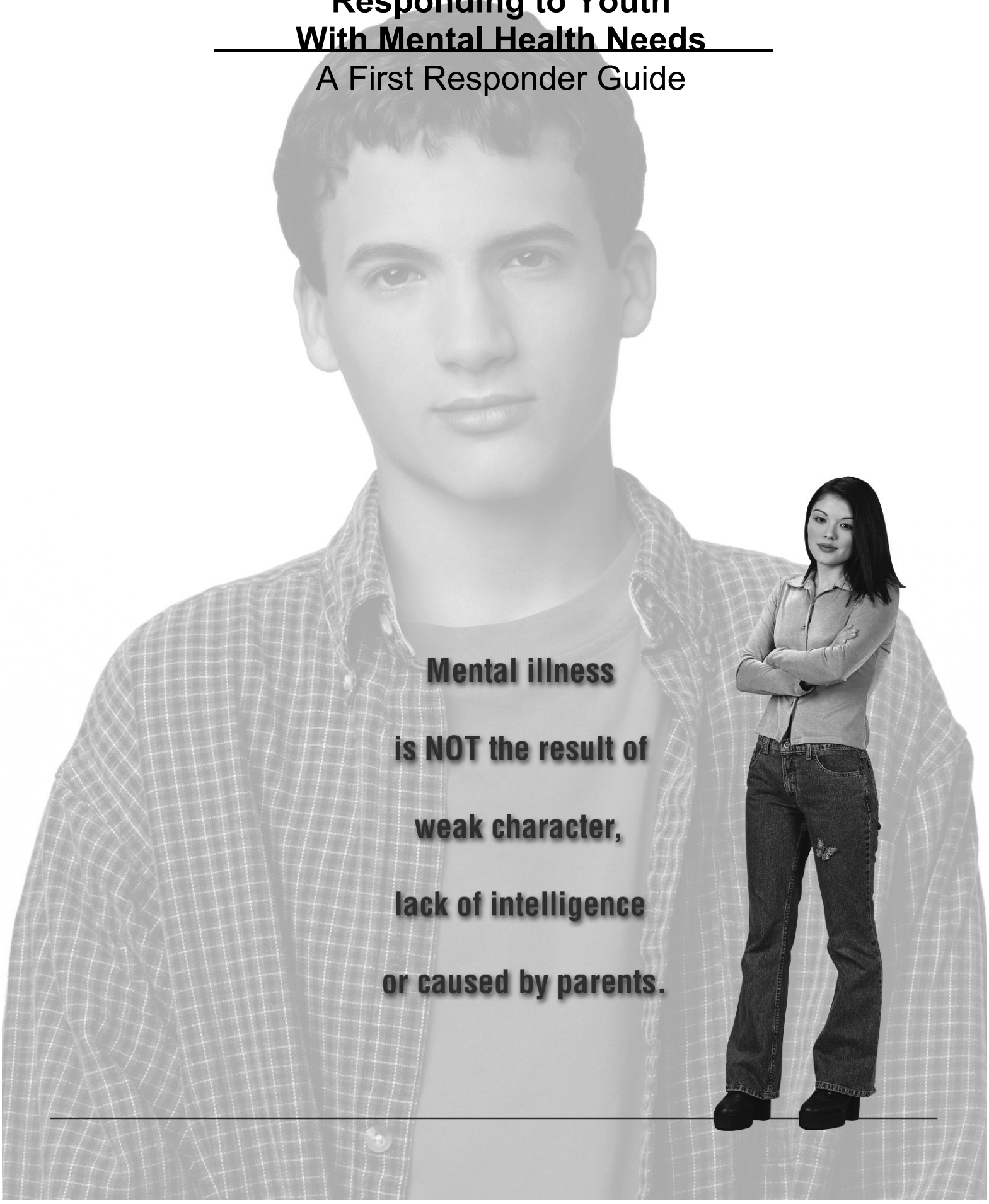
Responding to Youth
With Mental Health Needs

A First Responder Guide



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Local Mental Health Assistance Providers

On-Scene Assessment

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

Important Note: Involuntary behaviors such as impulsiveness and flawed thinking are recognized symptoms of mental illness, and are worsened by substance use. First Responders can augment their life saving function of stopping risky behaviors with an informed and compassionate approach.

