CareCertify LLC

245I Mental Health Training · CTSS Behavioral Aide Series

MHBA-02

Child & Adolescent Mental Illness

Participant Guide

Mental Health Behavioral Aides (CTSS) · Part of the 30-Hour Pre-Service Training

Updated July 2026 — Minn. Stat. 245I.05, subd. 3(c)(1)

Recognizing how mental illness shows up in children — so you can support, not diagnose.

Learning Objectives — by the end of this module you will be able to:

- Explain why mental illness looks different in children than in adults
- Recognize common child and adolescent mental health conditions
- Understand behavior as communication of an unmet need
- Describe how symptoms shift across ages and stages
- Support a child without diagnosing — and know when to escalate
- Use accurate, stigma-free language with children and families

Section 1: Why children aren't small adults

Mental illness in children shows up through behavior and development.

- **Behavior first.** Children often can't name feelings, so distress shows up as behavior — meltdowns, withdrawal, aggression, or regression.
- **Development matters.** What's typical at age 4 differs from age 14; symptoms are read against the child's stage of development.
- **Context matters.** Home, school, culture, and recent events all shape how a child presents — the same behavior can mean different things.
- **You observe, not label.** Your job is to notice and describe what you see, and share it with the team — not to diagnose.

Section 2: Anxiety and depression in youth

Two of the most common — and often missed — presentations.

- **Anxiety.** Excessive worry, clinginess, avoidance, physical complaints (stomachaches, headaches), or refusal to go to school.
- **Depression.** In children it can look like irritability and anger more than sadness, plus loss of interest, low energy, and withdrawal.

- **Watch the change.** A shift from how the child usually is — sleep, appetite, mood, or activity — is more telling than any single behavior.

Section 3: Attention, activity, and behavior

Conditions that show up strongly in home and school routines.

- **Attention & activity.** Inattention, impulsivity, and hyperactivity that are beyond what's typical for the child's age and get in the way daily.
- **Defiance.** A lasting pattern of angry, argumentative, defiant behavior toward authority — more than ordinary testing of limits.
- **Rule-breaking.** More serious, repeated violations of rules or others' rights; always a reason to loop in the professional.

These patterns overlap and often travel with anxiety, trauma, or learning differences — the team sorts that out.

Section 4: Trauma-related presentations

Trauma can drive behavior that's easy to misread.

- **Hypervigilance.** A child who seems always on guard, startles easily, or reacts big to small triggers may be responding to trauma.
- **Shutdown.** Others go quiet, numb, or 'checked out' — dissociation is also a trauma response, not defiance.
- **Reenactment.** Trauma can show up in play, drawings, or repeated themes; note it and share it with the team.
- **Ask 'what happened,'.** The trauma-informed question is 'what happened to this child?' — not 'what's wrong with this child?'

Section 5: Autism and developmental context

Neurodevelopmental differences shape how a child communicates and copes.

- **Communication & social.** Differences in communication, social interaction, and a need for routine and predictability are common.
- **Sensory needs.** Sound, light, texture, or crowds can overwhelm; what looks like 'acting out' may be sensory overload.
- **Strengths too.** Focus, honesty, memory, and deep interests are strengths to build on, not just challenges to manage.
- **Co-occurring.** Mental illness can co-occur with autism or a developmental disability; the plan guides how you support each child.

Section 6: Behavior is communication

Under most tough behavior is an unmet need the child can't yet put into words.

- **Look underneath.** Ask what the behavior might be communicating — fear, overwhelm, hunger, a need for control, or connection.

- **Name the need.** When you meet the need, the behavior often eases; punishing the behavior alone rarely teaches the missing skill.
- **Teach the skill.** The treatment plan targets the skill the child is missing; you help them practice a better way to get the need met.
- **Stay curious, not angry.** Curiosity keeps you regulated and helps the child feel safe enough to learn.

Section 7: Warning signs and when to escalate

Some signs always go to your supervisor or professional — same day.

- **Safety talk.** Any talk of suicide, self-harm, or wanting to die — take seriously and report immediately, following your crisis policy.
- **Harm to others.** Threats or serious aggression toward others; keep everyone safe and escalate now.
- **Big changes.** Sudden, marked changes in mood, sleep, eating, or functioning; or a child who seems to lose touch with reality.
- **New disclosures.** Disclosures of abuse or unsafe situations — follow mandated reporting and tell your supervisor.
- **Substance use.** Signs of alcohol or drug use in a youth — note and report to the team per your program's policy.
- **Trust your gut.** If something feels seriously off, escalate. It's always right to raise a concern.

Section 8: Words that reduce stigma

How we talk about children shapes how they see themselves.

- **Person first.** Say 'a child with anxiety,' not 'an anxious kid.' The child is not their diagnosis.
- **Describe, don't judge.** Document what you saw — 'left the room during the drill' — not labels like 'bad' or 'manipulative.'
- **Strengths & hope.** Name strengths and the skills growing; mental illness is treatable and children can and do get better.

Stigma keeps families from help. Accurate, kind language is part of treatment.

Section 9: Same condition, different ages

Read symptoms against where the child is developmentally.

- Young children: behavior, body complaints, regression
- School age: irritability, school refusal, friendship struggles
- Preteens: mood swings, withdrawal, risk-testing begins
- Teens: identity, isolation, risk behavior, self-harm risk
- Across ages: watch for change from the child's baseline
- Always: read behavior in the child's developmental context

You'll go deeper on development in the child development module — here, just connect age to how symptoms look.

