

POLICE POCKET GUIDE

RESPONDING

TO YOUTHS WITH
MENTAL HEALTH NEEDS



POLICE POCKET GUIDE

RESPONDING TO YOUTHS with MENTAL HEALTH NEEDS

DEDICATION

We dedicate this Pocket Guide to all the police officers of Massachusetts who serve and protect our homes, our communities, and our families. We honor your courage and praise your dedication. We salute your commitment to all members of our society and we appreciate and thank you for your understanding and respectful treatment of our mentally troubled youth.

SPECIAL THANKS

We wish to thank the Massachusetts families whose children suffer with emotional, behavioral and psychological disorders, for sharing their personal stories with us. Their children's experiences (both positive and negative) with law enforcement officers inspired the writing of this pocket guide.

ACKNOWLEDGEMENTS

This guide was written by the mothers of youths with mental health disorders. We thank the dedicated professionals in the fields of law enforcement, mental health, psychopharmacology, business, and teaching who advised and guided us through the writing of this resource.

Some of the information contained in this Pocket Guide has been gathered or condensed, with permission as needed, from informational publications from the National Alliance for the Mentally Ill (NAMI), the National Information Center for Children and Youth with Disabilities (NICHCY), the National Institute for Mental Health (NIMH), Sensory Integration Network (SI Network), and Police Executive Research Forum (PERF).

This publication was funded by a grant from:
Massachusetts Department of Mental Health

with aid and guidance from
Wayside Youth & Family Support Network

Gwen Healey and Janet Hirschhorn
© Copyright 2001
revised edition © Copyright 2001, 2002
All rights reserved.
Printed in the United States of America

The authors of this guide give permission and encouragement for the duplication and distribution of these materials, provided the source is acknowledged and usage is exclusively for not-for-profit individuals or organizations.

The complete text of this guide, additional information and parent resource materials will be available on the Internet at: www.ppal.net

TABLE OF CONTENTS

About Mental Illness	p. 4
Parents as Allies	p. 4
Public Safety	p. 5
On Scene Assessment	p. 5
Clinical Recommendations	p. 6
Disposition	p. 6
Points to Remember	p. 7
Mental Health Disorders	p. 7
Anxiety Disorders	p. 7
Panic Disorder	p. 8
Phobia	p. 8
Social Phobia	p. 8
Post Traumatic Stress Disorder (PTSD)	p. 8
Obsessive Compulsive Disorder (OCD)	p. 9
Generalized Anxiety Disorder	p. 9
Bipolar Disorder	p. 9
Depression/Major Depression	p.10
Schizophrenia	p.10
Borderline Personality (BPD)	p.10
Dissociative Disorders	p.11
Oppositional Defiant Disorder (ODD)	p.11
Conduct Disorder	p.11
ADD/ AD/HD	p.12
Self-Injuring Behaviors	p.12
Eating Disorder	p.12
Learning Disabilities	p.13
Non-Verbal Learning Disability (NLD)	p.13
Sensory Integration Dysfunction (DSI)	p.13
Psychiatric Medications	p.13
Antidepressants	p.14
Stimulants	p.14
Anti-anxiety Agents	p.14
Anti-obsessive Agents	p.14
Anti-psychotic Agents	p.15
Mood Stabilizers	p.15
Anti-aggression Agents	p.15
Medications to Treat Substance Abuse	p.15
Alphabet Soup	p.15
Glossary	p.16
Resources	p.18

ABOUT MENTAL ILLNESS

Mental illness can affect any sort of person. It is not a sign of weak character or lack of intelligence. Many well known people suffer with depression, bipolar disorder, or other mental health problems. Most mental illnesses are biological, caused in part by imbalanced brain chemicals. This can negatively effect behavior, judgment, perception, and other functions. Many individuals have illnesses that are episodic; meaning good days and bad days. Symptoms on good days may be so well controlled that others are unaware of the illness. However, symptoms on bad days may be impossible to control, often resulting in self imposed isolation. It should not be assumed that youths with mental health disorders have been abused. In fact, many youth who have mental health disorders also have loving homes and devoted parents.

Professionals and parents refer to mental illness in youths as mental health disorders or preferably, mental health needs. Even though the symptoms are similar for youths and adults, this term somehow seems less frightening. Sometimes a mental health need will emerge suddenly, but usually they develop over a period of time. Mental illness is just that, an illness. It is also a disability in that it interferes with thinking, feeling, and relating to others. Many youths go undiagnosed until their symptoms worsen in adolescence or young adulthood. At any given time, one in every five young people is suffering from a mental health problem. Two-thirds of those youths are not getting the help they need. When an officer encounters a youth with extreme behaviors the officer should consider the possibility of an undiagnosed mental health need and may need to refer the youth for a professional mental health evaluation.

All types of mental health needs can be diagnosed and treated. In most cases even youths with severe symptoms improve with treatment, often dramatically. Most youths with mental health needs lead fairly normal lives once their symptoms are controlled. Treatment and positive relationships with caring adults can allow these youths to live their lives much like their peers.

PARENTS AS ALLIES

Parents can be strong and effective allies to officers who are responding to a situation involving mentally troubled youth. Clear communication from the officer will help the parent to stay calm and be supportive as the officer interacts with the youth. A parent knows his or her own child best and can assist the officer by providing information about the youth's illness, symptoms, behaviors, medications, side effects, and the youth's interests and strengths as well. Additionally, the parent may have previously experienced similar situations with the youth and may be able to advise the officer about approaches that could defuse the situation, or conversely, provoke a negative or even hostile response.

In some cases, it may be unclear if a youth has a mental illness. In these cases an alert and informed police officer can suggest to the parent that a professional mental health evaluation may be needed. The officer can reassure and advise the parent, or when appropriate, assist in obtaining an evaluation by calling for a crisis team to intervene. Informed advice from a law enforcement professional can give a parent new insight into how to help the youth.

In particularly difficult situations, a parent may be frightened by a youth's aggressive or violent behavior, but is nevertheless, reluctant to call the police. The parent may fear a community's zero tolerance domestic violence policy, or assume that the officer will not understand the mental health problems and will arrest the youth. This is a valid fear since situations sometimes get out of control. By the time a parent reluctantly decides to involve police for safety reasons, the family may already be mired in conflict. In these situations, a parent needs reassurance that the officer's objective is not to arrest the youth, but to help.

