CRISIS FOR PARENTS PLANNING GUIDE

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MBHP

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When your child or adolescent is experiencing a serious mental health crisis, s/he is at serious risk of hurting her/himself, hurting others or is having severe, disorganized or dangerous train of thought, you will need to have your child/adolescent screened for hospitalization. Taking the time in a non-crisis situation can help make a difficult situation less stressful. **Here are some suggestions as to what you should know in case of an emergency:**

✦ Call your insurance carrier and ask who provides crisis team services for them. The crisis team and the hospital may be in different locations.

✦ Call your crisis team and admitting hospital and tell them this is not an emergency. Explain that you are establishing a plan for your child before it is needed.

✦ Language and terminology changes with every insurance carrier. Become familiar with the terminology of your mental health emergency provider.

✦ Ask questions before an emergency occurs. It is much easier for the crisis team to assist you if you are familiar with the terms they use.

✦ In a medical emergency, you would automatically go to the nearest emergency room. Mental health emergencies may be evaluated at different locations than the local hospital. Mental health crisis teams can be known as Emergency Services Programs, Crisis Evaluation Teams, Emergency Screening Teams to name a few. You must ask your insurance carrier to identify the mental health crisis team and the admitting psychiatric hospital.

✦ Keep a record of phone numbers and addresses.

✦ You should drive to the crisis team and admitting psychiatric hospital before a crisis arises. Become familiar with the route as well as the buildings. Locate parking, find the correct entrance, identify the admitting desk and waiting area. You may not be the one transporting your child from the crisis team to the hospital. Your child may be transported by ambulance.

This handbook is designed to provide families with a tool to guide them through a mental health crisis. **Take time and fill in all lines on the Parent Plan for Accessing Emergency Services Form (located on page 12-13)**.

ASK YOURSELF THE FOLLOWING QUESTIONS:

Will I be the best choice for transporting my child during this crisis?

- If not, what are my options:
  police, ambulance, friend, family ?

- How will I plan for my options in advance ?

Will I need help getting my child safely from the car to the crisis team? If yes, who will assist me?

Will I need to arrange for the care of other children during the crisis ? If yes, what are my options: parents, in-laws, siblings, neighbors?

Calling the Crisis Team

When speaking with the crisis team, be calm. Keep the conversation focused on why your child is not safe. Describe your child's risk-taking behavior and train of thought that requires hospital level of care. Be certain to give your child's diagnosis. Remember the crisis team is there to help you and your child. The more prepared you are in a crisis, the better the crisis team will be able to help you.

Begin your dialogue with the crisis team by stating :

Emphasize how your child's behavior and train of thought are seriously impacting the safety of your child and/or others. Be certain to give clear examples as to why this is not typical behavior for your child and make a clear connection between your child's crisis and her/his psychiatric profile. Provide examples of how these actions have escalated over the past 72 hours. Share concerns of other individuals in your child's life, such as school teachers, guidance counselors, neighbors, friends, etc. When calling the crisis team, be certain that the crisis team has a clear and total picture of your child's mental health crisis.

My child is a danger to her/himself or others and/or is having a disorganized/dangerous train of thought. Ask the crisis team to evaluate your child.

Give clear examples as to why your child is not able to keep herself/himself safe. Give clear examples as to why family members or community members are not safe. Give brief history of the build up of the crisis situation over the last 72 hours.

If your child has a past history requiring hospital level of care and is currently presenting a profile that requires hospital level of care, be certain that you share that information with the crisis team. This will enable the crisis team to take proactive steps.

Keep a log of individuals you speak with during this crisis.

Name	Organization	Title	Date/Time

Examples of calls to the crisis team are on the following pages.

The **unclear presentation** of your child's decompensation focuses on how your child's behavior is impacting the child or family. The crisis team may hear these scenarios as a child who is having behavioral problems and not that of a child experiencing a mental health crisis.

A **clear presentation** gives specific information regarding your child's diagnosis and actions. It clearly shows that your child is:
- experiencing a dangerous train of thought,
- a danger to others or
- a danger to her/himself.

The following scenarios are only examples of effective and ineffective communication between the parents and the crisis team. They are not meant to be used as scripts when calling the crisis team. Each child is unique and has individual needs that will need to be shared with the crisis team.

