PPAL'S POLICE POCKET GUIDE

TOOLS TO HELP POLICE AND FAMILIES PARTNER TOGETHER WHEN YOUTH ARE IN CRISIS

PPAL

Parent/Professional
Advocacy League

2022

Special thanks to the Brookline, Lincoln, Mansfield, and Worcester Police Departments, The Attachment Institute of New England, MassFAS, NAMI Massachusetts, Strategies for Youth, Youth Move National, and PPAL families across Massachusetts for their consultation in the development of this guide.

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POLICE POCKET GUIDE: TOOLS TO HELP POLICE AND FAMILIES PARTNER TOGETHER WHEN YOUTH ARE IN CRISIS

PPAL's Expanded Police Pocket Guide (PPG) provides useful information to help police officers restore stability and improve outcomes for youth and their families. We know the challenges youth and families face when managing behaviors and accessing services. The PPG builds upon PPAL's 27+ years of working with police to increase awareness around the specific mental health needs of youth and their families. The PPG also weaves in guidance from trusted medical, advocacy and law enforcement organizations. Citations and links to resources are highlighted throughout the guide and with footnotes.

When police are called to attend to youth in crisis, police will see and experience the youth's behaviors. ***A youth's behavior is not always what it appears to be.***

Police Pocket Guide hopes to…

- Raise awareness of
  - o Mental health concerns in youth
  - o Family experience
- Share tips on
  - o Approaches for calming
  - o Understanding risk
  - o Explaining to families the role of police, next steps, and psychiatric evaluations
- Provide first responders resources to share with families about
  - o 24/7 crisis supports
  - o Local resources
- Educate first responders with
  - o Tip sheets
  - o Additional resources

At PPAL, we work to create a better world for our children, support our communities and focus on the importance of families. The effect of racism and racial trauma on our children's mental health is real. We know that the disparity in getting care for children in communities of color shows up every day.

Now more than ever, we continue to pursue meaningful and enduring change to overcome acts that would threaten to corrode the fibers of our community. As we work to build, protect, and support our communities, there's no better tool than our collective power.

We stand ready to listen and work with individuals and organizations to create a more just world. June 2020

WHAT FAMILIES NEED POLICE TO KNOW

- **Mental health disorders are widespread**. It's estimated that there are 15 million US children and adolescents diagnosed with a mental health disorder. This number significantly underrepresents the actual numbers, since it is estimated that only about 7% of youth needing services receive help from mental health professionals.[1]
- Mental illness impacts children and teens across the United States. Mental illness knows no boundaries and impacts children of all genders and ethnic/ racial backgrounds.

NAMI. (2016). Mental Health Facts Children & Teens. https://www.nami.org/nami/media/nami-media/infographics/children-mh-facts-nami.pdf

[1] *Children's Mental Health*. (n.d.). https://Www.Apa.Org. Retrieved April 13, 2020 from https://www.apa.org/pi/families/children-mental-health

TRAUMA

Traumatic events are not isolated and impact many families. Youth interacting with the juvenile justice system have a statistically higher likelihood of trauma.

How should police think about trauma and youth?[2]

- Trauma may be a single life changing event, or it could be repetitive and ongoing.
- Trauma may be physical or psychological.
- Types of trauma include bullying, community violence, complex trauma, disasters, early childhood trauma, intimate partner violence, medical trauma, physical abuse, refugee trauma, sexual abuse, terrorism and violence, and traumatic grief.[3]

ADVERSE CHILDHOOD EXPERIENCES

Adverse Childhood Experiences (ACEs) are toxic stressors. While not all ACEs are traumatic events in the lives of children, it is important to understand what it means to be a child or adolescent with high ACE scores.

As explained by Robert Kinscherff[4], PhD, JD, these youth are:

- Disproportionately youth of color and extreme poverty.
- If white, youth are outliers in terms of poverty and/or maltreatment.
- More likely have earlier onset of mental health disorders and/or substance use disorders.
- More likely to underachieve or drop out of school.
- More likely to harm themselves, others, or both.
- Less likely to respond to usual special education or behavioral health treatment interventions.
- More likely to fail during or following justice system interventions.
- Less likely to stop behaviors with maturation.

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[2]National Institute of Mental Health. (n.d.). *NIMH » Helping Children and Adolescents Cope with Disasters and Other Traumatic Events: What Parents, Rescue Workers, and the Community Can Do.* https://www.nimh.nih.Gov/Index.Shtml. Retrieved April 13, 2020, from https://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-disasters-and-ot her-traumatic-events/index.shtml

[3]The National Child Traumatic Stress Network. (2017, October 30). Trauma Types [Text]. The National Child Traumatic Stress Network. https://www.nctsn.org/what-is-child-trauma/trauma-types

[4]Blitzman, J. D., & Kinscherff, R. (2020, February 12). *Implications of Neuroscience in Juvenile and Young Adult Justice*. Harvard Law School Association of Massachusetts, Boston, MA.

BRAIN DEVELOPMENT

A person's brain is not fully developed until at least 25 years. No matter how grown up a child or adolescent appears, youth react differently than adults. This is especially true during a crisis. The following graphic from Strategies for Youth illustrates the important differences between a child, teen and adult brain. https://strategiesforyouth.org/

Are They Out Of Their Minds?

These notes offer a way to think of brain development and how it affects people's perceptions, processing and responses. The changes taking place during each developmental phase of life are profound. Understanding the brain's characteristics in each phase helps interpret people's behaviors and respond effectively.

CHILD'S BRAIN

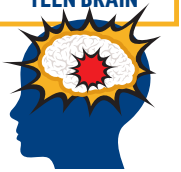
BRAIN CHARACTERISTICS

- Absorbs information easily
- Brain structure is most vulnerable to neglect/trauma
- Brain's "wiring" becomes permanent

BEHAVIOR CHARACTERISTICS

- Absorbs information
- Concrete thinking
- Great capacity to mimic and learn
- Imprinted by good/bad experiences
- Wants to please adults
- Magical thinking about cause and effect

TEEN BRAIN



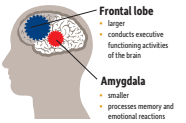
BRAIN CHARACTERISTICS

- Big amygdala
- Active pruning of un-useful neurons
- Myelination strengthens pathways between brain areas

BEHAVIOR CHARACTERISTICS

- Impulsive
- Extreme responses and difficulty self-regulating
- Concerned about image with peers
- Self-image trumps self-interest
- Tests boundaries
- Cannot quickly predict both positive and negative consequences
- Focuses on own emotional responses
- Easily distracted

ADULT BRAIN BY 25



BRAIN CHARACTERISTICS

- Frontal lobe harnesses amygdala

BEHAVIOR CHARACTERISTICS

- Can control expression of emotion and impulses
- Adheres to boundaries and recognizes benefits of doing so
- Able to plan and put things in sequence
- Can more accurately anticipate consequences.
- Less subject to peer influences as own identity "sets"

PTB-ATOOTH-0x1118

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P.O. Box 390174 • Cambridge, MA 02139 • 617.714.3789 • www.strategiesforyouth.org

ICEBERG REALTY FOR YOUTH BEHAVIORS

When a youth is in crisis, each of us can only see the behaviors or symptoms. Signs of mental illness may or may not be obvious.

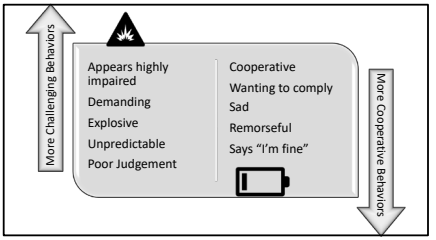
When interacting with a youth exhibiting unexpected behavior, ask
Is it possible this youth is exhibiting signs of

- A mental health condition?
- Drugs or alcohol use?
- An autism spectrum disorder?
- A trauma history or post-traumatic stress?
- Reactive Attachment Disorder (RAD)?

Image from https://parentswithconfidence.com/?attachment_id=1711

Mental Health Concerns: Special Considerations

Youth's behaviors may change rapidly during a crisis



- This youth has *hopes and dreams*. Today is likely not representative of who they are.
- Make no assumptions about *race, culture, or ethnicity*.
- Treat everyone with equal kindness and respect.

Does This Youth Have Mental Health Concerns?

How might mental health concerns, especially safety concerns, appear to police?	How might youth with mental health concerns view police?
• Intense anger, anxiety, or sadness • Trouble controlling emotions or irritability • Lost interest in activities and friends/isolated themselves • Alcohol, tobacco, or other drug use • Hurting others or destroying property • Low energy • Having thoughts of suicide • Self harm (e.g., burning or cutting their skin) • Bizarre thoughts/ideas • Scared/fearful	• Scared • Fearful • Confused • Angry • Embarrassed

Special Considerations:
There is no one way a youth will appear to the police. In the middle of a crisis, youth may appear very impaired or high strung in one moment and cooperative in another.

Adapted from NIMH's *Common Mental Health Warning Signs for Children and Teens* https://www.hhs.gov/ash/oah/adolescent-development/mental-health/adolescent-mental-health-basics/common-mental-health-warning-signs/index.html

Is This Youth Under the Influence of Drugs or Alcohol?

How might drug or substance use appear to police?

- Behavioral Signs
  - Acting irresponsibly, such as stealing
  - Avoiding eye contact
  - Isolating
  - Lying or making excuses
  - Skipping school/work
- Physical Signs
  - Change in appearance (bloodshot or glazed eyes, puffy face, cold or sweaty hands, arms/legs with track marks or covered in warm weather)
  - Poor hygiene
  - Changes in mood or attitude
  - Paranoia, irritability, anxiety, fidgeting
  - Trouble staying on task/focused

How might youth view police?

- May do things to avoid getting caught or in trouble
- Scared
- Embarrassed

Special Considerations:

It is not easy to distinguish between alcohol or substance intoxication, autism, epilepsy, and mental health issues. Involuntary behaviors such as impulsiveness and flawed thinking are recognized symptoms of mental health needs and worsen with substance use.

Adapted from Hazelden Betty Ford Foundation's *Early Warning Signs of Teen Substance Abuse* https://www.hazeldenbettyford.org/articles/warning-signs-teen-substance-use

Does This Youth Have a Trauma History?

Trauma is often mistaken for something else: non-cooperation, substance abuse, or mental illness.

How might trauma appear to police?

- Symptoms may include nausea, flashbacks, trembling, memory gaps, fear, anger
- Behaviors may include:
  - Avoidance or tuning out
  - Hypervigilance
  - Hostility or aggressiveness
  - Jumpiness or hyper reactivity
  - Trying to self protect
  - Being uncooperative
  - Appearing numb and showing no outward signs of distress. Alcohol or drugs may be used for this.

How might youth view police?

- Traumatized youth may see interactions as power and control. Feeling powerless in the presence of police may signal DANGER to them. They may:
  - Mistrust adults and authority figures and see police as abusers
  - Assume the worst
  - Be unable to regulate behavior

Special Considerations:

- Youth are not responsible for their own victimization.
- Trauma can halt typical development and interrupt a youth's ability to use coping strategies.

Adapted from Strategies for Youth's *Youth and Trauma* fact sheet and Vera Institute for *Justice's Police Perspectives* series.

Is It Possible Youth May Be On the Autism Spectrum?

While autism is often a hidden disability, individuals with autism may behave in ways that appear unusual. Communication and social interactions may present challenges. Naivety, rigidity around routine and rules, misunderstanding social cues/rules are among the challenges that could escalate into a crisis.

How might autism appear to police?

- Range of social impairments such as naivety or rigidity around situation
- Communication skills that do not match the situation -- this includes verbal abilities and comprehension
- Behaviors that do not match the situation

How might youth view police?

- With extreme anxiety
- With lack of understanding of situation, possibly with unexpected language or behaviors
- With confusion
- With misunderstanding of police role

Special Considerations:

- Youth will benefit from a calming presence, concrete language, extra space, and time.
- Always seek guidance from someone who knows this youth and ask what helps.

Does This Youth Have Reactive Attachment Disorder (RAD)?

RAD, a complex disorder, affects children who have lived with repeated, traumatic experiences. RAD is characterized by aggressive or violent behaviors. RAD may look like other mental health conditions. However, typical guidance/behavioral management is unlikely to work with youth. Ask the family what may be most helpful.

How might RAD appear to police?

- Anti-social behaviors, e.g. lying, stealing, manipulating, destructiveness, cruelty
- Intense rage or suppressed rage
- Violence toward family
- Difficult to calm down
- Resistance to control/limits and trying to control things themselves
- Withdrawal
- Irritability
- Little emotion
- Lack of eye contact
- Impulsivity
- Lack of predictability

How might youth view police?

- Unlikely to trust police
- Unlikely to be calmed by police
- Unlikely to be reassured by rules or guidance from police

Special Considerations:

Youth are likely to feel safest when:
*Given reassurance that they are safe and police can help them
*Police are able to de- escalate or diffuse a youth's emotions
*Given clear, concise directions and behavior guidelines
*Youth's name IS NOT used repeatedly, as that may be a trigger
*The role of a police officer is defined and maintained
*Eye contact is maintained, even if the youth may not make eye contact
*Redirected and reminded of boundaries that are safe and truthful

Adapted from The Attachment Institute of New England http://www.attachmentnewengland.com/website/index.html and AACAP's *Facts for Families, Attachment Disorders* https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Attachment-Disorders-085.aspx

SPECIFIC RISK CONCERNS FOR YOUTH WHO ARE LGBTQ+

LGBTQ+ people experience mental health issues at more than twice the rate of non-LGBTQ+ people.[5] The Trevor Project's National Survey on LGBTQ+ Youth Mental Health offers important information to understanding widespread risk for youth.

The Trevor Project reported:

> *"**39% of LGBTQ youth** seriously considered attempting suicide in the past twelve months, with more than half of transgender and non-binary youth having seriously considered [suicide]*
>
> ***71% of LGBTQ youth** reported feeling sad or hopeless for at least two weeks in the past year*
>
> ***Less than half of LGBTQ respondents** were out to an adult at school, with youth less likely to disclose their gender identity than sexual orientation*
>
> ***2 in 3 LGBTQ youth** reported that someone tried to convince them to change their sexual orientation or gender identity, with youth who have undergone conversion therapy more than twice as likely to attempt suicide as those who did not*
>
> ***71% of LGBTQ youth** in our study reported discrimination due to either their sexual orientation or gender identity*
>
> ***58% of transgender and non-binary youth** reported being discouraged from using a bathroom that corresponds to their gender identity*
>
> ***76% of LGBTQ youth** felt that the recent political climate impacted their mental health or sense of self*
>
> ***87% of LGBTQ youth** said it was important to them to reach out to a crisis intervention organization that focuses on LGBTQ youth and 98% said a safe space social networking site for LGBTQ youth would be valuable to them"* [6]

Police need to be aware of the increased risks for LGBTQ+ youth as well as the reality that youth may or may not have a supportive environment at home. LGBTQ+ young people hear significantly more negative comments than positive ones. They are constantly assessing risk.

