

A faded, light gray watermark of a police badge is centered in the background. The badge is shield-shaped with a pointed top and a decorative border. The word "POLICE" is visible across the middle of the badge.

Police Pocket Guide Responding to Youths with Mental Health Disorders

Parent/Professional Advocacy League (PAL)

This is the abbreviated version of the Police Pocket Guide. The full text can be downloaded free of charge at www.ppal.net

Some of the information contained in guide has been gathered or condensed, with permission as needed, from informational publications from the National Alliance on Mental Illness (NAMI), the National Information Center for Children and Youth with Disabilities (NICHCY), the National Institute for Mental Health (NIMH), Sensory Integration Network (SI Network), Police Executive Research Forum (PERF), The American Academy of Child and Adolescent Psychiatry, and the MA Department of Mental Health.

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**POLICE POCKET GUIDE
RESPONDING TO YOUTHS with MENTAL HEALTH NEEDS**

Abbreviated Version

DEDICATION

This guide is dedicated to all the police officers of Massachusetts who serve and protect our homes, our communities, and our families. We honor your courage, wisdom and and dedication. We thank you for your understanding, respectful and life changing interventions on behalf of our youth with mental health needs.

SPECIAL THANKS

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

ACKNOWLEDGEMENTS

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

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ABOUT MENTAL ILLNESS

Dispelling Myths about Mental Illness

It is not a result of weak character or lack of intelligence, and many youths with mental health disorders come from loving families. **Mental illness can affect any sort of person. 1 in 4 families are affected by mental illness according to the National Alliance on Mental Illness.** Professionals and parents refer to mental illness in youths as mental health disorders, or preferably, mental health needs.

Behaviors are Medical Symptoms

Sadly, when mental health needs go untreated, the effect may be a lifetime inability to function appropriately in work, family, or every day life. This loss in human potential can result in a long-term drain on public resources. **Therefore, when an officer encounters a youth with extreme or dysfunctional behaviors the officer should consider the possibility of an undiagnosed mental health disorder and refer the youth for a professional mental health evaluation.**

Mental Health Needs are Cured by Treatment, not Punishment

All types of mental health needs can be diagnosed and effectively treated. Most youths with mental health needs lead fairly normal lives once their symptoms are controlled. Treatment and positive relationships with caring adults can allow these youths to live their lives much like their peers.

PARENTS AS ALLIES

Parents can be strong and effective allies to officers who are responding to a situation involving a youth with mental health needs. Clear communication from the officer will help the parent to stay calm and be supportive as the officer interacts with the youth.

Families Provide Valuable Information

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

Investigate Medication Compliance

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

Advice for Officers to Give Parents

In an emergency, take your child to the nearest hospital ER or call 911. You can request an ambulance, and if needed, police assistance and/or a crisis team. Your child does not need to be physically ill to warrant emergency attention. As mentioned above, any child who is a danger to himself or others, or is having a disorganized, delusional or dangerous train of thought, should receive an emergency psychological evaluation, perhaps followed by hospitalization.

OFFICER AS AGENT FOR CHANGE

There are three ways officers can help youths with mental health needs.

- 1. Officers can Interrupt a Cycle of Deteriorating or Self-Destructive Behavior.** The presence of such behavior is frequently the cause of the officer's presence on the scene.
- 2. Officers can Demonstrate a Constructive Attitude.** Officers can teach families and youths by modeling an attitude of acceptance of behaviors as symptoms, of the youth as a valid human being, and through explaining the hopeful outcomes treatment can bring.
- 3. Officers can Refer to Evaluation, Treatment, or Other Relevant Resources.**

Officer Assisted VS Officer Initiated Evaluation

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

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

Arrest VS Evaluation

A parent may be frightened by a youth's aggressive or violent behavior, but is nevertheless, reluctant to call the police. The parent may assume that the officer will arrest the youth. This is a valid fear since situations sometimes get out of control. By the time a parent reluctantly decides to involve police for safety reasons, the family may already be mired in conflict. **In these situations, a parent needs reassurance that the officer's objective is not to arrest or harm, but to help.**

PUBLIC SAFETY

Best Served Through Informed Approach

No Increased Danger Compared to General Population

Most youths with mental health needs are no more violent or dangerous than those in the general population. In fact, many are withdrawn, fearful and uncomfortable dealing with others. If they become aggressive, it is usually because they feel frightened, confused, or hopeless. Sometimes youths who are severely ill do not even realize or recognize that they have a mental health need.

This lack of perception can cause a youth who is severely ill to be unable to accurately assess their surroundings or understand what is said to them. Fear and confusion about the situation can lead to unpredictable responses and may pose a threat to the personal safety of the youth with mental health needs, the responding officer or others at the scene. However, most youths with mental health needs are not this severely affected and are fully aware of the world around them.

Use of de-escalation techniques is essential when responding to disoriented or agitated youths.