Example of dangerous train of thought

Unclear Presentation

I cannot get Jimmy to come into the house. He just wants to be left alone. Jimmy likes sitting on the roof to scare me. I have tried to tell him to come in the house, but he just yells at me and tells me to leave him alone. The school does not know what to do with him. He has been fighting with the kids at school. No matter what I say to him, he just yells at me and tells me not to bother him. He stays up all night watching TV and then I cannot get him up for school. When he does go to school, the principal calls and tells me to pick him up, because they do not know what to do with him. Jimmy is either fighting with the teachers and students or sleeping in class. Someone has to do something with this kid. I can not control him.

Clear Presentation

Jimmy is sitting on the roof and threatening to jump. Jimmy believes he can jump off the roof and not be hurt. His thoughts are racing with the fantasy that he is superhuman. Jimmy is diagnosed with bipolar disorder. He is being treated by a psychiatrist and psychologist. I have called and left messages for each of them and have not heard back. I do not feel Jimmy is safe. I want him to be evaluated for emergency services. He does not respond to his name and becomes more agitated and defiant when I speak to him. When I speak to him, he screams nonsense statements back at me. He believes I am trying to hurt him and he needs to escape into his fantasy world to be safe. Jimmy has been acting more detached over the past several days. He sleeps most of the day and stays awake for most of the night. He has not been eating. He has fallen asleep in school. He has been in several fights at school with teachers and friends. His principal called to tell me Jimmy is oppositional beyond typical behavior. The principal is concerned about disciplining him, because Jimmy appears so emotionally fragile and unstable.

Example of danger to others

Unclear Presentation

Karen is very angry and breaking furniture and windows in the house. I cannot take her acting like this anymore. Karen will not answer my questions. I keep asking her why she is doing this, but she swears at me and calls me terrible names. She is mean to her brother and sister. Karen likes to fight with everyone. She hates her brother and sister as well as me. Karen does not like any authority figures. She will not do what any adult tells her to do. I cannot live like this anymore.

Clear Presentation

Karen has been diagnosed with major depression and oppositional defiant disorder. We have been trying to stabilize her with medication and have not met with a successful combination yet. Karen was hospitalized three months ago and has been struggling ever since. I have called her psychiatrist and he feels she needs to be seen by the crisis team. In the past week, Karen's anger has escalated. She has broken mirrors and windows with no regard for her own safety or the safety of her sisters and brothers. Karen is in the living room stabbing the walls with a knife. Her anger is out of control and she cannot explain why she is so angry. She appears to be controlled by her thoughts of anger and destruction. When I try to intervene she threatens me and my other children; verbally and physically. She has threatened to hurt anyone who comes into the room. I am afraid that she may hurt her brother and sister. Karen will not stop these actions regardless of my request for her to do so. I am afraid of her and for her.

Example of danger to self

Unclear Presentation

Danny is locked in the bathroom and won't come out. He's skipping school, and refuses to talk to anyone at home or school. He has no respect for his stuff-he gave all his birthday presents away to his friends just to make me angry. He has threatened to kill himself by taking all the pills in the house. He is doing everything possible to scare me.

Clear Presentation

Danny is locked in the bathroom threatening to kill himself and becomes more agitated when I try to calm him down. Danny is not able to listen to my concern for his safety. He has hidden pills all over the house as part of his plan to kill himself. Danny's threats to kill himself have escalated over the past several days. He has withdrawn from the family, skipped school and stated that he would be better off dead. Danny's guidance counselor at school has called and is very concerned about his behavior. Danny gave away his birthday presents to kids at school stating that he won't be needing them. I have been called to the school for the last three days to pick him up because he does not believe he can keep himself safe.

THE CRISIS TEAM FINDS YOUR CHILD IS NOT IN NEED OF HOSPITAL LEVEL OF CARE:

When calling the crisis team, make certain that your call is screened through a clinician.

When you arrive at the crisis team, your child should be evaluated by a child-trained clinician to determine if s/he needs hospital level of care. If the decision is made that your child will be best served in an environment other than the hospital, you may request that the clinician put in writing why your child does not meet hospital level of care. Alternative levels of care may be recommended for your child, such as but not limited to, day treatment, day hospital, therapeutic shelter or perhaps wraparound services. You may ask the clinician to put in writing her/his assessment of your child and a plan to keep your child safe.

If you are uncomfortable with the decision to take your child home, explain your concerns to the clinician. Remember, you know how your child was presenting prior to bringing her/him to the crisis team. You will need to be clear that your child is experiencing a mental health crisis. Explain why her/his behavior is not typical and restate why your child is a danger to her/himself or others.

