents and primary caregivers of adolescents are taught and practice all 4 of the Discipline Strategies for adolescents.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that 85% - 94% of parents and primary caregivers of children are taught and practice all 4 of the Discipline Strategies for children and 85% - 94% of parents and primary caregivers of adolescents are taught and practice all 4 of the Discipline Strategies for adolescents.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that 75% - 84% of parents and primary caregivers of children are taught and practice all 4 of the Discipline Strategies for children and 75% - 84% of parents and primary caregivers of adolescents are taught and practice all 4 of the Discipline Strategies for adolescents.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that 50% - 74% of parents and primary caregivers of children are taught and practice all 4 of the Discipline Strategies for children and 50% - 74% of parents and primary caregivers of adolescents are taught and practice all 4 of the Discipline Strategies for adolescents.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that less than 50% of parents and primary caregivers of children are taught and practice all 4 of the Discipline Strategies for children and less than 50% of parents and primary caregivers of adolescents are taught and practice all 4 of the Discipline Strategies for adolescents.

Item 20: Managing Future Behavior Problems (*Defiant Children* only)

At this point, the parents and primary caregivers of children with problematic behaviors have learned a wide variety of methods for rewarding or punishing their children's behaviors. All children occasionally develop behavior problems, and there is no reason to think that the children whose parents and primary caregivers have completed ***Defiant Children*** will not occasionally develop new problem behaviors as they grow up. The parents and primary caregivers now have the skills necessary to deal with these problems if they will simply take the time to think about them and set up a management program. Step 9 in ***Defiant Children*** addresses this area as does the Worksheet on page 247. Here are the 4 steps to follow if a new problem develops or an old problem returns:

- 1) Begin a record of the behavior problem in a notebook. Be specific about what the child is doing wrong. Record the rule the child is breaking and what you are doing to manage the behavior now.
- 2) Keep this record for a week or two. Then examine the situation to see if it may give you clues about how to deal with the problem. Many parents find they have returned to their ineffective habits, and that this is causing the problem. Here are some common habits to which parents and primary caregivers return:
 - a) Repeating commands too often.
 - b) Not giving effective commands.
 - c) Not providing positive attention, praise or a reward to the child for following the rule correctly. You have stopped your poker chip or point system too soon.
 - d) Not providing discipline immediately for the rule violation.
 - e) Stopping the one – to – one time with your child.Go back and review your handouts from this program to make sure you are using the methods properly.
- 3) If you need to, set up a special program for managing the problem behavior:
 - a) Explain to your child exactly what you expect him/her to be doing in the problem situation.
 - b) Set up a poker chip or point system to reward your child for following the rules.

- c) Use timeout immediately each time the problem behavior occurs.
 - d) If your records indicate that the problem behavior seems to be occurring in one particular place or situation, follow the 4 steps for Managing Children in Public Places.
 - e) Keep recording the behavior problem so you can tell when it begins to decrease.
- 4) If these methods fail, call the center for booster sessions.

Parents and primary caregivers are taught and practice all 4 steps of Managing Future Behavior Problems. It is the responsibility of the QMHP – CS and the CSSP to convey that these 4 steps have been taught according to Step 9.

Item 20 is scored 1 – 5 based on the information provided by the QMHP – CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that all 4 steps of Managing Future Behavior Problems are taught to and practiced by 95% - 100% of parents and caregivers of children with externalizing disorders.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that all 4 steps of Managing Future Behavior Problems are taught to and practiced by 85% - 94% of parents and caregivers of children with externalizing disorders.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that all 4 steps of Managing Future Behavior Problems are taught to and practiced by 75% - 84% of parents and caregivers of children with externalizing disorders.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that all 4 steps of Managing Future Behavior Problems are taught to and practiced by 50% - 74% of parents and caregivers of children with externalizing disorders.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that all 4 steps of Managing Future Behavior Problems are taught to and practiced by less than 50% of parents and caregivers of children with externalizing disorders.

Item 21: Problem–Solving Skills and Graduated Problem – Solving Skills (*Defiant Teens* only)

Parents, primary caregivers and adolescents with externalizing disorders meet together to be taught the steps for effective problem-solving and graduated problem – solving skills and to practice effective problem–solving and graduated problem – solving skills **across several sessions**. For initial practice together, problems that are the least intense are solved first so that the parents, primary caregivers and the adolescents can experience some immediate success. More intense problems are added gradually as the parents, primary caregivers and the adolescents are successful in solving less intense problems together. The QMHP – CS and CSSP assist the parents, primary caregivers and the adolescents to develop a hierarchy of problems (Issues Checklist) from the least intense to the most intense identified, ranked and prioritized by the parents, the primary caregivers and the adolescents. Steps 10, 11 and 12 and the Worksheets on pages 219 – 224 in the ***Defiant Teen*** are used to teach and practice effective problem – solving and graduated problem – solving skills. The effective problem – solving and graduated problem – solving exercises are intended to:

- 1) Gradually grant increasing independence
- 2) Distinguish negotiable from non – negotiable issues

- 3) Involve adolescents in problem – solving negotiable issues
- 4) Maintain good communication and
- 5) Develop reasonable expectations.