Section 10: Support without diagnosing

Recognition-level knowledge — the professional diagnoses and treats.

- **Notice & describe.** Use what you know to notice patterns and describe them clearly to the team — that's recognition, not diagnosis.
- **Never label the child.** Don't tell a child or family what condition you think they have; that's the professional's role.
- **Support the plan.** Help the child practice the coping and social skills the plan targets for their needs.
- **Bring it back.** Your observations help the professional refine the diagnosis and the plan over time.

Section 11: Working with families around mental illness

Families are experts on their child — and often carry worry and stigma.

- **Listen and respect.** Families know their child best; your observations and their knowledge together give the fullest picture.
- **Reduce shame.** Normalize that mental illness is common and treatable; reduce blame and stigma in how you talk.
- **Coach the taught skills.** Within the plan, help families use the same strategies at home so skills stick across settings.

Apply It — Scenarios

Anger that might be depression
A 12-year-old who used to be easygoing is now irritable, snapping at everyone, sleeping a lot, and dropping activities he loved. A parent says he's 'just being a difficult teen.'
The right response: → Notice the change from baseline — irritability plus withdrawal, sleep, and lost interest can be depression in youth. → Don't diagnose or label — describe the specific changes you've observed to your supervisor and the team. → Gently reduce stigma with the family — mood changes can be a health issue, not just attitude. → Support the plan's coping skills and stay alert for any talk of self-harm, escalating immediately if it appears.

Overwhelm that looks like defiance
During a noisy group activity, a child with autism covers his ears, refuses to participate, and then knocks over a chair. Staff want to treat it as a behavior problem to punish.
The right response: → Consider sensory overload — noise and crowd may be overwhelming, not willful defiance. → Support regulation first — a quieter space or a break, per the child's plan, before any expectation. → Describe the trigger and response for the team so the plan can build in sensory supports. → Reframe with staff — meeting the sensory need teaches more than punishing the overwhelm.

Key Terms

Term	What it means
Mental illness	A health condition affecting thinking, mood, or behavior; common in children and treatable.
Anxiety	Excessive worry or fear; in kids often avoidance, clinginess, or physical complaints.
Depression	Low or irritable mood with loss of interest and energy; in kids often looks like anger.

ADHD	Beyond-typical inattention, impulsivity, and hyperactivity that impair daily functioning.
ODD	Oppositional defiant disorder — a lasting pattern of angry, defiant behavior toward authority.
Trauma response	Hypervigilance, shutdown, or reenactment driven by frightening or harmful experiences.
Person-first language	'A child with…' rather than labeling the child by a diagnosis.
Recognition, not diagnosis	Noticing and describing patterns; diagnosis belongs to the professional.

Check Your Understanding

1. Why does mental illness often look different in children than in adults?

A. Children show distress through behavior and development because they can't always name feelings

B. Children never have real mental illness

C. Children always describe their feelings clearly

D. Mental illness is identical at every age

Answer: A — Kids show distress behaviorally, read against development.

2. Depression in children often looks like:

A. Only visible sadness and crying

B. High energy and euphoria

C. No change at all

D. Irritability and anger, with loss of interest and low energy

Answer: D — In kids, depression often presents as irritability more than sadness.

3. Serious, repeated rule-breaking or violation of others' rights is a reason to:

A. Handle it privately and not mention it

B. Punish and move on

C. Ignore it

D. Loop in the professional

Answer: D — Conduct problems always involve the professional.

4. Which is an accurate view of autism in CTSS work?

A. Autism means the child can't learn

B. Autism rules out mental illness

C. Strengths don't matter

D. Children have strengths to build on, and mental illness can co-occur

Answer: D — Build on strengths; conditions can co-occur; follow the plan.

5. A child discloses abuse during your visit. You must:

A. Follow mandated reporting and tell your supervisor

B. Keep it secret if asked

C. Investigate it yourself first

D. Wait to see if it repeats

Answer: A — Disclosures trigger mandated reporting.

6. How do symptoms tend to differ by age?

A. They are identical at all ages

B. Only teens ever have symptoms

C. Younger children show behavior and body complaints; teens show identity, isolation, and self-harm risk

D. Age is irrelevant

Answer: C — Read symptoms against developmental stage.

7. An easygoing 12-year-old is now irritable, withdrawn, sleeping a lot, and dropping interests. You should:

A. Tell the parent it's definitely depression

B. Ignore it as normal teen behavior

C. Punish the irritability

D. Describe the changes to the team and watch for self-harm; don't diagnose

Answer: D — Notice change, describe it, stay alert to safety.

What You Learned

- Mental illness in children shows up through behavior and development
- Anxiety, depression, ADHD, defiance, trauma, and autism have recognizable patterns
- Behavior is communication — look for the unmet need underneath
- Read symptoms against the child's age and watch for change from baseline
- You recognize and support; the professional diagnoses and treats
- Use person-first, stigma-free, strengths-based language
- Escalate safety concerns — self-harm, harm to others, big changes — immediately

Next: Recovery, Resiliency & Child Development (MHBA-03).

Legal & Training Basis

Content built to Minn. Stat. 245I.04 (mental health behavioral aide qualifications and scope) and 245I.05 (required training), for mental health behavioral aides in Children's Therapeutic Services and Supports (CTSS). This module is one hour of the 30-hour pre-service MHBA training. NOTE: the MHBA parent team training required by 245I.05 must use a curriculum approved by the commissioner (DHS) — this series supports, but does not replace, that approved curriculum. Recognition-level content; diagnosis and treatment belong to the qualified professional. Current as of July 2026.