What to look for

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

Clinical Recommendations

How to Respond

- Stay calm and don't overreact.
- Be friendly and accepting but remain firm and professional.
- Remove upsetting influences, distractions, and people from the scene.
- Gather information from family or bystanders.
- Indicate that you are trying to understand.
- Reassure the youth that you are there to help, not harm.
- Speak simply and briefly, and announce
- your actions before initiating them.
- Do not move suddenly, shout or give rapid orders.
- Avoid direct, continuous eye contact.
- If possible, do not touch the youth. Do not crowd his/her "comfort zone".
- Ask the youth for their cooperation, and allow them time to respond.
- Try to keep conversation concrete by redirecting the topic when needed.

- Be aware that your uniform and equipment may frighten the youth.
- Multiple first responders may increase the youth's level of agitation.
- Do not express anger, impatience or irritation.
- Do not force discussion or assume that an unresponsive youth cannot hear you. They may not understand or may be unable to respond.
- Recognize that the youth may be overwhelmed by sensations, thoughts, surroundings, frightening beliefs, internal sounds or voices.
- Acknowledge that the youth's delusions are real to him or her.
- Do not argue with delusional statements, or mislead the youth to think that you feel or think the same way.
- Do not use inflammatory language, such as "wacko" or "psycho" in the youth's presence or in the nearby vicinity. Mental health disorders do not affect a youth's ability to hear.

What To Do

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

If the youth is a danger to him/herself or a serious threat to others a first responder such as an officer must decide whether to place the youth in protective custody (if a crime has been committed) or initiate a mental health evaluation.

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

- Transport the youth to the designated facility or in a police vehicle (or other approved transportation).
- Contact the local crisis team for consultation of the youth's needs.
- Escort the parents as they transport their child to the designated facility.
- Stay on the scene until an ambulance arrives and the EMS team is sufficiently informed to take charge of the situation.

- Leave the youth in the care of their parent or guardian.
- Some other appropriate action that complies with the local standard procedures.

Points to Remember

- A first responder's ability to recognize symptoms of mental illness can be invaluable when assessing a scene.
- Mental illness and bizarre behavior are not criminal.
- Failure to follow instructions during a psychotic episode is most likely NOT a deliberate act of defiance.
- These youths heal with treatment, not jail. When incarcerated their illnesses often worsen, especially if psychiatric medications are withheld.
- Four out of every five runaway youths suffers from depression. (US Select Committee on Children, Youth & Families).
- Suicide is the third leading cause of death or 15-24 year olds (approx. 5,000 youths each year) and the sixth leading cause of death for 5-15 year olds.
- A sensitive intervention by a first responder can be a reassuring and steadying influence on a struggling youth, and can encourage the youth to cooperate.

Psychiatric Medications

Most youth who have a known diagnosis are prescribed medications; however, they may not be taking them as prescribed.

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

Some commonly prescribed medications are listed below, grouped in categories based upon the illnesses they are used to treat. Each medication is listed by its brand name, followed by the generic name in parentheses.

Anti-Depressants

There are four general categories of antidepressants used in the treatment of depression and other illnesses that include depression as a symptom.