The QMHP – CS and the CSSP will give the rationale for problem – solving and graduated problem – solving listed in the 5 items above and teach the steps for effective problem – solving and graduated problem – solving one at a time using a hypothetical problem. Following are the 8 steps for effective problem – solving and graduated problem - solving:

- 1) Everyone defines the problem.
- 2) Everyone participates in generating at least 12 solutions so there will be room for compromise.
- 3) Everyone evaluates the solutions based on the individuals like of the solutions and whether the individuals think they are realistic.
- 4) Everyone selects the solution most agreeable to all (everyone can live with the solution and everyone has to give up something to get something).
- 5) If there is not agreement on a solution, everyone participates in reaching compromise between the family’s two most liked and realistic solutions.
- 6) Everyone plans to implement the solution providing specifics to operationalize the plan (who, what, when, where, define compliance, who monitors for compliance, performance reminders, define consequences for compliance and non-compliance, anticipated barriers, behavior contract, etc.).
- 7) Everyone evaluates the implementation of the solution after a week or two of full implementation to give adequate time to see if the solution is working or not.
- 8) If the solution is not working, everyone may need to find another solution or redefine the problem. Or maybe the solution is a good one but one person is not motivated to stick with the plan consistently. In this case, implement a consequence suggested by a family member or by the person who is non-compliant.

Item 21 is scored 1 – 5 based on the information provided by the QMHP – CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress notes indicate that 95% - 100% of parents, primary caregivers and adolescents are taught and practice together the 8 steps for effective Problem – Solving and Graduated Problem – Solving.

The reviewer may give a score of 4 if:

- Child Progress notes indicate that 85% - 94% of parents, primary caregivers and adolescents are taught and practice together the 8 steps for effective Problem – Solving and Graduated Problem – Solving.

The reviewer may give a score of 3 if:

- Child Progress notes indicate that 75% - 84% of parents, primary caregivers and adolescents are taught and practice together the 8 steps for effective Problem – Solving and Graduated Problem – Solving.

The reviewer may give a score of 2 if:

- Child Progress notes indicate that 50% - 74% of parents, primary caregivers and adolescents are taught and practice together the 8 steps for effective Problem – Solving and Graduated Problem – Solving.

The reviewer may give a score of 1 if:

- Child Progress notes indicate that less than 50% of parents, primary caregivers and adolescents are taught and practice together the 8 steps for effective Problem – Solving and Graduated Problem – Solving.

Item 22: Communication Skills (*Defiant Teens only*)

Parents and primary caregivers meet with their adolescents with externalizing disorders to learn the general principles of good communication and to practice effective communication skills with each other **across several sessions**. Explain the rationale for these principles. The QMHP – CS and the CSSP define and model active listening and ask the parent/primary caregiver and the teen to practice active listening for a few minutes using a neutral topic. The QMHP – CS and the CSSP discuss the importance of the listener expressing feelings and opinions, including anger, frustration, sadness and other negative emotions. Point out that such expressions can be made without demeaning the other person. Then the QMHP – CS and the CSSP will teach negative communication styles and the positive alternatives. Each family member should begin monitoring him/herself for these negative habits and change to the positive alternatives whenever possible. Ask the family to start applying these principles to all their communications with each other. Specific skills are taught from Step 13 and 14 in *Defiant Teens* and the Worksheet on page 225. The General Principles of Good Communication are:

1. Listen when your teen/parent/primary caregiver is in the mood to talk, but don't force the teen to open up.
2. Use active listening to encourage your teen/parent/primary caregiver to express opinions and feelings.
3. Honestly express how you feel, good or bad, without being hurtful to your listeners.

Item 22 is scored 1 – 5 based on the information provided by the QMHP – CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate the all 3 steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by 95% - 100% of teens, parents and primary caregivers.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate the all 3 steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by 85% - 94% of teens, parents and primary caregivers.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate the all 3 of the steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by 75% - 84% of teens, parents and primary caregivers.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate the all 3 of the steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by 50% - 74% of teens, parents and primary caregivers.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate the all 3 of the steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by less than 50% of teens, parents and primary caregivers.

Item 23: Unreasonable Beliefs and Expectations (*Defiant Teens* only)

Parents, caregivers and adolescents with externalizing disorders meet together to be taught and to practice how to recognize and modify unreasonable beliefs and expectations **across several sessions**. Step 15, 16 and 17 and the Worksheets on pages 226 – 231 in *Defiant Teens* address Unreasonable Beliefs and Expectations. After living with defiant adolescents for as many years as they have, it is easy for parents and primary caregivers to think the worst and attribute their adolescents' behavior to malicious motives. Because the adolescents disobey so many rules and argue incessantly, many parents and primary caregivers believe that if their adolescents have more freedom, the adolescents will inevitably make serious mistakes and ruin their lives forever. This is called ruination. In addition, when adolescents make poor decisions and act coercively, some parents and primary caregivers attribute these actions to malicious intent, the adolescents are misbehaving intentionally to annoy or anger them. Other parents and primary caregivers have lifelong expectations that their adolescents will always obey them

and instinctively know how to behave perfectly. Such parents and primary caregivers often respond in a highly punitive manner that spurs rapid escalation of defiant behaviors. Some parents and primary caregivers believe that their adolescents will always love them and appreciate all they do for them which is very rare for most adolescents. They also believe that if they over - indulge their adolescents that they will win their adolescents' affection and obedience. They actually end up reinforcing manipulative and demanding behaviors. These unreasonable beliefs and expectations only increase family conflict.