If your child begins to fall apart shortly after you leave the crisis team, you may return to the crisis team for another evaluation. Ask the clinician what would indicate the need for hospital level of care that was not present at the first evaluation.

> If your child contracts for safety and is not willing or able to follow the plan, bring your child immediately back to the crisis team if she/he is a danger to her/himself or others.

The crisis team should have a plan for your child regardless of their findings. Ask for the plan in writing and be certain that you understand the plan and that you and your child can follow it safely.

The Plan should include:

1. Action steps for the family to follow when/if crisis reoccurs.
2. Follow up call from clinician within three hours.
3. Medical and psychiatric referrals.
4. Community resources: parent support groups, clinics, churches.

Ask questions while still at the crisis team. You can always call the crisis team back if the situation changes. Make certain that you are clear as to what your child needs and how you will be able to provide it before leaving the crisis team.

The Parent Plan for accessing crisis services provides parents with a step-by-step form that should cover the basic questions and information necessary to make your experience less complicated when contacting the crisis team, hospital admission and discharge planning. You are encouraged to fill in as much as possible prior to a crisis.

You may want to make several copies of the Parent Plan (page 12 & 13) for:

- **blank forms when information changes**
- **crisis team**
- **hospital**
- **psychiatrist**
- **school**
- **primary care physician**
- **case manager**

Identify and locate all necessary data prior to a crisis.

Child's Full Name _____

Date of Birth _____ Child's Age _____

Social Security # _____

Medicaid # _____

Treating Mental Health Clinician _____ Phone # _____

Treating Psychiatrist _____ Phone # _____

Primary Care Physician _____ Phone # _____

Primary Insurance Carrier _____ I.D.# _____

Mental Health Services Provider _____ Phone # _____

Crisis Team _____ Phone # _____

Secondary Insurance _____ I.D.# _____

Mental Health Service Provider _____ Phone # _____

Mental Health Diagnosis _____ Medical Diagnosis _____

Medications: (List all), if none, please state

Name	Dosage	Name	Dosage

Allergies: (If none, please state)

_____

_____

List Hospitalizations if any in the past 18 months

Hospital Name _____

Length of Stay _____ Admission Date __-__-__ Discharge Date __-__-__

Reason for Hospitalization _____

_____

Hospital Name _____

Length of Stay _____ Admission Date __-__-__ Discharge Date __-__-__

Reason for Hospitalization _____

_____

Hospital Name _____

Length of Stay _____ Admission Date __-__-__ Discharge Date __-__-__

Reason for Hospitalization _____

_____

Other Important Names and Addresses

Outpatient Therapist _____

Address _____

Phone _____ Fax _____

Psychopharmacologist _____

Address _____

Phone _____ Fax _____

Name of School _____

Address _____

Phone _____ Fax _____

School Psychologist _____ Phone# _____

D.M.H. Case Manager _____ Phone# _____

D.S.S. Case Manger _____ Phone# _____

Informed Consent for Treatment

At the time your child is hospitalized, or during the hospitalization, you will be asked to sign forms consenting to certain kinds of treatment. While it is necessary to allow medication trials, medical, and psychological testing to take place it is also important to understand the advantages and disadvantages of each procedure.

Administering any medication requires consent. Hospitals may ask you to sign a blanket release form allowing the administration of current medications as well as adding new ones. If you choose to do this, it is a good idea to firmly insist that any new medications be discussed with you before they are given. You may also decide to sign a release form allowing your child to receive only the medications she/he is already taking. Your consent for new medications can be given by phone, and written consent by fax if you are unable to be at the hospital when needed.

At the time you give consent, the doctor will list the pros and cons of a medication. If you have a concern of any kind, be sure to state it. Make sure you feel you have received enough information to satisfy your concerns.

You may also be asked to sign a blanket form for testing. Some tests such as blood tests and EKGs are routinely done before beginning certain medications and your consent will authorize those tests. Again, ask to be contacted before any testing is done so that you can understand the purpose and risks, if any, of each procedure. This also allows you to discuss each test with your child and lets her/him share fears and worries with you. Some children, for instance, may think that an EEG allows the doctor to read her/his thoughts. You can help your child make sense of each test.

If psychological testing is done, be sure to get the name and phone number of the psychologist giving the test. You may want to schedule a follow up appointment in person or on the phone to better understand the results. Since the results of this testing "paints" a psychological picture of your child, it is wise to review the results before releasing this information.