Selective Serotonin Reuptake Inhibitors (SSRI)

- Celexa (citalopram)
- Effexor (Venlafaxine)
- Luvox (Fluvoxamine)
- Paxil (Paroxetine)
- Prozac (Fluoxetine)
- Zoloft (Sertraline)
- Lexapro (escitalopram)

Atypical Antidepressants

- Desyrel (Trazodone) also used for sleep
- Serzone (Nefazodone)
- Wellbutrin (Bupropion)
- Asendin (amoxapine)
- Cymbalta (duloxetine)
- Ludiomil (maprotiline)
- Remeron, Remeron Sol Tab (mirtazepine)
- Emsam (selegiline)
- Effexor, Effexor XR (venlafaxine)

Tricyclic Antidepressants

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

Monoamine Oxidase Inhibitors (MAOI)

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

Stimulants

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

- Adderall (dextroamphetamine sulfate)
- Concerta (methylphenidate hydrochloride)
- Dexedrine (Dextroamphetarnine)
- Focalin, Focalin XR (dexmethylphenidate)
- Strattera (atomoxetine)
- Provigil, Attenace (modafinil)
- Ritalin (Methylphenidate)

Anti-Anxiety Agents

Used in the treatment of anxiety disorders.

- Ativan (lorazepam)
- Buspar (buspirone)
- Centrax (prazepam)
- Inderal (propranolol)
- Klonipin (clonazepam)
- Librium (chlordiazepoxide)

- ProSom (estazolam)
- Dalmane (flurazepam)
- Paxipam (halazepam)
- Versad (midazolam)
- Doral (quazepam)
- Restoril (temazepam)
- Halcion (triazolam)
- Serax (oxazepam)
- Tranzene (clorazepate)
- Valium (diazepam), Xanax (alprazolam)

Panic disorder, a sub-category of the anxiety disorders, is often treated with:

- Klonopin (clonazepam)
- Paxil (paroxetine)
- Xanax (alprazolam)
- Zoloft (Sertraline)

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

Anti-Obsessive Agents

Used to treat obsessive-compulsive disorder (OCD).

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

Anti-Psychotic Agents

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

Typical Anti-psychotics:

- Haldol (haloperidol)
- Loxitane (loxapine)
- Mellaril (thioridazine)
- Moban (molindone)
- Navane (thiothixene)
- Prolixin (fluphenazine)
- Orap (pimozide)
- Stelazine (trifluoperazine)

- Thorazine (chlorpromazine)
- Trilafon (perphenazine)

Atypical Anti-psychotics:

- Clozaril (clozapine)
- Risperdal (risperidone)
- Seroquel (quetiapine)
- Zyprexa (olanzapine)
- Abilify, Abilify Discmelt (aripiprazole)
- Invega (palperidone)
- Geodon (ziprasidone)

Mood Stabilizers

Used to treat bipolar disorder, aggression, and depression.

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

Anti-Aggression Agents

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

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

Medications To Treat Substance Abuse

- Catapress (Clonidine) – nicotine or opioid withdrawal symptoms
- Trexan (naltrexone) Patients taking this medicine on a scheduled basis will not experience a high should they use an opioid drug. Also used to treat alcohol dependence. Some psychiatrists prescribe this drug to youth who purposely cut themselves, under the theory that whatever satisfaction the cutting brings might be short-circuited, reducing the youth's incentive for self-injurious behavior.
- Antabuse (disulfiram) used in management of chronic alcoholism. Even small amounts of alcohol taken when this drug is in the body will make the patient ill, a severe reaction can be fatal.
- Atarax, Vistaril (hydroxyzine) – this antihistamine (allergy drug) is often used to treat nausea & vomiting, anxiety, and psychiatric emergencies including acute alcoholism.
- Campral (acamprosate)-alcohol dependence

• Revia, Depade, Vivitrol Suspension Injections (naltrexone)-Alcohol/opioid dependence.
• Buprenex, Subutex (buprenorphine), Suboxone (buprenorphine/naloxone)-Opioid dependence).
• Serentil (mesoridazine) – alcoholism
• Dolophine, Methadose (methadone) – treats narcotic withdrawal symptoms, can be habit-forming
• Zyban (bupropion)-Nicotine dependence

Alcohol withdrawal symptoms may also treated with

• Librium (chlordiazepoxide)
• Tranzene (clorazepate)
• Valium (diazepam)
• Serax (oxazepam)

Mental Health Disorders

Mental illnesses are now being diagnosed more accurately (and frequently) in children as scientific understanding of the brain progresses.

