NAMI SOUTHWESTERN ILLINOIS

Children & Adolescents with Brain Disorders
Resources Guide – 2016 Third Edition

NAMI SOUTHWESTERN ILLINOIS
2100 Madison Avenue, 4th Floor
Granite City, IL 62040
(618) 798-9788
http://namiswi.org **info@namiswi.org**

Purpose of This Guide

If a child/adolescent in your family has a mental illness, you are not alone. Members of the National Alliance on Mental Illness have learned the hard way about mental illness and services available. We have compiled information in this guide from many different sources, in the hope that it will be helpful to others as they find ways to understand and cope with mental illness in their family.

We acknowledge with sincere gratitude the Madison and St. Clair County Mental Health Board's whose funding made the printing of the Third Edition of the resource guide possible and NAMI members who were involved in assembling and editing the text, notably Jessica Gruneich, Executive Director of NAMI Southwestern Illinois.

This is the Third edition of our Resource Guide for Children & Adolescents with Brain Disorders from NAMI Southwestern Illinois.

The NAMI Southwestern Illinois Resource Guide is intended as an informational resource only and is not intended as legal and/or medical advice. Information contained within this resource guide is consistently changing and is subject to change without notice.
NAMI Southwestern Illinois does not endorse, nor is liable for, any use of the services listed.

Rev. 04/11/2016

Where families are helping families to manage severe mental illness

Alliance on Mental Illness (NAMI) is an organization "dedicated to the eradication of mental illness and to the improvement of the quality of life of those whose lives are affected by these diseases." There are more than a thousand NAMI affiliates in this country; forty of them are in Illinois. Members include individuals with mental illness, as well as family members and friends.

The mission of NAMI is to:

• Promote new and remedial programs/legislation that will provide meaningful assistance for consumers.

• Press for quality in-patient and out-patient treatment of persons with mental illness.

• Promote community support programs, including appropriate living arrangements linked with supportive social, vocational rehabilitation, and employment programs.

• Provide and advocate for family support activities.

• Support and advocate for research into the causes, alleviation, and eradication of mental illness.

• Seek improvement of private and governmental funding for mental health facilities and services, care, and treatment, and for residential and research programs.

• Work together with other mental health organizations and human service support providers.

• Promote enforcement of patient and family rights.

• Educate our members and the public about severe mental illness so that perceptions change and stigma is eliminated.

Most people who join a NAMI affiliate do so because they need information and ways to cope with the mental illness of their family member. They learn by talking with others, by attending educational meetings and through affiliate newsletters.

Contents:

Fighting Stigma by Changing Our Language

Use Person First Language in Mental Health Settings

For Example Say:	Instead of:
He / She has bipolar illness (or a diagnosis of....)	He / She is bipolar
He / She has schizophrenia (or a diagnosis of....)	He / She is schizophrenic
He / She has a mental health condition	He / She is emotionally disturbed / mentally ill
He / She has a mental illness	He / She is mentally ill
Person (singular)with a mental illness (singular)	The mentally ill .... OR People with mental illness
Persons/people / individuals (plural) with mental Illnesses (plural)	

General Rules to Speak, Write, Respect and Empower By Having vs. Being

To HAVE an illness, or to have the diagnosis of an illness, is notably different than to BE the illness. When I "have bipolar illness," I recognize that aspect of myself, much as I recognize that I "have brown eyes." When I "am bipolar," I take on the identify of BEING bipolar. It becomes me, and I become it. When we talk about an individual as separate from their mental health condition, we recognize the person first, and we acknowledge the person's power to overcome that condition and live a full life separate from it. I often tell people, "I may have it, but it doesn't have me!"

****

When to Seek Help for Your Child

Parents are usually the first to recognize their child has a problem. The earlier problems are addressed, the sooner they are resolved.

Step 1: Validate your concerns. By talking with your child's teachers, daycare or after-school providers, or a close relative who interacts on a regular basis with your child, you can begin to get a picture of how well your child is functioning. It is important to know how he or she is doing when with others, and how teachers or childcare professionals may compare his or her development with children of the same age.

Step 2: Warning signs of trouble. Based on your child's developmental phase, be aware of warning signs that something may be amiss.

CHILDREN OF ELEMENTARY SCHOOL AGE

• Difficulty in going to sleep, or taking part in activities that are normal for the child's age, or refusal to go to school on a regular basis
• Frequent, unexplainable temper tantrums
• Hyperactive behavior, fidgeting, or constant movement beyond regular playtime activities
• A steady and noticeable decline in school performance
• A pattern of deliberate disobedience or aggression
• Opposition to authority figures, and little or no remorse for breaking rules or norms.
• Persistent nightmares
• Poor grades in school despite trying very hard.
• Pronounced difficulties with attention, concentration, or organization

PRETEENS AND ADOLESCENTS

• Sustained, prolonged negative mood and attitude often accompanied by poor appetite, difficulty sleeping or thoughts of death
• Opposition to authority, truancy, theft, vandalism and consistent violation of the rights of others
• Abuse of alcohol, and/or drugs or heavy tobacco use
• Intense fear of becoming obese with no relationship to actual body weight; constant dieting; restrictive eating habits; purging food; or vomiting
• Frequent outbursts of anger or inability to cope with problems and daily activities
• Marked change in school performance
• Marked changes in sleeping and/or eating habits
• Persistent nightmares or many physical complaints
• Threats of self-harm or self-injury; harm or violence toward others
• Sexual acting out
• Threats to run away
• Strange thoughts and feelings and unusual behaviors
• Self-injury, talk of suicide or actual violence requires immediate attention. If necessary take your child to an emergency room where a psychiatric assessment can be done.

Step 3: Talk to your child's doctor. If you realize your child demonstrates any of the significant behaviors from the above list, you should bring your concerns to your child's doctor.
You may want to make a special appointment to talk about the difficulties your child is experiencing. Ask your child's primary care physician to make a referral to a mental health professional if he or she shares your concerns. A psychological assessment may be useful in order to determine how best to help your child.

Step 4: Get another opinion. Beware of "it's just a phase" if your instinct tells you your child indeed has a problem. Some family physicians and pediatricians may not recognize symptoms of mental disorders. If you are not comfortable that your concerns are adequately addressed by your child's doctor, you can request a second opinion. This might take the form of a consultation with a child and adolescent psychiatrist or developmental pediatrician. The developmental specialist can allay your fears about the appropriateness of behaviors at any given age. He/she also can confirm your concerns and assist you and your primary care physician in obtaining a complete assessment, and arrange for any interventions that may be appropriate. Trust your instincts!