Everybody has SOGIE: Sexual Orientation, Gender Identity and Gender Expression. Everyone has both sexuality and gender, just as everyone has race and ethnicity. One cannot look at and know another's sexuality or gender. **SOGIE** is an important part of identity and it's important not to make assumptions. Making assumptions will negatively affect the conversation.

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[5] National Alliance on Mental Illness. 2019. LGBTQ, hhttps://ww.nami.org/find-support/lgbtq

[6] The Trevor Project. 2019. *National Survey on LGBTQ Youth Mental Health*. https://www.thetrevorproject.org/wp-content/uploads/2019/06/The-Trevor-Project-National-Survey-Results -2019.pdf

TIPS FOR WORKING WITH LGBTQ+ YOUTH

Names and Pronouns

It's simple. Ask every youth what name and pronoun they prefer to use. Don't make assumptions about names and pronouns.
When a Youth Shares They are LGBTQ+

- Be supportive of the youth.
- Ask youth: How can I support you?
- Be aware of your own beliefs and understanding of LGBTQ+ youth.
- Be curious. Don't make assumptions.
- It's okay to make a mistake. Apologize. (Adults want to say the right thing, but they often make mistakes.)

Family Support

- Do not make assumptions! Family support may or may not be present.
- Ask youth: Who do you trust? Who do you talk to?
- Youth often look beyond family for guidance.

Confidentiality is Essential

- This is not a mandated conversation. Assure youth their confidentiality.

Important Medical Information

If a youth is held in detention or arrested, ask about

- Hormones
- Medications
- Gender expression tools such as binding. Police can help find compression vests for youth if binding materials are problematic when a youth is detained.

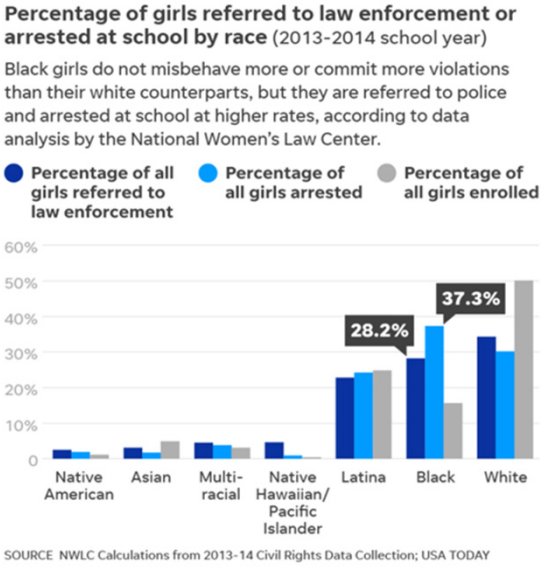
SPECIFIC RISK CONCERNS FOR GIRLS IN JUVENILE JUSTICE SYSTEMS

According to a Child Trends report,

> *"The majority of females in the juvenile justice system report having experienced physical, sexual, or emotional victimization.*
>
> *Many females first enter the system as runaways, or for other status offenses (offenses not considered illegal for adults),and cite abuse at home as a primary reason for leaving.*
>
> *Once in the system, they often do not receive adequate treatment and often have different needs than their male counterparts."*[7]

Race disparities persist, especially for Black girls. The following information and graphic are from *USA Today*.[8] Black girls are

> *"Nearly three times more likely than white girls to be referred to the juvenile court for delinquent offenses*
>
> *20% more likely to be detained*
>
> *20% more likely to be formally petitioned to court*
>
> *20% less likely to be placed in a diversion program."*



[7] *Juvenile Incarceration*. (n.d.). Child Trends. Retrieved April 13, 2020, from https://www.childtrends.org/indicators/juvenile-detention

[8] Rhor, M. (2019, May 15). *Pushed out and punished: One woman's story shows how systems are failing black girls. USA Today*. Retrieved from https://www.usatoday.com/in-depth/news/nation/2019/05/13/racism-black-girls-school-di scipline-juvenile-court-system-child-abuse-incarceration/3434742002/

SPECIFIC RISK CONCERNS FOR YOUTH WHO RUN AWAY OR ARE EXPERIENCING HOMELESSNESS

Youth experiencing homelessness have high rates of involvement with the juvenile justice system. These youth have an increased likelihood of the following:

- Substance use
- Delinquent behavior (dealing drugs, stealing and prostitution)
- Becoming a teenage parent
- Dropping out of school
- Suffering from sexually transmitted illnesses
- Meeting the criteria for mental illness

SPECIFIC RISK CONCERNS FOR YOUTH INVOLVED WITH CHILD WELFARE SYSTEMS

Children who have experiences with the child welfare system :

- Are prone to running away
- Are more likely to experience homelessness
- Have a hard time trusting people
- Have a fight and flight response

[9]Homelessness and Runaway. (n.d.). Retrieved July 25, 2019, from Youth.gov website: https://youth.gov/youth-topics/runaway-and-homeless-youth and
The Intersection of Homelessness, Behavioral Health Needs, and Justice Involvement. (n.d.). Retrieved from https://theinstitute.umaryland.edu/media/ssw/institute/national-center-documents/TA-Tidbit-Homelessness-Intersectwith-Behavioral-Health-and-Juvenile-Justice.pdf

[10]Child Welfare. (n.d.). Retrieved July 25, 2019, from Youth.gov website: https://youth.gov/youth-topics/runaway-and-homeless-youth/child-welfare-system

UNDERSTANDING THE FAMILY EXPERIENCE

FAMILY EXPERIENCE

COMMON EXPERIENCES FOR FAMILIES CALLING 911

- Families feel
  - Isolated and alone.
  - Judged and blamed when trying their best.
  - Worried that calling 911 will make the situation worse.
- Families call 911 when there's nowhere else to turn.
  - The situation is acute now.
  - In that moment, families lack resources to address the problem.
- Families should feel confident that first responders will
  - Respect the privacy and dignity of the family.
  - Respond and assist during a mental health crisis with skill and compassion.

RANGE OF REASONS FAMILIES DON'T WANT TO CALL 911

- Different stages of understanding the child and situation.
- Scared and worried
  - What will happen to the child or other children in the house?
  - Will they be taken away?
  - Will police involvement make things worse for the child?
- Embarrassed and confused.
- Don't know what happens after calling 911 and worry that
  - Police may insist on taking child to emergency room.
  - Child will be arrested.
  - Schools may be informed.
  - Custody issues raised.
  - Immigration status questioned
- Families should feel confident that first responders will
  - Respect the privacy and dignity of the family.
  - Respond and assist during a mental health crisis with skill and compassion.

> "I was so scared for my child's safety and didn't know who else to call. At the same time, I have lots of experience helping manage my child's behaviors. I felt better when it was clear the police were asking me what has helped in the past." A PPAL parent

START WITH A QUICK CHECK IN: When possible, ask a family or child for guidance to help keep things calm or prevent further escalation of behaviors.

Many youth have rigid responses and extreme behaviors that are likely to be accentuated in a crisis. It will be helpful to know key strategies that can help prevent a child from getting further agitated or stuck.

Ask: Is there anything I'm going to do that will further upset the child? Things to think about include touch, language, addressing child's fixation on something seemingly small (like a drink of water).

Involve families throughout the process

- Before interacting with youth, quickly check in with the family. Find out if there's anything you need to know about the child's triggers.
- Involve the family. Families bring useful knowledge in many ways - understanding background, triggers, strengths, medical concerns, and more.
- Talk about the options for what comes next.
- Start the plan for what comes next.

Explain the role of police

Police at the scene are in control of the situation. Police understand the range of options and need to communicate with youth and their families

- The rules.
- What's happening.
- The options and choices for what comes next.

Use appropriate language

- **Names Matter:** Ask a youth what name they would like to be called. If you are concerned you may not be able to pronounce the name, ask again.
- **Be Inclusive:** Inclusive language respects people's preferences and identities. Ask youth what pronouns they prefer to use. If you can, model by example: using preferred pronouns like he/him, she/hers, and they/them.
- **People First:** People-first language puts the emphasis on the whole person. We see the youth, not the condition. Say: "A person with mental illness" rather than "a mentally ill person." Say: "He has depression," not "He is depressed."
- **Respect:** Look at what someone has to offer.
- **Different Backgrounds:** Race, culture, and personal history influence how each of us hears things. What we say impacts people differently.

Listen attentively

- **Active Listening.** Listen and look for signs of mental illness, trauma, substance use, autism.
  - Check in with youth.
  - Ask questions.
  - Listen.
- **Validate the Youth's Experience.** Communicate your intent to listen to youth without judgement.

- Validation is listening to what youth is saying.
- Validation is communicating back to youth that you understand what the youth is saying. It's often a demonstration that you understand their feelings.

- **It's okay for police:**
  - To be sensitive and acknowledge what the youth is expressing regarding feelings.
  - To allow a youth to vent (and not document everything).
  - To reflect what you hear them saying.
  - Validation is not agreeing or arguing. Validation is listening with curiosity to understand.

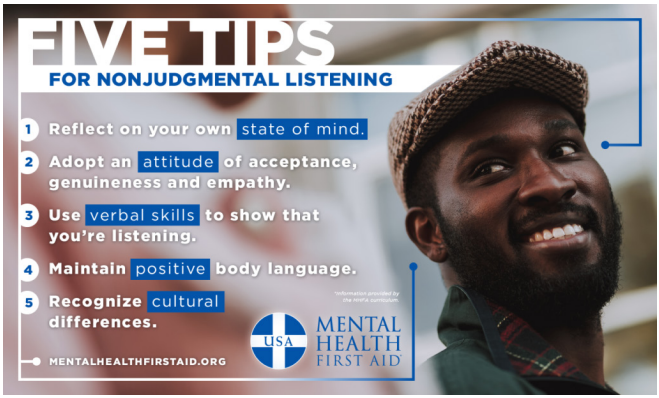
Assist and de-escalate

- Slow things down. Buy time.
- Ask the youth what helps.
- Ask the family what helps.
- Offer calming strategies.
- Change up the situation - redirect the situation.
- Offer distractions.
- If possible, offer youth another house/location to separate from family. (Sometimes both youth and family benefit from a break.)

Frame situation positively

- Remind youth you are there to help.
- Be empathetic.
- Offer choices that are positively stated and with options. Example: Would you like to talk here or there.
- Praise youth when you can.
- Be clear and signal what you are about to do.

Effective Interactions incorporates Strategies for *Youth's Best Practices for Effective Police/Youth Interactions for Relationship Building & Incident Interventions*.



For additional information: https://www.mentalhealthfirstaid.org/2019/08/five-tips-for-nonjudgmental-listening/

UTILIZING FAMILY KNOWLEDGE: QUESTIONS POLICE CAN ASK

Families are the experts on their children and can provide officers valuable. Below are examples of questions that may be helpful.

Prior Experience with 911 or Law Enforcement

- Has your family needed to access 911/law enforcement support for your child before?
- YES
  - What worked well?
  - Were there any challenges?

Medical History

- Does your child have medical concerns we should know about?
- Does your child have a diagnosis that would be helpful for us to know (e.g., ADHD, Reactive Attachment Disorder, Autism, etc.)?
- Medications:
  - Does your child take any medications?
  - Do you think your child took medications as prescribed today?
  - Have there been any recent changes in your child's medications?
- Has your child experienced a previous psychiatric evaluation or hospitalization?
- Does your child work with a therapist or psychiatrist? Have you tried calling?

Important Health and Wellbeing Information that Cannot Be Seen

- Is there a history of mental health issues?
- Has your child/family experienced a significant life event recently, e.g. death of loved one or pet, major illness, overdose, job loss, other loss?
- Does your child have a history of trauma?
- Does your child have any communication challenges?
  - Hearing loss
  - Verbal skill challenges
  - Developmental or learning issues that may make communication challenging

Caregiving Information

- Are you the primary caregiver and what is your relationship to the youth? Parent, grandparent, fostering, other kinship?
- Any recent changes to family structure: separation, divorce, change in partnership, change in household members?
- What else would be helpful for us to know?
  - Adoption
  - Attachment issue

- How does your child best communicate?
  - Verbally
  - PEC cards/picture cards
  - ASL
- How well does your child communicate?
- How will your child react if touched?
- Does your child have obsessive behaviors or get “stuck” in such a way that the child cannot process anything else or move forward until the specific issue is resolved?
- What helps in situations like these?
  - Things to say
  - Favorite topics, interests or toys
- What hurts in situations like these?
  - Are there things that will trigger your child further?
  - Anything to avoid saying or doing?

Note: If the parent is escalating things, it’s okay to redirect the parent to a job or speak with someone else.

> *“The police officer reminded me that my child didn’t do anything wrong and I didn’t do anything wrong. We needed additional help and did the right thing asking for help.” A PPAL caregiver*

From https://afsp.org/social-shareables

WHAT HELPS IMPROVE SAFETY FOR YOUTH

APPROACHES FOR CALMING

CALMING YOUTH THROUGH POLICE ACTIONS

Start the conversation low and slow rather than **HIGH AND LOUD**. When the interaction starts at an elevated level, it's hard to go down.

- Stay calm and manage your own reaction
- Remember the child's age and development
  - One approach does not fit all children
  - Under stress or because of personal challenges, child's abilities may be limited
- Adjust your body language
  - Relaxed/open posture
  - Neutral expressions
  - Use your body's position to help
    - Give youth space
    - Adjust eye level
- Language/tone/pitch that helps
  - Calm and slow
  - Short, simple, and specific statements
  - Empathetic
  - Narrate what you are going to do
  - Offer clear choices
  - Try to avoid saying "DON'T"
  - Praise when possible
  - Ignore escalating language, especially if conversation further dysregulates youth
- Remove upsetting influences, distractions, and people from the scene
- Language to consider:
  - "I understand that this is hard for you."
  - "My job is to help keep everyone safe."
  - "I want to help you and your family."
  - "I hear you saying…"
  - "You seem upset. Help me to understand…"
- Find out what motivates the youth - they have hopes and dreams.

REDIRECTING YOUTH TO NEXT STEPS

- If possible, give youth time to regulate.
  - It's hard to communicate with or redirect someone who is dysregulated.
  - This may include actively ignoring or not answering questions if the conversation is further dysregulating youth.
- Offer clear choices. Ex: "We can talk here or move to the other room."
- Be careful with your language. Literal and concrete is best.
- Repeat yourself.
- Check in with youth to make sure they are understanding you.
- Ask for a nod or thumbs up if youth unable to respond with words.

ASSESSING SAFETY

Part of assessing safety is understanding how the youth is functioning right now. Families can help to answer the question: **What's different about today?**

- How is the youth managing daily activities relative to their typical behaviors? Examples:
  - Energy level: higher or lower than usual? Dysregulated?
  - Sleeping (too much, too little, frequent nightmares?)
  - Frequent temper tantrums (number, length, ability to help console)
  - Excessive or changes in anxiety and worry
- How is the youth managing school and/or other activities relative to their typical behaviors? Examples:
  - Attending school, work, or activities?
  - Completing tasks and schoolwork?
- How is the youth managing interactions with others relative to their typical behaviors? Examples:
  - Engaging with family?
  - Engaging with friends?
  - Frequent aggression?