In addition to traditional diagnostic tools, researchers using modern imaging technologies have discovered brain differences in some mentally ill youth. The following pages describe some of the most commonly diagnosed mental health disorders.

The Anxiety Disorders

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

Panic Disorder

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

Phobia

A phobia is an intense, irrational, and disabling fear of something that poses little or no actual threat. The fear leads to avoidance of objects or situations and can cause extreme feelings of terror, dread, and panic.

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

Social Phobia

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

Exposure to the feared social situation provokes anxiety and is avoided if possible. When a social situation is impossible to avoid, the youth may endure it with intense anxiety and distress or may succumb to a panic attack. * Youths with social phobia may relate to adults in an appropriate way, without phobic behaviors.

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

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

A youth with PTSD may re-experience traumatic events in the form of recurrent and intrusive thoughts or nightmares.

A youth with PTSD may show phobic avoidance of anything that reminds him/her of the trauma, and may even be unable to recall details about it.

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

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

Obsessive-Compulsive Disorder (OCD)
This disorder is characterized by repetitive, intrusive, and unwanted thoughts (obsessions) and/or rituals (compulsions) that seem impossible to control.

Compulsive behaviors may include, but are not limited to, activities such as: counting and recounting, repeated rearranging or aligning of objects, tapping and knocking, turning lights on and off, locking and unlocking doors and windows and excessive hand washing.

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

Bipolar Disorder
Bipolar disorder, also know as manic depressive illness, is a serious but highly treatable brain disorder. A bipolar youth experiences highs and

lows: periods of mania and depression with normal moods in between.

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

During manic phases a youth may exhibit a number of "hyper" characteristics that may include: extreme irritability and distractibility, euphoria, increased energy, restlessness, racing thoughts or rapid talking, disrupted sleep, delusions of grandeur, very poor judgment, impulsiveness, reckless sexual encounters, abuse of drugs or alcohol, obnoxious, provocative or intrusive behaviors, and denial that anything is wrong.

First Responders may encounter bipolar youth more often than those with other mental health disorders.

Bipolar disorder is most effectively treated with a combination of counseling and medication.

Please see the following description of depression.

Depression/Major Depression
Clinical depression goes well beyond sadness, and is much more than having a bad day or coping with a major loss. Symptoms include persistent sadness and hopelessness, withdrawal from friends or activities, and poor school attendance or declining academic performance. The youth may experience a distressing level of indecision, an inability to concentrate, excessive sleep, a change in eating habits, a feeling of numbed emotions, and frequent physical complaints. A youth who is attempting to escape their depression may try to self medicate with street drugs or alcohol. There may be thoughts of death or suicide.

Any attempt at suicide, even an apparently small gesture, should receive professional intervention, since they often represent "the tip of the iceberg." Treatment usually includes a combination of counseling and anti-depressant medications.

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

Schizophrenia
Schizophrenia is a very serious mental illness that usually emerges in late adolescence or young adulthood. The symptoms of schizophrenia are

characterized as either positive (characteristics they have) or negative (the absence of normal characteristics).

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

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

The voices may warn of danger, tell the youth to take some action, or simply comment on life. Some youths hear multiple voices.

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

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

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

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

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

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

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

Oppositional Defiant Disorder (ODD)
ODD is a pattern of disobedient, hostile, and defiant rule breaking that lasts for an extended period and is longer than a typical child or adolescent “phase”.

Many ODD youths also have co-occurring AD/HD, anxiety, depression, learning disabilities, or other mental health disorders. Many professionals believe ODD is the early form of Conduct Disorder.

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

Conduct Disorder
Common behaviors include: bullying, threatening or intimidating, stealing, running away, lying, fire setting, truancy, breaking and entering, vandalism, cruelty to animals, fighting, and confrontation. Explosive anger is the primary maladaptive behavior and causes significant interference in social, academic, and occupational functioning.