Adolescents also have unreasonable beliefs and expectations. Most commonly, adolescents adhere to the "unfairness" triad of beliefs: ruination, unfairness and autonomy. "Unfairness" refers to the belief that parental rules are intrinsically unfair and arbitrary. "Ruination" refers to the belief that parental rules will ruin all the adolescents' fun. "Autonomy" refers to the belief that the adolescents should have total and complete freedom from parental restrictions. Adolescents who adhere rigidly to these beliefs experience more conflict with their parents and primary caregivers than adolescents whose expectations are more flexible.

As noted, the unreasonable beliefs and expectations of adolescents, parents and primary caregivers include:

- 1) Ruination
- 2) Malicious intent
- 3) Unfairness
- 4) Expectations for obedience/perfectionism
- 5) Expectations for love and appreciation
- 6) Expectations for complete autonomy

Cognitive Restructuring is used to help adolescents, parents and primary caregivers identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions. The steps to Cognitive Restructuring used include:

- 1) Identifying the extreme thought.
- 2) Providing a logical challenge to the extreme thought.
- 3) Helping the family member identify an alternative, more realistic thought.
- 4) Helping the family member collect evidence to disconfirm the extreme thought and confirm the more reasonable thought.

Item 23 is scored 1 – 5 based on the information provided by the QMHP-CS and the CSSP.

The reviewer may give a score of 5 if:

- Child Progress Notes indicate that 95% - 100% of parents, caregivers and adolescents meet together to be taught and practice the 4 steps for Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.

The reviewer may give a score of 4 if:

- Child Progress Notes indicate that 85% - 94% of parents, caregivers and adolescents meet together to be taught and practice the 4 steps for Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.

The reviewer may give a score of 3 if:

- Child Progress Notes indicate that 74% - 84% of parents, caregivers and adolescents meet together to be taught and practice the 4 steps for Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.

The reviewer may give a score of 2 if:

- Child Progress Notes indicate that 50% - 74% of parents, caregivers and adolescents meet together to be taught and practice the 4 steps for Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.

The reviewer may give a score of 1 if:

- Child Progress Notes indicate that less than 50% of parents, caregivers and adolescents meet together to be taught and practice the 4 steps for Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.

Fidelity Scale

Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers

Element	Source	1	2	3	4	5	Notes
A. System Support for Skills Training for Children, Adolescents, Parents and Primary Caregivers Effective implementation of Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers requires system support to ensure providers have the required qualifications, training and ongoing supervision. All three areas are essential to achieve fidelity.							
1. Credentials (RR) All providers of Skills Training are Qualified Mental Health Professionals – Community Services (QMHP-CS) or Community Services Specialists (CSSP).	Human Resources records	No	N/A	N/A	N/A	Yes	
2. Training (RR) The providers and supervisors of Skills Training have completed all training in the department-approved Skills Training models prior to the provision or supervision of Skills Training. Training records should include the name of the trainer, the dates of training and a statement that the center considers the provider or supervisor competent to provide or supervise the Skills Training models.	Training records	No	N/A	N/A	N/A	Yes	
3. Supervision (RR) Providers of Skills Training are supervised by a QMHP-CS trained in the department-approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using the department-approved models at least every month.	Supervision records	Less than 50% of providers of Skills Training are supervised by a QMHP-CS trained in the department – approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using the department – approved models less than every two months.	50% - 74% of providers of Skills Training are supervised by a QMHP-CS trained in the department – approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using the department – approved models at least every two months.	75% - 84% of providers of Skills Training are supervised by a QMHP-CS trained in the department – approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using the department – approved models at least once every month.	85% - 94% of providers of Skills Training are supervised by a QMHP-CS trained in the department – approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using the department – approved models at least every two weeks.	95% - 100% of providers of Skills Training are supervised by a QMHP-CS trained in the department – approved Skills Training models who has provided Skills Training to children, adolescents, parents and primary caregivers using the department – approved models at least once every week.	