Maintaining public safety may be especially challenging when a youth has never been diagnosed, has stopped taking prescribed medication, or has a dual diagnosis, that is, has a major mental health disorder and a co-occurring substance abuse problem.

Officer Evaluation of Potential for Harm

Even if an officer feels no threat to his or her own safety, the officer must keep on guard to the possibility that a youth with mental health needs may try to hurt him or herself, or react in a dramatic fashion to a perceived threat from the officer's presence, actions, the surroundings, or anything else.

A cautious and sensitive interaction that modifies standard procedures can be less threatening, de-escalate tensions and increase the likelihood of a successful outcome.

ON-SCENE ASSESSMENT

Substance Abuse as Symptom of Mental Health Need

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

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

OBSERVATIONS THAT MAY SIGNAL PRESENCE OF MENTAL HEALTH NEED

- history of mental health problems, and/or possession of psychiatric medications
- a wooden, emotionless facial expression and body language (see “flat affect” in glossary)
- incoherent thoughts or speech
- inability to focus or concentrate
- amnesia, including unable to recall an event, or certain personal information
- bizarre appearance, movements or behaviors
- delusions of personal importance or identity; unrealistic over-confidence; hypersexuality (see glossary)
- paranoia (unfounded, unreasonable fears)
- hallucinations or perceptions unrelated to reality
- agitation, often without clear reason
- self-medication with street drugs or alcohol,
- pronounced feelings of hopelessness, sadness or guilt, poor school attendance or declining academic performance, excessive sleep or inability to sleep, a change in eating habits, a feeling of despair or of numbed emotions, frequent physical complaints
- physical wounds such as cuts or burns which may be on a hidden part of the body – these may be self-inflicted.
- unusual under- or over-sensitivity to physical pain

- panic attacks: extreme fear and strong desire to escape with pounding heart, shortness of breath, chest pain, nausea, dizziness, shaking, sweating, numbness, or tingling sensations
- extreme swings in mood from mania (increased energy) to depression (low energy). Highs can include extreme irritability and distractibility, euphoria, increased energy, restlessness, racing thoughts or rapid talking, disrupted sleep, delusions of grandeur, very poor judgment, impulsiveness, reckless sexual encounters, abuse of drugs or alcohol, obnoxious, provocative or intrusive behaviors, and denial that anything is wrong. A younger child's symptoms often differ from those seen in adolescents, with periods of extreme irritability, agitation, or hostility.
- disorderly or aggressive attention-seeking behavior
- disobedient, hostile, and defiant rule breaking that goes on longer than a typical child or adolescent "phase".
- inappropriate and socially unacceptable expressions of verbal and physical aggression based on explosive anger including bullying, threatening or intimidating, stealing, running away, lying, fire setting, truancy, breaking and entering, vandalism, cruelty to animals, fighting, and confrontation. Warrants prompt professional evaluation.

- Lack of cause and effect thinking; lack of conscience; manipulative, sets adults against one another; preoccupation with fire, blood & gore; abnormal elimination patterns, may wet or soil themselves; obvious lies; false allegations of abuse; cruelty to or killing of animals and even other children. Warrants prompt professional evaluation.
- Disorganized, can't sit still or pay attention, impulsive (acts without considering consequences, e.g. reaches into the kitchen blender, or climbs too high)
- Distorted body image, dangerously underweight, or may binge and purge
- Infants with tactile defensiveness/ flinching, poor eye contact and sucking response, who do not return a smile, or are self abusive (head banging, etc).
- The child hears but frequently misunderstands speech, and has difficulty following directions.
- Tantrums when angry and frustrated, or during transitions (see glossary) when they may break things, attack others, or hurt themselves e.g. bang their heads, pull their hair, or bite their arms.
- Avoids eye contact or physical touch
- Takes speech literally, oblivious to social boundaries, body language and sarcasm
- Unable to recognize faces
- Frequently gets lost
- Gullible, lacks "common sense"

- Over- or under-sensitive to input from the senses, may withdraw or become nauseated if overwhelmed, or may talk too loud, touch others too much or too hard, or hurt themselves without noticing.
- Involuntary “tics” (see glossary) which worsen under stress including movements (such as

blinking, twitching, or spitting) and vocalizations or verbal outbursts (such as throat clearing, barking, or swearing). Officers who encounter such youths can adjust environmental factors (lighting, noise) and provide reassurance to reduce stress; a youth who spits may be able to redirect if offered a cup or container.

CLINICAL RECOMMENDATIONS

The following suggestions are from mental health professionals.

- Be patient and stay calm.
- Be friendly and accepting but remain firm and professional.
- If possible, meet unmet basic needs such as offering food or juice.
- Remove upsetting influences, distractions, and people from the scene. (Loud noises, flashing lights, unfriendly or prying bystanders)
- Recognize that the youth may be overwhelmed by sensations, thoughts, surroundings, frightening beliefs, internal sounds or voices.

