

A large, faint watermark of a police badge is centered on the page. The badge is shield-shaped with a crown on top and the word "POLICE" written across the middle. The watermark is light gray and serves as a background for the title text.

Police Pocket Guide

Responding to Youths with Mental Health Disorders

Parent/Professional Advocacy League (PAL)

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 on Mental Illness (NAMI), the National Information Center for Children and Youth with Disabilities (NICHCY), the National Institute for Mental Health (NIMH), Sensory Integration Network (SI Network), Police Executive Research Forum (PERF), The American Academy of Child and Adolescent Psychiatry, and the Massachusetts Department of Mental Health.

Initial development and printing of this publication was funded by a grant from the Massachusetts Department of Mental Health.

Current revision and printing of this publication was funded by grants from The Boston Foundation and the Massachusetts Behavioral Health Partnership (MBHP).

The original publication was created with aide and guidance from Wayside Youth & Family Support Network. This revised edition was produced with aide and guidance from the Parent Professional Advocacy League (PAL).

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POLICE POCKET GUIDE RESPONDING TO YOUTHS with MENTAL HEALTH NEEDS

Full Version

DEDICATION

This Pocket Guide is dedicated to all the police officers of Massachusetts who serve and protect our homes, our communities, your courage, wisdom and you for your understanding, interventions on behalf of health needs.



cated to all the police officers and protect our and our families. We honor and dedication. We thank respectful and life changing our youth with mental

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.

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ABOUT MENTAL ILLNESS

Dispelling Myths about Mental Illness

Mental illness is not a result of weak character or lack of intelligence; in fact, many well known and accomplished people have mental health problems, such as bipolar disorder or depression. Neither should it be assumed that youths with mental health needs have been abused, since many come from loving families.

**Mental Illness
Can Affect
Anyone**

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 emphasizes the possibility for healing with proper treatment.

Behaviors are Medical Symptoms

Mental illness is biological, caused in part by an imbalance of brain chemicals and a disability that interferes with perception, judgment, behavior, and relationships with others. Many individuals' mental health needs are episodic, meaning they experience good and bad days or months. On good days or months, symptoms may be undetectable, but on bad days or months, symptoms may be impossible to control. Sometimes mental health needs will emerge suddenly, but they usually develop over a period of time. This slow onset causes many youths to go undiagnosed until adolescence or young adulthood when their symptoms worsen. At any given time, one in five young people is suffering from a mental health problem. Two-thirds of those youths have not been diagnosed, or are not getting the help they need. Sadly, as a result, these youths may experience a lifetime inability to function appropriately in work, family, or every day life. This loss in human potential can result in a long-term drain on public resources.

Therefore, when an officer encounters a youth with extreme or dysfunctional behaviors the officer should consider the possibility of an undiagnosed mental health disorder and refer the youth for a professional mental health evaluation.

Mental Health Needs Cured by Treatment, Not Punishment

All types of mental health needs can be diagnosed and effectively 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 a youth with mental health needs. Clear communication from the officer will help the parent to stay calm and be supportive as the officer interacts with the youth.

Families Provide Valuable Information

A parent knows his or her own child best and can assist the officer by providing information about the youth's illness and behaviors. Additionally, the parent may have previously experienced similar situations and may be able to advise the officer about approaches that could calm the youth or provoke a "fight-or-flight" response. Knowledge of the youth's interests and strengths is useful during the intervention, as well.

Investigate Medication Compliance

Most youths with mental health needs are prescribed medications, but may not take them. A non-compliant youth may dislike the side effects, prefer the "high" of mania, or deny they are ill. Some youths may also misuse certain medications hoping to lose weight or get high. Therefore, the officer should ask about medication compliance, as refusal or misuse of his/her medications may explain the youth's inappropriate behaviors. However, the law does not require people with mental health needs to take their medications unless they are a danger to themselves or others.

Advice for Officers to Give to Parents

In an emergency, take your child to the nearest hospital ER or call 911.

You can request an ambulance, and if needed, police assistance and/or a crisis team. Your child does not need to be physically ill to warrant emergency attention. As mentioned above, any child who is a danger to himself or others, or is having a disorganized, delusional or dangerous train of thought, should receive an emergency psychological evaluation, perhaps followed by hospitalization.

OFFICER AS AGENT FOR CHANGE

Officer Assisted VS Officer Initiated Evaluation

In some cases, it may be unclear if a youth has a mental health need. 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.

Any child who is a danger to himself or others, or is having a disorganized, delusional or dangerous train of thought, should receive an emergency psychological evaluation, perhaps followed by hospitalization.

Arrest VS Evaluation

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 commu- nity's zero tolerance policy, or assume that the officer will not understand 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 or harm, but to help.**

1. Officers can Interrupt a Cycle of Deteriorating or Self-Destructive Behavior. The presence of such behavior is frequently the cause of the officer's presence on the scene.

2. Officers can Demonstrate a Constructive Attitude. Officers can teach families and youths by modeling an attitude of acceptance of behaviors as symptoms, of the youth as a valid human being, and through explaining the hopeful outcomes treatment can bring.

3. Officers can Refer to Evaluation, Treatment, or Other Relevant Resources.

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PUBLIC SAFETY

Best Served Through an Informed Approach

No Increased Danger Compared to General Population

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 youth who is severely ill 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 youth with mental health needs, 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.

Use of De-escalation Techniques is Essential When Responding to Disoriented or Agitated Youths.

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.

Officer Evaluation of Potential for Harm

Even if an officer feels no threat to his or her own safety, the officer must keep on guard to the possibility that a youth with mental health needs 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.

A Cautious and Sensitive Interaction that Modifies Standard Procedures Can Be Less Threatening, De-escalate Tensions and Increase the Likelihood of a Successful Outcome.

ON-SCENE ASSESSMENT

Substance Abuse as Symptom of Mental Health Need

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. In other words, youths with mental health needs will sometimes turn to alcohol or illegal drugs as a way to treat and cope with their symptoms. Fortunately, there are clues to help police evaluate and properly respond to the conduct of youth with mental health needs.

Involuntary behaviors such as impulsiveness and flawed thinking are recognized symptoms of mental health needs, and are worsened by substance abuse. When substance use is evident, an informed and compassionate approach will increase the likelihood of a safe and effective intervention. Again, we encourage the officer to consider referring the family to evaluation, treatment, or other relevant resources.

OBSERVATIONS THAT MAY SIGNAL PRESENCE OF MENTAL HEALTH NEED

Please see the disorders section for more observations.

- History of mental health problems, and/or possession of psychiatric medications
- A wooden, emotionless facial expression and body language (see “flat affect” in glossary)
- Incoherent thoughts or speech
- Inability to focus or concentrate
- Bizarre appearance, movements or behaviors
- Tantrums or acting younger than chronological age
- Delusions of personal importance or identity; unrealistic overconfidence; hypersexuality (see glossary)
- 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.