Element	Source	1	2	3	4	5	Notes
<p>B. Skills Training Strategies for Sessions with Children, Adolescents, Parents and Primary Caregivers The skills trainer conducts structured and goal-directed sessions to teach new skills to children, adolescents, parents and primary caregivers using established educational strategies. Generally sessions are taught sequentially because new sessions build on previous sessions unless the model specifies otherwise. In – Session practice includes practice of the new skills taught during the session until the children, adolescents, parents and primary caregivers correctly demonstrate the new skills. Homework Assignments are given to practice the new skills taught during each session and to facilitate generalization of the new skills to natural settings. These Skills Training Strategies are used across sessions during an episode of care. Reward Systems and Behavioral Contracts are used with each child and adolescent as appropriate to reinforce correct demonstration of new skills, to reinforce the generalization of these new skills to natural settings and to improve behaviors. These Skills Training Strategies apply to all Skills Training sessions regardless of the population.</p>							
<p>4. Structured and Goal-Oriented Sessions All Skills Training sessions are structured and goal- oriented and teach a specific content area.</p>	Child Progress Notes	Less than 50% of sessions are structured and goal-oriented and teach a specific content area.	50% - 74% of sessions are structured and goal-oriented and teach a specific content area.	75% - 84% of sessions are structured and goal-oriented and teach a specific content area.	85% - 94% of sessions are structured and goal-oriented and teach a specific content area.	95% - 100% of sessions are structured and goal-oriented and teach a specific content area.	
<p>5. In-Session Practice The QMHP-CS and the C SSP use modeling, role playing, behavioral rehearsal, feedback and correction, and interactive teaching to provide practice of new skills during the sessions.</p>	Child Progress Notes	In – session practice of new skills is present in less than 50% of sessions and at least 2 of methods noted are used for in – session practice.	In – session practice of new skills is present in 50% - 74% of sessions and at least 2 of the methods noted are used for in – session practice.	In – session practice of new skills is present in 75% - 84% of sessions and at least 2 of the methods noted are used for in – session practice.	In – session practice of new skills is present in 85% - 94% of sessions and at least 2 of the methods noted are used for in – session practice.	In – session practice of new skills is present in 95% - 100% of sessions and at least 2 of the methods noted are used for in – session practice.	
<p>6. Homework Assignments The QMHP-CS and the C SSP use Homework Assignments for the practice and generalization of new skills to natural settings for every session.</p>	Child Progress Notes	Less than 50% of sessions use Homework Assignments for the practice and generalization of new skills to natural settings.	50% - 74% of sessions use Homework Assignments for the practice and generalization of new skills to natural settings.	75% - 84% of sessions use Homework Assignments for the practice and generalization of new skills to natural settings.	85% - 94% of sessions use Homework Assignments for the practice and generalization of new skills to natural settings.	95% - 100% of sessions use Homework Assignments for the practice and generalization of new skills to natural settings.	
<p>7. Reward Systems for Children and Behavioral Contracts for Adolescents Parents and primary caregivers have established and implemented Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.</p>	Child Progress Notes	Less than 50% of parents and primary caregivers are taught to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for use with their children and adolescents throughout treatment.	50% - 74% of parents and primary caregivers are taught to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.	75% - 84% of parents and primary caregivers are taught to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.	85% - 94% of parents and primary caregivers are taught to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.	95% - 100% of parents and primary caregivers are taught to establish and implement Reward Systems for Children and Behavioral Contracts for Adolescents for daily use with their children and adolescents throughout treatment.	

Element	Source	1	2	3	4	5	Notes
<p>8. Established Educational Strategies The QMHP-CS and CSSP use the following established educational strategies in teaching skills training in every session:</p> <ol style="list-style-type: none"> 1) Methods to ensure understanding 2) Breaking information down into its component parts 3) Material review and repetition 4) Interactive teaching 5) Modeling 6) Behavioral rehearsal 7) Role playing and 8) Worksheets 	Child Progress Notes	The QMHP-CS and the CSSP use at least one of the Established Educational Strategies to teach Skills Training in every session.	The QMHP-CS and the CSSP use at least two of the Established Educational Strategies to teach Skills Training in every session.	The QMHP-CS and the CSSP use at least three of the Established Educational Strategies to teach Skills Training every session.	The QMHP-CS and the CSSP use at least four of the Established Educational Strategies to teach Skills Training every session.	The QMHP-CS and the CSSP use at least five of the Established Educational Strategies to teach Skills Training every session.	
<p>C. Content of Skills Training for Children and Adolescents with Externalizing Disorders Skills Training for Children and Adolescents with Externalizing Disorders is taught using <i>Skills Training for Children with Behavior Disorders</i> (ages 6 – 16) by Michael L. Bloomquist using chapters 9, 10 and 11 and chapters 13 and 14. The content must be taught in sequential order using the designated strategies across an episode of care unless specified otherwise by the model. Each session builds upon the previous sessions. Content areas relate specifically to teaching skills to cope effectively with life. The sessions teach and reinforce critical skills needed by children and adolescents with externalizing disorders. These skills are taught to all children and adolescents while their parents and primary caregivers are being taught either <i>Defiant Children</i> or <i>Defiant Teens</i>.</p>							
<p>9. Positive Social Behavior Skills Every child and adolescent with an externalizing disorder is taught and practices the following positive social behavior skills across several sessions:</p> <ol style="list-style-type: none"> 1) Taking turns 2) Sharing 3) Cooperating 4) Starting conversations 5) Apologizing to others 6) Asking questions 7) Playing fair 8) Following the rules 9) Ignoring when appropriate 10) Listening to others 11) Talking in a brief manner 12) Helping others 13) Making eye contact 14) Telling others about self 15) Inquiring about other's interests and desires 16) Complimenting others 17) Accepting compliments 	Child Progress Notes	Less than 9 of the Positive Social Behavior Skills noted are taught to and practiced by every child and adolescent in Skills Training.	At least 9 of the Positive Social Behavior Skills noted are taught to and practiced by every child and adolescent in Skills Training.	At least 11 of the Positive Social Behavior Skills noted are taught to and practiced by every child and adolescent in Skills Training.	At least 13 of the Positive Social Behavior Skills noted are taught to and practiced by every child and adolescent in Skills Training.	At least 15 of the Positive Social Behavior Skills noted are taught to and practiced by every child and adolescent in Skills Training.	