If you suspect that your child may have a mental health problem, you should seek a comprehensive evaluation by a mental health professional. It is especially helpful when this person is trained to work with children and adolescents. Throughout this assessment process, you should be directly involved and ask questions. It is important that you understand the process your child will undergo during an assessment and that you understand the results of the mental health evaluation. If your child is given a diagnosis be sure to ask for the full range of treatment options—therapy, medications, or a combination of both. If you are not completely comfortable with a particular clinician, treatment option, or are confused about specific recommendations, then consider a second opinion. Assessments are performed by specially trained psychiatrists and psychologists.

Before your child begins any treatment regimen, ask the following of your treating clinician:

• What are the recommended treatment options for my child?
• How will I be involved with my child's treatment?
• How will we know if the treatment is working?
• How long should it take before I see improvement?
• If my child needs medication, what are the side effects that might be expected?
• What should I do if the problems get worse or there is no improvement?

• What are the arrangements if I need to reach you after hours or in an emergency?
• Who covers for you when you are away from your office, out of town, or on vacation?
• Do you have an emergency contact number, or answering service?

You may also need to advocate having your child seen in a timely way, by the most appropriate clinician.

What you need to know about medications. Treatment with psychiatric medications is a serious decision for most of us. Conflicting research and "expert" claims have left us all wondering "what's best for my child?" Medications may be an important part of your child's treatment for a mental health problem. Psychiatric medication should only be used as one part of a comprehensive treatment plan. Ask your child's physician why other forms of therapy are not prescribed if only medication is offered. Although many types of medications have been tested and proven effective in children, there are just as many medications that have not been thoroughly investigated specifically for use in children under 18. When your doctor prescribes medication, ask him if the medication is indicated by the pharmaceutical company, or the Food and Drug Administration (FDA), specifically for use in children. If the clinician cannot answer yes, then this medication is being prescribed "off label," or in other words, the pharmaceutical company that developed the medication has not yet shown its efficacy in treating youngsters under the age of 18. If this is the case, insist that your doctor share with you the reasons for using the medication in question, and whether another form of treatment would be better prescribed.

Even when well-tested medications are used (and there are many safe medicines approved for use in children with a history of effectiveness), ongoing evaluation and monitoring by a physician is essential. By asking the following questions, children, adolescents, and their parents will gain a better understanding of why the psychiatric medication is being used and what to expect in the short and long term.

• Are there any laboratory tests (e.g. heart or blood test, etc.) which need to be done before my child begins taking the medication?
• How long will my child need to take this medication and how often will progress be checked?
• How will the decision be made to stop this medication?
• How will the medication help my child and how long before I see any improvement?
• Is this medication addictive? Can it be abused? What precautions need to be taken with this medication?
• Should the medicine be taken with food, or at a particular time of day?
• Has this medication proved helpful to other children with similar conditions?
• What are the side effects that commonly occur with this medication? What rarer side effects have been reported?
• What is the expected cost of the medication?
• Is there a generic version and has it been proven to be generally as helpful as the brand name medication?
• What is the recommended dosage? How often will the medication be taken?
• How long does it take before I'll see some results?
• Are there other medications or foods that my child should avoid while taking the medication?
• Are there any activities or sports that my child should not participate in while taking the medication?
• Will any tests (x-rays, MRIs, lab work) need to be done while my child is taking the medication? How often should I expect these tests to be needed?
• Should my child's teacher or the school nurse be informed to watch for any changes as the child begins treatment?
• When possible, your youngster should be included in the discussion about medications, using words they understand.

Sometimes preteens and adolescents can be embarrassed about taking medications, especially at school. This happens when they are singled out to report to a school nurse, or given their medication in front of others. Discuss these circumstances with your child and tell your doctor if your child mentions concerns of this nature.

National Alliance on Mental Illness

Getting an Accurate Diagnosis for Your Child
10 Steps for Families

Getting an accurate diagnosis for your child can be challenging. Several factors contribute to this challenge, including the following:

- Symptoms – that often include extreme behaviors and dramatic changes in behavior and emotions – may change and develop over time.
- Children and adolescents undergo rapid developmental changes in their brains and bodies as they get older and symptoms can be difficult to understand in the context of these changes.
- Children may be unable to effectively describe their feelings or thoughts, making it hard to understand what are really going on with them.
- It is often difficult to access a qualified mental health professional to do a comprehensive evaluation because of the shortage of children's mental health providers and some health care providers are reluctant to recognize mental illnesses in children and adolescents.

Despite these challenges, there is still plenty families can do to help their child get an accurate diagnosis and ultimately receive the most effective treatment, supports, and services. Here are ten steps that families should take to help their mental health services provider make an accurate diagnosis:

1. Record Keeping: organize and keep accurate records related to your child's emotional, behavioral, social, and developmental history. The records should include observations of the child at home, in school, and in the community. They should be shared with the child's treating provider to help in making a diagnosis. The records should include the following information:
   - Primary symptoms, behaviors, and emotions of concern;
   - A list of the child's strengths;
   - A developmental history of when the child first talked, walked, and developed social skills;
   - A complete family history of mental illness and substance use disorders – many mental illnesses run in families.
   - Challenges the child is facing in school, in social skill development, with developmental milestones, with behaviors, and with emotions;
   - The times of day or year when the child is most challenged;
   - Interventions and supports that have been used to help the child and their effectiveness – including therapy, medication, residential or community services, hospitalization, and more;
   - Settings that are most difficult for the child (i.e. school, home, social situations);
   - Any major changes or stresses in the child's life (divorce, death of a love one, etc);
   - Factors that may act as triggers or worsen the child's behaviors or emotions; and
   - Significant mood instability or disruptive sleep patterns.

   Families know their child best and their expertise is essential in securing an accurate diagnosis for their child.

2. Comprehensive Physical Examination: To make an accurate diagnosis, it is important to start the process with the child's primary care physician. A comprehensive physical examination should be done to rule out other physical conditions that may be causing a child's symptoms.