- Gather information from family or bystanders. Ask those who know the youth about any approaches that have calmed or escalated situations in the past; the youth's likes and dislikes; and, what precipitated the crisis.
- Do not move suddenly, shout or give rapid orders. Only one person should talk to and direct the youth.
- Announce your actions before initiating them.
- Speak simply and briefly, avoiding use of clinical jargon.
- Indicate that you are trying to understand. Reassure the youth that you are there to help, not harm.
- Avoid direct, continuous eye contact.
- If possible, do not touch the youth. Do not crowd his/her "comfort zone".
- Ask the youth for their cooperation, and allow them time to respond.
- Do not express anger, impatience, contempt or irritation.
- Ask youths how they feel and encourage them to speak out to others as well about their feelings and needs.
- Acknowledge that the youth's delusions are real to him or her.
- Do not argue with delusional statements, or mislead the youth to think that you feel or think the same way.
- Understand that you may not have a rational discussion, but try to keep conversation con-

- Understand that you may not have a rational discussion, but try to keep conversation concrete by redirecting the topic when needed. Respond to a delusional youth's feelings rather than to delusional content.
- A police uniform and equipment, multiple officers, or flashing lights are likely to frighten the youth, and produce increased agitation or a fight-or-flight response.
- Do not force discussion or assume that an unresponsive youth cannot hear you. They may not understand or may be unable to respond.
- Do not use inflammatory language, such as "wacko" or "psycho" in the youth's presence or in the nearby vicinity. Mental health disorders do not affect a youth's ability to hear.
- Use the minimal amount of restraint necessary to ensure the youth's safety, incorporating techniques to decrease sensory overload and redirect the youth's attention.
- Use referral to help connect youths to peers and mentors in the community.

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

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

DISPOSITION OPTIONS

Support Parent Wishes

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

Officers are Most Effective with Parents when they

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

Officer Initiated Psychiatric Evaluation

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

An evaluation performed by a mental health professional is often the first step for a youth to receive **treatment**. This evaluation is used to discover the underlying cause of the youth's behaviors and symptoms, and to determine what interventions will help most, also known as a treatment plan.

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

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

FACTS AND IMPLICATIONS

- A police officer's ability to recognize symptoms of mental illness can be invaluable when assessing a scene.
- A sensitive intervention by a police officer can be a reassuring and steadying influence on an internally struggling youth.
- Desperate parents can be guided to appropriate community resources by a knowledgeable officer.
- Symptoms of mental illness often first appear during adolescence.
- Mental illness and bizarre behavior are not criminal.
- Failure to follow police instructions during a psychotic episode is most likely NOT a deliberate act of defiance.
- These youths heal with treatment, not jail. When incarcerated their illnesses often worsen, especially since psychiatric medications are often withheld.
- Four out of every five runaway youths suffers from depression. (US Select Committee on Children, Youth & Families).
- Suicide is a serious concern: the 3rd leading cause of death for 15-24 year olds (approx. 5,000 youths each year) and the 6th leading cause of death for 5-15 year olds. Tragically, the rate of youth suicides has nearly tripled since 1960.

ABOUT SUICIDE

Fear of their child committing suicide is a parent's nightmare, and families suffer emotionally and experience "second hand" trauma by observing the ongoing suffering of their troubled youth. Their fears are not groundless – according to the American Association of Suicidology (AAS), in 2004 in the US suicide ranked the third leading cause of death in young people ages 15-19 and ages 15-24, and that year 283 children ages 10-14 completed suicide. They report that for every completed suicide, 100-200 attempts are made. They stress that **“not all adolescent attempters may admit their intent. Therefore, any deliberate self-harming behaviors should be considered serious and in need of further evaluation.”**

Risk Factors for Suicide in Youths

The following risk factors for suicide in youths were gleaned from AAS and NAMI (National Alliance on Mental Illness) informational publications.

- Presence of a psychiatric disorder (e.g., depression, substance abuse, conduct disorder e.g., runs away or has been incarcerated);
- Thoughts of suicide, death, dying or the afterlife (in a context of sadness, boredom, hopelessness or negative feelings)
- History of previous suicide attempts or self-harm
- Feelings of hopelessness
- Family history of suicide

- Impulsive and aggressive behavior, frequent expressions of rage
- Easy access to lethal methods especially firearms
- History of physical or sexual abuse (the youth may not admit to or recall the abuse)
- Exposure to another's suicidal behavior
- Recent severe stressor (e.g., difficulties in dealing with same-sex sexual orientation; unplanned pregnancy, legal trouble, significant real or anticipated loss, etc.)
- Family instability, significant family conflict
- Parental mental illness or dysfunction
- Impaired parent-child relationships
- History of recent interpersonal conflicts of any sort
- Disconnected from school or work, socially isolated