- Be patient and stay calm.
- Be friendly and accepting but remain firm and professional.
- If possible, meet unmet basic needs such as offering food or juice.
- Remove upsetting influences, distractions, and people from the scene. (Loud noises, flashing lights, unfriendly or prying bystanders)
- Recognize that the youth may be overwhelmed by sensations, thoughts, surroundings, frightening beliefs, internal sounds or voices.
- Gather information from family or bystanders. Ask those who know the youth about any approaches that have calmed or escalated situations in the past; the youth's likes and dislikes; and, what precipitated the crisis.
- Do not move suddenly, shout or give rapid orders. Only one person should talk to and direct the youth.
- Announce your actions before initiating them.
- Speak simply and briefly, avoiding use of clinical jargon.
- Indicate that you are trying to understand. Reassure the youth that you are there to help, not harm.
- 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.
- Do not express anger, impatience, contempt or irritation.
- Ask youths how they feel and encourage them to speak out to others as well about their feelings and needs.
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.
- Understand that you may not have a rational discussion, but try to keep conversation concrete by redirecting the topic when needed.
Respond to a delusional youth's feelings rather than to delusional content.
- A police uniform and equipment, multiple officers, or flashing lights are likely to frighten the youth, and produce increased agitation or a fight-or-flight response.
- Do not force discussion or assume that an unresponsive youth cannot hear you. They may not understand or may be unable to respond.

- 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.
- Use the minimal amount of restraint necessary to ensure the youth’s safety, incorporating techniques to decrease sensory overload and redirect the youth’s attention.
- Use referral to help connect youths to peers and mentors in the community.

Specialized Techniques for Responding to Youths with Reactive Attachment Disorder (RAD) (See the disorders section for a more complete explanation)

- These youths feel safest when you clearly maintain your role and boundaries as a law enforcement officer, especially if the youth tries to control the encounter or manipulate the officer.
- Even though they may avoid eye contact, these youths will feel safest if you maintain eye contact when speaking to them.
- If the youth is inappropriately demanding or clingy, direct the youth to stand or sit in a specific area.
- Redirect and then ignore nonsense speech and persistent chatter.
- Give clear, concise directions and behavior guidelines.
- If the youth is clearly lying, remind the youth that truth is healthy and that you only want to hear things that are real..
- When confronted with destructive or cruel behaviors be clear that they are not safe and not OK.
- When confronted with a panicked youth who is in “fight or flight” mode, de-escalate and diffuse emotion as much as possible. Officers who must pursue such youth are usually more successful approaching them on foot than in a vehicle, since the youth feels less threatened.
- Avoid repetition of the child’s name as this may trigger memories of past abuse.
- Reassure the youth in brief phrases that they are safe and that you will help them.

DISPOSITION OPTIONS

1. Support Parent Wishes

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

Officers Are Most Effective With Parents When They

- Approach with acceptance rather than blame or judgement
- Respect that parents need help
- Diffuse emotions by voicing understanding that they are going through a difficult time.

2. Officer Initiated Psychiatric Evaluation

If the youth is a danger to him/herself or a serious threat to others the officer is encouraged to initiate a mental health evaluation .

An evaluation performed by a mental health professional 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. (See "Treatment Plan" in Glossary)

When an officer determines a professional mental health evaluation is needed the officer may choose (in accordance with local policy) 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.
- Other appropriate action that complies with local standards and procedures.

FACTS AND IMPLICATIONS

- A police officer's ability to recognize symptoms of mental illness can be invaluable when assessing a scene.
- A sensitive intervention by a police officer can be a reassuring and steadying influence on a mentally struggling youth.
- Desperate parents can be guided to appropriate community resources by a knowledgeable officer.
- 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 since psychiatric medications are often withheld.
- At any given time, one in every five young people is suffering from a mental health problem. Two-thirds of those youths have not been diagnosed, or are not getting the help they need.
- Four out of every five runaway youths suffers from depression. (US Select Committee on Children, Youth & Families).
- Suicide is a serious concern: the 3rd leading cause of death for 15-24 year olds (approx. 5,000 youths each year) and the 6th leading cause of death for 5-15 year olds. Tragically, the rate of youth suicides has nearly tripled since 1960.
- These youths are sick and often scared and do not know what to do.

ABOUT SUICIDE

Fear of their child committing suicide is a parent's nightmare, and families suffer emotionally and experience "second hand" trauma by observing the ongoing suffering of their troubled youth. Their fears are not groundless – according to the American Association of Suicidology (AAS), in 2004 in the US suicide ranked the third leading cause of death in young people ages 15-19 and ages 15-24, and that year 283 children ages 10-14 completed suicide. They report that for every completed suicide, 100-200 attempts are made.

“Not all adolescent attempters may admit their intent. Therefore, any deliberate self-harming behaviors should be considered serious and in need of further evaluation.”

Risk Factors for Suicide in Youths

The following risk factors for suicide in youths were gleaned from AAS and NAMI informational publications.

- Presence of a psychiatric disorder (e.g., depression, substance abuse, conduct disorder e.g., runs away or has been incarcerated)
- Thoughts of suicide, death, dying or the afterlife (in a context of sadness, boredom, hopelessness or negative feelings)
- History of previous suicide attempts or self-harm
- Impulsive and aggressive behavior, frequent expressions of rage
- Feelings of hopelessness
- Easy access to lethal methods especially firearms
- History of physical or sexual abuse (the youth may not admit to or recall the abuse)
- Exposure to another's suicidal behavior
- Family history of suicide
- Recent severe stressor (e.g., difficulties in dealing with same-sex sexual orientation; unplanned pregnancy, legal trouble, significant real or anticipated loss, etc.)
- Family instability, significant family conflict
- Parental mental illness or dysfunction
- Impaired parent-child relationships
- History of recent interpersonal conflicts of any sort
- Disconnected from school or work, socially isolated

Officer Demeanor Important in Managing Suicidal Youths

Most important in managing a suicidal youth is an officer's willingness to listen. According to the AACP, "asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than putting thoughts in the child's head, such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems." Youths with mental health needs report that an officer who treats that youth with respect, empathy and realistic encouragement can give them new hope and perspective.

Observations that Signal Potential for Self-Harm or Suicide

In addition to the risk factors, the following observations signal the need for professional evaluation. Some are taken or abstracted from AAS fact sheets, NAMI publications, and the AACAP Teen Suicide Fact Sheet (AACAP, The American Academy of Child and Adolescent Psychiatry):

- A history of previous self-harm
- Current thoughts about wanting to die, to commit suicide, and/or intent to commit suicide (called suicidal ideation)
- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there’s no way out
- Self-medication with alcohol or drugs
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood or personality changes
- No reason for living; no sense of purpose in life
- Unusual neglect of personal appearance
- Loss of interest in pleasurable activities
- Not tolerating praise or rewards
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Verbal hints such as “I won’t be a problem for you much longer”
- Puts affairs in order such as giving away or throwing out important belongings
- May feel that they can’t
 - stop the pain
 - think clearly
 - make decisions
 - see any way out
 - sleep, eat, or work
 - get out of the depression
 - make the sadness go away
 - see the possibility of change
 - see themselves as worthwhile
 - get someone’s attention
 - seem to get control

De-escalation of environmental stressors and tensions are especially important if disorientation, increasing agitation or self-abuse are observed.

MENTAL HEALTH DISORDERS

Our fast paced, competitive contemporary culture makes childhood and adolescence a more complex, confusing and dangerous experience than ever before. Research has shown that prolonged stress can create changes in the brain and its function. Furthermore, there is a hereditary connection for many mental health disorders. They 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 associated specific brain differences with certain mental health disorders.

The following pages describe some of the most commonly diagnosed mental health and related disorders. These descriptions are intended 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, special education services, and/or a specialized school setting.

Panic Disorder

Panic attacks are instances of extreme fear, usually with a sense of looming danger and a 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 focus on 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.

Trauma or Post-Traumatic Stress Disorder (PTSD)

Also see the section on Dissociative Disorders.

Trauma is Defined as Psychical or Emotional Injury.