RECOGNIZING COMMON TRIGGERS FOR ADOLESCENTS

Often something has changed in an adolescent's life over the last day or two.

- Relationships - break ups, challenges, changing friendships
- Schools - suspension, exams, overwhelmed
- Social media - bullying, lack of popularity, challenges fitting in
- Other bullying
- Illness/death of loved ones - human and pets
- LGBTQ+ youth - bullying, isolation, teasing
- Family stress - parent separation, not able to have basic needs met, loss of job, immigration status, homelessness, parental incarceration
- Exposure to abuse
- Traumatic event or disasters, personal or community-wide
- Mental health condition deteriorating. PPAL sees social media stressors, bullying, and isolation contributing to worsening mental health. Youth share worries about conflicting pressures: fitting in vs. not being liked vs. bullying.
- Using alcohol or drugs
- Interactions with police or other officials with badges that trigger youth (e.g. court officials, probation, DCF)

Remember, when a crisis occurs, youth and their families are more likely to respond in a heightened emotional state versus a calm and rational one. Deteriorating mental health further complicates these interactions.

KNOWING THE WARNING SIGNS OF MENTAL ILLNESS
From NAMI: https://www.nami.org/learn-more/know-the-warning-signs

“Symptoms in children may include the following:
- Changes in school performance
- Excessive worry or anxiety, for instance fighting to avoid bed or school
- Hyperactive behavior
- Frequent nightmares
- Frequent disobedience or aggression
- Frequent temper tantrums

“Common signs of mental illness in adults and adolescents can include the following:
- Excessive worrying or fear
- Feeling excessively sad or low
- Confused thinking or problems concentrating and learning
- Extreme mood changes, including uncontrollable “highs” or feelings of euphoria
- Prolonged or strong feelings of irritability or anger
- Avoiding friends and social activities
- Difficulties understanding or relating to other people
- Changes in sleeping habits or feeling tired and low energy
- Changes in eating habits such as increased hunger or lack of appetite
- Changes in sex drive
- Difficulty perceiving reality (delusions or hallucinations, in which a person experiences and senses things that don't exist in objective reality)
- Inability to perceive changes in one’s own feelings, behavior or personality (“lack of insight” or anosognosia)
- Abuse of substances like alcohol or drugs
- Multiple physical ailments without obvious causes (such as headaches, stomach aches, vague and ongoing “aches and pains”)
- Thinking about suicide
- Inability to carry out daily activities or handle daily problems and stress
- An intense fear of weight gain or concern with appearance”

NAMI: National Alliance on Mental Illness. (n.d.). Know the Warning Signs. Retrieved April 13, 2020, from https://www.nami.org/learn-more/know-the-warning-signs

EXPLAINING THE ROLE OF POLICE AND NEXT STEPS TO FAMILIES

Families may need help understanding what happens when police are called, how police officers can help with a youth in crisis, and what happens after they are involved. Families will need and want to be involved in each step.

EXPLAIN TO FAMILIES - AS EARLY AS POSSIBLE - THE ROLE OF POLICE INVOLVEMENT.

Helpful things to explain to families:

- Once involved, police officers are in charge of managing the crisis situation.
- Police officers will want input from the family to help move toward the best possible outcome.
- What police can do:
  - Make the situation safe in the moment.
  - Talk with family members to better understand the situation and help identify best next steps to restore safety.
  - Initiate or facilitate a psychiatric evaluation and stay with family when an ambulance is called.
  - Come back again if the situation does not resolve or gets worse.
  - Offer families resources, such as parent support groups and emergency support lines.

> *"We were scared and confused. It really helped when the officer explained why our child needed an evaluation and what would happen next." A PPAL parent*

WHAT POLICE AND FAMILIES NEED TO KNOW ABOUT PSYCHIATRIC EVALUATIONS AND EMERGENCY ROOM VISITS

WHAT ARE THE MOST COMMON PSYCHIATRIC PROBLEMS THAT SEND CHILDREN TO THE EMERGENCY ROOM?[11]

- Behavioral dysregulation, resulting in a 911 call
- Self-injurious behavior, suicidal ideation, suicide attempt
- Range of behaviors at school, behavioral outburst or talk about hurting themselves or others
- Socioeconomic distress, when a child's behaviors result in the unraveling of untenable situations
- Substance abuse

[11]Child Mind Institute. (n.d.). Kids in Crisis: The View From the ER. Childmind.Org. Retrieved April 13, 2020, from https://childmind.org/article/kids-in-crisis-the-view-from-the-er/

PSYCHIATRIC EVALUATIONS

Most families are unfamiliar with psychiatric evaluations. If police are recommending a psychiatric evaluation, families will benefit from understanding what this means. The following are important points to share with families. PPAL's tip sheet, *PPAL's Guide to Youth Psychiatric Evaluations* can be found at the end of the document and at ppal.net. (Please feel free to share this tip sheet in your community.)

Why evaluate?

- When a youth is a danger to themselves or others, police should initiate a psychiatric evaluation.
  - Sometimes the need for an evaluation is clear to all.
  - Other times the police will need to explain what they are seeing and why an evaluation is a necessary next step.

Who can evaluate?

- Child's provider
- Emergency Service Program/Mobile Crisis Intervention (ESP/MCI), depending on the community, insurance coverage, age of youth
- Hospital Emergency Room (ER)

How does a youth get to a hospital emergency room?

- When police are involved, often an ambulance will be called.
- Parents/caregivers can also bring their youth to a local hospital ER.

What should families bring to the emergency room?

- Insurance card
- Treatment team contacts (therapist, psychiatrist, pediatrician)
- Medication in bottle or medication list
- Bag of items: cash/ATM card, change of clothes, phone charger, pen/paper

What should families expect in the emergency room?

- The wait in the ER is often quite long.
- The hospital will (1) medically stabilize child and (2) evaluate child's safety.
- An evaluation for what level of treatment is most appropriate will be made. Child will be discharged home, stay for further evaluation, or be recommended for inpatient treatment, day treatment/partial hospitalization, or other residential programs.

SUICIDE PREVENTION

In 2017, suicide was the second most common cause of death among children, youth, and adolescents ages 10-24. [12]It is important that police officers understand the risks and warning signs for children, youth, and adolescents.

→ Risk comprises factors that happen over time.
→ Warning signs signal immediate risk for suicide.

As a statewide family organization dedicated to improving the mental health and wellbeing of children, youth, and families, PPAL families think a lot about suicide prevention. Many families have experienced parenting children who are/were actively suicidal. The following information is at the intersection of what's relevant to youth and their families and what is instructive for police departments.

The following section contains information from national sources and addresses

- Facts related to gender and race
- Frequently asked questions
- Information on risk and warning signs
- Tips and questions police can use

It can be hard to identify who is at risk when many of the symptoms of mental health conditions potentially overlap with some common behaviors for children and teens. For this reason, families and police need to take talk or questions of suicide seriously.

[12] Curtin, S. C. (2019). Death Rates Due to Suicide and Homicide Among Persons Aged 10–24: United States, 2000–2017. 352, 8.

MORE THAN SAD is a free education program from The American Foundation for Suicide Prevention that teaches students, educators, and parents how to be smart about mental health.

The following information restates selected slides (with minor editing) from the presentation ***MORE THAN SAD, Suicide Prevention Education for Teachers and Other School Personnel*** PowerPoint by American Foundation for Suicide Prevention. (2019, March 12). https://afsp.org/our-work/education/more-than-sad/

RACE AND GENDER

US Youth Suicide Rates and Gender

At age 12, there is little difference between the suicide rate for boys and girls.

By age 18, the boys' rate is 5 times higher than the girls' rate (15 suicides per 100,000 boys vs. 3 per 100,000 girls).

This difference between the sexes remains through young adulthood, peaking at age 22, when the male suicide rate is more than 6 times the female rate.

Data: CDC 2017

Why the difference between gender? Some common reasons include:

It's more culturally acceptable for girls to seek help.

Gender differences in traits like aggression and impulsivity are thought to contribute to the higher rate of suicide in males across all ages.

Boys typically choose more lethal methods, such as firearms.

Suicide Rates by Race and Ethnicity

By Race (ages 10-24)

Racial Group	*Suicide Rate per 100,000*
American Indian/Alaskan Native	*16.24*
White	*11.26*
Asian/Pacific Islander	*8.42*
Black	*7.66*

By Ethnicity (Ages 10-24)

Ethnic Group	*Suicide Rate per 100,000*
Hispanic	*7.18*

Source: CDC, 2017

American Academy of Child & Adolescent Psychiatry Suicide Resource Center Frequently Asked Questions

HOW COMMON IS SUICIDE IN CHILDREN AND ADOLESCENTS?

Over 5,200 young people commit suicide each year. Suicide is the 2nd leading cause of death among young people 10 to 24 years of age, following unintentional injuries. For each completed suicide, there are several thousand attempts. Surveys of high school students indicate that 17.2% of high schoolers think about suicide each year, and by the end of high school, at least 7.4% of all children have actually made at least one suicide attempt. Although girls are twice as likely to attempt suicide, boys actually account for almost 80% of all suicide related deaths.

WHAT CAUSES SUICIDE IN CHILDREN AND ADOLESCENTS?

Thoughts about suicide and suicide attempts are often most often associated with depression. In addition to depression, other risk factors include:

- family history of suicide attempts
- exposure to violence
- impulsivity
- aggressive or disruptive behavior
- access to firearms
- substance abuse
- bullying
- feelings of hopelessness or helplessness
- acute loss or rejection

WHAT ARE THE WARNING SIGNS ASSOCIATED WITH CHILD AND ADOLESCENT SUICIDE?

Among both children and adolescents, the warning signs of suicide can include:

- Changes in eating or sleeping habits
- Frequent or pervasive sadness
- Withdrawal from friends, family and regular activities
- Frequent complaints about physical symptoms often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Decline in the quality of schoolwork
- Preoccupation with death and dying
- Among teenagers, the warning signs of suicide can also include:
- Drug or alcohol use
- Violent actions, rebellious behavior or running away
- Unusual neglect of personal appearance
- Marked personality change
- Loss of interest in pleasurable activities

Young people who are thinking about suicide may also stop planning for or talking about the future. They may begin to give away important possessions. They may also make overtly suicidal statements or comments such as, "I wish I was dead," or "I won't be a problem for you much longer."

Any child or adolescent with suicidal thoughts, plans or warning signs should be evaluated immediately by a trained and qualified mental health professional.

WHAT SHOULD I DO IF MY CHILD OR ADOLESCENT TALKS ABOUT SUICIDE?

If a child or adolescent says, “I want to kill myself” or “I’m going to commit suicide” always take the statement seriously and immediately seek assistance from a qualified mental health professional. People often feel uncomfortable talking about suicide. However, 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 you care and will give the young person the chance to talk about his or her problems.

Reprinted from American Academy of Child and Adolescent Psychiatry. (n.d.). Suicide Resource Center Frequently Asked Questions. Retrieved February 21, 2020, from https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Suicide_Resource_Center/FAQ.aspx#q1

https://afsp.org/social-shareables

Threats by Children: When are They Serious?
American Academy of Child & Adolescent Psychiatry *Facts for Families*

Every year there are tragedies in which children or adolescents shoot and kill people after making threats. When this occurs, everyone asks themselves, "How could this happen?" and "Why didn't we take the threat seriously?"

Most threats made by children or adolescents are not carried out. Many such threats are the child's way of talking big or tough, or trying to get attention. Sometimes these threats are a reaction to a perceived hurt, disappointment, or rejection.

What threats should be taken seriously?

Examples of potentially dangerous or emergency situations with a child or adolescent include:

- threats or warnings about hurting or killing oneself
- threats or warnings about hurting or killing someone
- threats to run away from home
- threats to damage or destroy property

Child and adolescent psychiatrists and other mental health professionals agree that it is very difficult to predict a child's future behavior. A person's past behavior, however, is still one of the best predictors of future behavior. For example, a child with a history of violent or assaultive behavior is more likely to carry out his/her threats and become violent.

When is there more risk associated with threats from children and adolescents?

The presence of one or more of the following increases the risk of violent or dangerous behavior:

- past violent or aggressive behavior (including uncontrollable angry outbursts)
- access to guns or other weapons
- bringing a weapon to school
- past suicide attempts or threats
- family history of violent behavior or suicide attempts
- blaming others and/or unwilling to accept responsibility for one's own actions
- recent experience of humiliation, shame, loss, or rejection
- bullying or intimidating peers or younger children
- a pattern of threats
- being a victim of abuse or neglect (physical, sexual, or emotional)
- witnessing abuse or violence in the home
- themes of death or depression repeatedly evident in conversation, written expressions, reading selections, or artwork

- preoccupation with themes and acts of violence in TV shows, movies, music, magazines, comics, books, video games, and internet sites
- mental illness, such as depression, mania, psychosis, or bipolar disorder
- use of alcohol or illicit drugs
- disciplinary problems at school or in the community (delinquent behavior)
- past destruction of property or vandalism
- cruelty to animals
- fire setting behavior
- poor peer relationships and/or social isolation
- involvement with cults or gangs
- little or no supervision or support from parents or other caring adult

What should be done if parents or others are concerned?

When a child makes a serious threat, it should not be dismissed as just idle talk. Parents, teachers, or other adults should immediately talk with the child. If it is determined that the child is at risk and/or the child refuses to talk, is argumentative, responds defensively, or continues to express violent or dangerous thoughts or plans, arrangements should be made for an **immediate assessment** by a mental health professional with experience evaluating children and adolescents. Evaluation of any serious threat must be done in the context of the individual child's past behavior, personality, and current stressors. In an emergency situation or if the child or family refuses help, it may be necessary to contact local police for assistance or take the child to the nearest emergency room for evaluation. Children who have made serious threats must be carefully supervised while awaiting professional intervention. Immediate evaluation and appropriate ongoing treatment of youngsters who make serious threats can help the troubled child and reduce the risk of tragedy.

Reprinted from American Academy of Child and Adolescent Psychiatry. (2019).
Threats by Children: When are they Serious? (No. 65; Facts for Families).
https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Childrens-Threats-When-Are-They-Serious-065.aspx

HOW POLICE OFFICERS CAN HELP PREVENT SUICIDE[13]

ASSESS: Is this a bad day or are depression/anxiety snowballing?

"Fact: 9 in 10 teens who take their own lives met criteria for a diagnosis of psychiatric or mental health condition or disorder—more than half of them with a mood disorder such as depression or anxiety." [14]

How is this fact important to police assessment? *"Depressed people often retreat into themselves, when secretly they're crying out to be rescued. Many times they're too embarrassed to reveal their unhappiness to others, including Mom and Dad. Boys in particular may try to hide their emotions, in the misguided belief that displaying the feeling is a fifty-foot-high neon sign of weakness."* [14]

LISTEN: What is being said and unsaid?