Officer Demeanor Important in Managing Suicidal Youths

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

Observations that Signal Potential for Self-Harm or Suicide

The following observations signal the need for professional evaluation. Some are abstracted from AAS fact sheets, NAMI publications, and The American Academy of Child and Adolescent Psychiatry Teen Suicide Fact Sheet:

- A history of previous self-harm
- Current thoughts about wanting to die, to commit suicide, and/or intent to commit suicide (called suicidal ideation)
- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there's no way out
- Self-medication with alcohol or drugs
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood or personality changes
- No reason for living; no sense of purpose in life
- Unusual neglect of personal appearance
- Loss of interest in pleasurable activities
- Not tolerating praise or rewards
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- Frequent complaints about physical symptoms, often related to emotions, such as stomach-aches, headaches, fatigue, etc.

- Verbal hints such as “I won’t be a problem for you much longer”
- Puts affairs in order such as giving away or throwing out important belongings
- May feel that they can’t
 - stop the pain
 - think clearly
 - make decisions
- see any way out
- sleep, eat, or work
- get out of the depression
- make the sadness go away
- see the possibility of change
- see themselves as worthwhile
- get someone’s attention
- seem to get control

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

MENTAL HEALTH DISORDERS

Research has shown that prolonged stress can create changes in the brain and its function. Furthermore, there are hereditary or other neurological connections for many mental health disorders. They are now being diagnosed more accurately (and frequently) in children as scientific understanding of the brain progresses. In addition to traditional diagnostic tools, researchers using modern imaging technologies have associated specific brain differences with certain mental health disorders.

The full version of The Police Pocket Guide describes many of the most commonly diagnosed mental health and related disorders. In this abbreviated version, we refer officers to the first bulleted section titled “Observations that may Signal the Presence of a Mental Health Need” for a partial list of symptoms they may observe. Officers are encouraged to download the complete guide from the PAL website at <http://ppal.net/default/>.

Trauma or Post-Traumatic Stress Disorder (PTSD)

Trauma is Defined as Physical or Emotional Injury

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

These symptoms can (but do not always) occur when a youth has been exposed to a traumatic event. Officers may encounter many types of trauma in families, and any of these types may provoke behaviors related to traumatic stress. Even observing someone else experiencing a trauma can produce “secondary trauma” in the observer.

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

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

A youth with trauma may:

- Re-experience traumatic events in the form of recurrent and intrusive thoughts or nightmares. He/she may experience flashbacks or hallucinations. In a younger child repetitive play may occur in which aspects of the trauma are expressed or reenacted.
 - Show phobic avoidance of anything that reminds him/her of the trauma, and may even be unable to recall details about it. He/she may
- show disinterest in formerly important activities, places or people, and feel depressed, detached, emotionally numb, or hopeless.
 - Show a number of forms of irritability, including insomnia, anger outbursts, impaired concentration, or a jittery condition. This may be expressed by disorganized, agitated or hostile behaviors.

Youths who suffer from trauma frequently use alcohol or other drugs to “self-medicate” in an attempt to dull painful memories or psychological torment.

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

Also see the section on Dissociative Disorders in the full guide.

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

Trauma has Wide Reaching Effects: Officers May Observe these Warning Signs of Trauma:

- Altered states of consciousness including, memory lapses or amnesia, hysteria, a feeling of numbness or feeling one is dissolving or in a dream, trance states possibly even becoming numb to physical pain, seeming to relive events (flashbacks), confused, fragmented or conflicting story told, multiple personality, may split into a “good” and a “bad” self, “doublethink” (a youth’s way of forgetting, excusing or discounting abuse, in order to “get by”)
- Attempts to hide abuse or keep it secret; denial
- Agitation, tense muscle tone
- Regressive behaviors such as clinging, thumb sucking or bedwetting
- Low self-esteem, feels shame, worthless or unlovable
- May show a false front or self to hide low self esteem
- Blames self for abuse, believes they are “bad”
- Judgment clouded by self-hatred and habit of obedience, may allow self to be harmed
- Attempts to be inconspicuous: may freeze in place, crouch, roll up in a ball, or keep face expressionless

- Attempts to appease abuser and other authority figures, may desperately “try to be good”
- Social isolation enforced by the abuser to preserve secrecy and control
- Compulsive risk-taking
- Self-medication with alcohol or illegal drugs
- Runaway attempts may begin by age seven or eight.
- Self-harming – may be used to relieve emotional pain or counter a sense of unreality
- Sexual promiscuity
- Unstable relationships with peers, abusive romances
- Physical complaints that may stem from stress, such as headaches, stomachaches, sleep disorders, even seizures
- Anxiety Disorders, Anorexia, or Depression
- Suicidality