PUBLIC SAFETY

Most youths with mental health needs are no more violent or dangerous than those in the general population. In fact, many are withdrawn, fearful and uncomfortable dealing with others. If they become aggressive it is usually because they feel frightened, confused, or hopeless. Sometimes youths who are severely ill do not even realize they have a mental health need. This lack of perception can cause a severely mentally disturbed youth to be unable to accurately assess their surroundings or understand what is said to them. Fear and confusion about where they are and what is happening can lead to unpredictable responses and may pose a threat to the personal safety of the troubled youth, the responding officer or others at the scene. However most youths with mental health needs are not this severely affected, and are fully aware of the world around them.

Maintaining public safety may be especially challenging when a youth has never been diagnosed, has stopped taking prescribed medication, or has a dual diagnosis; that is, has a major mental health disorder and a co-occurring substance abuse problem. Even if an officer feels no threat to his or her own safety, the officer must keep on guard to the possibility that a mentally troubled youth may try to hurt him or herself, or react in a dramatic fashion to a perceived threat from the officer's presence, actions, the surroundings, or anything else. In cases such as these, the responding officer may find modifying standard procedures to meet the needs of these young people is the best approach. A cautious and sensitive interaction that is non-threatening may help de-escalate tensions and increase the likelihood of a successful outcome.

ON-SCENE ASSESSMENT

It is not easy to distinguish between alcohol or substance intoxication, mental retardation, epilepsy, mental illness, and some other medical conditions. In fact, "self-medication" with alcohol or illegal drugs is a common complication found in adolescents with mental health problems. This makes it even more difficult for police to evaluate and properly respond to the conduct of the mentally troubled youth.

Important note: Involuntary behaviors such as impulsiveness and flawed thinking are recognized symptoms of mental illness, and are worsened by substance abuse. Law enforcement officers can augment their life saving function of stopping risky behaviors with an informed and compassionate approach.

The following observations may signal the presence of a mental health need:

- history of mental health problems, and/or possession of psychiatric medications
- a plain, emotionless facial expression and body language
- incoherent thoughts or speech
- inability to focus or concentrate
- bizarre appearance, movements or behaviors
- delusions of personal importance or identity; unrealistic over-confidence
- hallucinations or perceptions unrelated to reality
- agitation, often without clear reason
- pronounced feelings of hopelessness, sadness or guilt

CLINICAL RECOMMENDATIONS

The following suggestions are from mental health professionals. A strategy that includes patience is more likely to defuse a tense situation with a troubled youth.

- Stay calm and don't overreact.
- Be friendly and accepting but remain firm and professional.
- Remove upsetting influences, distractions, and people from the scene.
- Gather information from family or bystanders.
- Indicate that you are trying to understand. Reassure the youth that you are there to help, not harm.
- Speak simply and briefly, and announce your actions before initiating them.
- Do not move suddenly, shout or give rapid orders.
- Avoid direct, continuous eye contact.
- If possible, do not touch the youth. Do not crowd his/her "comfort zone".
- Ask the youth for their cooperation, and allow them time to respond.
- Understand that you may not have a rational discussion, but try to keep conversation concrete by redirecting the topic when needed.
- Be aware that your police uniform and equipment may frighten the youth. Multiple officers may increase the youth's level of agitation.
- Do not express anger, impatience or irritation.
- Do not force discussion or assume that an unresponsive youth cannot hear you. They may not understand or may be unable to respond.
- Recognize that the youth may be overwhelmed by sensations, thoughts, surroundings, frightening beliefs, internal sounds or voices.
- Acknowledge that the youth's delusions are real to him or her.
- Do not argue with delusional statements, or mislead the youth to think that you feel or think the same way.
- Do not use inflammatory language, such as "wacko" or "psycho" in the youth's presence or in the nearby vicinity. Mental health disorders do not affect a youth's ability to hear.

DISPOSITION

Many non-dangerous calls involving youth with mental health needs are best handled by supporting the parent's wishes and encouraging professional mental health intervention.

If the youth is a danger to him/herself or a serious threat to others the officer must decide whether to arrest (if a crime has been committed) or initiate a mental health evaluation.

When an officer determines a professional mental health evaluation is needed the officer may choose (in accordance with local law enforcement policy) to consider one of the following options:

- Transport the youth to the local crisis team or ER in a police vehicle.
- Summon the local crisis team to the scene to evaluate the youth.
- Escort the parents as they transport their child to the crisis team or ER.
- Stay on the scene until an ambulance arrives and the EMS team is sufficiently informed to take charge of the situation.
- Leave the youth in the care of their parent or guardian.
- Some other appropriate action that complies with the local standard procedures.

A professional evaluation is often the first step for a youth to receive treatment. This is necessary to discover the underlying cause of the youth's behaviors and symptoms, and to determine what interventions will help most.

A treatment plan may include individual, group, and/or family therapy. Other therapy types include anger management, behavioral therapy, social skills training, and therapeutic recreation. The plan may also include intervention for a learning disability.

POINTS TO REMEMBER

- A police officer's ability to recognize symptoms of mental illness can be invaluable when assessing a scene.
- Symptoms of mental illness often first appear during adolescence.
- Mental illness and bizarre behavior are not criminal.
- Failure to follow police instructions during a psychotic episode is most likely NOT a deliberate act of defiance.
- These youths heal with treatment, not jail. When incarcerated their illnesses often worsen, especially if psychiatric medications are withheld.
- Four out of every five runaway youths suffers from depression. (US Select Committee on Children, Youth & Families).
- Suicide is a serious concern. Suicide is the third leading cause of death for 15-24 year olds (approx. 5,000 youths each year) and the sixth leading cause of death for 5-15 year olds. Tragically, the rate of youth suicides has nearly tripled since 1960.
- Desperate parents can be guided to appropriate community resources by a knowledgeable officer.
- A sensitive intervention by a police officer can be a reassuring and steadying influence on a struggling youth, and can encourage the youth to cooperate. Police officers have a unique and phenomenal ability to "make things better".