Treatment is especially challenging because these youths are uncooperative and do not trust adults. Psychotherapy, behavioral therapy and psychiatric medications are generally all incorporated into a

comprehensive treatment plan. Conduct disordered youth often have additional challenges such as learning disabilities, depression or other mental health disorders.

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

In many cases parents and doctors will agree that stimulant medication (usually Ritalin, Adderall, or Concerta) should be part of the treatment plan.

A youth who receives treatment can become more independent, and learn to successfully manage their illness.

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

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

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

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

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

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

Learning Disabilities

Non-Verbal Learning Disability
(NLD/NVLD) NLD is a learning disability thought to result from differences in the "wiring" of the brain that influence perception and behavior. The strengths include eloquent verbal abilities, a strong vocabulary, and excellent rote memory. They remember the details, but often miss their significance.

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

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

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

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

Youth who are under-responsive to a sensation may seek to “turn up the volume” to increase the experience. They may seem “wound up” and talk too loud, or touch others too much or too hard. They may even hurt themselves without noticing. Youth who are over-responsive to stimulation may react negatively to motion, loud or busy environments, bright light, touch, or food smells. They may react with aggression, withdrawal, or even nausea.

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

About Mental Illness

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

In fact, many youth who have mental health disorders also have loving homes and devoted parents.

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

should consider the possibility of an undiagnosed mental health need and may need to refer the youth for a professional mental health evaluation.

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

Parents As Allies

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

In some cases, it may be unclear if a youth has a mental illness. In these cases an alert and informed first responder can suggest to the parent that a professional mental health evaluation may be needed.

The first responder can reassure and advise the parent, or when appropriate, assist in obtaining an evaluation by calling for a crisis team to intervene. Informed advice can give a parent new insight into how to help the youth.

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

Public Safety

Most youths with mental health needs are not more violent or dangerous than those in the general population. In fact, many are withdrawn, fearful and uncomfortable dealing with others. If they become aggressive it is usually because they feel frightened, confused, or hopeless. Sometimes youths who are severely ill do not even realize they have a mental health need. This lack of perception can cause a severely mentally disturbed youth to be unable to accurately assess their surroundings or understand what is said to them. Fear and confusion about where they are and what is happening can lead to unpredictable responses and may pose a threat to the personal safety of the troubled youth, the first responder or others at the scene. However most youths with mental health needs are not this severely affected, and are fully aware of the world around them.

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

Alphabet Soup

ED	Emotionally Disturbed
DHW	Department of Health and Welfare
ICCMH	Idaho Council on Children's Mental Health
IDFFCMH	Idaho Federation of Families for Children's Mental Health
IEP	Individual Education Plan
NIBH	North Idaho Behavioral Health
NAMI	National Alliance for the Mentally Ill
NIMH	National Institute for Mental Health
QPR	Question, Persuade, Refer (in response to concerns about the risk of self harm)
SED	Seriously Emotionally Disturbed
SPAN	Suicide Prevention Action Network

Glossary

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

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

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

Case Manager
An individual who organizes and coordinate services for an individual.

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

Confidentiality
The limiting of access to a child's records to his/her

parents and personnel having direct involvement with the child.

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

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

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

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

DSM IV
An official manual describing mental health disorders.

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

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

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

Individualized Education Program (IEP)
A written special education plan which describes a student's individual needs and the special education services that will be provided.

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

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

Mental Illness
A biological brain disorder that disrupts a person's thinking, feeling, moods, and ability to relate to others.

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

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

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

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

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

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

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

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

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

Screening
A preliminary assessment.

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

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

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

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

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

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

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. Includes both traditional mental health and support services. Support services are often unique, and address specific sources of stress, for example camp or outward-bound programs, specialized after school care, or an allowance.

Resources:
Idaho Federation of Families for Children's Mental Health, Inc. The Idaho Federation of Families for Children's Mental Health is a statewide network of families, local parent support groups, and professionals who advocate on behalf of youth with mental, emotional, or behavioral special needs. Programs include parent-to-parent support groups, parent education, and advocacy at the local, state, and national level as well as information and referral.