3. Co-occurring Conditions: Your child should be evaluated for co-occurring conditions, like learning disabilities, sensory integration problems, and other physical or mental disorders, that may cause behavioral problems or poor school performance. If you suspect that a co-occurring condition is affecting your child's ability to learn, ask the school to perform a psycho-educational evaluation.

4. Specialists in Children's Mental Health: After other physical conditions and learning disabilities are evaluated, it is time to meet with a qualified mental health provider. Your child's primary care physician may be able to refer you to a mental health professional. You can also ask for referrals from families involved with NAMI or other advocacy organizations. To find a child psychiatrist, visit the American Academy of Child and Adolescent Psychiatry website (www.aacap.org – click on: *Child and Adolescent Psychiatrist Finder*).

5. The Diagnostic and Evaluation Process: A medical diagnostic tool, like a blood test, MRI scan, or x-ray that will diagnose mental illnesses in children has not yet been developed. Your child's diagnosis should be made based on professional observation and evaluation, information provided by your family and other experts, and the criteria found in the latest version of the Diagnostic and Statistical Manual of Mental Disorders. This evaluation should include a comprehensive look at all aspects of your child's life in school, with family, with friends, and in the community. The provider evaluating your child is likely to ask you to fill out a checklist that provides a detailed profile of your child and the challenges your child is facing.

6. Adjustments in the Diagnosis: It may take several visits with a mental health professional before a diagnosis is made. The diagnosis may also change as new symptoms emerge or existing symptoms change. A diagnosis must be confirmed over time and thus an ongoing two-way communication between the treating provider and the family is necessary to track and monitor the child's condition and progress. Families should not hesitate to seek a second opinion if they are not confident in their child's evaluation and the diagnostic process. Getting a second opinion can be challenging because of the shortage of children's mental health providers.

7. Effective Interventions and Outcomes: If a diagnosis continues to change or cannot be reached right away, it is still important to focus on effective interventions to address the child's symptoms. The goal should be to achieve the outcomes that are most important to the child and family.

8. Working with the School: You should consider meeting with your child's teacher or other school officials to discuss appropriate accommodations and supports for your child. Families should work with the school to identify effective interventions, accommodations, and supports that promote positive behaviors, academic achievement, and prevent challenging behaviors in school. Families should ask their child's treating provider to identify interventions that can be used at school and at home to help your child acquire positive behaviors and academic achievement.

9. Service and Support Options: Ask your child's treating provider to recommend effective psychosocial interventions, skills training, support groups, and other options that can help your child cope with symptoms and develop the skills necessary to ultimately lead a full and productive life.

10. The Importance of Families: Never underestimate the importance of working with other families. There are many seasoned families who have walked the walk and are happy to share their wisdom and experience with families attempting to secure an accurate diagnosis and effective services for their child.

For some children, having a diagnosis is scary and they may be resistant to accept it. Others are relieved to know that what is happening to them is caused by an illness, that they are not alone, and that there are treatment options that can make them feel and do better. It is important to find ways to use the strengths and interests of your child to help him or her cope with difficult symptoms. Benefits are often derived from aerobic exercise, martial arts, music, and art – whatever it takes to provide your child with a therapeutic outlet. The diagnosis is one piece of a much larger puzzle.
Please visit NAMI's Child & Adolescent Action Center at www.nami.org/caac. May 2008

Childhood Mental Illness

Depending on what criteria for severity are used in diagnosing children with mental illness, anywhere from 6 to 12 percent of children have mental illness. Many adults with severe mental illness report onset of symptoms of their illness between ages 5 and 9.
Childhood and adolescent mental illnesses include:

• Anxiety Disorder
• Attention Deficit-Hyperactivity Disorder
• Autism
• Bipolar Disorder
• Clinical Depression
• Obsessive-Compulsive Disorder
• Panic Disorder
• Pervasive Developmental Disorder
• Schizophrenia

• Early treatment of the major psychiatric disorders can lessen the severity of recurrence over a lifetime.
• Pediatricians miss 83% of children with psychiatric diagnoses.
• 3 million children have a mental illness diagnosis in a one year period.
•1.4 million of these children receive care in mental health organizations.
• Pervasive Development Disorders, including Autism affect 1 to 1.5 of 1000 children.

Neurobiological Brain Disorder Warning Signs

Very Young Children

• Display very little emotion
• No interest in sights, sounds, touch
• Reject being held, playing with others
• Unusually difficult to console
• Unable to calm self
• Extremely fearful, on-guard • Sudden changes in behavior

Preschoolers

• Refusing to play with others
• Inadequate language, communication skills
• Frequent fights with peers, others
• Appears very sad

• Extreme mood swings
• Unusually fearful
• Unusual responses to situations
• Appears withdrawn
• Extremely active
• Loses skills they had earlier
• Sudden behavior changes
• Very accident prone
• Destructive to self, others, objects
• Show extreme immaturity

School-aged Children

• Confusion about what is real or imaginary; déjà vu; preoccupation with religion, meditation, superciliousness, belief in clairvoyance or sixth sense
• Suspiciousness or paranoid thinking
• Exaggerated self-opinion unrealistic sense of superiority
• Heightened or dulled perceptions, hallucinations; over acuteness of senses to sounds, touch, light, smell
• Odd thinking and speaking process; racing thoughts or slowed-down thoughts; talking about things irrelevant to context or going off the track
• Lack of close friends or confidants other than immediate relatives
• Passively going along with most social activities but in a disinterested or mechanical way
• Flat emotions; decrease in facial expressions, monotone speech; lack of spontaneity and flow of conversation; poor rapport
• Difficulty in abstract thinking
• Difficulty performing functions at work or school; drop in grades; change in eating, sleeping, appearance
• Increased irritability fear of losing parent, cries a lot, nightmares
• Feeling hopelessly overwhelmed; low self-esteem
• Irrational or delusional beliefs not a part of child's culture, do not respond to reason
• Poor concentration, worries about being harmed or harming others
• Performs rituals repeatedly (like washing hands, doing things in rigid manner or order
• Difficulty making decisions
• Alcohol or substance abuse; aggressive behavior

(Source: Division of DD/MH/SAS, Child and Family Services Section, Prevention, Early Intervention and Family Support Branch)