MENTAL HEALTH DISORDERS

The growing complexities and increased pace of our society and culture have brought new pressures to bear, making childhood and adolescence a more complicated, confusing and dangerous experience than ever before. Research has shown that prolonged stress can create changes in the brain and its function. Mental illnesses are now being diagnosed more accurately (and frequently) in children as scientific understanding of the brain progresses. In addition to traditional diagnostic tools, researchers using modern imaging technologies have discovered brain differences in some mentally ill youth. The following pages describe some of the most commonly diagnosed mental health disorders. These descriptions provide another point of view to help law enforcement officers more fully understand the behaviors they encounter.

THE ANXIETY DISORDERS

Anxiety disorders fall into several categories, as listed below. These disorders may have a biological basis or be triggered by environmental causes, such as the stress from coping with a learning disability. They are usually treated with psychiatric medications and a variety of therapies, such as social skills training, behavior management, and in some cases, a specialized school setting.

PANIC DISORDER

Panic attacks are instances of extreme fear, usually with a sense of looming danger and the strong desire to escape. Youth with this disorder may experience unrealistic worry, self-consciousness, or tension. Attacks can be spontaneous, or triggered by specific situations, and usually start suddenly. Physical symptoms include: pounding heart, shortness of breath, chest pain, nausea, dizziness, shaking, sweating, numbness, or tingling sensations.

PHOBIA

A phobia is an intense, irrational, and disabling fear of something that poses little or no actual threat. The fear leads to avoidance of objects or situations and can cause extreme feelings of terror, dread, and panic. The actual presence of the feared object or situation nearly always provokes an immediate anxiety response.

“Specific” phobias center around particular objects (e.g., certain animals) or situations (e.g., heights or enclosed spaces). These fears can substantially restrict a youth’s life. Some common phobias in youth include fears of: leaving home, boarding a bus, entering a classroom, attending a movie, taking tests, or responding to questions.

Except for very young children, youths with phobias usually recognize their fear is excessive or unreasonable but find themselves powerless to control their reactions.

SOCIAL PHOBIA

Children and adolescents with “social” phobia have an unreasonable expectation that they will fail in social settings with their peers.* They often feel hypersensitive to criticism, cave in easily to peer pressure, and suffer from low self-esteem. The youth fears he will humiliate himself.

Exposure to the feared social situation provokes anxiety and is avoided if possible. When a social situation is impossible to avoid, the youth may endure it with intense anxiety and distress or may succumb to a panic attack. The stress and subsequent avoidance behaviors interfere significantly with the youth’s normal routine, ability to work, academic functioning, social activities, and relationships.

*Youths with social phobia may relate to adults in an appropriate way, without phobic behaviors.

POST-TRAUMATIC STRESS DISORDER (PTSD)

PTSD is an anxiety disorder that can occur when a youth has been exposed to a traumatic event. The youth reacts with intense fear or helplessness to experiencing, witnessing, or learning of event(s) involving serious injury to self or others, such as suffering from domestic abuse or viewing the televised terrorist attacks on 9/11/2001.

Symptoms of PTSD vary widely, but generally fall into three categories: re-experience, avoidance, and irritability.

A youth with PTSD may re-experience traumatic events in the form of recurrent and intrusive thoughts or nightmares. He/she may experience flashbacks or hallucinations. In a younger child repetitive play may occur in which aspects of the trauma are expressed or reenacted.

A youth with PTSD may show phobic avoidance of anything that reminds him/her of the trauma, and may even be unable to recall details about it. He/she may show disinterest in formerly important activities, places or people, and feel depressed, detached, emotionally numb, or hopeless.

A youth with PTSD may show a number of forms of irritability, including insomnia, anger outbursts, impaired concentration, or a jittery condition. This may be expressed by disorganized, agitated or hostile behaviors.

PTSD causes significant distress and impairment in social, academic, or other important functioning. Youths who suffer from PTSD frequently use alcohol or other drugs to “self-medicate” in an attempt to dull painful memories or psychological torment.

Youths with this disorder are known to have high instances of attempted suicide.

OBSESSIVE-COMPULSIVE DISORDER (OCD)

This disorder is characterized by repetitive, intrusive, and unwanted thoughts (obsessions) and/or rituals (compulsions) that seem impossible to control. Adolescents may realize their symptoms don't make sense and are excessive, but younger children may be distressed only when they are prevented from carrying out their compulsive habits.

Compulsive behaviors may include, but are not limited to, activities such as: counting and recounting, repeated rearranging or aligning of objects, tapping and knocking, turning lights on and off, locking and unlocking doors and windows and excessive hand washing. The obsessions or compulsions cause significant distress once the youth recognizes the excessive and unreasonable nature of the activities. The activities are very time consuming (at least one hour a day) and significantly interfere with the youth's normal routine, academic functioning or social activities and relationships.

GENERALIZED ANXIETY DISORDER

Generalized Anxiety Disorder and Over-Anxious Disorder of Childhood are characterized by excessive anxiety and exaggerated worry about a number of events or activities (such as school work), that occurs a majority of days. The youth finds it difficult to control the worry and experiences one or more of these symptoms: feeling restless or edgy, difficulty concentrating, easily fatigued or mind going blank, irritability, muscle tension, sleep disturbance (difficulty falling or staying asleep or restless, dissatisfying sleep). Youths with this disorder usually anticipate the worst and often complain of fatigue, tension, headaches, and upset stomach.

BIPOLAR DISORDER

Bipolar disorder, also known as manic depressive illness, is a serious but highly treatable brain disorder. A bipolar youth experiences highs and lows: periods of mania and depression with normal moods in between.

A younger child's symptoms often differ from those seen in adolescents. The younger child generally has periods of extreme irritability, agitation, or hostility during a manic phase, while an older child often shows more adult patterns of mood swings.

During manic phases a youth may exhibit a number of “hyper” characteristics that may include: extreme irritability and distractibility, euphoria, increased energy, restlessness, racing thoughts or rapid talking, disrupted sleep, delusions of grandeur, very poor judgment, impulsiveness, reckless sexual encounters, abuse of drugs or alcohol, obnoxious, provocative or intrusive behaviors, and denial that anything is wrong. This unpredictable and intense behavior can make it difficult to maintain friendships. Isolation from their peers increases the youth's level of anxiety, adding to the risk of self-destructive behaviors.