Element	Source	1	2	3	4	5	Notes
<p>10. Assertiveness Skills Every child and adolescent with an externalizing disorder is taught and practices the following 8 Assertiveness Skills:</p> <ol style="list-style-type: none"> 1) Thinking ahead and planning 2) Saying “no” to peers 3) Refusing to cooperate with peers’ negative behaviors 4) Refusing to do negative things peers ask you to do 5) Asking for what you need and want 6) Apologizing when you are wrong or hurtful 7) Stating your opinion 8) Standing up for what you believe 	Child Progress Notes	Less than 5 of the Assertiveness Skills noted are taught to and practiced by every child and adolescent.	5 of the Assertiveness Skills noted are taught to and practiced by every child and adolescent.	6 of the Assertiveness Skills noted are taught to and practiced by every child and adolescent.	7 of the Assertiveness Skills noted are taught to and practiced by every child and adolescent.	All 8 Assertiveness Skills noted are taught to and practiced by every child and adolescent.	
<p>11. Social and General Problem – Solving Skills Every child and adolescent with an externalizing disorder is taught and practices all of the Social and General Problem – Solving Skills listed below:</p> <ol style="list-style-type: none"> 1) Stop! What is the problem? 2) Who or what caused the problem? 3) What does each person think and feel? 4) What are some plans? 5) What is the best plan? 6) Do the plan. 7) Did the plan work? 	Child Progress Notes	All 7 steps for Social and General Problem – Solving Skills are taught to and practiced by less than 50% of children and adolescents.	All 7 steps for Social and General Problem – Solving Skills are taught to and practiced by 50% - 74% of children and adolescents.	All 7 steps for Social and General Problem – Solving Skills are taught to and practiced by 75% - 84% of children and adolescents.	All 7 steps for Social and General Problem – Solving Skills are taught to and practiced by 85% - 94% of children and adolescents.	All 7 steps for Social and General Problem – Solving Skills are taught to and practiced by 95% - 100% of children and adolescents.	
<p>12. Relaxation Skills Every child and adolescent with an externalizing disorder is taught and practices Relaxation Skills to induce relaxation and to reduce tension when angry and uptight. Relaxation Skills include:</p> <ol style="list-style-type: none"> 1) Progressive Muscle Relaxation 2) Deep Breathing Exercises 3) Guided Imagery (selected by the QMHP-CS or CSSP) 4) Meditation (mantra) 5) Pleasant Visualizations (selected by the child or adolescent) 6) Robot/Rag Doll Techniques 	Child Progress Notes	1 of the noted Relaxation Skills is taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.	2 of the noted Relaxation Skills are taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.	3 of the noted Relaxation Skills are taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.	4 of the noted Relaxation Skills are taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.	5 of the noted Relaxation Skills are taught to and practiced by every child and adolescent to induce relaxation and to reduce tension when angry and tense.	

Element	Source	1	2	3	4	5	Notes
<p>13. Anger Management Skills Every child and adolescent with an externalizing disorder is taught and practices the following Anger Management Skills so they can express their anger differently in the future:</p> <ol style="list-style-type: none"> 1) How to recognize personal bodily signs of anger 2) How to recognize personal action signals of anger 3) How to recognize personal thoughts that lead to anger 4) Coping Self – Talk 5) Take effective action 	Child Progress Notes	All 5 Anger Management Skills noted are taught to and practiced by less than 50% of children and adolescents.	All 5 Anger Management Skills noted are taught to and practiced by 50% - 74% of children and adolescents.	All 5 Anger Management Skills noted are taught to and practiced by 75% - 84% of children and adolescents.	All 5 Anger Management Skills noted are taught to and practiced by 85% - 94% of children and adolescents.	All 5 Anger Management Skills noted are taught to and practiced by 95% - 100% of children and adolescents.	
<p>14. Skills to Understand and Express Feelings The QMHP-CS uses the 6 following interventions to teach every child and adolescent with an externalizing disorder to understand and express feelings:</p> <ol style="list-style-type: none"> 1) Teach and Increase feeling vocabulary 2) Model the expression of feelings 3) Ask questions that require feelings to be expressed in the answer 4) Label the child's and adolescent's feelings if they are unable to verbalize them 5) Reinforce the child and adolescent for expressing their feelings 6) Ask every child and adolescent to keep a "feelings" diary 	Child Progress Notes	All 6 interventions noted are used to teach and to practice the understanding and expression of feelings with less than 50% of children and adolescents with externalizing disorders.	All 6 interventions noted are used to teach and to practice the understanding and expression of feelings with 50% - 74% of children and adolescents with externalizing disorders.	All 6 interventions noted are used to teach and to practice the understanding and expression of feelings with 75% - 84% of children and adolescents with externalizing disorders.	All 6 interventions noted are used to teach and to practice the understanding and expression of feelings with 85% - 94% of children and adolescents with externalizing disorders.	All 6 interventions noted are used to teach and to practice the understanding and expression of feelings with 95% - 100% of children and adolescents with externalizing disorders.	
<p>15. Coping Self – Talk (Helpful Thoughts) Every child and adolescent with an externalizing disorder is taught and practices coping self - talk (helpful thoughts) to counter negative (unhelpful) thoughts about self, others and the world. Coping self - talk (helpful thoughts) involves teaching and practicing the following 3 skills:</p> <ol style="list-style-type: none"> 1) Helping the child and adolescent learn to identify their own negative 	Child Progress Notes	Less than 50% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).	50% - 74% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).	75% - 84% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).	85% - 94% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).	95% - 100% of children and adolescents are taught and practice the 3 skills involved in Coping Self – Talk (Helpful Thoughts).	