Abilities Often Impaired in Mental Illnesses

• The ability to stop and think before acting. (Impulse control, executive function, ADHD)
• The ability to feel calm and/or safe. (Anxiety)
• The ability to feel confident. (Depression/anxiety) • The ability to wait or to be patient. Time seems to pass very slowly. (ADHD, anxiety, mania)
• The ability to "back off" when others request it. (ADHD, mania, anxiety)
• The ability to have thoughts at the same speed as others (mind races from thought to thought) (mania)
• The ability to focus attention on things not of interest. (ADHD, mania, anxiety, depression)
• The ability to transition from one activity to another without emotional and behavioral turmoil. (ADHD, anxiety, many disorders)
• The ability to organize and/or summarize written and/or spoken communication. (Rambling, confusing communication patterns.) (ADHD, mania, schizophrenia, psychosis with depression)

• The ability to feel good. (Depression)
• The ability to feel bad. (Mania)
• The ability to feel worthwhile. (Depression)
• The ability to feel like living. (Depression)
• The ability to stop emotional pain. (Depression)
• The ability to stop intrusive thoughts, obsessions, auditory hallucinations. (Many, if not most)
• The ability to control movement and voice. (Tourette's)
• The ability to trust other people. (Anxiety, paranoia)
• The ability to relax. (Anxiety, ADHD, paranoia, mania)
• The ability to function in unstructured, ambiguous social situations Overwhelmed, flooded. (Many)
• The ability to feel energetic. (Depression
• The ability to calm down (mania, panic attacks)
• The ability to exercise "good judgment" and "common sense" (mania). To limit one's actions
• Motivation (the association of emotions with actions and memories) is broken. (Depression)
• The ability to "read" subtleties of social interactions, facial expressions and body language. (Asperger's Disorder, Autism)
• The ability to slow down. (Mania, ADHD)
• The ability to keep track of appointments. ADHD
• The ability to keep track of things. (ADHD, anxiety)
• The ability to be sure that something has been done; that is, the person is compelled to check or wash over and over again, never being "sure." (OCD)
• The ability to compromise. (Anxiety including OCD, disorders w/compositionality)
• The ability to see shades of gray. (Depression -- "all or nothing" thought patterns, schizophrenia, and other illnesses)
• The ability to recover quickly from emotional wounds (emotional resiliency). (Depression, anxiety)
• The ability to have social "give and take." (Many)
• The ability to persist. (Depression)
• The ability to get a good night's sleep. (Depression, bipolar, ADHD, anxiety)
• The ability to feel rested. (Depression)
• The ability to nourish one's body (eating disorders)
• The ability to leave home (agoraphobia), to leave another person (separation anxiety)
• The ability to use one's mind as one wants. The brain hijacks the person's control of his/her thoughts, emotions, and actions. (Every mental illness)
• The ability to want to meet other people's expectations (teacher, boss, parent). (Compositionality)
• The ability to believe one is meeting other people's expectations (scrupulosity, anxiety)
• The ability to be agreeable. (Compositionality)
• The ability to accept work direction. (Compositionality, anxiety)
• The ability to let someone else be in control. (Anxiety)
• The ability to be flexible and change plans quickly. (Anxiety)
• The ability to stop talking. (ADHD, mania)
• The ability to take turns in conversation. (Many)
• The ability to think realistically about oneself and one's abilities. (Depression/mania, others)
• The ability to experience reality the same way most other people do. (Most extreme in schizophrenia, but present in others.)
• The ability to shut out internal auditory hallucinations. (Psychosis of depression, bipolar, schizoaffective disorder, schizophrenia)
• The ability to shut out delusions (bipolar and schizophrenia)
• The ability to shut off endless cycles of worry or obsession. (Anxiety, esp. OCD)

Back-to-School Strategies for Parents of Children

Living with Mental Illness

For children living with mental illness, going back to school is loaded with potential obstacles and stressors including changing routines, scholastic and social expectations, separation, and excitement.

The start of the school year often triggers anxiety for parents of children with mental illnesses as well. New teachers and environments often mean new challenges, but they can also signal new opportunities for success. The following are some suggested strategies to consider and adapt to help build a foundation for a successful school year for the child living with mental illness.

1. Address any known problems in a straightforward manner as soon as school and teachers of any recent medication or treatment plans that are of significance. Communicate your support of the teacher's critical role with your child. Review any special education plans that were drafted the year before, if applicable. Provide information about your child's disorder and be a resource for information for the school and the teachers.

2. Secure arrangements to take the child to school before the first day. Do a walk through of the environment and meet teachers and office staff. Familiarity with his or her physical surroundings will help diminish first day anxieties.

3. Support self-esteem. Identify the child's strengths and hook the child in through existing interests. Keep on the lookout for a developing or possible friendship and encourage a sleep over, movie outing, or gaming day. Set small goals or suggest ideas first and then build to larger expectations, supporting and reinforcing along the way.

4. Help the child organize and structure. Working with the teacher, determine how assignments will be communicated and request an advanced copy of deadlines and assignments. Pop quizzes can be a disaster for a child struggling in his or her recovery; it is OK to request that a heads-up be afforded. If possible, ask the child to share his or her class schedule with you, but realize that sometimes recalling such details can be a challenge. If you have a fax machine, ask the teacher to fax assignment outlines weekly, or secure alternative arrangements to get them delivered to you each week.

5. Ask for and make arrangements to receive weekly behavior/performance updates. The end of a grading period is not the time to find out that the child has missed all homework assignments. Develop a form with the school's guidance or special education liaison and have this completed by all teachers each week. Having it faxed or delivered with the child each Friday will help keep you on top of successes and failures so that both can be addressed promptly.

6. Minimize distractions. Some strategies to consider include: take the child to school and avoid the bus for a week or two early in the year. Secure just-late arrival for the child to avoid crowded halls in the mornings. Ask that the child be assigned a seat near the front of the room. Or, for older students, request permission for use of a backpack with rollers so the child can have all materials available throughout the day, thus avoiding locker visits.

7. Avoid homework hassles. Remember, it is the child's work and grades, not the parents. Reinforce time management, break assignments down into parts with the child, support an organized place for after-school

work, and if, necessary, negotiate extended time for assignments. Set homework rules and boundaries early and stick to them.

8. Don't be afraid to raise the bar. With your child's input, determine what expectations you have for educational performance and stick to them. Confidence, self esteem, and recovery are all supported by success. Avoid automatically rescuing your child from all situations -- let the child experience self-reliance where possible and when appropriate.