Law enforcement officers may encounter bipolar youth more often than those with other mental health disorders. Attention seeking behavior can sometimes become disorderly or aggressive. The youth may fall in with “the wrong crowd” or self-medicate (experiment with alcohol and drugs) since they are often unable to determine the consequences of their actions.

Bipolar disorder is most effectively treated with a combination of counseling and medication. A youth with bipolar illness will often refuse medication once their symptoms are controlled, believing they no longer need medication. However, once interrupted, medications may be less effective if resumed and higher doses may be needed to obtain the same level of symptom control.

Please see the following description of depression.

DEPRESSION / MAJOR DEPRESSION

Clinical depression goes well beyond sadness, and is much more than having a bad day or coping with a major loss. Youth who suffer with depression cannot “snap-out-of-it” by trying hard. Depression affects the way a youth feels, thinks, and acts. Symptoms include persistent sadness and hopelessness, withdrawal from friends or activities, and poor school attendance or declining academic performance. The youth may experience a distressing level of indecision, an inability to concentrate, excessive sleep, a change in eating habits, a feeling of numbed emotions, and frequent physical complaints. A youth who is attempting to escape their depression may try to self-medicate with street drugs or alcohol. There may be thoughts of death or suicide.

Any attempt at suicide, even an apparently small gesture, should receive professional intervention, since they often represent “the tip of the iceberg”. Treatment usually includes a combination of counseling and anti-depressant medications. Supportive relationships with caring adults and the development of the youth’s strengths and abilities are two important factors in successful treatment. Activities that provide the youth personal attention from a mentoring adult and supervised peer socialization in small groups are ideal. Useful activities include team sports, scouting, faith-based youth groups, volunteering with the very young, the elderly, or animals, and expressive arts like drama, painting, and music.

Youth who experience a loss or who have attentional, learning, or conduct disorders are at a higher risk for depression.

SCHIZOPHRENIA

Schizophrenia is a very serious mental illness that usually emerges in late adolescence or young adulthood. The symptoms of schizophrenia are characterized as either positive (characteristics they have) or negative (the absence of normal characteristics).

Positive symptoms include bizarre behavior and psychosis, which refers to hallucinations, delusions, thought disorders, and hearing voices. Negative symptoms include an emotionless expression, apathy, and withdrawal.

Thought disorders are the diminished ability to think clearly and logically. Language may sound garbled to them, or their own speech may be garbled. Delusions are false beliefs, such as thinking others can hear their thoughts. Paranoid delusions are false beliefs that an outside force threatens them. For example, they may believe that aliens or an enemy government are attempting to steal the thoughts from their head.

Hallucinations are false perceptions which may be heard, seen, or felt, and may be perceived as voices. The voices may warn of danger, tell the youth to take some action, or simply comment on life. Some youths hear multiple voices.

Schizophrenia differs from other mental health disorders in that it is rarely controlled without strong psychiatric medications. However, once the schizophrenic youth adheres to a program of regular medication and therapy, there is substantial hope for a normalized life, including education, employment, family and friends.

BORDERLINE PERSONALITY DISORDER (BPD)

Youths with BPD are impulsive and unstable in their moods, personal relationships, and self-image. They have dramatic mood swings with periods of depression, extreme irritability, anxiety, and uncontrolled anger.

Peer friendships, family relations, and especially romantic relationships are frequently of the “on again, off again” pattern. BPD youth often make extremely poor choices that have a high risk for self-harm. They may drive or spend recklessly, binge on food, alcohol or drugs, or engage in impulsive sexual

activity. These youths often have very low self esteem and seek approval and acceptance from others, since they have little or no sense of self worth.

Some symptoms of BPD, such as anxiety or depression, can be treated with medication, but long-term counseling is usually necessary to correct harmful patterns of thinking and behaviors within relationships.

DISSOCIATIVE DISORDERS

This group of disorders is believed to be a response to trauma, as the effected individual attempts to distance themselves from something too awful to include in their view of themselves. Dissociative symptoms, or a full-blown Dissociative Disorder, can occur within another diagnosis especially the Anxiety Disorders, such as PTSD. There are 4 main subtypes of this disorder.

Probably the more common forms are Depersonalization Disorder and Dissociative Amnesia. In Depersonalization Disorder, the youth may experience feelings of being detached from their own body, as if they were an outside observer. They may feel the world around them, or their own experiences, to be somehow unreal. In Dissociative Amnesia the youth may at times be unable to recall personal information, including their own name, due to associating this information with an emotional shock or stress.

Far more rare, but more sensationalized in the media, are Dissociative Identity Disorder (once referred to as multiple personality disorder) and Dissociative Fugue. In the former, the youth may have two or more distinct identities that can take control of their personality, each with separate memories and characteristics. The latter is very rare and involves sudden, often distant, travel away from home, work or school with the inability to recall information about personal identity or the past.

Treatment of these disorders is similar to that of other disorders stemming from abuse or trauma, and may include forms of talk therapy and antidepressant or anti-anxiety medication.

OPPOSITIONAL DEFIANT DISORDER (ODD)

ODD is a pattern of disobedient, hostile, and defiant rule breaking that lasts for an extended period and is longer than a typical child or adolescent “phase”. Many ODD youths also have co-occurring AD/HD, anxiety, depression, learning disabilities, or other mental health disorders. The negative behaviors interfere significantly with the youth’s ability to make and keep friends, do well academically, and behave appropriately in public. Some youth initially labeled with ODD may recover from ODD behaviors after careful evaluation and targeted treatment of co-occurring diagnoses. Many professionals believe ODD is the early form of Conduct Disorder.

ODD is treated in much the same way conduct disorder is treated, i.e.: psychotherapy, behavioral therapy, and psychiatric medications in a comprehensive treatment plan.

CONDUCT DISORDER

More research is needed to better understand youths with this disorder, a complicated group who persistently disregard rules and violate other’s rights. Inappropriate and socially unacceptable behaviors often cause these youths to be viewed as delinquent rather than mentally ill. Their expression of anger takes several forms including verbal and physical aggression. Common behaviors include: bullying, threatening or intimidating, stealing, running away, lying, fire setting, truancy, breaking and entering, vandalism, cruelty to animals, fighting, and confrontation. Explosive anger is the primary maladaptive behavior and causes significant interference in social, academic, and occupational functioning.