Be certain you know who any information will be released to. The hospital has "Release of Information Forms" that allow them to send information directly to schools, doctors, therapists, agencies, etc. Sending information requires your consent. Be sure to include copies to anyone important to your child's continuing treatment. Ask to sign a release form to send psychological test results, intake assessment and discharge summary to yourself.

Important Questions to ask the first night of hospitlization

Who is the charge nurse for the unit ?

Name _____ Phone # _____

Best time to call? _____ Fax # _____

Who is the treating physician ?

Name _____ Phone # _____

Best time to call ? _____ Fax # _____

Be certain to state your goals and objectives for child's hospitalization with the intake person.

_____

_____

_____

What are the policy and procedure for visits and phone calls?

_____

_____

May siblings, family, friends, etc. visit ? Any age limits?

_____

_____

Visiting hours _____

Phone # to call child _____

May I have a handbook on policy and procedures?

_____

Do you have a handbook for children ?

_____

Child's needs:

May my child have personal items from home such as: favorite pillow, blanket, stuffed animal, Walkman, CDs, toys, etc.? Are any items not allowed?

_____

_____

Important Questions for First Night (*continued):*

What does the hospital need me to bring on my next visit ?
This can include school reports, copy of current prescriptions, and any other involved agencies or individuals.

_____

_____

_____

How much prior notice will I receive before my child is discharged ?

_____

_____

Who will contact me about my child's discharge date?

Name _____ Title _____

Phone# _____ Fax# _____

Best time to call _____

NOTES: _____

_____

_____

_____

_____

_____

_____

Discharge planning is an important part of your child's hospitalization. Today's managed care hospitalizations tend to be short with the goal of identifying a diagnosis and/or stabilization. You need to get as much information as possible before your child is discharged. This is also the time when you will want to get all the people involved who will be working with your family and child in the future. A discharge planning meeting is conducted to ensure that everyone understands what your child will need when she/he is discharged. This may include school, home and continuing mental health treatment.

If at all possible, do not go to this meeting alone. Plan to invite your advocate, child's therapist, friend, relative, or neighbor who can also listen to what the psychiatrist or hospital staff is recommending. This can be a stressful and emotional meeting. It is often the last substantial contact with the hospital staff and it is helpful to have another person who can listen. Make certain all your questions have been answered before leaving the meeting.

Questions to Ask at the Discharge Planning Meeting.

When you leave this meeting and your child has been discharged from the hospital, you will want to have a comprehensive plan. It should include:

- A layman's/parents understanding and comprehension of the diagnosis.
- Enough medication and/or a prescription for medications, if they have been prescribed, to last until your first meeting with your child's psychiatrist.
- Changes if any, in the school plan or the school setting.
- Referral requests to the Department of Mental Health or day treatment program if applicable.

Discharge planning should begin the first night of hospitalization

Who is the contact person at the hospital for discharge planning?

Name _____ Title _____

Phone # _____ Fax# _____

Best time to call _____

When will the discharge planning meeting be held?

Date _____ Time _____

Location _____

Who will arrange for all the necessary representatives to be present at the discharge meeting ?

Name _____ Title _____

Phone # _____ Fax# _____

Best time to call _____

Who is responsible for developing the discharge plan?

Name _____ Title _____

Phone# _____ Fax# _____

Best Time To Call _____

How much notice will I receive to prepare for my child's discharge planning meeting?

_____

Will my child be invited to attend all, part, or none of the meeting?

_____

How will the school be notified of any necessary modifications needed for my child's successful return to school?

_____

Who is responsible for providing this information to the school?

Name _____ Title _____

Phone # _____ Fax# _____

Best time to call _____

_____

Who do I contact if the plan fails shortly after discharge?

Name _____ Title _____

Phone # _____ Fax# _____

Best time to call _____

Remember you may invite anyone you think will be helpful.
Ask who the hospital has invited

Individuals you may want to invite to the discharge planning meeting can include but are not be limited to:

Parents
Child
Relatives
Siblings
Friend/Advocate
Outpatient therapist
Special Education Director or Special Education Liaison
Classroom Teacher

Outpatient psychiatrist _____

After school program representative _____

DMH or DSS case manager _____

MEETING ATTENDANTS DATE OF MEETING

Name_____Title_____

Phone #_____ Fax#_____

Day they were invited ____-____-_____

Individual who made the contact _____

Response to invitation Yes I will attend _____ Not able to attend _____

Name _____Title _____

Phone #_____ Fax#_____

Day they were invited ____-____-_____

Individual who made the contact _____

Response to invitation Yes I will attend _____ Not able to attend _____

Name _____ Title _____

Phone #_____ Fax# _____

Day they were invited ____-____-_____

Individual who made the contact _____

Response to invitation Yes I will attend _____ Not able to attend _____

Name _____ Title _____

Phone #_____ Fax# _____

Day they were invited ____-____-_____

Individual who made the contact _____

Response to invitation Yes I will attend _____ Not able to attend_____

When the family of a child or adolescent finds that services are denied or shortened, and the family believes that the decision is clinically unsound or all the information was not considered before the decision was made, an appeal may be filed.