9. Consistently discipline and support play. Some children respond to "time out," a "thinking room" or other interruption to behavior challenges. Whatever your choice, parent with firm but loving consistency and set and stick to boundaries. Cartoons and video games are a privilege and can be very calming for some children with mental illness by helping them to decompress and cope with a confusing world. If you have other children, the rules should overlap and there should be consistency with expectations around certain behaviors, regardless of a diagnosis, usually including respectfulness, manners, and chores.

10. Learn and express the law. Visit NAMI's Children and Adolescent Action Center Web site for valuable information on children's issues and to subscribe to the free Beginnings magazine. Visit the NAMI Web site to learn about IDEA, the Individuals with Disabilities Education Act. This law mandates a "free and appropriate education" for children with disabilities, including children with mental illness (or emotional disturbance as it is designated in IDEA.) Seek out and garner the support of other parents through your NAMI affiliate, and learn your child's rights as well as interventions that can be requested to support success.

Most importantly, parents should remember that they are the front line. They know more about their children than anyone else and their instincts are the sharpest. They are also human, have jobs and houses to run, other children to raise, and life stresses to manage. Parenting and personal balance are daily challenges for all, and especially for parents of children living with mental illness. Parents should be encouraged to ask questions, educate themselves, get support from others, remember to play themselves, and most importantly, never give up. Their love and support, regardless of the circumstances, are real and are ultimately all that really count.

Read more on NAMI's efforts to educate schools about mental illness by visiting the NAMI Web site. NAMI has developed an important resource, Parents and Teachers as Allies, which can be ordered from the NAMI Web site.
For the NAMI National website go to www.nami.org., for the local NAMI affiliate go to www.namiswi.org.

ADHD (Attention deficit hyperactivity disorder)

Attention deficit hyperactivity disorder (ADHD) is a condition in which characterized by inattention, hyperactivity and impulsivity. ADHD is most commonly diagnosed in young people, according to the Center for Disease Control and Prevention (CDC). An estimated 9% of children between ages 3–17 have ADHD. While ADHD is usually diagnosed in childhood, it does not only affect children. An estimated 4% of adults have ADHD.

With treatment, most people with ADHD can be successful in school, work and lead productive lives. Researchers are using new tools such as brain imaging to better understand the condition and to find more effective ways to treat and prevent ADHD.

Symptoms

While some behaviors associated with ADHD are normal, someone with ADHD will have trouble controlling these behaviors and will show them much more frequently and for longer than 6 months.

Signs of inattention include:

- Becoming easily distracted, and jumping from activity to activity.
- Becoming bored with a task quickly.
- Difficulty focusing attention or completing a single task or activity.
- Trouble completing or turning in homework assignments.
- Losing things such as school supplies or toys.
- Not listening or paying attention when spoken to.
- Daydreaming or wandering with lack of motivation.
- Difficulty processing information quickly.
- Struggling to follow directions.

Signs of hyperactivity include:

- Fidgeting and squirming, having trouble sitting still.
- Non-stop talking.
- Touching or playing with everything.
- Difficulty doing quiet tasks or activities.

Signs of impulsivity include:

- Impatience.
- Acting without regard for consequences, blurting things out.
- Difficulty taking turns, waiting or sharing.
- Interrupting others.

Causes

There are several factors believed to contribute to ADHD:

- **Genetics.** Research shows that genes may be a large contributor to ADHD. ADHD often runs in families and some trends in specific brain areas that contribute to attention.
- **Environmental factors.** Studies show a link between cigarette smoking and alcohol use during pregnancy and children who have ADHD. Exposure to lead as a child has also been shown to increase the likelihood of ADHD in children.

Diagnosis

ADHD occurs in both children and adults, but is most often and diagnosed in childhood. Getting a diagnosis for ADHD can sometimes be difficult because the symptoms of ADHD are similar to typical behavior in most young children. Teachers are often the first to notice ADHD symptoms because they see children in a learning environment with peers every day.

There is no one single test that can diagnose a child with ADHD, so meet with a doctor or mental health professional to gather all the necessary information to make a diagnosis. The goal is to rule out any outside

causes for symptoms, such as environmental changes, difficulty in school, medical problems and ensure that a child is otherwise healthy.

Treatment

ADHD is managed and treated in several ways:

- **Medications**, including stimulants, nonstimulants and antidepressants
- Behavioral therapy
- Self-management, education programs and assistance through schools or work or alternative treatment approaches

Related Conditions

Around two-thirds of children with ADHD also have another condition. Many adults are also impacted by the symptoms of another condition. Common conditions associated with ADHD include the following.

- Learning disabilities
- Oppositional defiant disorder: refusal to accept directions or authority from adults or others
- Conduct disorder, persistent destructive or violent behaviors
- Anxiety and depression
- Obsessive-compulsive disorder
- Bipolar disorder
- Tourette's syndrome
- Sleep disorders
- Bed-wetting
- Substance abuse

Symptoms from other conditions make treating ADHD more difficult. Talking to a skilled professional to help establish an accurate diagnosis can help increase the effectiveness of treatment.

- See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/ADHD#sthash.K5vRX4M6.dpuf
Article source 2016 NAMI.org webpage

National Alliance on Mental Illness
page printed from **http://www.nami.org/**
(800) 950-NAMI; info@nami.org

Anxiety Disorders in Children and Adolescents

Anxiety disorders are the most common mental health concern in the United States. An estimated 40 million adults in the U.S., or 18%, have an anxiety disorder. Approximately 8% of children and teenagers experience the negative impact of an anxiety disorder at school and at home. Most people develop symptoms of anxiety disorders before age 21 and women are 60% more likely to be diagnosed with an anxiety disorder than men.

Symptoms

Anxiety disorders are a group of related conditions, and each with unique symptoms. However, all anxiety disorders have one thing in common: persistent, excessive fear or worry in situations that are not threatening. People can experience one or more of the following symptoms:

Emotional symptoms:

- Feelings of apprehension or dread
- Feeling tense and jumpy
- Restlessness or irritability
- Anticipating the worst and being watchful for signs of danger

Physical symptoms:

- Pounding or racing heart and shortness of breath
- Upset stomach
- Sweating, tremors and twitches
- Headaches, fatigue and insomnia
- Upset stomach, frequent urination or diarrhea

Types of Anxiety Disorders

Different anxiety disorders have various symptoms. This means that each type of anxiety disorder has its own treatment plan. The most common anxiety disorders include:

Panic Disorder

Characterized by panic attacks—sudden feelings of terror—sometimes striking repeatedly and without warning. Often mistaken for a heart attack, a panic attack causes powerful, physical symptoms including chest pain, heart palpitations, dizziness, shortness of breath and stomach upset. Many people will go to desperate measures to avoid having an attack, including social isolation or avoiding going to specific places.