Element	Source	1	2	3	4	5	Notes
(unhelpful) thoughts 2) Helping the child and adolescent understand how these negative (unhelpful) thoughts negatively influence their emotions and 3) Helping the child and adolescent learn and practice positive counter thoughts (helpful) to change the negative (unhelpful) thoughts so they can experience more positive emotions.							
D. Content of Skills Training for Parents and Primary Caregivers Skills Training for Parents and Primary Caregivers of Children and Adolescents with Externalizing Disorders is taught using two Skills Training models, one for children and one for adolescents. For children, <i>Defiant Children</i> by Russell A. Barkley is used. For adolescents, <i>Defiant Teens</i> by Russell A. Barkley, Gwenyth H. Edwards and Arthur L. Robin is used. The content of these models must be taught in sequential order using the designated strategies across an episode of care unless specified otherwise by the model. Generally each session builds upon the previous sessions. Content areas relate specifically to teaching skills to cope effectively with life. The sessions teach and reinforce critical skills needed by the parents and primary caregivers of children and adolescents with externalizing disorders.							
16. Principles of Behavior Management The QMHP-CS and the CSSP teach every parent and primary caregiver the 6 Principles of Behavior Management and incorporate these principles into the majority of sessions: 1) The connection between the antecedent to a misbehavior, the misbehavior itself and the consequence for the behavior. 2) Anticipating and planning for misbehavior. 3) Implementing incentive programs before punishment. 6) The immediacy, specificity, predictability and consistency of consequences. 7) The reciprocity of family interactions and 6)The coercive behavior cycle.	Child Progress Notes	The QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into less than 50% of sessions.	The QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into 50% - 74% of sessions.	The QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into 75% - 84% of sessions.	The QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into 85% - 94% of sessions.	The QMHP-CS and the CSSP teach every parent and primary caregiver these 6 Principles of Behavior Management and incorporate them into 95% - 100% of sessions.	

Element	Source	1	2	3	4	5	Notes
<p>17. Developing Positive Attention Parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.</p>	Child Progress Notes	Less than 50% of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.	50%o – 74% of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.	75% -84% of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.	85% - 94% of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.	95% - 100%of parents and primary caregivers are taught and practice all aspects of spending one – on – one time with their children and adolescents during sessions and are given homework assignments to practice outside of sessions.	

Element	Source	1	2	3	4	5	Notes
<p>18. Developing Parental and Primary Caregiver Positive Attending Skills and Giving Effective Commands</p> <p>Parents and primary caregivers are taught and practice the following skills:</p> <ol style="list-style-type: none"> 1) Pay attention to, state appreciation for and praise compliant behavior. 2) Particularly give salient positive attention and rewards when household rules and routine chores are done without reminders. 3) Pay attention to, state appreciation for and praise compliance with a command. 4) When giving a command, make sure you mean it and will follow through. 5) Do not present commands as a question or a favor. 6) Do not give too many commands at once. 7) Tell the child or adolescent what to do rather than what not to do. 8) Reduce distractions before giving a command. 9) Be cautious of commands that involve the concept of time. It is better to give commands about things you want done NOW. 10) For children, the parent and primary caregiver need to make sure the children are paying attention to the command, ask the children to repeat the command and make up chore cards for the children. 	Child Progress Notes	Parents and primary caregivers of children are taught and practice 6 of the 10 (including #10) components for increasing positive attention and giving effective commands and parents and primary caregivers of adolescents are taught and practice 5 of 9 components for increasing positive attention and giving effective commands.	Parents and primary caregivers of children are taught and practice 7 of the 10 (including #10) components for increasing positive attention and giving effective commands and primary caregivers of adolescents are taught and practice 6 of 9 components for increasing positive attention and giving effective commands.	Parents and primary caregivers of children are taught and practice 8 of the 10 (including #10) components for increasing positive attention and giving effective commands and primary caregivers of adolescents are taught and practice 7 of 9 components for increasing positive attention and giving effective commands.	Parents and primary caregivers of children are taught and practice 9 of the 10 (including #10) components for increasing positive attention and giving effective commands and primary caregivers of adolescents are taught and practice 8 of 9 components for increasing positive attention and giving effective commands.	Parents and primary caregivers of children are taught and practice all 10 of the components for increasing positive attention and giving effective commands and primary caregivers of adolescents are taught and practice all 9 components for increasing positive attention and giving effective commands.	
<p>19. Discipline Strategies</p> <p>Parents and primary caregivers of children are taught and practice all 4 of the Discipline Strategies for children and the parents and primary caregivers of adolescents are taught and practice all 4 of the Discipline</p>	Child Progress Notes	Less than 50% of parents and primary caregivers of children are taught and practice all 4	50% - 74% of parents and primary caregivers of children are taught and practice all 4	75% - 84% of parents and primary caregivers of children are taught and practice all 4	85% - 94% of parents and primary caregivers of children are taught and practice all 4	95% - 100% of parents and primary caregivers of children are taught and practice all 4	