An appeal *is a request for a review of a benefits decision. For example, if a hospitalization was denied, and the family, outpatient therapist, etc. believes the wrong decision was made, an appeal may be filed. An appeal should be completed in a time frame that is responsive to the urgency of the situation. This means that an appeal about crisis care must be responded to quickly (48 hours is a common guideline); an appeal about the outpatient benefit may take longer.*

A grievance *is a complaint made to a hospital, insurance company, clinic, agency, etc. in order to have a treatment decision reconsidered or protested. A grievance must be responded to within a short amount of time. A grievance is used to correct treatment practices that are of poor quality, or to file a complaint about an incident or practice that is unfair or caused harm.*

All appeals and grievances should be made in writing. If made verbally (by phone or in person), they usually will not initiate a formal review process. Instead, the verbal complaint is simply considered an informational call.

When access to services or to information is limited, always "go up the ladder." For instance, if you are attempting to find a child psychiatrist and the customer service representative at your insurance company is only offering three names at a time, s/he is limiting access to information. Imagine further that two of the three names are not child psychiatrists or are not taking new patients-you are not being offered a choice of qualified providers. To obtain what you need – a choice of qualified professionals – ask to speak to a supervisor. If you are still denied choices, go up one more level. The more senior the person, the greater her/his ability to be flexible and help you resolve the problem.

Even if you do not wish to file a formal complaint or appeal, it is worthwhile to ask for clarification of any decision or practice you don't understand. For example, if one hospital is selected and not another, ask why. If visits are restricted or information limited, ask questions. Often these practices are a matter of policy, not law.

Alphabet Soup

ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AMI	Alliance for the Mentally Ill
ART	Adolescent Residential Treatment
BD	Behaviorally Disturbed
CAP	Collaborative Assessment Program
CHINS	Child in Need of Services
CIRT	Child Intensive Resident Treatment
DMA	Division of Medical Assistance
DMH	Department of Mental Health
DSM	Diagnostic Systems Manual
DSS	Department of Social Services
DYS	Department of Youth Services
ED	Emotionally Disturbed
EEG	Electroencephalogram
EKG	Electrocardiogram
ESP	Emergency Service Program
FAPE	Free and Appropriate Education
HMO	Health Maintenance Organization
ICM	Intensive Case Management
IEP	Individual Education Plan
I&R	Information and Referral
IRTP	Intensive Residential Treatment Program
ISP	Individual Service Plan
ITP	Individual Treatment Plan
LEA	Local Education Authority
LRE	Least Restrictive Environment
LSS	Local Service System
LSW	Licensed Social Worker
MCO	Managed Care Organization
MSW	Master's Degree in Social Work
MRC	Massachusetts Rehabilitation Center
MRI	Magnetic Resonance Imaging
NAMI	National Alliance for the Mentally Ill
NIMH	National Institute for Mental Health
OCD	Obsessive Compulsive Disorder
ODD	Oppositional Defiant Disorder
PA	Prior Approval
PAL	Parent Professional Advocacy League
PDD	Pervasive Developmental Disorder
PO	Probation Officer
PSTP	Program Specific Treatment Plan
PTSD	Post Traumatic Stress Disorder
SED	Seriously Emotionally Disturbed
TS	Tourrette Syndrome

Glossary

Acting Out	Self-harming, aggressive, violent and/or disruptive behavior.
Acute	Marked by a sudden onset and lasting a short time but demanding urgent attention.
Affect	Feeling, emotion.
Anxiety Disorder	Exaggerated or inappropriate responses to the perception of internal or external dangers.
Assessment	A professional review of the needs of a child and family which usually includes a review of physical and mental health, intelligence, school perfomance, family situation and behavior in the community.
Behavior Disorder	Displaying disruptive behavior in home, school or other settings. This behavior is usually significantly different from socially accepted norms for the child's age and situation.
Bipolar Disorder	A mood disorder with elevated or irritable mood, usually accompanied by a major depressive episode. Also known as manic depression.
Blanket Release Form	A consent form allowing treatment, testing or release of information which does not specify the individual procedures or the distribution of information.
Case Manager	An individual who organizes and coordinates services for an individual.
Charge Nurse	Nurse in charge of a hospital unit.
Chronic	Having long duration or frequent recurrences.