Phobias

Everyone tries to avoid certain things or situations that make them uncomfortable or even fearful. However, for someone with a phobia, certain places, events or objects create powerful reactions of strong, irrational fear. Most people with specific phobias have several triggers. To avoid panicking, someone with specific phobias

will work hard to avoid their triggers. Depending on the type and number of triggers, this fear and the attempt to control it can seem to take over a person's life.

Generalized Anxiety Disorder (GAD)

GAD produces chronic, exaggerated worrying about everyday life. This can consume hours each day, making it hard to concentrate or finish routine daily tasks. A person with GAD may become exhausted by worry and experience headaches, tension or nausea.

Social Anxiety Disorder

Unlike shyness, this disorder causes intense fear, often driven by irrational worries about social humiliation– "saying something stupid," or "not knowing what to say." Someone with social anxiety disorder may not take part in conversations, contribute to class discussions, or offer their ideas, and may become isolated. Panic attack symptoms are a common reaction.

Other anxiety disorders include: agoraphobia, separation anxiety disorder and substance/medication-induced anxiety disorder involving intoxication or withdrawal or medication treatment.

Causes

Scientists believe that many factors combine to cause anxiety disorders:

- **Genetics.** Some families will have a higher than average numbers of members experiencing anxiety issues, and studies support the evidence that anxiety disorders run in families. This can be a factor in someone developing an anxiety disorder.
- **Environment.** A stressful or traumatic event such as abuse, death of a loved one, violence or prolonged illness is often linked to the development of an anxiety disorder.

Diagnosis

The physical symptoms of an anxiety disorder can be easily confused with other medical conditions like heart disease or hyperthyroidism. Therefore, a doctor will likely perform an evaluation involving a physical examination, an interview and lab tests. After ruling out a medical illness, the doctor may recommend a person see a mental health professional to make a diagnosis.

Using the Diagnostic and Statistical Manual of Mental Disorders (DSM) a mental health professional is able to identify the specific type of anxiety disorder causing the symptoms as well as any other possible disorders including depression, ADHD or substance abuse which may be involved. Tackling all disorders through comprehensive treatment is the best recovery strategy.

Treatment

As each anxiety disorder has a different set of symptoms, the types of treatment that a mental health professional may suggest also can vary. But there are common types of treatment that are used:

- Psychotherapy, including cognitive behavioral therapy
- Medications, including ant anxiety medications and antidepressants

The two main types of treatment for an anxiety disorder involves therapy and medication.

Psychotherapy

Cognitive behavioral therapy (CBT) is an effective treatment for anxiety disorders. One type of CBT is called exposure response prevention. This treatment is helpful for certain anxiety disorders like phobias and social anxiety. Its aim is to help a person develop a more constructive response to a fear. The goal is for the person with exposure to experience less anxiety over time and give him or her tools for coping with symptoms.

Medication

Some people find that medication is helpful in managing an anxiety disorder. Talk with your doctor about the potential benefits, risks and side effects.

- Anti-anxiety medications. Certain medications work solely to reduce the emotional and physical symptoms of anxiety. Benzodiazepines such as alprazolam (Xanax) can treat social phobia, generalized anxiety disorder and panic disorder.
- Antidepressants. Many antidepressants may also be useful for treating anxiety that is mixed with depression. Some antidepressants may be useful for PTSD, generalized anxiety disorder and OCD, but may require higher doses.

- See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders/Treatment#sthash.gKD50szf.dpuf

Related Conditions

Anxiety disorders can be seen with other mental health conditions, such as:

- Depression
- Substance abuse
- ADHD
- Eating disorders
- Trouble sleeping

Anxiety can often make these related conditions worse, so talk with a mental health care professional if anxiety begins to interfere on a daily basis.

- See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders/Overview#sthash.SHlaMYXp.dpuf

Asperger Syndrome

The Diagnostic and Statistical Manual of Mental Disorders (4th Edition), known as DSM IV, published in 1994, defines Asperger syndrome (AS) as marked by "severe and sustained impairment in social interaction" along with "restricted repetitive and stereotyped patterns of behavior."

As a parent, what behaviors might I suspect as indicative of this disorder?

The more general traits that may be observed include awkwardness in social situations, an intense preoccupation with certain specific (often unusual) topics, self-directed orientation, a lack of understanding of social cues, and clumsiness caused by lack of motor coordination.

What is meant by "severe and sustained impairment in social interaction"?

A child with AS often has problems with normally developed verbal as well as non-verbal interaction tools. The child may, for example, not meet the eyes of a person speaking, seem to lack facial expressiveness, or not use normal body posturing and gestures. This affects social interaction in a negative way.

What are "restricted repetitive patterns of behavior"?

This kind of behavior is demonstrated by a preoccupation with certain actions or objects within a restricted range. Rather than applying an intense interest to a variety of subjects, the child with AS has interests of a rather narrow scope, like aliens or computers, bus routes or sports schedules, maps and charts.

This restricted repetitive behavior also is exhibited through a very rigid, non-negotiable adherence to specific nonfunctional routines or rituals. The child with this disorder may, for example, insist on walking a certain route to school without deviation. The child is inflexible about following a certain sequence of events--he or she may need to walk in a circle before sitting down or dress in a specific order. These nonfunctional routines can be of critical importance to the child with Asperger.
Given a choice in clothing, the child might create what seems like a uniform that is worn day after day.

How is Asperger different from autism?

A child with Asperger experiences no clinically significant delay in cognitive development and does not experience a gross delay in developing language skills.

Other differences are:

• Children with autism tend to think concretely and have much difficulty with symbolic thinking and pretend play, whereas Asperger children can be quite imaginative although themes may be repetitive.

• Asperger children tend to have motor coordination difficulties not seen in autism.

What about relationships with peers?