"Not all, but most kids who are thinking about suicide (this is called suicidal ideation) tip off their troubled state of mind through troubled behaviors and actions. Studies have found that one trait common to families affected by a son's or daughter's suicide is poor communication between parents and child. However, there are usually three or more issues or factors going on all at once in a child's life at the time when he or she is thinking about taking his or her life." [14]

KNOW: "Never shrug off threats of suicide as typical teenage melodrama" [14]

"Any written or verbal statement of 'I want to die' or 'I don't care anymore' should be treated seriously. Often, children who attempt suicide had been telling their parents repeatedly that they intended to kill themselves… the threat is a desperate plea for help." [14]

"'Red flags' warrant your immediate attention and action by seeking professional help right away:

- *"Nothing matters."*
- *"I wonder how many people would come to my funeral?"*
- *"Sometimes I wish I could just go to sleep and never wake up."*
- *"Everyone would be better off without me."*
- *"You won't have to worry about me much longer."* [14]

RESPOND: When teenagers talk about suicide or make these sorts of comments, APA advises

- Do not react with shock ("What are you, crazy?!") or scorn ("That's a ridiculous thing to say!").
- Do not say, "You don't mean that!"
- Be willing to listen nonjudgmentally. "In a calm voice, you might say, "I see. You must really, really be hurting inside."

[13] Adapted with minor edits from 10 Things Parents Can Do to Prevent Suicide. (2019, January 17). [American Academy of Pediatrics]. HealthyChildren.Org. https://www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Te n-Things-Parents-Can-Do-to-Prevent-Suicide.aspx

QUESTIONS POLICE CAN ASK TO HELP PREVENT SUICIDE

It's okay to ask questions about suicide

- Asking questions does not cause youth to become suicidal.
- Your comfort asking about suicide will be important for effective inquiry.
- Questions are best when they are short, to the point, developmentally appropriate and nonjudgmentally asked.

Consider these suggestions when talking with youth of different ages[15]

- The approach is similar for tweens (8-12 years) and teens (13-17 years).
- Change language based on the youth's level of sophistication and self-awareness.
- Use language that makes sense, taking into account age, development and what you know they are thinking about.
- For **younger children**,
  - Ask about physical symptoms, like stomach aches.
  - Ask about changes in feelings, like getting upset or angry more lately.
  - If it seems to you that they feel hopeless, trapped or overwhelmed, ask if they ever think about hurting themselves or ending their life.
- For **older children** (or those with demonstrated awareness of their thoughts and feelings), about
  - Ask their understanding of the situation.
  - Ask about other symptoms like
    - sleep problems.
    - mood changes.
    - feelings of hopelessness.
    - feeling trapped or overwhelmed.

Possible questions to ask if you are concerned a youth may be suicidal

- What do you think happens when you die? (*younger children*)
- Do you wish you could go to sleep and not wake up? (*younger children*)
- Have you thought of suicide? (*older children*)
- Have you ever tried to kill yourself? (*older children*)
- Are you thinking of hurting yourself? Killing yourself? (*older and younger children*)
- Do you feel so bad that you have thoughts of dying? How often? (older and younger children)

Questions adapted from sources [14 and 15]

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[14] Kennebeck, MD, S., & Bonin, PhD, L. (2018, June 27). S*uicidal ideation and behavior in children and adolescents: Evaluation and management*. UpToDate. https://www.uptodate.com/contents/suicidal-ideation-and-behavior-in-children-and-adolescents-evaluation-and-management

[15] American Foundation for Suicide Prevention. (2017, April 26). *Teens and Suicide: What Parents Should Know*. AFSP. https://afsp.org/campaigns/talk-about-mental-health-awareness/teens-and-suicide-what-parents-should-know/

POLICE POCKET GUIDE RESOURCES

All resources can be found at PPAL's website https://ppal.net/

PPAL RESOURCES FOR FAMILIES

1. Mental Health and Emergency Resources for Families, Youth and Young Adults
2. Mental Health and Emergency Resources for Transition-age Youth and their Families
3. Guide to Youth Psychiatric Evaluations

PPAL RESOURCES FOR FIRST RESPONDERS

4. Mental Health Concerns
5. Psychiatric Medications
6. Alphabet Soup
7. Glossary of Commonly Used Words in the Care of Youth with Mental Health Needs
8. Resources for First Responders

MENTAL HEALTH AND EMERGENCY RESOURCES FOR FAMILIES, YOUTH AND YOUNG ADULTS

Emergency Resources Available 24/7

It's okay to ask for help. These Massachusetts and national resources are free and confidential support lines

EMERGENCY CLINICAL ASSESSMENT

Massachusetts Emergency Service Program/Mobile Crisis Intervention
Teams of clinicians available for mental health and substance abuse crisis assessment, intervention and stabilization services. *These services are available for many, **not all**, children, adolescents and young adults depending on location and/or insurance.*

Call 1-877-382-1609
Additional information: www.masspartnership.com/member/ESP.aspx

RUNAWAY/HOMELESS YOUTH SUPPORT

National Runaway Safeline
Hotline for youth who are thinking about running away or already have. Families can get support and be connected to resources.

Call 1-800-786-2929
Additional information: https://www.1800runaway.org/

Basic Centers

Locate Basic Centers throughout the United States and additional information/support services. (Note: Not a 24/7 call center.)

Call: 1-800-621-4000
Additional information: https://www.benefits.gov/benefit/625

DOMESTIC VIOLENCE

MASSACHUSETTS SafeLink
Free. 24/7 domestic violence hotline and a resource for anyone affected by domestic or dating violence. English and Spanish speaking volunteers. Support for other languages.

Call 1-877-785-2020
Additional information: https://www.casamyrna.org/get-support/safelink/

National Domestic Violence Hotline
Free. 24/7 confidential hotline.

Call: 1-800-799-7233
Additional information https://www.thehotline.org/

SUICIDE OR EMOTIONAL CRISIS LINE SUPPORTS

Support from trained staff for yourself or someone you are worried about.

National Suicide Prevention Lifeline*
Call 800-273-TALK (8255) for crisis support.
TTY: 1-800-799-4889 Spanish: 1-888-628-9454
Online chat and additional information: www.suicidepreventionlifeline.org

Crisis Text Line*
Text HOME to 741741 for crisis support.
Additional information: www.crisistextline.org

Samaritans Massachusetts Helpline
Call or text 1-877-870-4673 for crisis support.
Additional information: https://samaritanshope.org/

Crisis Lines for LGBTQ Youth
Trevor Project*
Provides suicide prevention and crisis intervention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people.
Trevor Lifeline: Call 1-866-488-7386
TrevorText: Text START to 678678
TrevorChat and additional information: www.thetrevorproject.org/Help

Trans Lifeline*
Provides emotional and financial support to transgender people in crisis.
Call 1-877-565-8860
Additional information: http://www.translifeline.org

***Information from:** https://www.sprc.org/livedexperience/tool/crisis-lines

CRISIS LINE FOR SEXUAL ASSAULT SURVIVORS

Rape, Abuse and Incest National Network (RAINN), National Sexual Assault Hotline

Call 1-800-656-4673 for confidential support, information, advice or referrals in English or Spanish.

Please make sure you are in a safe place and that you are using a secure device and Internet connection.

Additional information: https://www.rainn.org/

AFTER A CRISIS: Resources for Accessing Mental Health and Crisis Services and Supports

If you have this resource, it's likely the last few days have been tough for your family. We get it! We know what it's like to feel scared, alone, worried and confused about what to do next. That's why we have prepared this resource to help you identify additional information, resources or support

SUPPORT DURING BUSINESS HOURS

PPAL (Parent Professional Advocacy League)

PPAL's focus is helping families whose children have ***emotional, behavioral and mental health needs*** in Massachusetts. PPAL is a family-based and statewide organization. Families are encouraged to call the PPAL offices (Statewide or Worcester) for more information on family support and youth programming. PPAL staff can also help families with youth involved in the juvenile justice system. For more information and resources and a list of statewide family support groups, go to:
http://ppal.net/

Call Statewide Office (Waltham): 1-617-542-7860
Call Worcester Office: 1-508-767-9725

Youth MOVE Massachusetts
Youth Move Massachusetts is a youth-led national organization empowering young adults to use their voices to change the mental health, juvenile justice, child welfare and education systems. For more information about community-based individual and group peer support resources, and more, go to:
https://youthmovemassachusetts.net/

NAMI Massachusetts
NAMI Mass offers education and support for families. Families can call NAMI Mass Compass for help answering questions on mental health topics and finding resources.
Additional information:
https://namimass.org/ or COMPASS@namimass.org

Call 1-617-704-6264 / 1-800-370-9085

William James College INTERFACE Referral Service
INTERFACE provides a free, ***confidential mental health and wellness referral Helpline*** for families in many communities. See website for participating communities. For all families, INTERFACE website offers many resources for families and youth.
Additional information:
https://interface.williamjames.edu/

Call 1-888-244-6843

Network of Care Massachusetts

Comprehensive, searchable directory to help Massachusetts residents find information on mental health, substance use and related social services and supports in their communities. Directory includes 5,000+ programs and organizations, searchable by keyword and zip code. Program descriptions include contact information, as well as information on populations served, relevant eligibility and fee information.
https://massachusetts.networkofcare.org/mh/

FAMILY CRISIS GUIDES

A Parent and Caregiver Guide to Helping Your Family Before, During, and After a Crisis (2019) from Judge Baker Children's Center includes tools and practical steps for helping a family member know who to call when things feel out of control and how to increase a family's ability to manage a crisis should it occur.
English & Spanish guide:
https://jbcc.harvard.edu/resources

Crisis Planning Guide for Parents (1998) from PPAL in English & Spanish
http://ppal.net/publications/guides

If You Are Experiencing a Crisis from NAMI Mass
https://namimass.org/in-a-crisis/

LOOKING FOR A REFERRAL TO CLINICAL SERVICES

Organizations that may be able to help:

- Pediatrician/doctor for referral to MCPAP
  https://www.mcpap.com/Default.aspx
- PPAL https://ppal.net/
- Youth MOVE Massachusetts
  https://youthmovemassachusetts.net/
- Behavioral Health Services for Children and Adolescents
  https://ppal.net/general-information/
- Children's Behavioral Health Initiative
  https://www.mass.gov/childrens-behavioral-health-initiative-cbhi
- Mass Family Voices
  https://fcsn.org/mfv/
- NAMI Massachusetts
  https://namimass.org/
- School clinics

PPAL'S GUIDE TO YOUTH PSYCHIATRIC EVALUATIONS

Why evaluate?

- When a youth is a danger to themselves or others, police should initiate a psychiatric evaluation.
- Sometimes the need for an evaluation is clear to all.
- Other times the police will need to explain what they are seeing and why an evaluation is a needed next step.
- Police: Be sure to ask youth/family if the youth has a therapist or psychiatrist to be contacted.

Who can evaluate?

- Child's provider: If the child has a therapist or psychiatrist, police can stay with the family as they try to reach the provider for guidance.
- Emergency Service Program/Mobile Crisis Intervention (ESP/MCI): In Massachusetts, police may be able to call for MCI to come to the child for crisis assessment. This service is available 24/7 and may be able to provide intervention, stabilization and care coordination. MCI services are available to many but may not be available to everyone depending on age/insurance.
- Hospital Emergency Room

How does a youth get to a hospital emergency room (ER)?

- Often if police are involved, an ambulance will be called. The ambulance employees will ask questions, much like the ones police asked, to understand the situation and be able to communicate with the hospital staff. Police will stay on the scene to help share information with the ambulance company. Sometimes police will be able to share information directly with hospital staff. Sometimes, but not always, a family member can ride with the youth.
- Parents/caregivers can bring their child to a local hospital emergency room.

What should families bring to the emergency room?

- Insurance card
- Treatment team contacts (therapist, psychiatrist, pediatrician)
- Medication in bottle or medication list
- Bag (cash/ATM card, change of clothes, phone charger, pen/paper)
- What happens when youth arrive in the emergency room?
- Expect to wait. The emergency room may be crowded and chaotic and take a long time. This waiting is challenging and frustrating and it's just the way it is.
- Families:
  - Need to be prepared to share relevant history of treatment, hospital psychiatric evaluations and hospital stays
  - Should try to take notes about everything - who talks with you and your child, recommendations, etc.
  - Stay with their children. (It's okay to ask for time to make calls, use the bathroom, get some food, etc.)

- In the emergency room:
- Medical stabilization is the first priority.
- Your child will be supported to be safe.
  - Several hospital staff members will ask for information, most often triage nurses, pediatricians and psychiatric teams. Each has a slightly different role in the assessment.
  - An emergency evaluation will assess safety and focus on three issues: thoughts, plans and intent. *Right now, is your child a danger to themselves or others.*

What happens during the emergency room evaluation?

- Medical team will talk with the parent/guardian and their child.
- Often the medical team will ask to speak with a child alone. This is okay and important as it is not uncommon for children to hide or protect parents from their pain and suicidal thoughts/plans. Parents can ask to speak to the medical team alone.
- Families can request a Patient Advocate to help explain the process and move things along.

What happens as a result of the emergency room evaluation?

Evaluation may be called disposition

- ER psychiatric evaluation IS an evaluation for what level of treatment is most appropriate. (Options range from discharged to home to inpatient hospitalization.)
- ER psychiatric evaluation IS NOT a time for specific recommendations regarding behavioral management or medications.

What are the most common disposition options?

- Discharged to home:
  - Youth may be discharged to home with or without recommendations for additional treatment.
  - If discharged with recommendation for outpatient treatment, caregivers should receive the following information
    - When to bring youth back to hospital for dangerous behaviors.
    - Safety suggestions for things to put away/change at home to make the environment safer.
- Recommended for hospitalization (inpatient treatment or day program/partial hospitalization):
  - *Inpatient treatment* - Youth may be transferred to an inpatient care unit. It's likely the child will need to wait for some time in the ER, possibly days, until a bed is found. The hospital will make a recommendation based on insurance, age, needs of child, location of hospital, etc. Parents are encouraged to ask questions about the options.
  - *Other hospital-level treatment* may include day programs (also called partial hospitalization), CBATs (community based acute treatment), ART (acute residential treatment).

What should a family do if they don't agree with a hospital's recommendations?

- State and document concerns with emergency room staff
- Consider filing a complaint with the Department of Public Health who licenses hospital ERs.
- Contact PPAL if you need assistance. https://www.mass.gov/how-to/file-a-complaint-regarding-a-hospital

Helpful Information

Julia Johnson Attaway's *"Taking a Child to the Emergency Room: An open letter about what the ER can (and can't) do for your child in a psychiatric emergency"*
https://childmind.org/article/taking-a-child-to-the-emergency-room/

MENTAL HEALTH CONCERNS

The challenging behaviors first responders are called to address **may** be the result of a mental health or related disorder. As a first responder, understanding the signs and symptoms is crucial to recognize a youth's needs IN THE **MOMENT**.

Some children and adolescents face serious challenges in their ability to handle emotions, behave, or learn as a result of mental health issues and other disorders and/or concerns, such as learning disabilities, developmental disabilities, autism or substance use. The cause of these issues is often multi-faceted. Common causes include genetics, environment, trauma, brain structure, physical illness, and peer pressure.

Treatment is possible for each of the following conditions and disorders. Appropriate evaluations and early treatment/intervention are always important. Medication, therapy and specialized school instruction may be part of the plan to best support a youth.