Treatment is especially challenging because these youths are uncooperative and do not trust adults. Psychotherapy, behavioral therapy and psychiatric medications are generally all incorporated into a comprehensive treatment plan. Conduct disordered youth often have additional challenges such as learning disabilities, depression or other mental health disorders.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (AD/HD, ADD, ADHD)

Doctors believe that chemical differences in the brain cause AD/HD, the most commonly diagnosed behavior disorder in children. AD/HD youth find it hard to sit still, control their behavior, and pay attention. They may be disruptive, disorganized, have difficulty following instructions, and may “over-focus” on favorite activities. Youth with AD/HD often lack social skills and have trouble making and keeping friends. Law enforcement officers may encounter these youth when they act before they think, known as “impulsivity”. AD/HD youth have been known to run into traffic, reach into the kitchen blender, or climb too high, all without considering the consequences.

AD/HD can continue to be a problem in adolescence. Such youth, especially those who go untreated, may not develop the appropriate social, academic, and organizational skills they need to function successfully as adults. Even with treatment, repeated frustrations at school and with peers can sometimes provoke a secondary anxiety disorder or depression.

Kids with AD/HD can be helped best with a team approach. Parents, teachers, and other involved adults should work with the child to develop consistent goals and strategies. Tools for success include developing time management skills, checklists, and following structured routines. Self-hypnosis has been used effectively by some youths, as well. In many cases parents and doctors will agree that stimulant medication (usually Ritalin, Adderall, or Concerta) should be part of the treatment plan. A youth who receives treatment can become more independent, and learn to successfully manage their illness.

SELF-INJURING BEHAVIORS

Self-injuring behaviors are intentional, but non-life threatening, attempts to escape psychological pain by the self-infliction of physical pain. This is most often, but not exclusively, practiced by girls and is done solely for the self-injurer, not as an attempt to manipulate others. Although the harm is deliberate, they often feel guilt and even revulsion at their own behaviors. “Cutting” is the most common form of self-injury, but burning, bone breaking and even severe eye injuring or sexual mutilation are known methods of intentional self-harm.

Although surprisingly common, families, friends, even counselors and doctors may be unaware that a patient is self-injuring. “Cutters” tend to make many shallow cuts on the upper arms, thighs or other hidden areas. Wearing long sleeves in hot weather may be a clue that a youth may be self-injuring. Youths who practice intentional self-harm need professional intervention and support and understanding from family and friends. Psychiatric medications may help with co-occurring symptoms of depression or anxiety.

EATING DISORDERS

The 3 main categories of eating disorders include compulsive overeating, anorexia, and bulimia. Until recently eating disorders had been seen primarily in girls; but increasingly, boys are identified.

Anorexia is the refusal to maintain body weight at a normal level through self-inflicted starvation, as a result of a distorted body-image. Although underweight, the anorexic youth has an intense fear of gaining weight or becoming fat.

Bulimia is a process of binge eating followed by self-induced vomiting, abuse of laxatives, diuretics, enemas, or other medications. Fasting and excessive exercise are also commonly used methods to induce rapid weight reduction.

Eating disorders are treated with counseling and sometimes with psychiatric medications to address co-occurring depression or anxiety.

LEARNING DISABILITIES

NON-VERBAL LEARNING DISABILITY (NLD/NVLD)

NLD is a learning disability thought to result from differences in the “wiring” of the brain that influence perception and behavior. The strengths include eloquent verbal abilities, a strong vocabulary, and excellent rote memory. They remember the details, but often miss their significance.

Weaknesses fall into three categories. First, physical coordination may be poor, with either balance problems or poor handwriting. Second, they are chronically disorganized (of both thoughts and belongings), have problems visualizing (including problems reading maps or recognizing faces), and a tendency to get lost. The last category, social difficulties, is the biggest challenge to their daily existence.

NLD youth do not recognize nonverbal communication, such as body language or facial expression. They interpret words (even sarcasm) in the most literal and concrete way. They must be taught to understand the facial expressions of others and the significance of their own demeanors. NLD youth must learn how to engage socially because they can unwittingly offend others with their inappropriate expressions, behaviors and conversation.

These youth have difficulty both with new situations, and with “changing gears” from one situation to another. They lack social judgment and are often viewed as gullible or clueless. Their lack of “common sense” makes them easy to manipulate into participating in unsafe, inappropriate, and even illegal activities.

SENSORY INTEGRATION DYSFUNCTION (DSI)

These youth process sensations inaccurately, in a way that causes either over-sensitivity or under-sensitivity to stimulation. They may also be uncoordinated.

Youth who are under-responsive to a sensation may seek to “turn up the volume” to increase the experience. They may seem “wound up” and talk too loud, or touch others too much or too hard. They may even hurt themselves without noticing.

Youth who are over-responsive to stimulation may react negatively to motion, loud or busy environments, bright light, touch, or food smells. They may react with aggression, withdrawal, or even nausea.

Sensory Integration Dysfunction can be treated by an occupational therapist, who may prescribe exercises to help the child re-train their perceptions and reactions.

PSYCHIATRIC MEDICATIONS

Many very effective medications are available for the treatment of mental health disorders. Although medication does not cure mental health disorders, the correct medications can lessen the burdens of the illness and make it easier to function more successfully at home, in school, and socially.

Most youth who have a known diagnosis are prescribed medications; however, they may not be taking them as prescribed. Rationales for refusing medication can include: not recognizing they are ill, finding the side effects intolerable, preferring the “high” their illness causes, and countless other excuses. Youth may also misuse certain medications with the goal of losing weight or getting high.

Some psychiatric medications have side effects such as sedation, agitation, impaired coordination, hand tremors, facial spasms, weight gain, or nausea. Their effectiveness can be altered by the consumption of alcohol, caffeine, citrus, some herbal supplements, and some over the counter medications, or smoking cigarettes.

Some commonly prescribed medications are listed below, grouped in categories based upon the illnesses they are used to treat. Many of them, especially the antidepressants, are used to treat more than one type of disorder. Each medication is listed by its brand name, followed by the generic name in parentheses.

CAUTION: This information is not complete and should not be used for diagnosis or treatment. For more complete drug information, see <http://www.nami.org/> or <http://www.medscape.com/> (free registration).

ANTI-DEPRESSANTS

There are four general categories of antidepressants used in the treatment of depression and other illnesses that include depression as a symptom. Medications are categorized in each of the following groups based upon the way they work in the body.