Although much of the literature still refers to PTSD as applying to adults and children equally, many families and providers now prefer to say “they show signs of trauma” or “traumatic stress” when speaking of children and youths.

These symptoms can (but youth has been exposed to may encounter many types these may provoke behavior-stress. Even observing a trauma can produce observer.

Youths with this disorder are known to have an elevated suicide rate.

do not always) occur when a traumatic event. Officers of trauma in families; any of iors related to traumatic someone else experiencing “secondary trauma” in the observer.

The youth reacts with intense fear or helplessness to experiencing, witnessing, or learning of event(s) involving serious injury to self or others, ranging from the death of a pet or grandparent, painful medical treatments, viewing the televised coverage of hurricanes or terrorist attacks, being bullied by peers, or chronic belittling, physical, or sexual abuse.

A youth with trauma 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.
- 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.
- 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.

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

The following information is abstracted from multiple sources including *Trauma and Recovery* by Judith Herman M.D., and “Understanding and Dealing With Secondary Trauma in Children”_by Michael G. Conner, Psy.D..

Trauma has Wide Reaching Effects: Officers may Observe These Warning Signs of Trauma

- Altered states of consciousness including, memory lapses or amnesia, hysteria, a feeling of numbness or feeling one is dissolving or in a dream, trance states possibly even becoming numb to physical pain, seeming to relive events (flashbacks), confused, fragmented or conflicting story told, multiple personality, may split into a “good” and a “bad” self, “doublethink” (a youth’s way of forgetting, excusing or discounting abuse, in order to “get by”)
- Attempts to hide abuse or keep it secret; denial
- Agitation, tense muscle tone
- Regressive behaviors such as clinging, thumb sucking or bedwetting
- Low self-esteem, feels shame, worthless or unlovable
- May show a false front or self to to hide low self esteem
- Blames self for abuse, believes they are “bad”
- Judgment clouded by self-hatred and habit of obedience, may allow self to be harmed
- Attempts to be inconspicuous: may freeze in place, crouch, roll up in a ball, or keep face expressionless
- Attempts to appease abuser and other authority figures, may desperately “try to be good”
- Social isolation enforced by the abuser to preserve secrecy and control
- Compulsive risk-taking
- Self-medication with alcohol or illegal drugs
- Runaway attempts may begin by age seven or eight.
- Self-harming – may be used to relieve emotional pain or counter a sense of unreality
- Sexual promiscuity
- Unstable relationships with peers, abusive romances
- Physical complaints that may stem from stress, such as headaches, stomachaches, sleep disorders, even seizures
- Anxiety Disorders, Anorexia, or Depression
- Suicidality

Responding to Youths with Trauma

- Listen and allow the youth to tell it their way.
- The youth may use defiance or opposition as a form of self-preservation.
- Speak to the youth appropriately for their age level, or even more simply, as stress decreases the ability to take in information. Their emotional age may be younger than their chronological one.
- Younger children may be better able to express their feelings and experiences with the help of a play therapist using drawing and role-playing with dolls or puppets.
- Be interested in what youths tell each other.
- Don't argue about matters of opinion but do offer clear options to help them understand.
- Explain to the youth what is going on and what will happen next.
- Recognize your own feelings: if you are angry (even if you are angry at an abuser) the youth will assume you are angry with him/her and may disintegrate further.
- Perpetrators of abuse are likely to maintain and enforce secrecy, attempt to undermine the victim's credibility, and offer denial and excuses for signs of abuse.
- If a youth must be removed from the home, suggest that they bring along a treasured possession and a photo of someone special to them.

Perspectives on Trauma

Since youths who have been abused typically have been dependent on their abusers for survival, they are often loyal and devoted to their abusers, take their sides, and support their stories.

Survivors of abuse typically feel powerless to change or be different.

Only a very small percentage of youths with trauma will become aggressive, delinquent or homicidal; most will turn aggression inward, often with self-destructive behaviors done in secret.

Artistic and creative expression of all kinds is thought to be especially therapeutic for trauma survivors. Encourage the youth to develop a well-rounded life by forming friendships, developing hobbies and skills, and connecting with mentors to provide ongoing support, and provide referrals to these re-

Supportive interaction with an officer can help an isolated youth feel a greater sense of belonging to the wider community and self-worth. Youths and their families will feel safest when the officer maintains a clearly defined role as peace officer. Youths should be guided to look to appropriate community resources.

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
- 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 common events or activities. School work, homework, and peer relationships are common stressors. 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 youth with bipolar disorder experiences highs (mania) and lows (depression) with normal moods in between. They tend to have poor judgment, are easily swayed by others, and are less mature than their peers. Their 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.

During manic phases an adolescent may exhibit a number of "hyper" characteristics, including: 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.

A younger child's symptoms often differ from those seen in adolescents, with periods of extreme irritability, agitation, or hostility during a manic phase.

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 disorder will often refuse medication once their symptoms are controlled, believing they no longer need it. 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 section about depression, for a description of the "lows" of Bipolar Disorder.

Depression / Major Depression

Clinical depression goes well beyond sadness, and is much more than having a bad day or coping with a major loss. Youths 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 despair or 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 antidepressant medications. Supportive relationships with caring adults and the development of the youth’s strengths and abilities are two important factors in successful treatment of depression. 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 often stemming from psychosis (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. Spoken language may be perceived as garbled, 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 youth with schizophrenia 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. According to NIMH, “There is a high rate of self-injury without suicide intent, as well as a significant rate of suicide attempts and completed suicide in severe cases. Patients often need extensive mental health services, and account for 20 percent of psychiatric hospitalizations.”

Dissociative Disorders

This group of disorders is believed to be a response to trauma, as the affected 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.

Reactive Attachment Disorder

Abstracted from information, including a fact sheet by AACAP, and experiences of parents with children with RAD.

Reactive Attachment Disorder (RAD) is a rare, complex, and severe illness stemming from ineffective bonding, or attachment, between a child and their mother or other primary caregiver. It can be brought on by anything from an abrupt change in a day care provider, upon whom the child was emotionally dependent, to the death of the mother, multiple foster care placements, or being raised with an ineffective parenting style. Signs are difficult to isolate as they are similar to that of some other disorders; diagnosis must be made only after a complete and professional evaluation.

Infants may display tactile defensiveness (flinching or startling when older than 8 weeks), increased muscle tension, poor eye contact and sucking response, do not return a smile, and may be self abusive (head banging, etc).

Older children and youths typically do not trust and resist control by their parents or primary caregiver. They carry intense suppressed rage and find many ways to punish their caregiver. If abused, they may blame the parent who failed to protect them more than they blame their abuser. These youths may display the following symptoms:

- superficially engaging and charming
- lack of eye contact
- Indiscriminately affectionate with strangers,
- Lack of ability to give and receive affection on parent' terms – not cuddly
- Inappropriately demanding and clingy
- Intentionally destructive to self, others and property; accident prone
- Cruelty to or killing of animals and even other children
- Obvious lying
- Stealing
- Poor impulse control, may appear hyperactive
- Learning delays
- Lack of cause and effect thinking
- Lack of conscience
- Abnormal eating patterns and speech patterns
- Abnormal elimination patterns, may wet or soil themselves
- Poor peer relationships
- Preoccupation with fire, blood & gore
- Persistent nonsense questions and chatter
- Tries to take control openly or in sneaky ways
- Sets adults against one another, manipulative
- False allegations of abuse
- Parents may appear angry or hostile (due to always being under attack from their child)

Adopted children are at a higher than usual risk of developing RAD. With appropriate parenting techniques and treatment, which usually include treating and training the family or caregiver along with the youth, the youth can often recover and have healthy, satisfying relationships. Referral for a thorough evaluation is essential.