IDFFCHM
1509 S. Robert St. Suite 101
Boise, ID 83705
(800) 905-3436 or (208) 433-8845
www.idahofederation.org

Idaho State Agencies
Many resources can be located by beginning at the main Idaho state website at www.accessidaho.org. Look under agency listings for the Department of Health and Welfare, State Department of Education and Department of Juvenile Corrections.

Department of Health and Welfare (DHW), Community and Family Services Program

Provides individualized clinical care and support. Services include: crisis stabilization and response services, assessment, day treatment, case management and outpatient treatment. For information and referral as well as services, contact the local Department of Health and Welfare office:

Region	City	(All 208)	24-Hour Emergency No.
I	Bonners Ferry	267-3187	888-769-1405
I	Coeur d'Alene	769-1515	888-796-1405
I	Kellogg	784-1351	888-796-1405
I	Sandpoint	265-4523	888-769-1405
I	St. Maries	245-2541	888-769-1405
I	Grangeville	983-2522	866-788-7811
II	Lewiston	799-4360	866-788-7811
II	Moscow	882-0670	866-788-7811
II	Orofino	476-7449	866-788-7811
III	Caldwell	459-0092	800-424-0297
III	Emmett	365-3515	800-424-0297
III	Nampa	465-8452	800-424-0297
III	Payette	642-6416	800-424-0297
IV	Boise	334-6800	800-660-6474
IV	McCall	634-2228	800-660-6474
IV	Mountain Home	587-9061	800-660-6474
V	Bellevue	788-3584	208-734-4000
V	Burley	678-0974	208-734-4000
V	Jerome	324-8862	208-734-4000
V	Twin Falls	734-4000	208-734-4000
VI	American Falls	226-5186	208-235-5869
VI	Blackfoot	785-5826	208-235-5869
VI	Malad	766-2281	208-235-5869
VI	Pocatello	239-6200	208-235-5869
VI	Preston	852-0634	208-235-5869
VI	Soda Springs	547-4317	208-235-5869
VII	Idaho Falls	528-5700	208-528-5700
VII	Rexburg	359-4751	208-528-5700
VII	Salmon	756-3336	208-528-5700

Region I

1120 Ironwood Drive, Suite 101
Coeur d'Alene, ID 83814-2659
Phone: (208) 769-1515
Fax: (208) 769-1473

Benewah County
222 South Seventh Street,
Room G-35 P.O. Box 248
St. Maries, ID 83861
Phone: (208) 245-2541
Fax: (208) 245-7131

Bonner County
1717 West Ontario
Sandpoint, ID 83864
Phone: (208) 265-4529
Fax: (208) 263-4198

Boundary County
Route 4, 6522 Tamarack
Bonners Ferry, ID 83805
Phone: (208) 267-3187
Fax: (208) 267-3251

Kootenai County
1120 Ironwood Drive
Coeur d' Alene, ID 83814
Phone: (208) 769-1456
Fax: (208) 666-6789

Shoshone County
35 Wildcat Way, Suite B
Kellogg, ID 83837
Phone: (208) 784-1351
Fax: (208) 784-1356

Region 2

Clearwater County
416 Johnson Avenue
Orofino, ID 83544
P.O. Box 712
hone: (888) 400-5771
Fax: 476-3636

Idaho County
Camas Resource Center
216 South C Street
P.O. Box 548
Grangeville, ID 83530
Phone: (888) 983-0620
Fax: 983-2440

Latah County
1350 Troy Highway
Moscow, ID 83843
Phone: (888) 660-2433
DD/MH Fax: 883-0615
FACS/SR Fax: 882-8575

Nez Perce County
State Office Building
1118 “F” Street
P.O. Drawer B
Lewiston, ID 83501
Phone: (208) 799-4400
Fax: (208) 799-3350