Selective Serotonin Reuptake Inhibitors (SSRI)

Celexa (citalopram), Effexor (Venlafaxine), Luvox (Fluvoxamine), Paxil (Paroxetine), Prozac (Fluoxetine), Zoloft (Sertraline)

Atypical Antidepressants

Desyrel (Trazodone) also used for sleep, Serzone (Nefazodone), Wellbutrin (Bupropion)

Tricyclic Antidepressants

Anafranil (clomipramine), Elavil or Endep (amitriptyline), Norpramin (desipramine), Pamelor or Aventyl (nortriptyline), Remeron (mirtazapine), Sinequan or Adapin (doxepin), Tofranil (mipramine), and Triptil or Vivactil (protriptyline)

Monoamine Oxidase Inhibitors (MAOI)

Marplan (isocarboxazid), Manerix (moclobemide), Nardil (phenelzine), Parnate (tranylcypromine)

STIMULANTS

Treat AD/HD. Certain antidepressants with stimulant properties such as Wellbutrin and Norpramine are also used.

Adderall (dextroamphetamine sulfate), Concerta (methylphenidate hydrochloride), Cylert (Pemoline), Dexedrine (Dextroamphetamine), Ritalin (Methylphenidate)

ANTI-ANXIETY AGENTS

Used in the treatment of anxiety disorders.

Ativan (lorazepam), Buspar (buspirone), Centrax (prazepam), Inderal (propranolol), Klonopin (clonazepam), Librium (chlordiazepoxide), Serax (oxazepam), Tranzene (clorazepate), Valium (diazepam), Xanax (alprazolam)

Panic disorder, a sub-category of the anxiety disorders, is often treated with: Klonopin (clonazepam), Paxil (paroxetine), Xanax (alprazolam), Zoloft (Sertraline)

Although not in this class, Tenex (guanfacine, primarily used to treat hypertension) has an unlabeled use for treating ADHD because of its sedative side effects .

ANTI-OBSESSIVE AGENTS

Used to treat obsessive-compulsive disorder (OCD).

Anafranil (clomipramine), Luvox (fluvoxamine), Paxil (paroxetine), Prozac (fluoxetine), Zoloft (sertraline)

ANTI-PSYCHOTIC AGENTS

There are two general categories of anti-psychotics used to treat schizophrenia, and mania that is unresponsive to mood stabilizers. Typical anti-psychotics are the older, less prescribed medications. Atypical anti-psychotics are newer, more frequently prescribed, and generally have fewer side effects. These medications are also sometimes used to treat Tourette's Syndrome and Nonspecific Aggression.

Typical Anti-psychotics:

Haldol (haloperidol), Loxitane (loxapine), Mellaril (thioridazine), Moban (molindone), Navane (thiothixene), Prolixin (fluphenazine), Serentil (mesoridazine), Stelazine (trifluoperazine), Thorazine (chlorpromazine), Trilafon (perphenazine)

Atypical Anti-psychotics:

Clozaril (clozapine), Risperdal (risperidone), Seroquel (quetiapine), Zyprexa (olanzapine)

MOOD STABILIZERS

Used to treat bipolar disorder, aggression, and depression.

Depakote (valproic acid); Eskalith, Lithobid, Lithonate, and Lithotabs (lithium), Lamictal (Lamotrogine), Neurontin (Gabapentin), Tegretol (carbamazepine), Topamax (Topiramate),

ANTI-AGGRESSION AGENTS

Used to treat aggression, irritability, mood instability. Mood stabilizers and anti-anxiety medications are also used as anti-aggression agents.

Catapress (Clonidine-normally for hypertension), Inderal (Propranolol-normally for hypertension or other heart problems)

MEDICATIONS TO TREAT SUBSTANCE ABUSE

Catapress (Clonidine)- nicotine or opioid withdrawal symptoms

Trexan (naltrexone) Patients taking this medicine on a scheduled basis will not experience a high should they use an opioid drug. Also used to treat alcohol dependence. Some psychiatrists prescribe this drug to youth who purposely cut themselves, under the theory that whatever satisfaction the cutting brings might be short-circuited, reducing the youth's incentive for self-injurious behavior.

Antabuse (disulfiram) used in management of chronic alcoholism. Even small amounts of alcohol taken when this drug is in the body will make the patient ill, a severe reaction can be fatal.

Atarax, Vistaril (hydroxyzine) - this antihistamine (allergy drug) is often used to treat nausea & vomiting, anxiety, and psychiatric emergencies including acute alcoholism.

Serentil (mesoridazine) - alcoholism

Dolophine, Methadose (methadone) – treats narcotic withdrawal symptoms, can be habit-forming

Alcohol withdrawal symptoms may also treated with Librium (chlordiazepoxide), Tranzene (clorazepate), Valium (diazepam), Serax (oxazepam)

ALPHABET SOUP

ART	Adolescent Residential Treatment
CAP	Collaborative Assessment Program
CHINS	Child in Need of Services
ED	Emotionally Disturbed
FST	Family Stabilization Team (a home-based service)
IEP	Individual Education Plan
IRTP	Intensive Residential Treatment Program
NAMI	National Alliance for the Mentally Ill
NIMH	National Institute for Mental Health
PAL	Parent Professional Advocacy League
SED	Seriously Emotionally Disturbed

GLOSSARY

Acute

Having a sudden onset and lasting a short time but demanding urgent attention.

Affect

The visible expression of emotion, especially facial expression. "Flat affect" describes a plain, emotionless facial expression and body language.

Assessment

A professional evaluation of the youth's condition and needs. This usually includes a physical exam, mental health and intelligence testing, school performance, and a review of their family situation and behavior in the community.

Case Manager

An individual who organizes and coordinates services for an individual.

Clinician

An individual providing mental health services such as a psychologist, social worker or other therapist as distinguished from a researcher or investigator.

Confidentiality

The limiting of access to a child's records to his/her parents and personnel having direct involvement with the child.

Consent

Informed consent requires that the person giving the permission understand the risks, benefits and possible ramifications.

Crisis Residential Treatment Services

Short term, round the clock treatment provided in an unlocked, non-hospital setting during a crisis. The purpose of this treatment is to avoid hospitalization, stabilize the child and determine the next steps.