The following pages briefly describe some of the most commonly diagnosed mental health concerns and related disorders that impact children and adolescents. As a non-profit family advocacy organization, PPAL relies on clinical information from trusted resources. The following definitions come from several national organizations. All information has been cited.

For more detailed information on mental health concerns and disorders, please see the following resources.

- **American Academy of Child & Adolescent Psychiatry's** (AACAP) Family Resources, including Glossary of Symptoms and Illnesses and Facts for Families https://www.aacap.org/AACAP/Families_and_Youth/Family_Resources/Home.aspx
- **American Psychiatry Association** (APA) https://www.psychiatry.org/patients-families
- **Child Mind Institute's** *Topics A-Z* https://childmind.org/topics-a-z/
- **National Alliance on Mental Illness** (NAMI) Mental Health Conditions https://www.nami.org/Learn-More/Mental-Health-Conditions
- **National Institute of Mental Health** (NIMH) https://www.nimh.nih.gov/health/publications/children-and-adolescents-listing.shtml

ALCOHOL AND DRUG ABUSE

AACAP explains:

"Experimentation with alcohol and drugs during adolescence is common. Unfortunately, teenagers often don't see the link between their actions today and the consequences tomorrow. They also have a tendency to feel indestructible and immune to the problems that others experience.

"Using alcohol and tobacco at a young age has negative health effects. Some teens will experiment and stop, or continue to use occasionally without significant problems. Others will develop a dependency, moving on to more dangerous drugs and causing significant harm to themselves and possibly others. It is difficult to know which teens will experiment and stop and which will develop serious problems. Teenagers at risk for developing serious alcohol and drug problems include those:

- with a family history of substance use disorders
- who are depressed
- who have low self-esteem, and
- who feel like they don't fit in or are out of the mainstream

"Warning signs of teenage alcohol and drug use may include:

Physical: Fatigue, repeated health complaints, red and glazed eyes, and a lasting cough.

Emotional: personality change, sudden mood changes, irritability, irresponsible behavior, low self-esteem, poor judgment, depression, and a general lack of interest.

Family: starting arguments, breaking rules, or withdrawing from the family.

School: decreased interest, negative attitude, drop in grades, many absences, truancy, and discipline problems.

Social problems: new friends who are less interested in standard home and school activities, problems with the law, and changes to less conventional styles in dress and music." [1]

[1] American Academy of Child and Adolescent Psychiatry. (2018). Teens: Alcohol and Other Drugs (No. 3; Facts for Families). American Academy of Child and Adolescent Psychiatry.

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teens-Alcohol-And-Other-Drugs-003.aspx

ANXIETY DISORDERS

AACAP defines anxiety as “fearful anticipation of further danger or problems, accompanied by an intense unpleasant feeling (dysphoria) or physical symptoms”[2] While everyone experiences anxiety sometimes, children with anxiety disorders are overwhelmed by intense feelings that do not match the situation or triggers. Anxiety in children may present as:

1. **“Separation Anxiety Disorder:** Excessive anxiety concerning separation from home or from those to whom the child is attached. The youngster may develop excessive worrying to the point of being reluctant or refusing to go to school, being alone, or sleeping alone. Repeated nightmares and complaints of physical symptoms (such as headaches, stomach aches, nausea, or vomiting) may occur.
2. **“Generalized Anxiety Disorder:** Excessive anxiety and worry about events or activities such as school. The child or adolescent has difficulty controlling worries. There may also be restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep difficulties.
3. **“Panic Disorder:** The presence of recurrent, unexpected panic attacks and persistent worries about having attacks. Panic Attack refers to the sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. There may also be shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of "going crazy" or losing control.
4. **“Phobias:** Persistent, irrational fears of a specific object, activity, or situation (such as flying, heights, animals, receiving an injection, seeing blood). These intense fears cause the child or adolescent to avoid the object, activity, or situation.” [3]

ATTACHMENT DISORDERS

AACAP explains: “Attachment Disorders are psychiatric illnesses that can develop in young children who have problems in emotional attachments to others. Parents, caregivers, or physicians may notice that a child has problems with emotional attachment as early as their first birthday. Often, a parent brings an infant or very young child to the doctor with one or more of the following concerns:

- severe colic and/or feeding difficulties
- failure to gain weight
- detached and unresponsive behavior
- difficulty being comforted
- preoccupied and/or defiant behavior
- inhibition or hesitancy in social interactions
- being too close with strangers

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[2] American Academy of Child and Adolescent Psychiatry. (n.d.). Anxiety. American Academy of Child and Adolescent Psychiatry. Retrieved February 3, 2020, from https://www.aacap.org/AACAP/Families_and_Youth/Glossary_of_Symptoms_and_Illnesses/Anxiety.aspx

[3] American Academy of Child and Adolescent Psychiatry. (n.d.). Anxiety. American Academy of Child and Adolescent Psychiatry. Retrieved February 3, 2020, from https://www.aacap.org/AACAP/Families_and_Youth/Glossary_of_Symptoms_and_Illnesses/Anxiety.aspx

"Most children with attachment disorders have had severe problems or difficulties in their early relationships. They may have been physically or emotionally abused or neglected. Some have experienced inadequate care in an institutional setting or other out-of-home placement. Examples of out-of-home placements include residential programs, foster care or orphanage. Others have had multiple traumatic losses or changes in their primary caregiver. The exact cause of attachment disorders is not known, but research suggests that inadequate care-giving is a possible cause. The physical, emotional and social problems associated with attachment disorders may persist as the child grows older.

"Children who have attachment issues can develop two possible types of disorders: Reactive Attachment Disorder and Disinhibited Social Engagement Disorder.

Reactive Attachment Disorder (RAD)
"Children with RAD are less likely to interact with other people because of negative experiences with adults in their early years. They have difficulty calming down when stressed and do not look for comfort from their caregivers when they are upset. These children may seem to have little to no emotions when interacting with others. They may appear unhappy, irritable, sad, or scared while having normal activities with their caretaker. The diagnosis of RAD is made if symptoms become chronic.

Disinhibited Social Engagement Disorder (DSED)
"Children with DSED do not appear fearful when meeting someone for the first time. They may be overly friendly, walk up to strangers to talk or even hug them. Younger children may allow strangers to pick them up, feed them, or give them toys to play with. When these children are put in a stranger situation, they do not check with their parents or caregivers, and will often go with someone they do not know."[4]

ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD)

Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most common mental conditions impacting children. AACAP explains that ADHD "is a condition which includes difficulties with attention, increased activity, and difficulties with impulsivity. Estimates show that between 3 and 7 percent of school-aged children and about 4 percent of adults have ADHD."

Children with ADHD may find it difficult to concentrate, stay on task, manage impulsive behaviors and act in a way that matches expectations at school or home. Law enforcement officers may encounter youth with ADHD who behave impulsively and act before they think about the risks or consequences of their actions.

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[4] American Academy of Child and Adolescent Psychiatry. (2014). Attachment Disorders (No. 85; Facts for Families). https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Attachment-Disorders-085.aspx

[5] American Academy of Child and Adolescent Psychiatry. (2018, July). ADHD Resource Center. American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/ADHD_Resource_Center/Home.aspx

AUTISM SPECTRUM DISORDER

APA explain that "Autism Spectrum Disorder (ASD) is a complex developmental disorder that can cause problems with thinking, feeling, language and the ability to relate to others. It involves persistent challenges in social interaction, speech and nonverbal communication, and restricted/ repetitive behaviors. The effects of ASD and the severity of symptoms are different in each person."

"Characteristics of autism spectrum disorder fall into two categories.

- **Social interaction and communication problems:** including difficulties in normal back-and-forth conversation, reduced sharing of interests or emotions, challenges in understanding or responding to social cues such as eye contact and facial expressions, deficits in developing/maintaining/ understanding relationships (trouble making friends), and others.
- **Restricted and repetitive patterns of behaviors, interests or activities:** hand-flapping and toe-walking, playing with toys in an uncommon way (such as lining up cars or flipping objects), speaking in a unique way (such as using odd patterns or pitches in speaking or "scripting" from favorite shows), having significant need for a predictable routine or structure, exhibiting intense interests in activities that are uncommon for a similarly aged child, experiencing the sensory aspects of the world in an unusual or extreme way (such as indifference to pain/temperature, excessive smelling/touching of objects, fascination with lights and movement, being overwhelmed with loud noises, etc), and others." [6]

BORDERLINE PERSONALITY DISORDER & OTHER PERSONALITY DISORDERS

APA explains:

"There are 10 specific types of personality disorders. Personality disorders are long-term patterns of behavior and inner experiences that differ significantly from what is expected. The pattern of experience and behavior begins by late adolescence or early adulthood and causes distress or problems in functioning. Without treatment, personality disorders can be long-lasting. Personality disorders affect at least two of these areas:

- Way of thinking about oneself and others
- Way of responding emotionally
- Way of relating to other people
- Way of controlling one's behavior" [7]

Borderline Personality Disorder

APA defines Borderline Personality Disorder as "a pattern of needing to be taken care of and submissive and clingy behavior. People with dependent personality disorder may have difficulty making daily decisions without

[6] American Psychiatric Association. (n.d.). Get Help With Autism. Psychiatry.Org. Retrieved May 29, 2020, from https://www.psychiatry.org/patients-families/autism

[7] American Psychiatric Association. (2018, November). What Are Personality Disorders? American Psychiatric Association. https://www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders

reassurance from others or may feel uncomfortable or helpless when alone because of fear of inability to take care of themselves." [8]

AACAP explains: "Young people may be moody and irritable at times. They may also feel sensitive to being left out. Learning how to regulate emotions is a normal part of growing up. For some teens these emotions can be more extreme and a sign of serious problems. If your teen is experiencing intense and frequent mood swings, impulsive behaviors, self-harm or difficulties in relationships, it could be due to a psychiatric condition called Borderline Personality Disorder (BPD).

Common signs of BPD include:

- Problems managing thoughts and feelings such as:
  - Frequent dramatic mood swings
  - Episodes of rage
  - Feeling "empty" or "numb"
  - Frequent changes in self image
  - Suicidal thoughts
- Dangerous and impulsive behaviors such as:
  - Self-harm (e.g. cutting or burning oneself)
  - Suicidal behaviors
  - Unsafe sexual encounters
  - Illegal drug use
- Problems in relationships such as:
  - Poor boundaries
  - Intense and unstable relationships
  - Frantic efforts to avoid rejection or abandonment
  - Feeling misunderstood" [9]

CONDUCT DISORDERS, INCLUDING OPPOSITIONAL DEFIANT DISORDER (ODD)

The Child Mind Institute explains that children with behavior and conduct disorders "have problems with control of their emotions and behavior. While all children are occasionally unable to control their impulses, these children have unusual difficulty for their age, resulting in behavior that violates the rights of others and/or brings them into conflict with authority figures." [10]

Conduct disorders differ from behaviors often seen in teens. AACAP explains:

"'Conduct disorder' refers to a group of repetitive and persistent behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules, respecting the rights of others, showing empathy, and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than

[8] American Psychiatric Association. (2018, November). What Are Personality Disorders? American Psychiatric Association. https://www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders

[9] American Academy of Child and Adolescent Psychiatry. (2019). *Borderline Personality Disorder in Young People* (No. 127; Facts for Families). American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Borderline_Personality_Disorder_Young_People-127.aspx

[10] Child Mind Institute. (n.d.). Behavior and Conduct Disorders in Children. Child Mind Institute. Retrieved February 3, 2020, from https://childmind.org/topics/disorders/behavior-and-conduct-disorders/

mentally ill. Many factors may lead to a child developing conduct disorder, including brain damage, child abuse or neglect, genetic vulnerability, school failure, and traumatic life experiences." [11]

Behaviors that may occur: [12]
- Aggression to people and animals
- Destruction of property
- Deceitfulness, lying or stealing
- Serious violation of rules

There is "a repetitive and persistent pattern of behavior in which they violate the rights of others, or violate norms or rules that are appropriate to their age." [13] This severe behavior can be seen at home, at school and in the community.

Oppositional Defiant Disorder (ODD)

AACAP explains: "All children are oppositional from time to time, particularly when tired, hungry, stressed, or upset. They may argue, talk back, disobey, and defy parents, teachers, and other adults. Oppositional behavior is a normal part of development for two to three year olds and early adolescents. However, openly uncooperative and hostile behavior becomes a serious concern when it is so frequent and consistent that it stands out when compared with other children of the same age and developmental level and when it affects the child's social, family, and academic life.

"In children with *Oppositional Defiant Disorder (ODD)*, there is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the child's day to day functioning.

"Symptoms of *ODD* may include:
- Frequent temper tantrums
- Excessive arguing with adults
- Often questioning rules
- Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehavior
- Often being touchy or easily annoyed by others
- Frequent anger and resentment
- Mean and hateful talking when upset
- Spiteful attitude and revenge seeking

"The symptoms are usually seen in multiple settings but may be more noticeable at home or at school." [14]

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[11] American Academy of Child and Adolescent Psychiatry. (2018). *Conduct Disorder* (No. 33; Facts for Families). American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Conduct-Disorder-033.aspx

[12] American Academy of Child and Adolescent Psychiatry. (2018). *Conduct Disorder* (No. 33; Facts for Families). American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Conduct-Disorder-033.aspx

[13] American Academy of Child and Adolescent Psychiatry. (n.d.). *Conduct Disorder*. American Academy of Child and Adolescent Psychiatry. Retrieved February 3, 2020, from https://www.aacap.org/AACAP/Families_and_Youth/Glossary_of_Symptoms_and_Illnesses/Conduct_Disorder.aspx

[14] American Academy of Child and Adolescent Psychiatry. (2019). *Oppositional Defiant Disorder* (No. 72; Facts for Families). American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Children-With-Oppositional-Defiant-Disorder-072.aspx

Bipolar Disorder (Manic-Depression) "Bipolar disorder is a brain disorder that causes severe or unusual shifts in mood, energy level, thinking, and behavior. People with bipolar disorder experience episodes of mania where they have overly happy or extremely irritable moods and increases in energy." [15]

Depression According to *Depression: Parents' Medication Guide* by AACAP and APA

"Depression is a serious illness that can affect almost every part of a young person's life and significantly impact his or her family. Depression is a type of mood disorder that can damage relationships among family members and friends, harm school performance, and limit other educational opportunities. Depression can negatively affect eating, sleeping, and physical activity. Because it can result in so many health problems, it is important to recognize the signs of depression and get the right treatment. When depression is treated successfully, most children can get back on track with their lives.

"Although depression can occur in young children, it is much more common in adolescents (youth ages 12–18 years). Depression before children reach puberty occurs equally in boys and girls. After puberty, depression is more common in girls." [16]

[15] American Academy of Child and Adolescent Psychiatry. (n.d.). *Bipolar Disorder (Manic Depression)*. American Academy of Child and Adolescent Psychiatry. Retrieved February 3, 2020, from https://www.aacap.org/aacap/families_and_youth/glossary_of_symptoms_and_illnesses/Bipolar_Disorder.aspx

[16] American Academy of Child and Adolescent Psychiatry, & American Psychiatric Association. (2018). *Depression: Parents' Medication Guide*. https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/DepressionGuide-web.pdf

EATING DISORDERS: ANOREXIA NERVOSA, BULIMIA NERVOSA AND AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

AACAP explains:

“Disordered eating related to stress, poor nutritional habits, and food fads are relatively common problems for youth. In addition, two psychiatric eating disorders, anorexia nervosa and bulimia, are on the increase among teenage girls and young women and often run in families. These two eating disorders also occur in boys, but less often.