Element	Source	1	2	3	4	5	Notes
<p>Strategies for adolescents. The Discipline Strategies are:</p> <ol style="list-style-type: none"> 1) Time out procedures (children) 2) Response cost procedures (both) 3) Grounding (adolescents) 4) Behavioral contracts (adolescents) 5) Point systems (both) 6) Managing Children in Public Places (children) 		Discipline Strategies for children and less than 50% of parents and primary caregivers of adolescents are taught and practice all 4 Discipline Strategies for adolescents.	Discipline Strategies for children and 50% - 74% of parents and primary caregivers of adolescents are taught and practice all 4 Discipline Strategies for adolescents.	Discipline Strategies for children and 75% - 84% of parents and primary caregivers of adolescents are taught and practice all 4 Discipline Strategies for adolescents.	Discipline Strategies for children and 85% - 94% of parents and primary caregivers of adolescents are taught and practice all 4 Discipline Strategies for adolescents.	Discipline Strategies for children and 95% - 100% of parents and primary caregivers of adolescents are taught and practice all 4 Discipline Strategies for adolescents.	
<p>20. Managing Future Behavior Problems (Defiant Children only) Parents and caregivers of children with externalizing disorders are taught and practice all 4 steps for Managing Future Behavior Problems. The 4 steps are:</p> <ol style="list-style-type: none"> 1) Begin a record of the behavior problem in a notebook. 2) Keep this record for a week or two. 3) If needed, set up a special program for managing the behavior problem. 4) If these methods fail, call the center for booster sessions. 	Child Progress Notes	All 4 steps of Managing Future Behavior Problems are taught to and practiced by less than 50% of parents and primary caregivers of children with externalizing disorders.	All 4 steps of Managing Future Behavior Problems are taught to and practiced by 50% - 74% of parents and primary caregivers of children with externalizing disorders.	All 4 steps of Managing Future Behavior Problems are taught to and practiced by 75% - 84% of parents and primary caregivers of children with externalizing disorders.	All 4 steps of Managing Future Behavior Problems are taught to and practiced by 85% - 94% of parents and primary caregivers of children with externalizing disorders.	All 4 steps of Managing Future Behavior Problems are taught to and practiced by 95% - 100% of parents and primary caregivers of children with externalizing disorders.	
<p>21. Problem – Solving Skills and Graduated Problem – Solving Skills (Defiant Teens only) Parents, primary caregivers and adolescents are taught and practice together the 8 steps for effective Problem – Solving and Graduated Problem – Solving. The 8 steps are:</p> <ol style="list-style-type: none"> 1) Everyone defines the problem. 2) Everyone participates in generating at least 12 solutions. 3) Everyone evaluates the solutions. 4) Everyone selects the solution most agreeable to all. 5) If there is not agreement, everyone participates in finding a compromise between the family's two most liked and realistic 	Child Progress Notes	Less than 50% of parents, primary caregivers and adolescents are taught and practice together the 8 steps of effective Problem – Solving and Graduated Problem – Solving.	50% - 74% of parents, primary caregivers and adolescents are taught and practice together the 8 steps of effective Problem – Solving and Graduated Problem – Solving.	75% - 84% of parents, primary caregivers and adolescents are taught and practice together the 8 steps of effective Problem – Solving and Graduated Problem – Solving.	85% - 94% of parents, primary caregivers and adolescents are taught and practice together the 8 steps of effective Problem – Solving and Graduated Problem – Solving.	95% - 100% of parents, primary caregivers and adolescents are taught and practice together the 8 steps of effective Problem – Solving and Graduated Problem – Solving.	

Element	Source	1	2	3	4	5	Notes
<p>solutions.</p> <p>6) Everyone plans to implement the solution.</p> <p>7) Everyone evaluates the implementation of the solution after a week or two.</p> <p>8) If the solution is not working, everyone participates in finding another solution, redefining the problem or giving consequences to the person not complying with the solution.</p>							
<p>22. Communication Skills (Defiant Teens only) Parents, primary caregivers and adolescents meet together to be taught and to practice all 3 steps of the General Principles of Good Communication and to be taught and to practice together how to substitute positive communication alternatives for negative ones. The General Principles of Good Communication are:</p> <p>1) Listen when your teen/parent/primary caregiver is in the mood to talk, but don't force the teen to open up.</p> <p>2) Use active listening to encourage your teen/parent/primary caregiver to express opinions and feelings.</p> <p>3) Honestly express how you feel, good or bad, without being hurtful to your listeners.</p>	Child Progress Notes	All 3 of the steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by less than 50% of adolescents, parents and primary caregivers.	All 3 of the steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by 50% - 74% of adolescents, parents and primary caregivers.	All 3 of the steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by 75% - 84% of adolescents, parents and primary caregivers.	All 3 of the steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by 85% - 94% of adolescents, parents and primary caregivers.	All 3 of the steps of the General Principles of Good Communication and how to substitute positive communication alternatives for negative ones are taught to and practiced together by 95% - 100% of adolescents, parents and primary caregivers.	