There are special techniques for responding to these youths, please see the Clinical Recommendations section of this guide.

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 youths with ODD 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 as sick due to mental illness. 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 distrustful. 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 needs.

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 youths 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) or a new, non-stimulant medication called Strattera, 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, mostly seen in girls, are intentional but non-life threatening attempts to escape psychological pain by inflicting physical pain. This is done solely for the self-injurer, and 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, other people may be unaware the youth is self-injuring. "Cutters" tend to make many shallow cuts in hidden areas. Wearing long sleeves or pants in hot weather may be a clue that a youth is self-injuring.

Youths who practice intentional self-harm need professional intervention, including evaluation of potential suicidality, and should be screened for trauma. They also need support and understanding from family and friends. Psychiatric medications may help with co-occurring symptoms of depression or anxiety.

Eating Disorders

The three 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. Although underweight, the anorexic youth sees herself as fat. Her distorted body-image contributes to 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. **A severely underweight youth who is not receiving or complying with medical treatment for their eating disorder is experiencing a medical emergency.**

Other Neurological Disabilities

Although neurological disabilities are not specifically mental health problems, they are also caused by differences in the brain. Youth who struggle with neurological disabilities may display unusual behaviors caused by their impaired perceptions, and are at increased risk for developing a mental health disorder. The neurological disabilities below are just a sample of the many types officers may encounter.

Central Auditory Processing Disorder (CAPD)

The child hears, but has a problem understanding what is said. They may be a "poor" listener, frequently misunderstand speech, and have difficulty following directions. Their ability to take in and learn information may be impaired by this. Officers should not assume that disobedience is deliberate. They need simple, clear instructions with reduction of both background noise and of visual distractions.

Autism and Asperger's Disorder

These two related disorders are part of a larger group of disorders called Pervasive Developmental Disorder or PDD, associated with varying levels of dysfunction in social interactions and ability to communicate. They also may display restricted and/or repetitive patterns of behavior, interests, and activities.

Autistic Spectrum Disorder (ASD)

This term encompasses both Autism and Asperger's Syndrome. See below for how Asperger's is distinguished from Autism.

Many children with autism also have mental retardation. Typically they avoid eye contact or physical contact, use repetitive motions, and are distressed by changes in routine. In addition, they may become overloaded by sensory input from any of the five senses. They are often unable to interpret what others are thinking or feeling and frequently misunderstand or "miss" clues such as tone of voice or body language.

Youths with ASD often have difficulty regulating their emotions. Officers may observe crying, verbal outbursts, disruptive or physically aggressive behavior, or tantrums, particularly when these youths are in a strange or overwhelming environment, when angry and frustrated, or even during transitions (see glossary). At such times they may break things, attack others, or hurt themselves. In their frustration, some bang their heads, pull their hair, or bite their arms.

These youths often have difficulty understanding and complying with social expectations and are rarely competent to remain unsupervised. They may wander away from home without regard for their own safety, remove their clothing, pick up objects that attract them, and otherwise require containment and protection. These youths will often be motivated or calmed by special phrases or certain treats, and officers are encouraged to seek such information from those who know or routinely care for the youth. Officers are encouraged to use all the de-escalation procedures mentioned in the earlier portion of this guide when called to assist such youths, and to return them to an appropriately supervised setting.

Asperger's Disorder or Syndrome

Youths with this disorder experience a lack of social skills and difficulty with social relationships; poor coordination and concentration; and a restricted range of interests. They may avoid eye contact and physical touch. Unlike youths with Autism, their intelligence is normal or above normal, they normally are able to read, and their language skills are adequate in the areas of vocabulary and grammar. They may have a remarkable talent in one specific area, such as math, sculpture or playing piano. However, these youths may have difficulty understanding subtleties of communication such as body language, irony and humor. Asperger's is sometimes incorrectly referred to as "high-functioning autism."

Officers may encounter youths with Asperger's Syndrome who have been fooled or harmed by others, or who are having difficulty negotiating a new situation or environment. A high level of frustration can produce outbursts; however, these youths often learn to manage themselves socially by learning rules and their applications. When called to assist such youths, officers are encouraged first to use de-escalation procedures. Second, to ask the youth who the officer can contact to learn more about their needs. This contact can help the officer determine if the youth should be returned to a more supervised setting or can be released with some simple reorientation.

Officers are encouraged to speak simply and directly, knowing that whatever they say will likely be accepted by the youth as literally true, and likely be remembered forever.

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 youths have difficulty both with unfamiliar 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 Processing Disorder (SPD)

Previously called Sensory Integration Dysfunction, these youth process sensations inaccurately, in a way that causes either over-sensitivity or under-sensitivity to stimulation. They may also be uncoordinated or clumsy.

Over-sensitive youth may react negatively to motion, loud or busy environments, bright light, touch, or smells. Reactions may include aggression, withdrawal, or even nausea. Companions and bystanders may be unclear about the cause of the youth's distress.

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, touch others too much or too hard, or even hurt themselves without noticing. These reactions may become evident at a very young age.

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

Tourette's Syndrome (TS)

Tourette's syndrome (TS) is a neurological condition rather than a learning disability or a mental health disorder. However, youths with TS are prone to co-occurring mental health needs including OCD, other anxiety disorders, and ADHD.

Symptoms, called "tics", are involuntary and range from mild to severe. They include movements (such as blinking, twitching, or spitting) and vocalizations or verbal outbursts (such as throat clearing, barking, or swearing). These involuntary behaviors can result in rejection by peers and adults alike. Social rejection and other stresses often escalate the intensity, frequency and variety of tics, worsening both symptoms and isolation.

Treatments include relaxation techniques, and medication for especially bothersome tics. Officers who encounter such youths can adjust environmental factors (lighting, noise) to reduce stress; a youth who spits may be able to redirect if offered a cup or container.

PSYCHIATRIC MEDICATIONS

Many medications effectively reduce and control the symptoms of psychiatric disorders. Together with counseling, they help youths function more successfully at home, in school, and socially.

Effects of some medications can be altered by substances such as certain foods, caffeine, herbs, and tobacco. Some medications have side effects like sedation, agitation, impaired coordination, tremors or spasms, weight changes, or nausea. Some of these medications also have a potential for abuse.

A partial list of commonly prescribed medications follows. Many are used to treat more than one type of disorder. Each is listed by its brand name, followed by the generic name in parentheses. For more complete drug information, see <http://www.nami.org> or <http://www.medscape.com> or MassMedline at www.massmedline.com (their # 866-633-1617) or contact a pharmacist or a psychiatrist.

WARNING: This information should not be used for diagnosis or treatment.

ADHD Medications (Stimulants)

Treat AD/HD, may improve attention span or self-control, potential for abuse.

- Adderall (dextroamphetamine sulfate)
- Concerta (methylphenidate sustained-release)
- Dexedrine (dextroamphetamine)
- Focalin (dexmethylphenidate hydrochloride)
- Metadate (methylphenidate)
- Ritalin (methylphenidate)

Certain antidepressants with stimulant properties such as Wellbutrin and Norpramine also treat ADHD.

Nonstimulant ADHD Medications

- Strattera (atomoxetine)
- Catapres (clonidine HCL)

Antidepressants

There are five 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.