“Parents frequently wonder how to identify symptoms of anorexia nervosa and bulimia. These disorders are characterized by a preoccupation with food and a distortion of body image. Unfortunately, many teenagers hide these serious and sometimes fatal disorders from their families and friends.

“Symptoms and warning signs of **anorexia nervosa and bulimia** include the following:

- A teenager with anorexia nervosa is typically female, and a perfectionist and a high achiever in school. At the same time, she suffers from low self-esteem, irrationally believing she is fat regardless of how thin she becomes. Desperately needing a feeling of mastery over her life, the teenager with anorexia nervosa experiences a sense of control only when she says "no" to the normal food demands of her body. In a relentless pursuit to be thin, the girl starves herself. This often reaches the point of serious damage to the body, and in a small number of cases may lead to death.
- The symptoms of bulimia are usually different from those of anorexia nervosa. The patient binges on large quantities of high-caloric food and/or purges her body of dreaded calories by self-induced vomiting, extreme exercise, or laxatives. The binges may alternate with severe diets, resulting in dramatic weight fluctuations. Teenagers may try to hide the signs of throwing up by running water while spending long periods of time in the bathroom. Frequent vomiting can cause a serious threat to the patient's physical health, including dehydration, hormonal imbalance, the depletion of important minerals, and damage to vital organs.

“Binge eating can also occur on its own without the purging of bulimia and can lead to eventual purging. Children with binge eating disorder also require treatment from a mental health professional.

“Avoidant/Restrictive Food Intake Disorder (or ARFID) is another eating disorder which can occur in younger children or adolescents. It involves a disturbance in eating or feeding which includes substantial weight loss or a lack of expected weight gain, and nutritional deficiencies. ARFID can lead to dependence on a feeding tube or dietary supplements.” [17]

[17] American Academy of Child and Adolescent Psychiatry. (2018). Eating Disorders in Teens (No. 2; Facts for Families). American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teenagers-With-Eating-Disorders-002.aspx

FETAL ALCOHOL SYNDROME

The term Fetal Alcohol Spectrum Disorder (FASD) represents a broad group of physical, neurological and behavioral disorders that can occur in an individual whose mother consumed alcohol during pregnancy.

Individuals with fetal alcohol related disorders often have learning disabilities, social-emotional disorders, poor mood regulation, ADHD with pronounced impulsivity and/or hyperactivity, problems with memory and many other brain-based deficits.

Unfortunately, FASD is routinely underdiagnosed and often misdiagnosed, leading to incorrect or ineffective services for children, adolescents and adults desperately needing support. [18]

Based on recent national studies of women of childbearing age, Massachusetts is in the top seven states for alcohol use by women in this demographic. [19]

NON-VERBAL LEARNING DISORDER

Learning Disabilities Association of America explains: “Non-Verbal Learning Disability (NVD or NVLD), is a disorder which is usually characterized by a significant discrepancy between higher verbal skills and weaker motor, visual-spatial and social skills.” Individuals have “trouble interpreting nonverbal cues like facial expressions or body language and may have poor coordination.” [20]

OBSESSIVE-COMPULSIVE DISORDER (OCD)

AACAP explains: “Obsessive-Compulsive Disorder (OCD) is seen in as many as 1-3% of children and adolescents. OCD is characterized by recurrent intense obsessions and/or compulsions that cause severe distress and interfere with day-to-day functioning.” [21]

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[18] William James College. (n.d.). *Specialized Assessment of Fetal Alcohol Spectrum Disorders (FASD)*. William James College. Retrieved February 3, 2020, from https://www.williamjames.edu/community/brenner-center/specialized-assessment-of-fetal-alcohol-spectrum-disorders.cfm

[19] *What is FASD?* (2018, December 19). MassFAS. https://massfas.org/what-is-fasd/

[20] Learning Disabilities Association of America. *Non-Verbal Learning Disabilities*. (2013, September 12). Learning Disabilities Association of America. https://ldaamerica.org/types-of-learning-disabilities/non-verbal-learning-disabilities/

[21] *Obsessive Compulsive Disorder Resource Center*. (2019, July). American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Obsessive_Compulsive_Disorder_Resource_Center/Home.aspx

AACAP explains:

"All children and adolescents experience stressful events which can affect them both emotionally and physically. Their reactions to stress are usually brief, and they recover without further problems. A child or adolescent who experiences a catastrophic event may develop ongoing difficulties known as post-traumatic stress disorder (PTSD). The stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred (ex. they may be the victim or a witness of physical abuse, sexual abuse, violence in the home or in the community, automobile accidents, natural disasters (such as flood, fire, earthquakes), and being diagnosed with a life threatening illness). A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his/her relationship to the victim(s).

"Following the trauma, children may initially show agitated or confused behavior. They also may show intense fear, helplessness, anger, sadness, horror or denial. Children who experience repeated trauma may develop a kind of emotional numbing to deaden or block the pain and trauma. This is called dissociation. Children with PTSD avoid situations or places that remind them of the trauma. They may also become less responsive emotionally, depressed, withdrawn, and more detached from their feelings." [22]

"PTSD can occur when a teenager experiences a shocking, unexpected event that is outside the range of usual human experience. The trauma is usually so extreme that it can overwhelm their coping mechanisms and create intense feelings of fear and helplessness. The traumatic event may be experienced by the individual directly (e.g. physical or sexual abuse, assault, rape, kidnaping, threatened death), by observation (witness of trauma to another person), or by learning about a trauma affecting a close relative or friend. Whether teens develop PTSD depends on a combination of their previous history, the severity of the traumatic event, and the amount of exposure.

"Symptoms include:

- Recurrent, intrusive, and distressing memories of the event
- Recurrent, distressing dreams of the event
- Acting or feeling as if the traumatic event were recurring
- Intense psychological distress when exposed to reminders of the traumatic event and consequent avoidance of those stimuli
- Numbing of general responsiveness (detachment, estrangement from others, decreased interest in significant activities)
- Persistent symptoms of increased arousal (irritability, sleep disturbances, poor concentration, hyper-vigilance, anxiety). [23]

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[22] American Academy of Child and Adolescent Psychiatry. (2013). *Posttraumatic Stress Disorder (PTSD)* (No. 70; Facts for Families). American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Posttraumatic-Stress-Disorder-PTSD-070.aspx

[23] American Academy of Child and Adolescent Psychiatry. (n.d.). *Post-Traumatic Stress Disorder (PTSD)*. American Academy of Child and Adolescent Psychiatry. Retrieved March 2, 2020, from https://www.aacap.org/AACAP/Join_AACAP/AACAP/Families_and_Youth/Glossary_of_Symptoms_and_Illnesses/Post_Traumatic_Stress_Disorder_PTSD.aspx

SCHIZOPHRENIA, EARLY PSYCHOSIS AND PSYCHOSIS

AACAP explains schizophrenia is "[a] psychotic disorder characterized by severe problems with a person's thoughts, feelings, behavior, and use of words and language. Psychotic symptoms often include delusions and/or hallucinations. These delusions in schizophrenia are often paranoid and persecutory in nature. Hallucinations are usually auditory and may include hearing voices speaking in the third person, as well as to each other, commenting on the patient's deeds and actions. Schizophrenia does not mean 'split personality.' Most people develop schizophrenia before 30 years of age with some having their first episode in the teenage years." [24]

NAMI explains:

"Most people think of psychosis as a break with reality. In a way it is. Psychosis is characterized as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't. These disruptions are often experienced as seeing, hearing and believing things that aren't real or having strange, persistent thoughts, behaviors and emotions. While everyone's experience is different, most people say psychosis is frightening and confusing.

"Psychosis is a symptom, not an illness, and it is more common than you may think. In the U.S., approximately 100,000 young people experience psychosis each year. As many as 3 in 100 people will have an episode at some point in their lives." [25]

SELECTIVE MUTISM

NIMH explains: "A somewhat rare disorder associated with anxiety is selective mutism. Selective mutism occurs when people fail to speak in specific social situations despite having normal language skills. Selective mutism usually occurs before the age of 5 and is often associated with extreme shyness, fear of social embarrassment, compulsive traits, withdrawal, clinging behavior, and temper tantrums. People diagnosed with selective mutism are often also diagnosed with other anxiety disorders." [26]

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[24] American Academy of Child and Adolescent Psychiatry. (n.d.). *Schizophrenia*. American Academy of Child and Adolescent Psychiatry. Retrieved February 3, 2020, from https://www.aacap.org/AACAP/Families_and_Youth/Glossary_of_Symptoms_and_Illnesses/Schizophrenia.aspx

[25] *Early Psychosis and Psychosis*. (n.d.). NAMI: National Alliance on Mental Illness. Retrieved February 3, 2020, from https://www.nami.org/earlypsychosis

[26] *NIMH » Anxiety Disorders*. (n.d.). Retrieved April 2, 2020, from https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

SUICIDE IN CHILDREN AND TEENS

The *PPAL Police Pocket Guide* has additional information and tips for suicide prevention in children and teens.

The following information is reprinted directly from AACAP's *Facts for Families*, No. 10, Updated Jun 2018, *Suicide in Children and Teens* [27]

Suicides among young people continue to be a serious problem. Suicide is the second leading cause of death for children, adolescents, and young adults age 15-to-24-year-olds.

The majority of children and adolescents who attempt suicide have a significant mental health disorder, usually depression.

Among younger children, suicide attempts are often impulsive. They may be associated with feelings of sadness, confusion, anger, or problems with attention and hyperactivity.

Among teenagers, suicide attempts may be associated with feelings of stress, self-doubt, pressure to succeed, financial uncertainty, disappointment, and loss. For some teens, suicide may appear to be a solution to their problems.

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriately treated with a comprehensive treatment plan.

Thoughts about suicide and suicide attempts are often associated with depression. In addition to depression, other risk factors include:

- family history of suicide attempts
- exposure to violence
- impulsivity
- aggressive or disruptive behavior
- access to firearms
- bullying
- feelings of hopelessness or helplessness
- acute loss or rejection

[27] American Academy of Child and Adolescent Psychiatry. Suicide in Children and Teens (No. 10; Facts for Families). (2018). American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx

Children and adolescents thinking about suicide may make openly suicidal statements or comments such as, “I wish I was dead,” or “I won’t be a problem for you much longer.” Other warning signs associated with suicide can include:

- changes in eating or sleeping habits
- frequent or pervasive sadness
- withdrawal from friends, family, and regular activities
- frequent complaints about physical symptoms often related to emotions, such as stomachaches, headaches, fatigue, etc.
- decline in the quality of schoolwork
- preoccupation with death and dying

Young people who are thinking about suicide may also stop planning for or talking about the future. They may begin to give away important possessions.

People often feel uncomfortable talking about suicide. However, asking your child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Specific examples of such questions include:

- Are you feeling sad or depressed?
- Are you thinking about hurting or killing yourself?
- Have you ever thought about hurting or killing yourself?

Rather than putting thoughts in your child’s head, these questions can provide assurance that somebody cares and will give your child the chance to talk about problems.

Parents, teachers, and friends should always err on the side of caution and safety. Any child or adolescent with suicidal thoughts or plans should be evaluated immediately by a trained and qualified mental health professional.

TOURETTE’S SYNDROME

AACAP explains:

“Tourette's Syndrome is characterized by multiple motor tics and at least one vocal tic. A tic is a sudden, rapid movement of some of the muscles in the body that occurs over and over and doesn't serve any purpose. The location, frequency, and complexity of tics changes over time. Motor tics frequently involve the head, central body, legs, and arms. They may result in simple movements such as eye blinking, or more complex movements such as touching and squatting. Vocal tics can include sounds such as grunts, barks, sniffs, snorts, coughs, and obscenities.

“Tourette's Syndrome is always diagnosed before the age of eighteen - most commonly appearing around seven years of age. It occurs more often in males than females and symptoms are usually present for life. The severity of Tourette's varies a great deal over time, but improvement can occur during

late adolescence and in adulthood. Teens with Tourette's Syndrome often have additional problems with obsessions, compulsions, hyperactivity, distractibility, and impulsiveness." [28]

TRAUMA AND CHILD ABUSE

(Additional information on the impact of trauma can be found in the *PPAL Police Pocket Guide*. Additional stress-related disorders are explained within this *Mental Health Concerns and Related Disorders* document.)

AACAP explains that each state has its own definition of child abuse. Most of the definitions include the following:

- *"Physical child abuse* is physical injury or intent to hurt a child as a result of hitting, kicking, shaking, burning or otherwise harming a child.
- *Sexual child abuse* is when a child is used by another person for that person's sexual satisfaction.
- *Emotional child abuse* is a pattern of behavior that hurts a child's emotional development or sense of well-being.
- *Child neglect* is failure to provide for a child's basic needs such as food, housing or schooling.
- *Interpersonal violence* includes actions when a person intentionally hurts another person. This includes community, intimate partner (domestic) violence, and bullying.
- *Community violence* is violence that happens in a child's neighborhood or community.
- *Intimate partner violence* is physical or sexual violence, the threat of violence, or emotional abuse towards a current or past spouse or intimate partner.
- *Bullying* is repeated negative acts by one or more children against another." [29]

[28] American Academy of Child and Adolescent Psychiatry. Tourette's Syndrome. (n.d.). American Academy of Child and Adolescent Psychiatry. Retrieved February 3, 2020, from https://www.aacap.org/AACAP/Families_and_Youth/Glossary_of_Symptoms_and_Illnesses/Tourettes_Syndrome.aspx

[29] American Academy of Child and Adolescent Psychiatry. (n.d.). Child Abuse Resource Center Frequently Asked Questions. Retrieved March 2, 2020, from https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Child_Abuse_Resource_Center/FAQ.aspx#question1

PSYCHIATRIC MEDICATIONS

The American Academy of Child and Adolescent Psychiatry (AACAP) website has three helpful information sheets about psychiatric medication for children and adolescents.

- Facts for Families, *Psychiatric Medication for Children and Adolescents Part I - How Medications Are Used* [1]
- Facts for Families, *Psychiatric Medication for Children and Adolescents: Part II - Types Of Medications* [2] **(The following medication list was taken from this fact sheet.)**
- Facts for Families, *Psychiatric Medication for Children and Adolescents Part III: Questions To Ask* [3]

🔍👮 Many parents find medication to be an effective and necessary treatment for their children and adolescents. Decisions around if, when and how to use medications are often challenging for families. Monitoring and assessing side effects presents additional challenges.