Element	Source	1	2	3	4	5	Notes
<p>23. Unreasonable Beliefs and Expectations (<i>Defiant Teens only</i>) Parents, primary caregivers and adolescents meet together to be taught and to practice the 4 steps of Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions. Unreasonable Beliefs and Expectations include:</p> <ol style="list-style-type: none"> 1) Ruination 2) Malicious Intent 3) Unfairness 4) Expectations for obedience and perfectionism 5) Expectations for love and appreciation 6) Expectations for complete autonomy. <p>The 4 steps for Cognitive Restructuring are:</p> <ol style="list-style-type: none"> 1) Identifying the extreme thought. 2) Providing a logical challenge to the extreme thought. 3) Helping the family member identify an alternative, more realistic thought. 4) Helping the family member collect evidence to disconfirm the extreme thought and confirm the more reasonable thought. 	Child Progress Notes	Less than 50% of parents, primary caregivers and adolescents meet together to be taught and to practice the 4 steps of Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.	50% - 74% of parents, primary caregivers and adolescents meet together to be taught and to practice the 4 steps of Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.	75% - 84% of parents, primary caregivers and adolescents meet together to be taught and to practice the 4 steps of Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.	85% - 94% of parents, primary caregivers and adolescents meet together to be taught and to practice the 4 steps of Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.	95% - 100% of parents, primary caregivers and adolescents meet together to be taught and to practice the 4 steps of Cognitive Restructuring to identify and modify unrealistic beliefs, unreasonable expectations and distorted attributions.	

V. REFERENCES

Selected Models:

- ***Skills Training for Children with Behavior Disorders*** by Michael L. Bloomquist (10 - 14 individual sessions based on chapters 9, 10 and 11 and chapters 13 and 14 – for children and adolescents – ages 6 – 16)
- ***Defiant Children*** by Russell A. Barkley (10 - 14 individual sessions for parents and primary caregivers of children ages 2 - 12)
- ***Defiant Teens*** by Russell A. Barkley, Gwenyth H. Edwards and Arthur L. Robin (16 - 20 individual sessions for parents and primary caregivers of adolescents ages 13 – 17 – adolescents are included in several sessions with their parents and primary caregivers – 1) Problem – Solving Skills and Graduated Problem – Solving Skills 2) Communication Skills and 3) Unreasonable Beliefs and Expectations)

Additional References:

- Farmer, Elizabeth M., Compton, Scott N., Burns, Barbara J. "Review of the Evidence Base for Treatment of Childhood Psychopathology: Externalizing Disorders." *Journal of Consulting and Clinical Psychology*, 2002, Volume 70, Number 6, pages 1267 – 1302.
- Jensen, Peter, Wasserman, Gail A., Ko, Susan J. "Guidelines for Child and Adolescent Mental Health Referral." Columbia University.
- Eyberg, Sheila. *Parent Child Interaction Training*. Department of Clinical and Health Psychology, University of Florida, Gainesville, Florida 32610.
- Kazdin, Alan E. *Problem Solving Skills Training*. Department of Psychology, Yale University, New Haven, Conn. 06520
- Lochman, John E. *Social Skills Training, Anger Coping*. Duke University Medical Center, Durham, North Carolina 27710
- Patterson, Gerald. *Family Skills Training*. carleen@olsc.org
- Adesso, V.J. and Lipson, J.W. "Group Training of Parents as Therapists for their Children." *Behavior Therapy*, 1981.
- Blum, N.J., Williams, G.E., Friman, P.C. and Christopherson, E.R. "Disciplining Young Children: The Role of Verbal Instructions and Reasoning." 1995.
- McMahon, R.J. and Forehand, R. *Parent Training for the Non-Compliant Child*, 1984.
- Snyder, J. and Brown, K. "Oppositional Behavior and Non-Compliance in Pre-School Children: Environmental Correlates and Skills Deficits." *Behavioral Assessment*, 1983.
- Bierman, K.L. and Furman, W. "The Effects of Social Skills Training and Peer Involvement on the Social Adjustment of Pre-Adolescents." *Child Development*. 1984.
- Dodge, K.A., "Social-Cognitive Mechanisms in the Development of Conduct Disorder and Depression." *Annual Review of Psychology*. 1993.
- Masten, A.S., Coatsworth, D.J., Neeman, J., Gest, S.D., Tellegen, A. and Garmezy, N. "The Structure and Coherence of Competence from Childhood through Adolescence." *Child Development*. 1995
- Cote, Sylvana, Tremblay, Richard E., Nagin, Daniel, Zoccolillo, Mark, Vitaro, Frank. "Childhood Behavioral Profiles Leading to Conduct Disorder. *Journal of American Child and Adolescent Psychiatry*. September, 2002.
- Burke, Jeffrey D., Loeber, Rolf, and Birmaher, Boris. "Oppositional Defiant Disorder and Conduct Disorder." *Journal of American Academy of Child and Adolescent Psychiatry*. November, 2002.
- Vance, J. Eric, Bowen, Natasha, Fernandez, Gustavo, and Thompson, Shealy. "Risk and Protective Factors as Predictors of Outcome in Adolescents with Psychiatric Disorder and Aggression." *Journal of American Child and Adolescent Psychiatry*. January, 2002.