Responding to Youths with Trauma

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

Perspectives on Trauma

- Since youths who have been abused typically have been dependent on their abusers for survival, they are often loyal and devoted to their abusers and take the abuser's side, supporting the abuser's story.
- Only a very small percentage of youths with trauma will become aggressive, delinquent or homicidal; most will turn aggression inward, often with self-destructive behaviors done in secret.
- Survivors of abuse typically feel powerless to change or be different.
- Artistic and creative expression of all kinds is thought to be especially therapeutic for trauma survivors. Encourage the youth to develop a well-rounded life by forming friendships, developing hobbies and skills, and connecting with mentors to provide ongoing support, and provide referrals to these resources.
- Supportive interaction with a law enforcement officer can help an isolated youth feel a greater sense of belonging to the wider community, and a greater sense of self-worth.
- Youths and their families will feel safest when the officer maintains a clearly defined role as peace officer. Youths should be guided to look to appropriate community resources for attention.

PSYCHIATRIC MEDICATIONS

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

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

The full version of this guide contains a partial list of commonly prescribed medications. For more complete drug information, please refer to the full version or the following resources: NAMI, www.nami.org, Medscape, www.medscape.com, MassMedline, www.massmedline.com, (866) 633-1617.

ALPHABET SOUP

ADD, ADHD Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder
ART/ARTP Acute Residential Treatment/Program
ASD Autism Spectrum Disorder
BIRTP Behavioral Intensive Residential Treatment Program
BPD Borderline Personality Disorder
CANS Child & Adolescent Needs & Strengths – (see glossary)
CAP Collaborative Assessment Program
CBHI Children’s Behavioral Health Initiative – (see resources)
CHINS Child in Need of Services
CSA Community Service Agency
DBT Dialectical Behavioral Therapy
DSI Dysfunction of Sensory Integration, now called SPD
DSM Diagnostic Systems Manual (book of official diagnostic criteria)
ED Emotionally Disturbed
EMDR Eye Movement Desensitization and Reprocessing therapy
EPSTD Early Periodic Screening Diagnosis & Treatment (Medicaid term)
FST Family Stabilization Team (a home-based service)
ICC Intensive Care Coordination (see glossary)
IEP Individualized Education Program (Plan)
IRTP Intensive Residential Treatment Program
MAAPS Massachusetts Association of 766 Approved Private Schools

MASSPAC Mass. Parent Advisory Council
NAMI National Alliance on Mental Illness
NIMH National Institute for Mental Health
NLD/NVLD Non-verbal Learning Disability
OCD Obsessive-Compulsive Disorder
ODD Oppositional Defiant Disorder
PAC or SPED PAC Parent Advisory Council or
Special Education Advisory Council

PAL Parent Professional Advocacy League
PDD Pervasive Developmental Disorder
PTSD Post Traumatic Stress Disorder
RAD Reactive Attachment Disorder
SAMHSA Substance Abuse & Mental Health
Services Admin. (Federal)
SED Serious Emotional Disturbance
SPD Sensory Processing Disorder

GLOSSARY

504 Plan

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

766 Approved School

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

Acute

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

Adjudicated

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

Advocacy

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

Affect

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

Agitation

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

Amnesia

Memory loss due either to neurological or emotional problems.

Assessment

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

CANS

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

Case Manager

An individual who organizes and coordinates services for a client.

Catatonic

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

Chronic

Any condition that persists a long time or recurs frequently.

Clinician

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

Comorbid

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

Confidentiality

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

Consent

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

Crisis Residential Treatment Services

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

Crisis Team

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

Programs; Crisis Evaluation Teams, Emergency Screening Teams.

DSM IV

An official manual describing mental health disorders.

Day Treatment

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

Defense Mechanism

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

Delusions

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

Dual Diagnosis

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

Dysphoric Mood

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

Early Intervention

Recognizing warning signs that a youth is at risk for mental health problems and taking early action to address the problems. Early intervention can help youth get better more quickly and prevent problems from becoming worse. Also, the title of a specific care program for children with special health needs from birth until 3 years of age. After that time, the local school system becomes responsible for the therapies that Early Intervention was/would have provided.

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Evaluation

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

Executive Function

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

Flat affect

Lack of emotional expression, see "affect".

Home Based Services

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

Homicidal ideation

Thoughts about killing someone.

Hypersexuality

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

Intensive Care Coordination (ICC)

Wraparound model of service planning and delivery

Ideation

Medical term for “thinking about”.

Impulsivity

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

Individualized Education Program (IEP)

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

Inpatient Hospitalization

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

Labile

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

Mental Health

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

Mental Illness

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

Outpatient

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

Paranoia

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

Partial Hospitalization/Day Treatment

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

“Pink papered”

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

Pressured Speech

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

Psychological Evaluation

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

Psychiatrist

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

Psychologist

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

Psychopharmacologist

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

Psychosis

A disorder characterized by social withdrawal, distortions of reality (severe depression, agitation, delusions, hallucinations) and loss of contact with the environment.