- Celexa (citalopram)
- Cymbalta (duloxetine)
- Desyrel (trazadone)
- Effexor (venlafaxine)
- Lexapro (escitalopram)
- Paxil (paroxetine)
- Prozac (fluoxetine)
- Remeron (mirtazapine)
- Serzone (nefazodone)
- Wellbutrin (bupropin)
- Zoloft (sertraline)

Mood Stabilizers

Used to treat bipolar disorder, aggression, and depression. Some also treat epilepsy.

- Depakote (divalproex)
- Eskalith, Lithonate, Lithotabs (lithium)
- Lamictal (lamotrigine)
- Tegretol (carbamazepine)
- Topamax (topiramate)
- Trileptal (oxcarbazepine)

Anti-psychotic Agents

Anti-psychotics treat schizophrenia, and mania that is unresponsive to mood stabilizers. The two general categories include the older, less often prescribed Typical Antipsychotics, and the newer Atypical Antipsychotics that have fewer side effects. Sometimes they are used to treat Tourette's Syndrome and Aggression as well.

- Abilify (aripiprazole)
- Clozaril (clozapine)
- Geodon (ziprasidone)
- Haldol (haloperidol)
- Mellaril (thioridazine)
- Risperdal (risperidone)
- Seroquel (quetiapine)
- Thorazine (chlorpromazine)
- Trilafon (perphenazine)
- Zyprexa (olanzapine)

Anti-anxiety Agents

Used in the treatment of anxiety disorders.

- Ativan (lorazepam)
- Buspar (buspirone)
- Klonopin (clonazepam)
- Librium (allopurinol)

ALPHABET SOUP

ADD, ADHD	Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder
ART/ARTP	Acute Residential Treatment/Program
ASD	Autism Spectrum Disorder
BIRTP	Behavioral Intensive Residential Treatment Program
BPD	Borderline Personality Disorder
CANS	Child & Adolescent Needs & Strengths – (see glossary)
CAP	Collaborative Assessment Program
CBHI	Children’s Behavioral Health Initiative – (see resources)
CHINS	Child in Need of Services
DBT	Dialectical Behavioral Therapy
DSI	Dysfunction of Sensory Integration, now called SPD
DSM	Diagnostic Systems Manual (book of official diagnostic criteria)
ED	Emotionally Disturbed
EMDR	Eye Movement Desensitization and Reprocessing therapy
EPSTD	Early Periodic Screening Diagnosis & Treatment (Medicaid term)
FST	Family Stabilization Team (a home-based service)
ICC	Intensive Care Coordination (see glossary)
IEP	Individualized Education Program (Plan)
IRTP	Intensive Residential Treatment Program
MAAPS	Massachusetts Association of 766 Approved Private Schools
MASSPAC	Mass. Parent Advisory Council
NAMI	National Alliance for the Mentally Ill
NIMH	National Institute for Mental Health
NLD/NVLD	Non-verbal Learning Disability
OCD	Obsessive-Compulsive Disorder
ODD	Oppositional Defiant Disorder
PAC	Parent Advisory Council
PAL	Parent Professional Advocacy League
PDD	Pervasive Developmental Disorder
PTSD	Post Traumatic Stress Disorder
RAD	Reactive Attachment Disorder
SAMHSA	Substance Abuse & Mental Health Services Admin. (Federal)
SED	Serious Emotional Disturbance
SPD	Sensory Processing Disorder

GLOSSARY

504 Plan

An educational plan a public school may provide to a student with a disability, modifying curriculum & testing requirements.

766 Approved School

Private schools that meet Massachusetts requirements to provide special education to children with disabilities.

Acute

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

Adjudicated

Under the protection or guardianship, and jurisdiction of the court.

Advocacy

Actively supporting a cause or an individual with the goal of providing the best services or interventions.

Affect

The visible expression of emotion, especially facial expression. See “Flat affect”, which describes a plain, emotionless facial expression and body language.

Agitation

An expression of mental stress or biochemical imbalance that may include an increased level of physical activity (pacing, twitching, can’t sit still) and uncontrolled emotional outbursts.

Amnesia

Memory loss due either to neurological or emotional problems.

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.

CANS

Child & Adolescent Needs & Strengths – an assessment tool primarily through MassHealth/Medicaid, results are easily understood by families

Case Manager

An individual who organizes and coordinates services for a client.

Catatonic

Describes a motionless, trance-like state with stiff muscles; may not speak or respond.

Chronic

Any condition that persists a long time or recurs frequently.

Clinician

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

Comorbid

The existence of two or more conditions when each influences the other.

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.

DSM IV

An official manual describing mental health disorders.

Day Treatment

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

Defense Mechanism

An automatic reaction that protects a youth from anxiety and negative emotions. For example, denial of responsibility or disruptive behavior when feeling pressured.

Delusions

False beliefs, such as thinking others can hear one's thoughts.

Dual Diagnosis

The existence of two conditions that aggravate one another, usually indicates a mental illness together with a substance use or abuse problem.

Dysphoric Mood

An unpleasant mood such as sadness, anxiety, or irritability.

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. Also, the title of a specific care program for children with special health needs from birth until 3 years of age. After that time, the local school system becomes responsible for the therapies that Early Intervention was/would have provided.

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.

Executive Function

Refers to the specific cognitive functions of planning, organizing, and strategizing.

Flat affect

Lack of emotional expression, see “affect”.

Home Based Services

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

Homicidal ideation

Thoughts about killing someone.

Hypersexuality

Overly suggestive and promiscuous behavior, when seen in youths this is often considered a symptom of an untreated mental health need.

Intensive Care Coordination (ICC)

Wraparound model of service planning and delivery

Ideation

Medical term for “thinking about”.

Impulsivity

Increased and age-inappropriate level of acting without thinking or seeming unable to consider or predict consequences, often considered a symptom of a mental health need.

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.

Labile

An unstable mood with repeated, rapid and abrupt shifts in behavior and emotions.

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 Health Need

The preferred term for mental illness in children and youths.

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.

Paranoia

False belief that an outside force threatens one's safety.

Partial Hospitalization/Day Treatment

A partial or full day treatment program, generally for youths transitioning from an inpatient hospital setting back into their school and community; or, as a means to prevent an inpatient hospital admission.

"Pink papered"

A legal document that allows a police officer to involuntarily transport a youth to receive an evaluation.

Pressured Speech

Speech that is increased in amount and intensity, or accelerated and difficult or impossible to interrupt. Usually it is loud and forceful, and may continue when no one is listening.

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 youths as patients 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 (severe depression, agitation, delusions, hallucinations) and loss of contact with the environment.

Psychotic break

When perception impaired by brain dysfunction (see “psychosis”) puts a youth out of touch with reality and renders them incapable of safe or effective function. Hospitalization is usually required.

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

Short-term care for a youth in their home or at another location, designed to provide relief to the primary caregivers.

Screening

A preliminary assessment.

Social Worker

A mental health professional trained to provide a variety of services that often include, but not always, counseling and/or therapy and case management services to individuals, families or groups.

Suicidal ideation

Having thoughts about suicide, with or without a definite plan or determination to carry through the act.

Support Services

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

Tantrum

Similar to the familiar “temper tantrum”, this outburst of physical violence, usually directed at the environment but sometimes directed at self or others, is sometimes seen in youths with brain damage, learning disabilities or mental health needs. It usually stems from the youth feeling “overloaded” with emotional or sensory input.

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 by maintaining the youth in a less restrictive living situation.