🔍👫 **Families** looking for information about psychiatric medications are encouraged to talk with their child's pediatrician. AACAP offers a Child and Adolescent Psychiatrist Finder: https://www.aacap.org/AACAP/Families_and_Youth/Resources/CAP_Finder.aspx

Additional information:

- Child Mind Institute https://childmind.org/topics/concerns/medication/
- National Alliance on Mental Illness https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Types-of-Medication

[1] American Academy of Child and Adolescent Psychiatry. (2017). *Psychiatric Medication for Children and Adolescents Part I - How Medications Are Used (Facts for Families)*. American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Psychiatric-Medication-For-Children-And-Adolescents-Part-I-How-Medications-Are-Used-021.aspx

[2] American Academy of Child and Adolescent Psychiatry. (2017). *Psychiatric Medication for Children and Adolescents Part II - Types Of Medications (Facts for Families)*. American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Psychiatric-Medication-For-Children-And-Adolescents-Part-II-Types-Of-Medications-029.aspx

[3] American Academy of Child and Adolescent Psychiatry. (2012.). *Psychiatric Medication for Children and Adolescents Part III: Questions To Ask - 51 (Facts of Families)*. American Academy of Child and Adolescent Psychiatry. Retrieved February 13, 2020, from https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Psychiatric-Medication-For-Children-And-Adolescents-Part-III-Questions-To-Ask-51.aspx

From **The American Academy of Child and Adolescent Psychiatry**
Facts for Families, Psychiatric Medication For Children And Adolescents: Part II - Types Of Medications

ADHD MEDICATIONS Stimulant and non-stimulant medications may be helpful as part of the treatment for attention-deficit/hyperactivity disorder (ADHD). They come in several different forms, such as pills, patches, and liquid forms. Examples of stimulants include Dextroamphetamine (Dexedrine, Adderall, Vyvanse, Procentra), Methylphenidate (Concerta, Daytrana, Metadate, Ritalin), and Dexmethylphenidate (Focalin). Non-stimulant medications include Atomoxetine (Strattera), Guanfacine (Tenex, Intuniv), and Clonidine (Kapvay).

ANTIDEPRESSANT MEDICATIONS Antidepressant medications may be helpful in the treatment of depression, school phobias, panic attacks and other anxiety disorders, bedwetting, eating disorders, obsessive-compulsive disorder, posttraumatic stress disorder, and attention-deficit/hyperactivity disorder. There are several types of antidepressant medications. Examples of **selective serotonin reuptake inhibitors** (SSRIs) include: Fluoxetine (Prozac), Sertraline (Zoloft), Paroxetine (Paxil), Fluvoxamine (Luvox), Citalopram (Celexa), and Escitalopram (Lexapro). Examples of **serotonin norepinephrine reuptake inhibitors** (SNRIs) include Venlafaxine (Effexor), Desvenlafaxine (Pristiq), and Duloxetine (Cymbalta). Examples of **atypical antidepressants** include Bupropion (Wellbutrin), Nefazodone (Serzone), Trazodone (Desyrel), and Mirtazapine (Remeron). Examples of **tricyclic antidepressants** (TCAs) include Amitriptyline (Elavil), Clomipramine (Anafranil), Imipramine (Tofranil), and Nortriptyline (Pamelor). Examples of monoamine oxidase inhibitors (MAOIs) include Phenelzine (Nardil) and Tranylcypromine (Parnate).

ANTIPSYCHOTIC MEDICATIONS These medications can be helpful in controlling psychotic symptoms (delusions, hallucinations) or disorganized thinking. They are also used to treat irritability in autism. These medications may also help muscle twitches ("tics") or verbal outbursts as seen in Tourette's disorder. They are occasionally used to treat severe anxiety and may help in reducing very aggressive behavior. Examples of **first generation antipsychotic medications** include Chlorpromazine (Thorazine), Thioridazine (Mellaril), Fluphenazine (Prolixin), Trifluoperazine (Stelazine), Thiothixene (Navane), and Haloperidol (Haldol). **Second generation antipsychotic medications** (also known as atypical or novel) include Aripiprazole (Abilify), Clozapine (Clozaril), Risperidone (Risperdal), Olanzapine (Zyprexa), Paliperidone (Invega), Quetiapine (Seroquel), Ziprasidone (Geodon), Iloperidone (Fanapt), Lurasidone (Latuda), and Asenapine (Saphris).

MOOD STABILIZERS AND ANTICONVULSANT MEDICATIONS These medications may be helpful in treating bipolar disorder, severe mood symptoms and mood swings (manic and depressive), aggressive behavior, and impulse control disorders. Examples include Lithium (lithium carbonate, Eskalith, Lithobid), Valproic Acid (Depakote, Depakene), Carbamazepine (Tegretol), Lamotrigine (Lamictal), and Oxcarbazepine (Trileptal).

ANTI-ANXIETY MEDICATIONS Selective serotonin reuptake inhibitors (SSRIs) are used to treat anxiety in children and adolescents and are described above in the Antidepressant section. There are also other medications used to treat anxiety in adults. These medications are rarely used in children and adolescents but may be helpful for brief treatment of severe anxiety. These include benzodiazepines, antihistamines, and atypical antipsychotics. Examples of benzodiazepines include Alprazolam (Xanax), lorazepam (Ativan), Diazepam (Valium), and Clonazepam (Klonopin). Examples of antihistamines include Diphenhydramine (Benadryl) and Hydroxyzine (Vistaril). Examples of atypical anti-anxiety medications include Buspirone (BuSpar) and Zolpidem (Ambien).

SLEEP MEDICATIONS A variety of medications may be used for a short period to help with sleep problems. Examples include melatonin, Trazodone (Desyrel), Zolpidem (Ambien), Zaleplon (Sonata), Eszopiclone (Lunesta), and Diphenhydramine (Benadryl).

LONG-ACTING MEDICATIONS Many newer medications are taken once a day. These medications have the designation SR (sustained release), ER or XR (extended release), CR (controlled release), or LA (long-acting).

POLICE POCKET GUIDE ALPHABET SOUP

ADD/ADHD	Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder
ART/ARTP	Acute Residential Treatment/Program
ASD	Autism Spectrum Disorder
BHCA	Behavioral Health Services for Children and Adolescents
BPD	Borderline Personality Disorder
CBHI	Children's Behavioral Health Initiative
CBT	Cognitive Behavioral Therapy
CRA	Child Requiring Assistance
DBT	Dialectical Behavioral Therapy
DSM	Diagnostic Systems Manual, book of official diagnostic criteria
ED	Emotionally Disturbed
ED	Emergency Department
EMDR	Eye Movement Desensitization and Reprocessing therapy
FASD	Fetal Alcohol Syndrome
FST	Family Stabilization Team, a home-based service
ICC	Intensive Care Coordination
IEP	Individualized Education Program
IRTP	Intensive Residential Treatment Program
MCPAP	Massachusetts Child Psychiatry Access Program
NAMI	National Alliance on Mental Illness
NLD/NVLD	Non-Verbal Learning Disability
OCD	Obsessive-Compulsive Disorder
ODD	Oppositional Defiant Disorder
PPAL	Parent/Professional Advocacy League
PDD	Pervasive Developmental Disorder
PTSD	Post Traumatic Stress Disorder
RAD	Reactive Attachment Disorder
SED	Serious Emotional Disturbance

Also see the PPAL Massachusetts Department of Youth Services (DYS) Alphabet Soup
http://ppal.net/wp-content/uploads/2011/01/PPAL-DYS-Alphabet-soup.pdf

GLOSSARY OF COMMONLY USED WORDS IN THE CARE OF YOUTH WITH MENTAL HEALTH NEEDS

504 Plan A formal arrangement by schools to support students with disabilities. Students must qualify for services. A 504 plan is not specific to special education. It often includes accommodations.

Acute Denotes "conditions or symptoms of sudden onset, short duration, and often great intensity."[1]

Adjudication "[J]uvenile court process that determines if the youth committed the act for which he or she is charged. The term 'adjudicated' is similar to 'convicted' and indicates that the court concluded that the youth did commit a crime." [2]

Affect "[A]ny experience of feeling or emotion, ranging from suffering to elation, from the simplest to the most complex sensations of feeling, and from the most normal to the most pathological emotional reactions." [1]

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

Case Manager An individual who organizes and coordinates services for a client.

Catatonia "[S]tate of muscular rigidity or other disturbance of motor behavior, such as catalepsy, extreme overactivity, or adoption of bizarre postures." [1]

Children's Behavioral Health Initiative (CBHI) MassHealth's CBHI services are available for children and youth under the age of 21. CBHI services include Intensive Care Coordination, In-Home Therapy, Family Support and Training, Therapeutic Mentoring Services, In Home Behavioral Health Services, Mobile Crisis Intervention, and other MassHealth services for children and youth. Most services are home and community-based.

Community Based Acute Treatment (CBAT) Intensive, short-term acute residential units for children and adolescents with behavioral and emotional difficulties. These units provide a safe and structured therapeutic environment for youth. These units are often an alternative to inpatient hospitalization and help bridge back to home.

Chronic Denotes "conditions or symptoms that persist or progress over a long period of time and are resistant to cure." [1]

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

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[1] Medical terms taken from the American Psychological Association's (APA) Dictionary of Psychology. Retrieved Winter 2020. https://dictionary.apa.org/

[2] Juvenile Justice Information Exchange. Glossary. Retrieved April 8, 2020. https://jjie.org/hub/racial-ethnic-fairness/glossary/

Comorbidity "[S]imultaneous presence in an individual of more than one illness, disease, or disorder." [1]

Confidentiality Federal law requires healthcare information to be kept private. Upon turning 18 years old, the individual is in control of privacy rights and must give consent to allow parents access to information and participation.

Consent "[V]oluntary assent or approval given by an individual: specifically, permission granted by an individual for medical or psychological treatment, participation in research, or both. Individuals should be fully informed about the treatment or study and its risks and potential benefits." [1] (Parents and guardians are asked to sign consent forms for children in their care.)

Crisis Plan In the CBHI program, a crisis plan includes 3 tools that can be used alone or together to prevent, prepare for, and work through a crisis:

- Safety Plan: tool to help youth identify goals and action steps for use during a crisis.
- Advance Communication to Treatment Provider: written document that can be shared with providers who might be providing crisis support and may include preferred treatment and interventions.
- Supplements to the Safety Plan and Advance Communication: written document that captures important information that may be hard to remember in a crisis.

Crisis Team/Emergency Services Program Mobile Crisis Intervention Teams provide behavioral health crisis assessment (mental health and substance use disorder crisis), intervention and stabilization services, 24/7 365 days a year. In some communities this service is available to all residents; other places it is insurance dependent.

DSM V 5th Edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* by the American Psychiatric Association, 2013.

Day Treatment Nonresidential, intensive mental health treatment services which allow youth to return home at night.

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

Delusion "[O]ften highly personal idea or belief system, not endorsed by one's culture or subculture, that is maintained with conviction in spite of irrationality or evidence to the contrary."[1]

Detoxification " [A] therapeutic procedure, popularly known as **detox**, that reduces or eliminates toxic substances (e.g., alcohol, opioids) in the body... In many cases, detoxification occurs in a clinic, hospital unit, or residential rehabilitation center devoted to treating individuals for the toxic effects of alcohol or drug overdose and to managing their acute withdrawal symptoms; these facilities may also provide professional- or peer-run social support during the detox process (known as **social setting detoxification**)." [1]

Dual Diagnosis "[T]he identification of two distinct disorders that are present in the same person at the same time, for example, the coexistence of depression and a substance dependence disorder (e.g., alcohol or drug dependence)." [1]

Dysphoria '[A] mood characterized by generalized discontent and agitation." [1]

Early Intervention (1) Early action to address warning signs that a youth is at risk for mental health problems. (2) Specialized services for children from birth until 3 years of age to address developmental delays.

Emergency Services Program Mobile Crisis Intervention See *Crisis Team*

Evaluation A process that begins with a professional assessment and results in an opinion about a child's mental and emotional state. May also look at health, academic performance and behavior at home. May include recommendations about treatment or placement.

Executive Functions "[H]igher level cognitive processes of planning, decision making, problem solving, action sequencing, task assignment and organization, effortful and persistent goal pursuit, inhibition of competing impulses, flexibility in goal selection, and goal-conflict resolution." [1]

Flat Affect "[T]otal or near absence of appropriate emotional responses to situations and events." [1]

Guardian Ad Litem "[A]n individual appointed by the court to represent in a lawsuit someone who is incapacitated either by age or by mental or physical disability. The individual's status as guardian ad litem is temporary and is dissolved upon resolution of that lawsuit." [1]

Home-Based Services Short-term services provided in the home to help youth and their family members improve skills, safety and stability. Services may be covered by insurance and/or state agencies.

Homicidal Ideation Thoughts about killing someone.

Hypersexuality "[E]xtreme frequency of sexual activity, or an inordinate desire for sexual activity." [1]

Intensive Care Coordination (ICC) Service that facilitates the care planning and coordination of services for youth with MassHealth youth with serious emotional disturbance (SED) and are under the age of 21 and enrolled in MassHealth Standard or CommonHealth. Care planning is driven by the needs of the youth and developed through a wraparound planning process consistent with Systems of Care philosophy.

Ideation "[T]he process of forming ideas and images." [1]

Impulsive "[D]escribing or displaying behavior characterized by little or no forethought, reflection, or consideration of the consequences of an action, particularly one that involves taking risks." [1]

Individualized Education Program (IEP) "[A] plan describing the special education and related services specifically designed to meet the unique educational needs of a student with a disability. Each IEP must be documented in writing, tailored to a particular child, and implemented in accordance with the requirements of U.S. federal law. The IEP must be created by a team

of individuals that includes, but is not restricted to, parents, teachers, a representative of the school system, and an individual who will evaluate the child's needs and monitor progress." [1]

Inpatient "[A] person who has been formally admitted to a hospital for a period of at least 24 hours for observation, diagnosis, or treatment, as distinguished from an outpatient or an emergency-room patient." [1]

Intensive/Therapeutic Foster Care A home with trained foster parents where a youth with diagnosed emotional and behavioral issues lives and has access to specialized services.

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

Labile Affect "[H]ighly variable, suddenly shifting emotional expression." [1]

Mental Disorder "[A]ny condition characterized by cognitive and emotional disturbances, abnormal behaviors, impaired functioning, or any combination of these. Such disorders cannot be accounted for solely by environmental circumstances, and may involve physiological, genetic, chemical, social, and other factors." [1]

Naloxone (Narcan, Evzio) Medication designed to rapidly reverse opioid overdose.

Outpatient Services "[H]ealth care services performed for registered ambulatory patients in hospital units, clinics, doctors' offices, and mental health centers." [1] Examples include diagnosis, assessment, and family and individual counseling.

Paranoid State "[A] condition characterized by delusions of persecution or grandiosity that are not as systematized and elaborate as in a delusional disorder or as bizarre as in paranoid schizophrenia. Also called paranoid condition." [1]

Partial Hospitalization/Day Treatment A partial or full-day treatment program. Youth may use these services when transitioning from an inpatient hospital setting back into their school and community or as a treatment plan to prevent an inpatient hospital admission.

"Pink Papered" See Section 12. This name refers to the pink form for Section 12.