Psychotic break

When perception is impaired by brain dysfunction (see "psychosis") puts a youth out of touch with

reality and renders them incapable of safe or effective function. Hospitalization is usually required.

Release Form

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

Residential Services

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

Respite Services

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

Screening

A preliminary assessment.

Social Worker

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

Suicidal ideation

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

Support Services

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

Tantrum

Similar to the familiar “temper tantrum”, this outburst of physical violence, usually directed at the

environment but sometimes directed at self or others, is sometimes seen in youths with brain damage, learning disabilities or mental health needs. It usually stems from the youth feeling “overloaded” with emotional or sensory input.

Therapeutic Foster Care

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

Therapeutic Group Homes

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

Tic

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

Therapy

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

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Trauma

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

Transition

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

Transitional Services

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

Treatment Plan

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

Trigger

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

Withdrawing Behavior

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

Wraparound Services

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

RESOURCES

Special Information for Law Enforcement Officers

Advocates, Inc., www.advocatesinc.org See their Community Justice programs including jail diversion for adults and teens, and connection with the Framingham Jail Diversion Project

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

(901) 545-5700.

Substance Abuse and Mental Health Services Administration (SAMHSA), www.samhsa.gov

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

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

The Ohio Criminal Justice Coordinating Center of Excellence, www.neoucom.edu/CJCCOE Promotes jail diversion alternatives for people with mental illness throughout Ohio, includes resources such as a downloadable advocacy handbook.

The Criminal Justice/Mental Health Consensus Project, www.consensusproject.org A repository of information about all aspects of jail diversion, reentry, and enhanced treatment for offenders

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with mental illness. Helps policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses

U.S. Department of Justice, Bureau of Justice Assistance, www.ojp.usdoj.gov/BJA/ Administers federal mental health courts program, provides resources and information for jail diversion, publications and reports, information about federal funding sources.

NAMI's CIT in Action Newsletter offers periodic announcements and information about jail diversion, CIT and other forensic issues. To subscribe, please email laurau@nami.org

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

Massachusetts State Agencies & Federal Programs

Department of Education (DOE)

www.doe.mass.edu (781) 338-3300 MA educational services, standards and protections cover the special education of students with all types of disabilities, including those with mental health needs. DOE and local school systems may provide mental health treatment, including specialized educational settings, for youths with mental health needs through their Special Education departments. Within DOE, the Program Quality Assurance Department (PQA) **(781) 338-3700** monitors compliance and manages complaints. The Bureau of Special Education Appeals (BSEA) **(781) 338-6400** is an independent division that offers a formal hearing process for dispute resolution.

Department of Mental Health (DMH)

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

Department of Mental Retardation (DMR)

www.mass.gov/dmr (617) 727-5608 Provides support services to families who have a child with a developmental disability, and to adults with mental retardation. Families can receive individualized service coordination and flexible family supports that may include community recreation, respite or other support services. Adults age 18 and over may qualify for employment services, day programs, residential care, or other programs.

Department of Public Health (DPH)

www.state.ma.us/dph (617) 624-6000 Through a vast array of programs and services, DPH promotes healthy people living in healthy environments. Their extensive website includes consumer helplines, information on food and drug

quality control, public health hospitals, community care centers, the Office of Patient Protection, violence prevention programs, disaster management, and much more.

Department of Social Services (DSS)

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

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

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

Division of Medical Assistance (DMA) www.state.ma.us/dma Administers all Mass-Health/Medicaid publicly funded health care

plans. Eligibility requirements vary with the plan type. See **Health Insurance Programs and Information.**

Massachusetts Rehabilitation Commission (MRC) www.state.ma.us/mrc (800) 245-6543 Assists individuals with disabilities who are no longer in high school to live independently and become employed. The three main divisions are Vocational Rehabilitation, Independent Living, and Disability Determination Services. Mass residents are able to go through MRC for initial and continuing eligibility determination for the Federal SSI program.

Children's Behavioral Health Initiative

[www.mass.gov/?](http://www.mass.gov/?pageID=eohhs2subtopic&L=4&LO=Home&L1=Gove)

[pageID=eohhs2subtopic&L=4&LO=Home&L1=Gove&L2=Special+Commissions+and+Initiatives&L3=Children's+Behavioral+Health+Initiative&sid=Eeohhs2](http://www.mass.gov/?pageID=eohhs2subtopic&L=4&LO=Home&L1=Gove&L2=Special+Commissions+and+Initiatives&L3=Children's+Behavioral+Health+Initiative&sid=Eeohhs2)

The Children's Behavioral Health Initiative is an undertaking by the Executive Office of Health and Human Services (EOHHS) and Mass-Health to implement the Order in a lawsuit known as Rosie D. et. al. v. Patrick. The delivery of mental health care to children and youths is to be improved and better organized in several major ways, including more accessible assessment, screening, and community-based treatment.