Tic

An involuntary neurological symptom, may range from mild to severe. Includes movements such as blinking, twitching or spitting, and verbal outbursts such as throat clearing, animal sounds, or swearing. Outbursts may be related to the current situation, reflecting whatever was best left unsaid, e.g., “Mr. Big Nose.” See Tourette’s Syndrome in the Disorders.

Therapy

Treatment of any medical problem. There are many forms including physical treatments such as physical therapy and speech therapy; treatment with medications; social therapies that rehearse appropriate behaviors; alternate approaches such as vitamins, artistic expression, acupuncture or pets; behavior plans that dictate a series of consequences both good and bad for certain behaviors; and counseling type therapies that mostly involve talking or playing with a therapist.

Trauma

Physical or emotional injury especially resulting from violence, disaster or sudden shock or loss.

Transition

The process of moving from one setting, location or activity to another. Or, moving from adolescence to adulthood. Many youths with brain damage, learning disabilities or mental health needs experience a high level of anxiety during transitions and require extra soothing and de-escalation procedures in order to make these types of changes without overloading emotionally. For example, an autistic youth may balk at entering or disembarking from their school bus even though they do it on a daily basis. Transition into young adulthood is a time of higher risk for youths with mental health needs and requires careful resource planning and special supports.

Transitional Services

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

Treatment Plan

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.

Trigger

Any life event or change that provokes the onset, recurrence, or exacerbation of one or more symptoms of a mental disorder.

Withdrawing Behavior

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

Wraparound Services

A full range of services tailored to the needs of a youth and their family, meant to be family centered and youth guided. Includes both traditional mental health and support services. Support services are unique, and address specific stressors, for example camp, outward-bound programs, or specialized after-school activities.

RESOURCES

Special Information for Law Enforcement Officers

Advocates, Inc. <http://www.advocatesinc.org/index.htm> See their Community Justice programs including jail diversion for adults and teens, and connection with the Framingham Jail Diversion Project

Memphis Police Crisis Intervention Team <http://www.memphispolice.org>
A national model, the Memphis Police Crisis Intervention Team (CIT) is a highly successful, unique partnership between the Memphis Police Department, Memphis chapter of NAMI, local mental health providers, University of Memphis and University of Tennessee. Select, specially trained CIT officers respond to calls involving mentally ill citizens, then proactively maintain friendly relationships through periodic check-ins. Contact Major Sam Cochran (901) 545-5700.

Substance Abuse and Mental Health Services Administration (SAMHSA) <http://www.samhsa.gov> From the US Department of Health & Human Services, SAMHSA administers the federal jail diversion grant program and offers resource information, publications, and other helpful information about criminal justice and mental health. Some of the topics offered include Children & Families, Co-occurring Disorders, Criminal & Juvenile Justice, Mental Health System Transformation, Psychological Trauma and Training, Suicide Prevention, and other concerns that touch the lives of youths with mental health needs.

Police Executive Research Forum (PERF) <http://www.policeforum.org/>
A national membership organization of progressive police executives ... dedicated to improving policing and advancing professionalism through research and involvement in public policy debate. Site offers information about criminal justice and mental health, community policing and other relevant information).

The Ohio Criminal Justice Coordinating Center of Excellence (CJ/CCoE)
<http://www.neoucom.edu/CJCCOE>

Established in May 2001 to promote jail diversion alternatives for people with mental illness throughout Ohio, includes resources such as a downloadable advocacy handbook.

The Criminal Justice/Mental Health Consensus Project
<http://www.consensusproject.org>

A repository of information about all aspects of jail diversion, reentry, and enhanced treatment for offenders with mental illness. "The Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments Justice Center, is an unprecedented, national effort to help local, state, and federal policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses who come into contact with the criminal justice system."

U.S. Department of Justice, Bureau of Justice Assistance
<http://www.ojp.usdoj.gov/BJA>

Administers federal mental health courts program, provides resources and information for jail diversion, publications and reports, information about federal funding sources.

CIT in Action Newsletter offered by NAMI (see description of NAMI in the Organization section) is distributed via NAMI's forensic list-serv, which distributes periodic announcements and information about jail diversion, CIT and other forensic issues. If you wish to subscribe, please send an email to laurau@nami.org

Autism, Advocates and Law Enforcement Professionals: Recognizing and Reducing Risk Situations for People With Autism Spectrum Disorders (a book by Dennis Debbaudt)

Massachusetts State Agencies & Federal Programs

Department of Education (DOE) www.doe.mass.edu (781) 338-3300

MA educational services, standards and protections cover the special education of students with all types of disabilities, including those with mental health needs. DOE and local school systems may provide mental health treatment, including specialized educational settings, for youths with mental health needs through their Special Education departments. Within DOE, the Program Quality Assurance Department (PQA) (781) 338-3700 monitors compliance and manages complaints. The Bureau of Special Education Appeals (BSEA) (781) 338-6400 is an independent division that offers a formal hearing process for dispute resolution.

Department of Mental Health (DMH) www.state.ma.us/dmh

Administers and funds community based programs that provide individuals and families with mental health counseling and support services, home based services, inpatient programs, residential treatment, day treatment and more. For information and eligibility requirements, contact your "Area Office" for a referral to the nearest DMH service site, or check the website. General Information/Referral Specialist, M-F from 9AM-5PM (800) 221-0053. Main Office 617-626-8000; Metro Boston Area, 617-626-9200; Western Area 413-587-6200; Central Area 508-368-3838; NorthEast Area 978-863-5000; MetroSuburban Area 508-616-3500; SouthEastern Area 508-897-2000.

Department of Mental Retardation (DMR) www.mass.gov/dmr (617) 727-5608

Provides support services to families who have a child with a developmental disability, and to adults with mental retardation. Families can receive individualized service coordination and flexible family supports that may include community recreation, respite or other support services. Adults age 18 and over may qualify for employment services, day programs, residential care, or other programs.

Department of Public Health (DPH) www.state.ma.us/dph (617) 624-6000

Through a vast array of programs and services, DPH promotes healthy people living in healthy environments. Their extensive website includes consumer helplines, information on food and drug quality control, public health hospitals, community care centers, the Office of Patient Protection, violence prevention programs, disaster management, and much more.

Department of Social Services (DSS) Responds to reports of child abuse or neglect and provides parent and family support services. Takes protective actions when an investigation determines it is necessary. Programs include foster care and adoptive services for children under DSS care and protection. DSS also works with the Juvenile Courts to provide for the care of youths with CHINS petitions. Abuse hotline **(800) 792-5200**; Foster care and Adoption **(800) 543-7508**.

Department of Youth Services (DYS): (617)727-7575 or www.mass.gov/dys DYS is the juvenile justice agency in MA. Operates 100 programs including 64 facilities, ranging from staff secure group homes to highly secure locked units, and 36 programs to service youth who live in the community (residing with a parent, guardian, foster parent or residing in an independent living program).

Division of Insurance (DOI) www.state.ma.us/doi
Operates a general consumer helpline at (617) 521-7777 regarding all types of insurance. DOI includes the Bureau of Managed Care that oversees HMOs operating within MA 617-521-7372.

Division of Medical Assistance (DMA) www.state.ma.us/dma
Administers all MassHealth/Medicaid publicly funded health care plans. Eligibility requirements vary with the plan type. See **Health Insurance Programs and Information**.

Children's Behavioral Health Initiative
http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Children's+Behavioral+Health+Initiative&sid=Eeohhs2&b=terminalcontent&f=masshealth_government_overview_child-bh-hlth-intiative&csid=Eeohhs2
The Children's Behavioral Health Initiative is an undertaking by the Executive Office of Health and Human Services (EOHHS) and MassHealth to implement the Order in a lawsuit known as Rosie D. et. al. v. Patrick. The delivery of mental health care to children and youths is to be improved and better organized in several major ways, including more accessible assessment, screening, and community-based treatment.