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

Conduct Disorder Persistent patterns of behavior that violate the rights of others or age appropriate social norms.

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

Consent Permission that is usually given by signing a form allowing a designated person to administer a test or treatment or for releasing information. *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 a 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. Also known as *Emergency and Crisis Services, Emergency Services Programs, Crisis Evaluation Teams, Emergency Screening Teams.*

Day Treatment Nonresidential, intensive program of services which allows the child to return home at night.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) A reference manual of mental health disorders developed by the American Psychiatric Association. Used by clinicians to understand and diagnose a mental health problem. Also used by insurance companies to determine necessary services.

Emotional Disorder A disorder exhibiting emotional, behavioral and/or social impairments that interfere with a child's academic, developmental and social progress and family or other relationships.

Evaluation The process of collecting information about a child through a series of tests, observations and interviews which results in an opinion about a child's mental and emotional state. May include recommendations about treatment or placement.

Home Based Services Services provided in a family's home for a defined time to deal with a mental health problem. The goal is usually to prevent the child from being placed out of the home (including hospitalization).

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

Inpatient Hospitalization Mental health treatment in a hospital setting for 24 hours a day. The purpose of inpatient hospitalization is to stabilize and provide treatment to a child in crisis and a possible danger to self or others and to diagnose and evaluate when this can not be done in an outpatient setting.

Least Restrictive Environment An educational and/or treatment setting that provides services for a child while imposing as few limits or constraints as possible.

Major Depressive Episode A mood disorder with a depressed mood that interferes with day-to-day functioning.

Managed Care A practice to supervise the delivery of health care services. Managed care may specify the mental health providers a family can see as well as the number of visits and kinds of services that will be covered.

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.

Neurologist A medical doctor specializing in diagnosis and treatment of diseases of the nervous system.

Oppositional Disorder A display of underlying aggression by patterns of obstinate, but often passive behavior. Negativism, stubbornness, dawdling, procrastination are often behaviors used by children with this disorder to provoke adults.

Outpatient Treatment available at local mental health clinics or from private therapists. This can include diagnosis, assessment, family and individual counseling. The child usually lives at home.

Pervasive Developmental Disorder Severe delays in the development of social behavior and/or language.

Post Traumatic Disorder Anxiety disorder following a traumatic event.

Primary Care Physician A medical doctor who provides general health care and provides referrals to specialists when needed.

Primary Insurance Provider — The insurance company designated to cover medical costs when an individual is insured by more than one company. For example, when each parent carries health insurance for the child, one company will assume the lead in covering costs, the other company can be billed for uncovered expenses.

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

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

Psychologist — A mental health professional with advanced training who can administer psychological tests, evaluate and treat emotional disorders.

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

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

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

Respite Services — A service providing temporary care for a child to provide a break for her/his parents, thereby increasing their overall effectiveness. May be provided in the home or at another location.

Schizophrenia — A disorder characterized by disturbance in thought processes, impaired interpersonal relationships and inappropriate or blunted affect. The child may also exhibit hallucinations or delusions.

School Phobia — Fear of going to school associated with anxiety about leaving home and family members.

Screening — An assessment or evaluation to determine the appropriate services and/or setting for a child.

Secondary Insurance — The insurance company designated to pay for costs not covered by the primary insurance. For example, when each parent carries health insurance for the child, one company will assume the lead in covering costs, the other company can be billed for uncovered expenses.

Simple Phobia — Irrational fears of a specific object, activity or situation.

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

Support Services — Transportation, financial help, support groups, respite services and other specific services to children and families.

Therapeutic Foster Care — A home where a child with emotional disturbance lives with trained foster parents with 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 child 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.

Treatment — An intervention designed to change behaviors related to a child's emotional or behavioral difficulties. Also used to help the child and family cope with problems resulting from the child's difficulties.

Withdrawing Behavior — Behavior expressing reduced interest in activities and contact with others. Can include absence of speech, regression to babyhood, exhibition of fears and depression.

Wraparound Services — A full range of services designed for the specific needs of the individual child and family. These services should include a menu of support services as well as traditional mental health services.

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