The child may not make friends easily, or at all, and may not seem interested in sharing experiences or interests with those around him. For example, a child developing normally may show his artwork to people around him or bring a toy to his sister or brother to look at, but a child with AS will not as readily do so.

A child or adolescent with AS may seem unwilling or uninterested in responding to others in a socially or emotionally reciprocal way. For example, the child may ignore or seem to not notice when a person expresses affection toward him or prompts conversation. On the other hand, Asperger individuals may highly desire social interaction, but their poor social skills result in failure which can cause anxiety and depression.

What about the course of Asperger syndrome?

AS usually presents between ages 2 and 6 years, but is often not recognized until later. As far as doctors know, the disorder is present throughout the course of a person life. It has often been diagnosed as late as young adulthood.

Who gets Asperger?

Not much is known about how common the syndrome is because few studies have been done. Prevalence rates are estimated to range from .024 percent to .36 percent based on studies in Canada and Goteborg, Sweden, respectively.

Boys appear to have a higher incidence than girls at a 4:1 ratio. There is likely a genetic component which

What treatments can be considered useful or helpful for the child or adolescent with Asperger?

Because securing educational and related services may be difficult due to the lack of knowledge about Asperger, it is important for the parents and clinician to work closely together to supply the patient and school personnel with the necessary information and help. Educational interventions are often necessary and should be individual accommodations to the persons needs. Because these students generally do well with memory tasks, teaching in a rote fashion may help the individual to retain the information presented.

Deficits in social skills may be remediated in small groups usually led by a mental health professional or speech and language pathologist.

Depending on the presence and extremity of associated symptoms, psycho-pharmacological interventions may help. Examples of associated symptoms that may be effectively treated with medication are hyperactivity, impulsivity, inattention, mood instability, temper outbursts, depression, anxiety and obsessive-compulsive symptoms.

Summary:

Early intervention and treatment is the single most important effort a parent can make to influence the outcomes for a child or adolescent with Asperger. Finding a clinician that can make the diagnosis of Asperger may be the more significant hurdle in getting appropriate treatment for your child.

Resources:

Autism and AS, by Uta Frith, Cambridge University Press, London, UK, 1991 ($17.95)

For more information on the Internet, look for the "Asperger Disorder Homepage" at http://www.ummed.edu/pub/o/ozbayrak/asperger.html

National Alliance on Mental Illness
page printed from **http://www.nami.org/**
(800) 950-NAMI; info@nami.org

Child and Adolescent Bipolar Disorder

Can children and adolescents get bipolar disorder?

Bipolar disorder can occur in children and adolescents and has been investigated by federally funded teamsin children as young as age six.

How common is it in children and adolescents?

Although once thought rare, caseloads of patients examined for federally funded studies have shown that approximately 7 percent of children seen at psychiatric facilities fit the research standards for bipolar disorder.

What are the symptoms of bipolar disorder in children and adolescents?

One of the biggest challenges has been to differentiate children with mania from those with attention deficit hyperactivity disorder. Since both groups of children present with irritability, hyperactivity and distractibility, these symptoms are not useful for the diagnosis of mania. By contrast, elated mood, grandiose behaviors, flight of ideas, decreased need for sleep and hyper sexuality occur primarily in mania and are uncommon in ADHD. Below is a brief description of how to recognize these mania-specific symptoms in children.

- **Elation.** Elated children may laugh hysterically and act infectiously happy without any reason at home, school or in church. If someone who did not know them saw their behaviors, they would think the child was on his/her way to Disneyland. Parents and teachers often see this as "Jim Carey-like" behaviors.

- **Grandiose behaviors.** Grandiose behaviors are when children act as if the rules do not pertain to them. For example, they believe they are so smart that they can tell the teacher what to teach, tell other students what to learn and call the school principal to complain about teachers they do not like. Some children are convinced that they can do superhuman deeds (e.g., that they are Superman) without getting seriously hurt, e.g. "flying" out of windows.

- **Flight of ideas.** Children display flight of ideas when they jump from topic to topic in rapid succession during a normal conversation-not just when a special event has happened.

- **Decreased need for sleep.** Children who sleep only 4-6 hours and are not tired the next day display a decreased need for sleep. These children may stay up playing on the computer and ordering things or rearranging furniture.

- **Hypersexuality.** Hypersexual behavior can occur in children without any evidence of physical or sexual abuse in children who are manic. These children act flirtatious beyond their years, may try to touch the private areas of adults (including teachers) and use explicit sexual language.

In addition, it is most common for children with mania to have multiple cycles during the day from giddy, silly highs to morose, gloomy suicidal depressions. It is very important to recognize these depressed cycles because of the danger of suicide.

What treatments-medications and psychosocial-have been shown to be effective and what are their side effects?

First, it is important to recognize that bipolar disorder in children and adolescents is an emerging field and there is much more to learn. A comprehensive evaluation including family history is essential to understanding the diagnosis and the consideration of other possible diagnoses.

Bipolar disorder raises many risks in youth including substance use, suicide and poor school performance.

Be sure to ask your clinician about a comprehensive treatment approach. For an example of how expert clinicians conceptualize approaches to treatment for this condition, please review the **Treatment Guidelines by the American Academy of Child and Adolescent Psychiatry from March 2005.**

There are medications that have been FDA approved for use in teens with bipolar disorder. All other medication use is "off label" which means that it has not been approved by the FDA for this purpose. Those drugs that are FDA approved were studied for effectiveness in short-term studies-which means we do not understand the positive impact and side effects of longer term use.

Medications mentioned in this section

Abilify*
Aripipazole
Depakote*
Lithium
Olanzapine
Quetiapine
Resperidol*
Risperidone
Seroquel*
Topamax*
Topiramate
Valproic acid
Zyprexa*

*Brand name

Antipsychotics

Several of the atypical antipsychotics - aripipazole (Abilify), quetiapine (Seroquel) and risperidone (Resperidol)-have FDA approval for bipolar disorder in youth ages 10 to 17. Olanzapine (Zyprexa) has FDA approval for youths ages 13 to 17 with bipolar 1 disorder.

Lithium

Lithium, which is a mood stabilizer that is not an antipsychotic, also has FDA approval for youths aged 12 to17. All of these compounds have important side effects that can include weight gain, increased cholesterol and diabetes risk for the anti psychotics. Lithium has risks in thyroid and kidney side effects. More needs to be learned about the safe and effective use of these medications over time in youth with bipolar disorder.