Massachusetts Rehabilitation Commission (MRC) www.state.ma.us/mrc (800) 245-6543

Assists individuals with disabilities who are no longer in high school to live independently and become employed. The three main divisions are Vocational Rehabilitation, Independent Living, and Disability Determination Services. Mass residents are able to go through MRC for initial and continuing eligibility determination for the Federal SSI program.

Job Corps www.jobcorps.dol.gov (800) 733-5627

This Federal program of the Department of Labor for at-risk youth provides free education and job training. Youth ages 16-24 may apply to any of the 118 Job Corps Centers located through the nation, including three in MA. Comprehensive services include mentoring, vocational training, education, life skills, residential, medical, dental & vision benefits, recreation, allowance stipends, savings, bonus options, job placement & more. Devens MA 978-772-7933, Chicopee MA (413) 593-5731

Supplemental Security Income (SSI) www.ssa.gov/SSA_Home.html

(800) 772-1213 Information re: Social Security programs including SSI, OR call (800) 245-6543 at the MRC, for MA resident new applications.

A Federal program, SSI provides a monthly stipend for disabled children and adults to assist with the basic needs of food, clothing, and housing. Family income limits are waived when a child is in a long term residential treatment program or hospitalization.

Health Insurance Programs and Information

Health Care For All Health Helpline www.hcfama.org (800) 272-4232

Provides information and referral to other health programs, assists individuals in advocating for their health care needs.

MassResources.org <http://www.massresources.org/>

provides useful information about a wide range of assistance programs for people in need living in Massachusetts. It provides information on what benefits are available, how to apply, eligibility requirements, benefit amounts, and answers to commonly asked questions.

The Parents' How-To Guide to Children's Mental Health Services in Massachusetts

www.childrenshospital.org/mentalhealthguide, or www.bostonbar.org/theguide For a printed copy, contact 617-778-1934 or <http://www.bostonbar.org/theguide/index.htm> The Bar Association website has partial info for free download but to download the entire guide go to the Children's Hospital Boston site, which has supplemental information available as well. Also see their page for their Children's Mental Health Campaign, at <http://www.childrenshospital.org/about/Site1394/mainpageS1394P27sublevel85.html>

MassHealth www.state.ma.us/dma (800) 841-2900 Customer Service Center or (888) 665-9993 Enrollment Center

The MA version of the Federal Medicaid program provides free or low cost health insurance to qualifying MA residents. All youth programs provide early and periodic diagnosis, screening, and treatment. Covered services include hospitalization, MD visits, prescription drugs, mental health services, and more.

Massachusetts Behavioral Health Partnership (MBHP) 1-800-495-0086 or **www.masspartnership.com** Manages mental health and substance abuse services for many MassHealth members.

Bureau of Managed Care www.state.ma.us/doj/ 617-521-7372

Branch of the DOI that oversees statutory compliance of managed health care plans based in and operating within MA.

Department of Public Health www.state.ma.us/dph 617) 624-6000

The Department of Public Health is in charge of CenterCare, a free health care program for low-income Massachusetts residents with chronic health conditions. CenterCare members get free self-management support services and primary and preventive health care services at community health centers (CHCs). To find a community health center near you, visit the Locate Mass CHCs page on the Massachusetts League of Community Health Centers web site, at <http://www.massleague.org/HealthCenters.htm> or call the League's Patient Referral Line at 1-800-475-8455.

DPH also runs the Office of Patient Protection (see separate entry below) at 800-436-7757, as well as their Bureau of Substance Abuse Services at 800-327-5050.

Children's Medical Security Plan www.cmspkids.com for enrollment applications call **888-665-9993**, general info or members call **(800) 909-2677**

A state-funded health care plan for MA youths through age 18 who are ineligible for MassHealth. Provides access to primary and preventive care, including outpatient but not inpatient mental health care.

CommonHealth www.state.ma.us/dma/masshealthinfo/commonhealth

(888) 665-9993 A MassHealth plan for disabled children and adults who make too much money to get MassHealth Standard. Adults who work can still get this insurance.

Premium Assistance or Family Premium Assistance Programs

To get an application call the MassHealth Enrollment Center at **(888) 665-9993**, for those already receiving premium assistance call **(800) 462-1120**

Under DMA's Benefit Coordination & Recoveries Unit, this program pays private insurance premiums for Mass Health eligible members, and partial premium costs for others under certain circumstances. For more info see the Boston Public Health Commission website at http://www.bphc.org/howto/ins_premium.asp

Office of Patient Protection www.state.ma.us/dph/opp/index.htm **(800)**

436-7757 A DPH program that provides a process for consumers to obtain an external review of managed care health benefit denials.

MassMedline <http://www.massmedline.com> **(866) 633-1617**

A free, confidential service available to all Massachusetts residents who are seeking information regarding their medications. Whether you are having difficulties affording your medications or want to know what the side effects are to your prescriptions, MassMedLine can help. By calling a toll-free help line, you can speak to pharmacists and case managers one-on-one to receive personal assistance with answering your pharmacy related questions or finding programs to help with the cost of your medications.

Massachusetts Department of Social Services: 617-748-2000 or www.mass.gov/dss includes a link for the Collaborative Assessment Program or CAP, and information useful for officers and for families about domestic violence and child abuse. Families can under some circumstances request counseling, substance abuse treatment, residential placement and other services from this agency.

Massachusetts Department of Youth Services: 617-727-7575 or www.mass.gov/dys Under some circumstances, may provide counseling, substance abuse treatment, and residential placement.

Massachusetts Department of Early Education & Care: www.eec.state.ma.us 617-988-6600 (EEC) “Offers ...services and resources for children with special needs and their families. ... oversees federal IDEA preschool special education funds and works with public schools regarding special education services for young children ages 3 to 5.”

Massachusetts Department of Education: 781-338-3000 or www.doe.mass.edu DOE funds multiple types of special education settings for youths with mental health needs.

Legal

Mental Health Legal Advisors <http://www.mass.gov/mhlac> 617-338-2345

The legal staff of MHLAC provides legal referrals, information, and advice to individuals, lawyers, mental health professionals and the general public. MHLAC reviews new developments in mental health, housing, family, and disability civil rights law through its legal journal, the *Advisor*, and publications such as the *Mental Health Law Guide* and the *Managed Care Packet*.

Bazelon Center for Mental Health Law www.bazelon.org

“The Bazelon Center for Mental Health Law uses a coordinated approach of litigation, policy analysis, coalition-building, public information and technical support for local advocates in four broad areas of advocacy.” Site includes a wealth of published materials, including some free downloads,

Wrights Law

www.wrightslaw.com - a great resource for educational law information

Parent Support & Advocacy Organizations

Parent/Professional Advocacy League (PAL) <http://ppal.net/default> (617) 542-7860

The Massachusetts chapter of The Federation of Families for Children's Mental Health, PAL 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. Coordinators advise parents, facilitate support groups and promote youth mental health awareness in the community. The organization conducts family-centered research to help advocate for system change, and there are many useful publications for free download on their web site, including this guide, a parent manual on accessing emergency mental health care, and copies of research reports. To request a referral to the Coordinator in your area, phone the the main office at (617) 542-7860.