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

5627 Federal program of the Department of Labor for at-risk youth provides free education and job training. Youth ages 16-24 may apply to any

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of the 118 Job Corps Centers located through the nation, including three in MA. Comprehensive services include mentoring, vocational training, education, life skills, residential, medical, dental & vision benefits, recreation, allowance stipends, savings, bonus options, job placement & more. Devens, MA **978-772-7933**, Chicopee, MA **(413) 593-5731**

Supplemental Security Income (SSI)

www.ssa.gov/SSA_Home.html (800) 772-1213

Information re: Social Security programs including SSI, OR call **(800) 245-6543** at the MRC, for MA resident new applications. A Federal program, SSI provides a monthly stipend for disabled children and adults to assist with the basic needs of food, clothing, and housing. Family income limits are waived when a child is in a long term residential treatment program or hospitalization.

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Health Insurance Programs and Information

Health Care For All Health Helpline

www.hcfama.org (800) 272-4232

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

MassResources.org www.massresources.org

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

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

www.childrenshospital.org/mentalhealthguide, or www.bostonbar.org/theguide For a printed copy,

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

MassHealth www.state.ma.us/dma/
(800) 841-2900 Customer Service Center
(888) 665-9993 Enrollment Center The state's Medicaid program that provides free or low cost health insurance to qualifying MA residents. All youth programs provide early and periodic diagnosis, screening, and treatment. Covered services include hospitalization, MD visits, prescription drugs, mental health services, and more.
Massachusetts Behavioral Health Partnership (MBHP) (800) 495-0086
www.masspartnership.com Manages mental health and substance abuse services for many MassHealth members.
Bureau of Managed Care www.state.ma.us/doi/
617-521-7372 Branch of the DOI that oversees

statutory compliance of managed health care plans based in and operating within MA.
Department of Public Health
www.state.ma.us/dph (617) 624-6000 In charge of CenterCare, a free health care program for low-income MA residents with chronic health conditions. CenterCare members get free self-management support services and primary and preventive health care services at community health centers (CHCs). To find a CHC, visit www.massleague.org/HealthCenters, or call the Community Health Centers League's Patient Referral Line, (800) 475-8455. DPH also runs the Office of Patient Protection (see separate entry below), (800) 436-7757, as well as the Bureau of Substance Abuse Services, (800) 327-5050.

Children's Medical Security Plan

www.cmspkids.com For enrollment applications call, **(888) 665-9993**, general info or members, call **(800) 909-2677** A state-funded health care plan for MA youths through age 18 who are ineligible for MassHealth. Provides access to primary and preventive care, including outpatient but not inpatient mental health care.

CommonHealth **www.state.ma.us/dma/masshealthinfo/commonhealth** **(888) 665-9993**

A MassHealth plan for disabled children and adults who make too much money to get MassHealth Standard. Adults who work can still get this insurance.

Premium Assistance or Family Premium Assistance Programs To get an application call the MassHealth Enrollment Center, **(888) 665-9993**

For those already receiving premium assistance call (800) 462-1120 Under DMA's Benefit Coordination & Recoveries Unit, this program pays private insurance premiums for Mass Health eligible members, and partial premium costs for others under certain circumstances. For more info, visit the Boston Public Health Commission website, **www.bphc.org/howto/ins_premium.asp**
Office of Patient Protection **www.state.ma.us/dph/opp/index.htm** **(800) 436-7757** A DPH program that provides a process for consumers to obtain an external review of managed care health benefit denials.

MassMedline www.massmedline.com

(866) 633-1617 A free, confidential service available to all MA residents who are seeking information regarding their medications. You can speak to pharmacists and case managers one-on-one to receive personal assistance with answering your pharmacy related questions or finding programs to help with the cost of your medications.

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

Massachusetts Department of Youth Services

(617) 727-7575 www.mass.gov/dys Under some circumstances, may provide counseling, substance abuse treatment, and residential placement.

Massachusetts Department of Early Education & Care www.eec.state.ma.us (617) 988-6600

Oversees federal IDEA preschool special education funds and works with public schools regarding special education services for young children ages 3 to 5.

Massachusetts Department of Education

(781) 338-3000 www.doe.mass.edu Funds multiple types of special education settings for youths with mental health needs.

Legal

Mental Health Legal Advisors

www.mass.gov/mhlac (617) 338-2345

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

Bazelon Center for Mental Health Law

www.bazelon.org “The Bazelon Center for Mental Health Law uses a coordinated approach of litigation, policy analysis, coalition-building, public information and technical support for local advocates in four broad areas of advocacy.” Site in-

cludes a wealth of published materials, including some free downloads

Wrights Law www.wrightslaw.com A great resource for educational law information

Parent Support & Advocacy Organizations

Parent/Professional Advocacy League (PAL)

www.ppal.net/default The MA chapter of The Federation of Families for Children's Mental Health, PAL is a statewide network of families, local Parent Support Coordinators, and professionals who advocate on behalf of youth with mental, emotional or behavioral special needs. Coordinators advise parents, facilitate support groups and promote youth mental health awareness in the community. The organization conducts family-centered research to help advocate for system change, and there are many useful publications for free download on their web site, including this guide, a parent manual on accessing emergency mental health care, and copies of

research reports. To request a referral to the Coordinator in your area, call **(617) 542-7860**.