Region 3

3402 Franklin Road
Caldwell, ID 83605-6932
Phone: (208) 454-8351

Canyon County
3402 Franklin Road
Caldwell, ID 83605-6932
Phone: (208) 454-0421

Gem County
1024 Fernlee
Emmett, ID 83617
Phone: (208) 365-3515

Nampa Field Office
823 Park Centre Blvd.
Nampa, ID 83651
Phone: (208) 465-8444

Payette County
Washington County
515 North 16th Street
Payette, ID 83661
Phone: (208) 642-6400

Region 4

1720 Westgate Drive, Suite A
Boise, ID 83704
Phone: (208) 334-6700
Fax: (208) 334-6738

Ada County & Boise County
1720 Westgate Dr., Suite D
Boise, ID 83704
Phone: (208) 334-6700

Elmore County
2420 American Legion Blvd.
Mountain Home, ID 83647
Phone: (208) 587-9061

Valley County
299 South Third
McCall, ID 83638
Phone: (208) 634-2229

Region 5

601 Pole Line Road, Suite 3
Twin Falls, ID 83301
Phone: (208) 736-3020
Fax: (208) 736-2116

Jerome County, Gooding County & Lincoln County
126 North Adams
P.O. Box 109
Jerome, ID 83338

Blaine County & Camas County
621 N. Main
Bellevue, ID 83313
Phone: (208) 788-3584

Cassia County & Minidoka County
2241 Overland Avenue, Suite 1
Burley, ID 83318
Phone: (208) 678-1121

Region 6
1070 Hiline Road, Suite 390
Pocatello, ID 83205-4166
Phone: (208) 239-6280
Fax: (208) 239-6299

Bannock County
1070 Hiline Road
Pocatello, ID 83205-4166
Phone: (208) 239-6280
Fax: (208) 239-6299

Bingham County
Health and Welfare
Developmental Disabilities
Family and Children Services
Self Reliance
701 East Alice
Blackfoot, ID 83221
Phone: (208) 782-2600
Fax: (208) 785-1003

Adult Mental Health
720 East Alice P.O. Box 129
Blackfoot, ID 83221
Phone: (208) 782-5871
Fax: (208) 785-5887

Caribou County
Health and Welfare
184 South Main Street
Soda Springs, ID 83276
Phone: (208) 547-4317
Fax: (208) 547-4810

Franklin County
Health and Welfare
223 North State
Preston, ID 83263
Phone: (208) 852-0634
Fax: (208) 852-2136

Oneida County
30 North 100 West
Malad City, ID 83252
Phone: (208) 766-2281
Fax: (208) 766-4429 (only fax to Preston Office if you know a staff member is there)

Power County
569 Bannock Avenue
American Falls, ID 83221
Phone: (208) 226-5186
Fax: (208) 226-5835

Region 7

150 Shoup Avenue, Suite 19
Idaho Falls, ID 83402
Phone: (208) 528-5799
Fax: (208) 528-5776

Bonneville County
Clark County
Jefferson County
150 Shoup Avenue, Suite 19
Idaho Falls, ID 83402
Phone: (208) 528-5799

Butte County
213 West Grand
Arco, ID 83213
Phone: (208) 527-3461

Custer County
Lemhi County
Health and Welfare
1301 Main Street, Suite 3B
P.O. Box 610
Salmon, ID 83467
Phone: (208) 756-3336

Fremont County
Madison County
Teton County
333 Walker Drive
Rexburg, ID 83440
Phone: (208) 359-4750

Local School Districts
The Individuals with Disabilities Education Act (IDEA) includes emotional disturbance in the definition of a child with a disability. Children 3 to 21 evaluated as having emotional disturbance and how, because of the disability need special education and related services are eligible for services under IDEA. School districts are required to ensure that a free, appropriate public education is available to students with a disability who reside in the district and are eligible for special education. Contact the local school district special education office.