**Federation of Families for Children's Mental Health www.ffcmh.org
(240) 403-1901** A national, family-run organization dedicated to helping children with mental health needs and their families achieve a better quality of life. This organization provides leadership and technical assistance to a nation-wide network of family-run organizations; leads and pursues advocacy on a national level; and, collaborates with child-serving organizations to transform mental health care in America.

AD-IN (Attention Deficit Information Network) www.addinfonetwork.com
A specialized network that offers support and information to families of children with ADHD. They also offer training, professional speakers, and referrals.

AL-ANON/ALATEEN www.al-anon.org (888) 425-2666
Support groups for friends & family members of people with drinking problems. ALATEEN groups are exclusively for young friends & family members. In MA many chapters also include those whose loved ones have substance use & abuse problems.

Alcoholics Anonymous www.alcoholics-anonymous.org (617) 426-9444
A 12-step program that supports & educates people with drinking problems. Group meetings are held in hundreds of locations.

National Autism Association

<http://www.nationalautismassociation.org/index.php> or 877-622-2884

“educate and empower families affected by autism and other neurological disorders, while advocating on behalf of those who cannot fight for their own rights.” Emphasizes possibility of recovery. Includes much info about Autism including a symptoms video and treatment options discussion, Has multiple programs, including their Families First Program, which gives grants to some families with an autistic child, for marital counseling. Excellent resource links page.

Asperger’s Association of New England (AANE) <http://www.aane.org/> or (617) 393-3824 offers a comprehensive menu of services including training for families and professionals, written information, employment assistance and socialization opportunities.

<http://www.autisminfo.com>

loads of info and links

Children and Adults with Attention Deficit Disorder (CHADD) home page. CHADD works to improve the lives of people with AD/HD through education, advocacy and support. **www.chadd.org**

Massachusetts Substance Abuse Information and Education Help Line (800) 327-5050 24 hour national helpline provides referrals to local treatment programs and resources.

Family Ties www.massfamilyties.org (800) 905-TIES (8437)

Parent-to-Parent support network for families of children with disabilities or chronic illnesses. Regional Parent Coordinators provide information, support and referral, and match new members with a more experienced parent of a child with a similar diagnosis.

Federation for Children With Special Needs www.fcsn.org (800) 331-0688 (617) 236-7210 Provides information, support and assistance to parents of children with disabilities, their professional partners, and communities. FCSN specializes in training and advocacy on the topics of education & special education, early childhood programs and health care, for children with disabilities. Information is available on their website (training schedule, calendar of events, database & links) as well as an extensive collection of fact sheets available by telephone request.

**Learning Disabilities Association of Massachusetts www.ldam.org
(781) 890-5399**

This organization offers conferences for parents and professionals, a comprehensive resource directory, "Ask the Expert," an on-line newsletter, and a publication for professionals.

**Massachusetts Advocates for Children www.massadvocates.org
(617) 357-8431**

Helpline for parent questions regarding education needs, free legal representation for a select few regarding education needs, and advocacy in state legislation.

**Massachusetts Eating Disorders Association www.medainc.org
(617) 558-1881** MEDA offers referrals, teen support groups, educational presentations, trainings, and resources for students, teachers, families, coaches, and other professionals.

**Massachusetts Families Organizing For Change www.mfofc.org
(800) 406-3632** Provides information, leadership training, and advocacy support to families of children with developmental disabilities. Website offers a varied and interesting collection of links.

Family Voices <http://www.familyvoices.org>
Organization for families with Children with Special Health Care Needs, includes information about health care financing, parent support, advocacy, publications and more. Excellent newsgroup links families and professionals caring for children with special health care needs, massfamilyvoices@yahoogroups.com

**Parents Helping Parents www.parentshelpingparents.org
800 632-8188** This 24 hour emergency line, or (800) 882-1250 for office or support group locations, provides 24 hour Parental Stress line and parent support groups provide nonjudgmental, anonymous support to parents under severe stress who want to improve their parenting skills and family relationships.

Secret Shame www.selfharm.net
This is a plain-talk self-help site about self-injurious behavior, written in conversational style by a British therapist.

Information

All Kinds of Minds www.allkindsofminds.org

This non-profit institute offers useful information about learning differences including a newsletter, discussion groups, & library; the organization offers teacher training and assessment of individual children.

Collaborative Problem Solving Institute www.explosivechild.com

A nonprofit organization established to fund research on explosive/noncompliant children and adolescents and to fund services to underprivileged youths who might not have access to quality mental health services.

Easing the Teasing: How Parents Can Help Their Children

www.ericdigests.org/2000-1/teasing.html

An Educational Resources Information Center article, available for free download. More resources on this topic including some in Spanish, and promo for the related book, can be found at the author's site www.easingtheteasing.com

MAAPS (MA Association of 766 Approved Private Schools)

www.spedschools.com/ (781) 245-1220

Private schools accredited by MA to provide special education to children with disabilities. To obtain the MAAPS Directory of Member Schools call, or download free from their website.

Mental Health America www.nmha.org/ (800) 969-6642

Info Line; extensive website that includes many well-written fact sheets on child & adolescent mental health topics.

National Alliance on Mental Illness (NAMI) www.nami.org

(800) 370-9085 and National Alliance on Mental Illness of Massachusetts (NAMI-MA) www.namimass.org 781-938-4048

A support, advocacy, and information organization for people with mental illness and their families. Offers free classes, including a class on children's challenging behaviors, printed materials, and a website rich with clear information about mental illness.

National Center for Post-Traumatic Stress Disorder www.ncptsd.org

(802) 296-5132

Originally created by congress, this organization provides information on PTSD in children and other civilians as well as in military experience.

National Institute for Mental Health (NIMH) www.nimh.nih.gov

Federally sponsored, well organized and presented site. It is easily searchable, with sections on research, clinical trials, fact sheets, conference listings, and more.

NICHCY National Information Center for Children and Youth with Disabilities www.nichcy.org (800) 695-0285

Comprehensive information on disabilities and related issues for families, educators, and other professionals. Much of the information is free or inexpensive, some downloadable.

NLDline www.nldline.com (860) 693-3738

Site offers a cornucopia of resources intended to promote early intervention for Non-Verbal Learning Disabilities. Topics include a camp listing, calendar, question & answer bulletin board & chat room, parenting tips & stories, IEP info, teacher education, referrals, and professional articles.

Nonverbal Learning Disorders Association www.nlda.org (860) 570-0217

Professional association, site offers excellent interventions page.

Sensory Integration Network www.sinetwork.org

Offers current sensory integration resources and information to families, consumers and professionals.

National Wraparound Initiative <http://www.rtc.pdx.edu/nwi/> or

206-685-2477 Definitive source of information and training about this medical care model.

The Attachment Institute of New England

<http://attachmentnewengland.com/faq.html> 508-799-2663

Assessment, treatment, resource links, parent support group, regarding Reactive Attachment Disorder

Association for Treatment and Training in the Attachment of Children (ATTACH)

<http://www.attach.org> 866-453-8224 advocates for public awareness and sponsors public education, quarterly newsletter, annual conference, membership directory, and other benefits.

The Trauma Center at the Justice Resource Institute

<http://www.traumacenter.org> or General Number:(617) 232-1303 Clinical

Intake:(617) 232-0687 Offers treatment, resource links including downloadable resources for first responders, and training assessments, research, publications and videos for professionals.

PAL

Parent/Professional Advocacy League (PAL)
45 Bromfield St., 10th Floor
Boston, MA 02108
617-542-7860
Fax 617-542-7832
info@ppal.net
www.ppal.net