Crisis Team

Services available 24 hours/day, 7 days/week during a mental health crisis. The crisis team will determine the severity of the crisis and determine the next steps. Every community is served by a Designated Crisis Team. Also known as Emergency and Crisis Services, Emergency Services Programs; Crisis Evaluation Teams, Emergency Screening Teams.

Day Treatment

Nonresidential, intensive program of mental health services which allow the youth to return home at night.

DSM IV

An official manual describing mental health disorders.

Early Intervention

Recognizing warning signs that a youth is at risk for mental health problems and taking early action to address the problems. Early intervention can help youth get better more quickly and prevent problems from becoming worse.

Evaluation

A process that begins with a professional assessment and results in an opinion about a child's mental and emotional state. May include recommendations about treatment or placement.

Home Based Services

Short term services provided in the home to help a family deal with a youth's mental health problems.

Individualized Education Program (IEP)

A written special education plan which describes a student's individual needs and the special education services that will be provided.

Inpatient Hospitalization

Around the clock mental health treatment in a hospital setting. The purpose of inpatient hospitalization is to stabilize and treat a youth in crisis.

Mental Health

Mental health includes a person's feelings, thoughts and actions when faced with life's situations. It also includes how people handle stress, relate to others, make decisions and see themselves.

Mental Illness

A term usually used to refer to severe mental health problems in adults.

Outpatient

Treatment provided in the community. This can include diagnosis, assessment, family and individual counseling.

Psychological Evaluation

An evaluation that tests a child's intelligence, aptitudes and abilities, social skills, emotional development and thinking skills.

Psychiatrist

A medical doctor specializing in emotional, behavioral and mental disorders. Qualified to prescribe medication and admit to hospitals.

Psychologist

A mental health professional with advanced training who can administer psychological tests, and evaluate and treat emotional disorders. Is not a medical doctor and cannot prescribe medications.

Psychopharmacologist

A psychiatrist who specializes in treating mental health disorders with medications.

Psychosis

A disorder characterized by social withdrawal, distortions of reality and loss of contact with the environment.

Release Form

A consent form signed by a parent, guardian, or the court, allowing treatment, testing, or release of information.

Residential Services

Treatment in a setting that provides educational instruction and 24-hour care for youth who require continuous supervision and care.

Respite Services

Provides short term care for a youth in the home or at another location.

Screening

A preliminary assessment.

Social Worker

A mental health professional trained to provide services to individuals, families or groups.

Support Services

May include transportation, financial help, support groups, recreation, respite services and other services to children and families.

Therapeutic Foster Care

A home with trained foster parents where a youth with emotional disturbance lives and has access to other support services.

Therapeutic Group Homes

Community based, home-like settings providing intensive treatment services, with 24-hour supervision. Services offered in this setting try to avoid inpatient hospitalization and move the youth to a less restrictive living situation.

Transition

The process of moving from one setting to another. Also can mean moving from one activity to another, such as evening to bedtime.

Withdrawing Behavior

Showing a reduced interest in activities and contact with others. Can include absence of speech, regression, fearful behavior, and depression.

Transitional Services

Helps youth move into adulthood or into the adult mental health system. Includes mental health care, supported housing, and vocational services.

Wraparound Services

A full range of services tailored to the needs of a youth and their family. Includes both traditional mental health and support services. Support services are often unique, and address specific sources of stress, for example camp or outward-bound programs, specialized after school care, or an allowance.

RESOURCES

Parent Professional Advocacy League

MA State Chapter, Federation of Families for Children's Mental Health

The Parent Professional Advocacy League is a statewide network of families, local parent support coordinators, and professionals who advocate on behalf of youth with mental, emotional or behavioral special needs. Parent support coordinators advise parents, facilitate parent support groups and participate in special projects that promote youth mental health awareness. Please call for information about standards of care, meeting times, and public policy issues.

59 Temple Place, Suite 664, Boston MA 02111

(617) 542-7860 or (800) 537-0446 <http://ppal.net>

Massachusetts State Agencies

Many resources can be located by beginning at the main website. Look at <http://www.mass.gov/portal/>

The Department of Mental Health (DMH)

Provides individualized clinical care and support. Services include: inpatient services; residential treatment and support; day services; outpatient services; medication management; educational, employment and rehabilitation opportunities for adults; and coordinated interagency programs and family and school supports for children and adolescents. For info and referrals call (800) 221-0053 <http://www.state.ma.us/dmh/>

The Department of Medical Assistance (DMA)

Administers MassHealth program. Through MassHealth, DMA offers a broad range of health-care services. Qualified MassHealth members may be able to get doctor visits, prescription drugs, hospital stays, and many other important services. Families who do not qualify by income may be able to "buy in" to the program to obtain secondary insurance to help with a special needs child's special medical expenses, such as copays and extended mental health services. (800) 841-2900 or visit <http://www.state.ma.us/dma/> or <http://www.state.ma.us/dma/>

Commonhealth

Supplemental Insurance through MassHealth, see the DMA website. (800) 322-1448

The Department of Mental Retardation (DMR)

Provides services to youths with certain disorders. (617) 727-5608 or <http://www.dmr.state.ma.us/index.htm>

The Department of Social Services (DSS)

To report abuse/neglect or for info on foster care/adoption call 1-800-KIDS-508
Families may also call for help or advice. <http://www.state.ma.us/dss/>

The Department of Public Health (DPH)

(617) 624-6000 <http://www.state.ma.us/dph/>

The Department of Youth Services (DYS)

Provides services for some youths (617) 727-7575

The Department of Education (DOE)

Ask for info and note phone number of relevant office at
(781) 338-3700 or search <http://www.doe.mass.edu/>

Massachusetts Division of Insurance (DOI)

Consumer helpline (617) 521-7777 or <http://www.state.ma.us/doi/>

Massachusetts Rehabilitation Commission (MRC)

assistance with transition to adult independence or adult systems of care (617) 357-8137 or
(800) 245-6543 <http://www.state.ma.us/mrc/>

Department of Transitional Assistance (DTA)

Food stamps and more (800) 445-6604 <http://www.state.ma.us/dta/>

Service Providers & Treatment

Advice to Parents: In an emergency, go to the nearest hospital emergency room or call 911. You can request an ambulance, and if needed you may request law enforcement assistance as well. Your child does not need to be physically sick to warrant emergency attention and/or hospitalization. Any child who is a danger to himself or others, and/or is having a disorganized or dangerous train of

thought, warrants psychological evaluation on an emergency basis, perhaps followed by hospitalization.