Federation of Families for Children's Mental Health

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

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

AL-ANON/ALATEEN **www.al-anon.org**
(888) 425-2666

Support groups for friends & family members of people with drinking problems. ALATEEN groups are exclusively for young friends & family members. In MA many chapters also include those whose loved ones have substance use & abuse problems.

Alcoholics Anonymous
www.alcoholics-anonymous.org (617) 426-9444
A 12-step program that supports & educates peo-

ple with drinking problems. Group meetings are held in hundreds of locations.

National Autism Association
www.nationalautismassociation.org
(877) 622-2884

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

Asperger's Association of New England (AANE)
www.aane.org (617) 393-3824 Offers a comprehensive menu of services including training for families and professionals, written information, employment assistance and socialization opportunities.

www.autisminfo.com Loads of info and links
Children and Adults with Attention Deficit Disorder (CHADD) www.chadd.org Works to improve the lives of people with AD/HD through education, advocacy and support.

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

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

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

Federation for Children With Special Needs

www.fcsn.org (800) 331-0688 (617) 236-7210

Provides information, support and assistance to parents of children with disabilities, their professional partners, and communities. Specializes in training and advocacy on the topics of education & special education, early childhood programs and health care, for children with disabilities. Information is available on their website (training schedule, calendar of events, database & links) as well as an extensive collection of fact sheets available by telephone request.

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

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

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

Hotline for parent questions regarding education needs, free legal representation for some regarding education needs, and advocacy in state legislation.

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

teachers, families, coaches, and other professionals.

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

Family Voices www.familyvoices.org Organization for families with Children with Special Health Care Needs, includes information about health care financing, parent support, advocacy, publications and more. Excellent newsgroup links families and professionals caring for children with special health care needs, massfamily-voices@yahogroups.com

Parents Helping Parents

www.parentshelpingparents.org 800 632-8188

24 hour Parental Stress line, (800) 882-1250

Parent support groups provide nonjudgmental, anonymous support to parents under severe stress who want to improve their parenting skills

Information

All Kinds of Minds www.allkindsofminds.org Offers useful information about learning differences including a newsletter, discussion groups, & library; the organization offers teacher training and assessment of individual children.

Collaborative Problem Solving Institute

www.explosivechild.com Funds research on explosive/noncompliant children and adolescents and services to underprivileged youths who might

and family relationships.

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

not have access to quality mental health services.

Easing the Teasing: How Parents Can Help Their Children www.ericdigests.org/2000-1/teasing

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

MAAPS (MA Association of 766 Approved Private Schools) www.spedschools.com (781) 245-1220

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

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

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

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

Provides support, advocacy, and information for people with mental illness and their families. Offers free classes, support groups, printed mate-

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rials, and a website rich with clear information on mental illness.

National Center for Post-Traumatic Stress Disorder www.ncptsd.org (802) 296-5132

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

National Institute for Mental Health (NIMH)

www.nimh.nih.gov Easily searchable, with sections on research, clinical trials, fact sheets, conference listings, and more.

National Information Center for Children and Youth with Disabilities (NICHCY) www.nichcy.org (800) 695-0285 Comprehensive information on disabilities and related issues for families, educators, and other professionals. Much of the information is free or inexpensive, some downloadable.

NLDline www.nldline.com (860) 693-3738 Offers a cornucopia of resources intended to promote early intervention for Non-Verbal Learning Disabilities. Topics include a camp listing, calendar, question & answer bulletin board & chat room, parenting tips & stories, IEP info, teacher education, referrals, and professional articles.

Nonverbal Learning Disorders Association

www.nlda.org (860) 570-0217 Professional association, site offers excellent interventions page.

Sensory Integration Network www.sinetwork.org

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

National Wraparound Initiative

www.rtc.pdx.edu/nwi 206-685-2477 Definitive source of information and training about this

medical care model.

The Attachment Institute of New England

www.attachmentnewengland.com

508-799-2663 Assessment, treatment, resource links, parent support group, regarding Reactive Attachment Disorder

www.attach.org 866-453-8224 Advocates for public awareness and sponsors public education, quarterly newsletter, annual conference, membership directory, and other benefits.

The Trauma Center at the Justice Resource Institute www.traumacenter.org General Number:

(617) 232-1303 Clinical Intake:(617) 232-0687

Offers treatment, resource links including downloadable resources for first responders, and training assessments, research, publications and videos for professionals

PAL

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