Pressured Speech "[A]ccelerated and sometimes uncontrolled speech that often occurs in the context of a hypomanic episode or a manic episode." [1]

Psychological Examination "[A]n investigation by means of interviews, observations of behavior, and administration of psychological tests that evaluates an individual's personality, adjustment, abilities, interests, and functioning in important areas of life and that assesses the presence or severity of any psychological problems that the individual may have. It may contribute to the diagnosis of mental disorder and help to determine the type of treatment required." [1]

Psychiatrist "[A] physician who specializes in the diagnosis, treatment, prevention, and study of mental, behavioral, and personality disorders." [1] Psychiatrists are qualified to prescribe medications.

Psychologist "[A]n individual who is professionally trained in one or more branches or subfields of psychology...The professional activities of psychologists are also varied but can include psychological counseling, involvement in other mental health care services, educational testing and assessment, research, teaching, and business and organizational consulting." [1]

Psychosis "[A]n abnormal mental state involving significant problems with reality testing. It is characterized by serious impairments or disruptions in the most fundamental higher brain functions—perception, cognition and cognitive processing, and emotions or affect—as manifested in behavioral phenomena, such as delusions, hallucinations, and significantly disorganized speech." [1]

Psychotic Episode "[A] period during which an individual exhibits psychotic symptoms, such as hallucinations, delusions, and disorganized speech." [1]

Psychotherapy/Therapy "[A]ny psychological service provided by a trained professional that primarily uses forms of communication and interaction to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behavior patterns." [1] (Therapy can be offered across many professions including speech therapy and physical therapy.)

Residential School "[A] special educational facility that provides live-in services for children with intellectual or developmental disability. Although historically significant, the use of such facilities greatly diminished during the latter part of the 20th century, and children with these conditions now receive public education in their home communities." [1] Residential schools also serve children with mental health needs.

Respite Care "[A]ssistance, supervision, and recreational or social activities provided for a limited period to a child, older adult, or person with a disability or chronic illness in order to temporarily relieve family members from caregiving responsibilities. These services may be provided on a scheduled or unscheduled basis, either regularly or occasionally, after school hours, during weekends, or overnight." [1]

Safety Plan Tool to help identify goals and action steps for use during a crisis.

Section 12 Massachusetts law that allows emergency restraint and hospitalization of persons posing risk of serious harm by reason of mental illness. The transport to a facility and initial psychiatric evaluation as well as the admission for up to three days are all commonly referred to as being **"Sectioned."** A Section 12 application may be submitted by a physician, nurse practitioner, qualified psychiatric nurse, qualified psychologist, licensed independent clinical social worker, or police officer.

Section 35 Massachusetts law that allows a qualified person (defined as a spouse, blood relative, guardian, police officer, physician, or court official) to request court order requiring someone to be civilly committed and treated involuntarily for an alcohol or substance use disorder.

Section 51A It is the name of the report used to notify the Department of Child and Family Services (DCF) of suspected abuse or neglect.

Section 51B Investigation by the Department of Child and Family Services (DCF) to determine if DCF supports the allegation of abuse or neglect.

Section 68A Diagnostic study of a child between the ages of 12-18 years by the Massachusetts Department of Youth Services; report and recommendations. Court referral for a youth's mental health evaluation.

Sectioned See Section 12.

Screening "[T]he initial evaluation of a patient to determine his or her suitability for psychological or medical treatment generally, a specific treatment approach, or referral to a treatment facility. This evaluation is made on the basis of medical or psychological history, mental status examination, diagnostic formulation, or some combination of these." [1]

Social Worker A professional "devoted to helping individuals, families, and other groups deal with personal and practical problems within the larger community context of which they are a part. Social workers address a variety of problems, including those related to mental or physical disorder, poverty, living arrangements, child care, occupational stress, and unemployment, especially through involvement in the provision of social services." [1] Social workers work with youth and/or families in many settings, including in schools and agencies and privately.

Substance Withdrawal "[A] syndrome that develops after cessation of prolonged, heavy consumption of a substance. Symptoms vary by substance but generally include physiological, behavioral, and cognitive manifestations, such as nausea and vomiting, insomnia, mood alterations, and anxiety." [1]

Suicidal Ideation "[T]houghts about or a preoccupation with killing oneself, often as a symptom of a major depressive episode. Most instances of suicidal ideation do not progress to attempted suicide." [1]

Support Services Range of service that may include transportation, financial help, support groups, recreation, respite services, and other services to children and families.

Tic "[A] sudden, involuntary vocalization (**vocal tic**) or contraction of a small group of muscles (**motor tic**) that is recurrent and nonrhythmic. Tics may be simple (e.g., eye blinking, shoulder shrugging, grimacing, throat clearing, grunting, yelping) or complex (e.g., hand gestures, touching, jumping, echolalia, coprolalia). They may be psychogenic in origin, or they may occur as an adverse effect of a medication or other substance or result from a head injury, neurological disorder, or general medical condition." [1]

Treatment "[T]he administration of appropriate measures (e.g., drugs, surgery, psychotherapy) that are designed to relieve a pathological condition." [1]

Trauma '[A]ny disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. Traumatic events include those caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge an individual's view of the world as a just, safe, and predictable place." [1]

Transition The process of moving from adolescence to adulthood.

Transitional Services Services to help youth move into adulthood or into the adult mental health system. May include mental health care, supported housing, and vocational services.

Treatment Plan "[T]he recommended steps of intervention that the therapist or counselor devises after an assessment of the client has been completed." [1]

Trigger "[A] stimulus that elicits a reaction. For example, an event could be a trigger for a memory of a past experience and an accompanying state of emotional arousal." [1]

Withdrawing Response "[I]n behavioral psychology, any behavior designed to sever contact with a noxious stimulus." [1]

Wraparound "Wraparound differs from many service delivery strategies, in that it provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. With support from a team of professionals and natural supports, the family's ideas and perspectives about what they need and what will be helpful drive all of the work in Wraparound." [3]

[3] National Wraparound Initiative (NWI). Retrieved April 8, 2020. https://nwi.pdx.edu/wraparound-basics/

RESOURCE LIST FOR FIRST RESPONDERS

This resource list highlights the most relevant resources for law enforcement officers working to understand the needs of youth experiencing mental health challenges and their families. (This is not intended to be a comprehensive list.) For additional resources see: http://ppal.net/

MENTAL HEALTH TRAINING AND EDUCATION

- **The International Association of Chiefs of Police** (IACP) initiated **The One Mind Campaign** "to ensure successful interactions between police officers and persons affected by mental illness."
  - Information regarding community partnerships and training: https://www.theiacp.org/projects/one-mind-campaign
  - Toolkit: Enhancing Police Responses to Children Exposed to Violence https://www.theiacp.org/sites/default/files/2018-08/CEVToolkit.pdf
- **CIT International, Inc.**, in August 2019, published the first comprehensive guide for communities to best practices for starting and sustaining Crisis Intervention Team (CIT) programs. This guide includes the perspectives of NAMI, the National Council for Behavioral Health and Policy Research Associates, Inc. http://www.citinternational.org/
  - *Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises* http://www.citinternational.org/bestpracticeguide
- **Mental Health First Aid for Public Safety** is a training curriculum for teaching law officers "to identify, understand and respond to signs of mental illnesses and substance use disorders." https://www.mentalhealthfirstaid.org/population-focused-modules/public-safety/
- **National Alliance on Mental Illness (NAMI)** is a grassroots organization that has long worked to educate families, individuals, educators and others. NAMI has several programs and guides:
  - For information on Crisis Intervention Team Programs, including CIT for youth: https://www.nami.org/Get-Involved/Law-Enforcement-and-Mental-Health Crisis prevention and de-escalation techniques are included and very important in supporting youth with mental health needs.
  - Designing CIT Programs for Youth, including step-by-step guide here
  - For information on warning signs, mental health conditions, medications, and more: https://www.nami.org/Learn-More

ADDITIONAL TOOLKITS AND ORGANIZATIONS

- **U.S. Department of Justice's Bureau of Justice Assistance** *Police-Mental Health Collaboration Toolkit (PMHC)*, The PMHC Toolkit "provides resources for law enforcement agencies to partner with service providers, advocates, and individuals with mental illness and/or intellectual and developmental disabilities (I/DD). The goal of these partnerships is to ensure the safety of all, to respond effectively, and to improve access to services and supports for people with mental illness and I/DD." https://pmhctoolkit.bja.gov
- **The Council of State Governments Justice Center** *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs* https://csgjusticecenter.org/publications/police-mental-health-collaborations-a-framework-for-implementing-effective-law-enforcement-responses-for-people-who-have-mental-health-needs/
- *Police Perspectives Guidebook Series, Building Trust in a Diverse Nation* by **Vera Institute of Justice** https://www.vera.org/publications/police-perspectives-guidebook-series-building-trust-in-a-diverse-nation
- **Justice for Families** offers information, training and alliances with local organizations committed to ending the youth incarceration epidemic. Justice for families was founded and is run by parents and families who have experienced the juvenile justice system with their children. https://www.justice4families.org/

MASSACHUSETTS-BASED ORGANIZATIONS

- **PPAL (Parent Professional Advocacy League) PPAL's focus** is helping families whose children have emotional, behavioral and mental health needs in Massachusetts. PPAL is a family-based and statewide organization. Families are encouraged to call the PPAL offices (Boston or Worcester) for more information on family support and youth programming. PPAL staff can help families with youth involved in the juvenile justice system. PPAL developed the Police Pocket Guide and offers training about the guide. Additional information: http://ppal.net/
- **Massachusetts Juvenile Detention Alternatives Initiative (JDAI)** With the support of the Annie E. Casey Foundation and Massachusetts Juvenile Justice leaders, JDAI is a juvenile justice reform initiative that ensures that "the right youth, is in the right place, for the right reasons." https://www.mass.gov/service-details/juvenile-detention-alternatives-initiative-jdai

  JDAI has produced several helpful Research and Policy Briefs - *The Adolescent Brain and Positive Youth Development, Reducing Racial and Ethnic Disparities, School Discipline, Trauma and Delinquency, Family Engagement in Juvenile Justice, and Detention: Research, Utilization and Trends*. https://www.mass.gov/service-details/research-and-policy-briefs
- **NAMI Massachusetts** Criminal Justice Diversion Program and Compass Hotline Support https://namimass.org/nami-mass-criminal-justice-diversion-project/ Additional information: https://namimass.org/ or COMPASS@namimass.org

- **Massachusetts Crisis Intervention Team** (CIT) Programs are supported by grants from Massachusetts Department of Mental Health. Regional Training and Technical Assistance Centers (TTACs) are located around the state. For more information, contact Matthew Broderick, Manager of Forensic Operations and Policy Massachusetts Department of Mental Health Matthew.Broderick@MassMail.State.MA.US
- **Strategies for Youth** is a Cambridge-based organization working to improve police-youth interactions. Resources available, including information on the teen brain and trauma. https://strategiesforyouth.org/

AUTISM SPECTRUM DISORDER

- **ALEC (Autism and Law Enforcement Coalition)** offers autism awareness training for first responders. https://lifeworksarc.org/service/alec-first-responder-training/
- **Autism Risk and Safety Management** https://www.autismriskmanagement.com/
  - Online trainings, presentations, and downloadable resources
  - *Autism & Law Enforcement: 25 Field Response Tips* https://www.autismriskmanagement.com/wp-content/uploads/2016/07/Law_Enforcement.pdf
- *Information for First Responders* **Autism Speaks** https://www.autismspeaks.org/information-first-responders

CULTURALCONSIDERATIONS

- *Police Perspectives Guidebook Series, Building Trust in a Diverse Nation* by **Vera Institute of Justice** "This first guide in the series, *How to Increase Cultural Understanding*, recognizes that police officers may be unfamiliar with some of the communities they are responsible for keeping safe. Residents of these communities may have public safety needs and challenges that are difficult for police to understand…This guide provides a brief historical perspective of policing, tips on community-informed policing and maximizing collaboration with communities of color, strategies for how best to build trust during contentious incidents, and information on trauma and community-informed policing strategies." https://www.vera.org/publications/police-perspectives-guidebook-series-building-trust-in-a-diverse-nation
- **The Center for Children's Law and Policy** *Racial And Ethnic Disparities Reduction Practice Manual* http://www.cclp.org/redpracticemanual/ "is a tool for public officials, agency administrators, community leaders, parents, and other advocates for children who are working to create more equitable and effective juvenile justice systems."

LGBTQ YOUTH

Police Perspectives Guidebook Series, Building Trust in a Diverse Nation by **Vera Institute of Justice** https://www.vera.org/publications/police-perspectives-guidebook-series-building-trust-in-a-diverse-nation

SUBSTANCE USE

Massachusetts Organization for Addiction Recovery (MOAR) offers support, education and trainings on the value of recovery from alcohol and other addictions for individuals recovering, families and friends. https://www.moar-recovery.org/

SUICIDE PREVENTION FOR LAW ENFORCEMENT OFFICERS

- **Suicide Prevention Resource Center** Law Enforcement Resources https://www.sprc.org/settings/law-enforcement, including *Fact Sheet: The Role of Law Enforcement Officers in Preventing Suicide*
- The Alliance Action developed **Prevention Resources and Tools for Youth in Contact with the Juvenile Justice System Task Force**, including resources aimed at supporting suicide prevention in the juvenile justice setting. https://theactionalliance.org/communities/juvenile-justice
- *If Someone Tells You They're Thinking About Suicide: A #RealConvo Guide from AFSP* (**American Foundation for Suicide Prevention**) https://afsp.org/if-someone-tells-you-theyre-thinking-about-suicide-a-realconvo-guide-from-afsp/
- **#BeThe1To from National Suicide Prevention Lifeline**. *Be the One to Help Save a Life*, 5 action steps http://www.bethe1to.com/bethe1to-steps-evidence/

TRAUMA

- *Helping Children and Adolescents Cope with Disasters and Other Traumatic Events: What Parents, Rescue Workers, and the Community Can Do* by **National Institute of Mental Health** https://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-disasters-and-other-traumatic-events/index.shtml
- *Understanding Childhood Trauma* Brochure from Boston University School of Public Health: https://www.mass.gov/service-details/parent-and-caregiver-support

YOUTH EXPERIENCING HOMELESSNESS

- *The Intersection of Homelessness, Behavioral Health Needs, and Justice Involvement* by **Policy Research Associates, Inc.** in partnership with **TA Network** focuses on the behavioral needs of youth experiencing both homelessness and the justice system. https://theinstitute.umaryland.edu/media/ssw/institute/national-center-documents/TA-Tidbit-Homelessness-Intersect-with-Behavioral-Health-and-Juvenile-Justice.pdf
- **Massachusetts Unaccompanied Homeless Youth Commission** The Massachusetts State Plan to End Youth Homelessness has a goal " to build a system in which every community in the Commonwealth has coordinated, developmentally appropriate, and trauma-informed resources that are effective, regionally accessible, and reliably funded." To find **resources and locations**, https://www.mass.gov/orgs/ma-unaccompanied-homeless-youth-commission/locations?_page=1
- **The Compass Project at LUK** https://luk.org/ This program focuses on ending youth homelessness, primarily in *Worcester*. It is also involved in state policy reform and can be used as a resource. https://luk.org/services/counseling-mainmenu-396/the-compass-project