Families should check with their insurance company about outpatient and inpatient providers (please see the insurance section, above). Some hospitals and schools provide intensive, specialized treatment. You may also call the state agencies to request assistance or apply for services.

Insurance & Financial Resources

Children's Medical Security Plan

provides free or low-cost health insurance to Massachusetts residents under the age of 19 who are ineligible for MassHealth. 800-909-2677 <http://www.cmspkids.com/>

Supplemental Security Income (SSI)

Pays money to some families with children who are disabled or hospitalized long-term, as in a residential treatment program lasting over 12 months (800) 772-1213
<http://www.ssa.gov/notices/supplemental-security-income>

Healthcare for All

Help with insurance, Medicaid and health care questions (617) 350-7279
<http://www.hcfama.org>

Education/School

Massachusetts Association of 766 Approved Private Schools

To obtain the MAAPS Directory of Member Schools call (781) 245-1220
Or free download from their site at <http://www.spedschools.com>

Information & Support Groups

AL-ANON/ALATEEN

support groups for family members of alcoholics or others with addiction problems
(781) 843-5300 <http://www.al-anon.org/>

Alcoholics Anonymous

(617) 426-9444 <http://www.alcoholics-anonymous.org/>

National Alliance for the Mentally Ill (NAMI)

A support and information organization for the mentally ill and their families. Offers free classes, printed materials, and a website rich with clear information about mental illness.
(800) 370-9085 <http://www.nami.org>

Minuteman Attention Deficit Information Network (AD-IN)

Parent Support Network (978) 369-3785 781-455-9895 <http://www.addinforonetwork.com/>

Families Organizing For Change

Family support/advocacy for children with developmental disabilities (800) 406-3632
<http://www.communitygateway.org/mfofc/>

Federation for Children With Special Needs

Special education, free parent training, and advocacy referrals for families. Website with extensive links to other projects, organizations, legislative links, and sources of information. (800) 331-0688 (617) 236-7210 <http://www.fcsn.org>

Federation of Families for Children's Mental Health

National advocacy organization (703) 684-7710 <http://www.ffcmh.org>

Learning Disabilities Association of Massachusetts

(781) 891-5009 <http://www.ldam.org>

LDA (Learning Disabilities Association) of America

4156 Library Road, Pittsburgh, PA 15234-1349
(412) 341-1515 <http://www.ldanatl.org/>

Massachusetts Eating Disorders Association

(617)558-1881 <http://www.medainc.org/>

National Center for Post-Traumatic Stress Disorder

Originally created by congress, this organization provides information on PTSD in children and other civilians as well as in military experience.(802) 296-5132 <http://www.ncptsd.org/>

NICHCY National Information Center for Children and Youth with Disabilities

PO Box 1492, Washington DC 20013-1492
Provides information on disabilities and related issues for families, educators, and other professionals. Much of the information is free or inexpensive, some downloadable. Comprehensive.
1-800-695-0285 (Voice/TTY) OR (202) 884-8200 (Voice/TTY) <http://www.nichcy.org/>

National Mental Health Association

Info Line (800) 969-6642 <http://www.nmha.org/>

National Institute for Mental Health (NIMH)

Well organized and presented searchable site, with sections on research, clinical trials, information about the disorders, about conferences, and more. <http://www.nimh.nih.gov/>

NLDline

All about Nonverbal Learning Disorders (860) 693-3738 <http://www.nldline.com/>

Nonverbal Learning Disorders Association

(860) 570-0217 PO Box 220, Canton, CT 06019-0220, <http://www.nlda.org>

Parents Helping Parents

Help with parenting issues (800)882-1250 <http://www.php.com>

Sensory Integration Network

The KID Foundation, 1901 West Littleton Blvd, Littleton, CO 80120 <http://www.sinetwork.org/>

Legal**Disability Law Center**

Information and free legal assistance to people w/disabilities (617) 723-8455

MASS Advocacy Center

100 Boylston ST, 2nd floor, suite 200, Boston MA (617) 357-8431

Mental Health Legal Advisors Committee

State agency within the Supreme Court offers legal advice, information and referral service for people with mental disabilities and their families. (617) 338-2345 www.state.ma.us/MHLAC

Professional Innovators

The Amen Clinic, and their websites <http://www.amenclinic.com/ac/default.asp> and <http://www.brainplace.com/bp/default.asp>

BrainPlace.com has information about new research on brain differences of persons with emotional and behavioral disorders, and the effects of substance abuse on the hardware of the brain. Medical images that demonstrate this correlation are displayed.

Amenclinic.com is a link to the California clinic and research lab that publishes all this, and outlines their innovative treatment approaches.

Bob Brooks Ph.D.

Lectures/titles available include "Angry, Disruptive, and At-Risk Students: Strategies for Fostering Self-Esteem and Resilience" <http://www.drrobertbrooks.com/>

The Memphis Police Crisis Intervention Team is a community based program targeted to respond to crisis events. In 1988, the Memphis Police Department joined in partnership with the Memphis chapter of the Alliance for the Mentally Ill, mental health providers, and two local universities; the University of Memphis and the University of Tennessee. Info is available for interested communities by contacting Major Sam Cochran.

[http://www.memphispolice.org/communit.htm#Crisis Intervention Team \(CIT\)](http://www.memphispolice.org/communit.htm#Crisis%20Intervention%20Team%20(CIT))
or call 901-545-5700 Memphis Police Dept, 201 Poplar, Memphis TN 38103

Judy S. Freedman, M.S.W., L.C.S.W., "Easing the Teasing"

write PO Box 471, Glencoe, IL, 60022 or <http://www.easingtheteasing.com>
Website has strategies children can use to cope with teasing

Ross W. Greene, Ph.D.

Author of The Explosive Child, about easily frustrated, inflexible children.
<http://www.explosivechild.com>

Sue Thompson

Author of The Source for Nonverbal Learning Disorders, available from LinguiSystems, Inc.(800) 776-4332 <http://www.linguisystems.com/>