Idaho State Department of Education
Website for the Bureau of Special Education
http://www.sde.idaho.gov/SpecialEducation. Contact the coordinator of Special Education Technologies, (208) 332-6919

Idaho Juvenile Justice System (County Probation and Department of Juvenile Corrections)
The Juvenile Corrections Act provides the legal framework for responding to juveniles who commit law violations. The goals of the system are to hold juveniles accountable for the harm they caused, help assure community safety, and provide opportunities for skill development. For information about services Contact:

Idaho Department of Juvenile Corrections
400 N 10th St, 2nd floor
Boise, ID 83702
Phone: (208) 334-5100
Fax: (208) 334-5120
www.djc.state.id.us

Correctional Centers
Region 1
140 Southport Ave
Lewiston, ID 83501
Phone: (208) 799-3332

Region 2
1650 11th Ave N
Nampa, ID 83687
Phone: (208) 465-8443

Region 3
2220 East 600 North
St. Anthony, ID 83445
Phone: (208) 624-3462

District Liaisons

District 1 & 2 – Jim Crowley
1250 Ironwood Dr. # 304
Coeur d' Alene, ID
Phone: (208) 769-1449
Fax: (208) 666-6734
Jim.crowley@idjc.idaho.gov

District 3 & 4 – Shelly McCoshum
1650 11th Ave N
Nampa, ID 83687
Phone: (208) 465-7443 ext. 131
Fax: (208) 465-8484
Shelly.mccoshu@idjc.idaho.gov

District 4 & 5 – Bev Ashton
1061 Blue Lakes Blvd North,
Twin Falls, ID 83301 # 204
Phone: (208) 736-4776
Fax: (208) 736-4778
Bev.ashton@idjc.idaho.gov

District 7 & 8 – Bill Lasley
1070 Hiline Rd, #320
Pocatello, ID 83201
Phone: (208) 236-6395
Fax: (208) 236-6422
William.lasley@idjc.idaho.gov

Other Resources

Contact information can be obtain from either the Careline by dialing 211 or (800) 926-2588 or by contacting the Idaho Federation of Families at (800) 905-3436

Idaho Careline
Dial 211 or call (800) 926-2588. Provides information and referral to a variety of services throughout the state of Idaho

Idaho Child Welfare Research and Training Center
Provides video tapes and printed material for parents and professionals seeking information about children's mental health and chemical dependency and related issues. Coeur-d'Alene (208) 676-1186

National Alliance for the Mentally Ill (NAMI)
A support and information organization for the mentally ill and their families. Offers printed material and in depth website with clear information about mental illness www.nami.org (800) 370-9085

National Institute for Mental Health (NIMH)
Provides website with sections on research, clinical trials, information about mental health disorders, conferences and more. www.nimh.nih.gov

Suicide Prevention Action Network of Idaho (SPAN)
A statewide non-profit organization that provides leadership for suicide prevention in Idaho. (208) 860-1703 http://www.spanidaho.org

If you are in crisis, call the Idaho Suicide Hotline:
(800) 273-8255—24 hours a day.

Better Todays. Better Tomorrows.
For Children's Mental Health
A Gatekeeper Education Program
Idaho State University
Institute of Rural Health
12301 W. Explorer Dr. #102
Boise, ID 83713
(208) 562-8646
todays@isu.edu
www.isu.edu/irh/bettertodays

Dedication
We dedicate this First Responders Guide to all the first responders of Idaho who serve and protect our homes our communities, and our families. We honor your courage and praise your dedication. We salute your commitment to all members of our society and we appreciate and thank you for your understanding and respectful treatment of our mentally troubled youth.

Special Thanks
We wish to thank the Idaho 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 first responders inspired the writing of the pocket guide.

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Costs associated with this publication are available from The Idaho Department of Health and Welfare

For more information or additional copies of this guide, Please contact:

Department of Health and Welfare
450 West State. St.
P.O Box 83720
Boise, ID 83720-0036
(208) 334-5722
Fax: (208) 332-7268

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