Anticonvulsants

The use of anticonvulsants such as valproic acid (Depakote) and topiramate (Topamax) are not FDA approved for use in youth with bipolar disorder.

Antidepressants

The FDA warning on antidepressants and the increased risk of suicidal ideation is also worth noting as some youth present first with depressive symptoms.

The medication management of youth bipolar disorder requires a clear understanding of the limited scientific data for longer term use. It is also important to know what side effects need to be monitored in youth.

Are there any side effects associated with these treatments, including those that may only occur in young people?

Side effects that are particularly troublesome and that are worse in children include the following. Atypical neuroleptics (except aripiprazloe) are associated with marked weight gain in many children. One day we hope to have specific genetic tests that will tell us beforehand which people will gain weight on these medications, but right now it is trial and error. The dangers of this weight gain include glucose problems that may include the onsetof diabetes and increased blood lipids that may worsen heart and stroke problems later in life. In addition, these drugs can cause an illness called tardive dyskinesia-irreversible, unsightly, repeated movements of the tongue in and out of the mouth or cheek-and some other movement abnormalities. Depakote may also be associated with increased weight and possibly with a disease called polycystic ovarian syndrome (PCOS), which in some cases may be associated with infertility later in life. Lithium has been the market the longest and is the only medication that has been shown to be effective against future episodes of mania and of depression and of completed suicides. Some people who take lithium over a long time will need a thyroid supplement and in rare cases may develop serious kidney disease.

It is very important that children on these medications be monitored for the development of serious side effects. These side effects need to be weighed against the dangers of bipolar disorder itself, which can rob children of their childhood.

How do children and adolescents with this disease fare over time and as adults?

At this time, is challenging to educate a child whose mood is much too "high" or too "low." Therefore educators need regrettably, bipolar disorder in children and youth appears to be more severe and have a much longer road to recovery than is seen with adults. While some adults may have episodes of mania or depression with better functioning between episodes, children seem to have continuous illness over months and years.

Does bipolar disorder in children have an impact on educational achievement?

It to be aware of the diagnosis and make special arrangements.

Is suicide a risk?

Talking about wanting to die, asking why they were born or wishing they were never born must be taken very seriously. Even quite young children can hang themselves in the shower, shoot themselves or complete suicide by other means.

Reviewed by Ken Duckworth, M.D., July 2010

National Alliance on Mental Illness
page printed from **http://www.namLorg/**
(800) 950-NAMI; info@nami.org

Depression in Children and Adolescents Fact Sheet

How common is depression in children and adolescents?

Studies have shown that on any single day (called "point prevalence" by epidemiologists) about 2 percent of school-aged children and about 8 percent of adolescents meet the criteria for major depression. Looking in the long term, the numbers are higher-for instance, one in five teens has experienced depression at some point.
In primary care settings the rates of depression are higher still-as many as 28 percent for adolescents.
Preschool depression has begun to attract interest in the literature but much more needs to be learned about how mood disorders may affect this age group.

Which youth get depression?

During childhood, the number of boys and girls affected are almost equal. In adolescence, twice as many girls as boys are diagnosed. Well over half of depressed adolescents have a recurrence within seven years. Several factors increase the risk of depression, including a family history of mood disorders and stressful life events. Repeated episodes of depression can take a great toll on a young mind. It is prudent to get an evaluation followed by tailored treatment to prevent the social isolation, self-esteem consequences and safety risk of persistent depression.

Do youth with depression need treatment? Will they just "grow out of it"?

Episodes of depression in children appear to last six to nine months on average, but in some children they may last for years at a time. When children are experiencing an episode they do less well at school, have impaired relationships with their friends and family, internalize their feelings and have an increased risk for suicide. To ignore these warning signs and hope for the best while the child tries to cope is a risky decision. There are effective treatments for youth depression.

How can you tell if your child is depressed?

Signs that frequently help parents or others know that a child or teen should be evaluated for depression
include:

- feeling persistently sad or blue;
- talking about suicide or being better off dead;
- becoming suddenly much more irritable;
- having a marked deterioration in school or home functioning;
- reporting persistent physical complaints and/or making many visits to school nurses;
- failing to engage in previously pleasurable activities or interactions with friends; and
- abusing substances.

Because the child or teen experiencing depression may not show significant behavioral disturbance - that is, the depression may be taking an internal toll without disturbing the family – parents sometimes “hope for the best” or fail to get a child evaluated.

What are the treatments for children and adolescents with depression?

There are two main groups of treatments for children with depression with well- demonstrated evidence of efficacy:

1. Psychotherapy (talk therapy)
2. Pharmacotherapy (medications)

Additionally, in September 2009 a study was published by Fristad, *etal.* demonstrating that family psycho education was beneficial for children with depression ages 8-12. This is a key area for further study.

All treatment options have risks and benefits. The best strategy is to educate yourself about the choices you can make, share the decision with your child or teen and evaluate what is best for your child. Untreated depression confers a real risk of suicide, so it is important to consider that no treatment also carries risks.

Exercise and social support are also necessary elements of any good treatment plan to address youth depression. These interventions may fail to address more serious symptoms but remain important components throughout the course of treatment.

Rigorous studies have shown both talk therapy and medications to be useful. Both treatments were more effective than when a placebo alone was given in the NIMH-funded Treatment for Adolescents with Depression Study (TAOS). This landmark study also demonstrated that the combination of the two interventions is likely to create even better results than either one alone.

There are two different kinds of psychotherapy that studies have shown to be effective for children and/or adolescents-cognitive behavioral therapy (CBT) and interpersonal therapy (IPT). CBT concentrates on changing the negative attributional bias (seeing every cup as half-empty) associated with major depression. CBT attempts to challenge the automatic negative thinking that may contribute to depression. IPT focuses on a patient's self-concept and relationships with peers and family. More unstructured therapy with a supportive person may also be helpful but is more difficult to study. Ask potential therapists about the kind of psychotherapy they practice and why they feel it might help your child.

Antidepressant therapy can be an effective treatment option for child and adolescent depression, but it also carries risks. Fluoxetine (Prozac) is the only antidepressant specifically approved by the FDA for the treatment of depression in children ages 8 and older. Doctors can prescribe other antidepressant medications "off label" (not specifically approved by the FDA for that condition). If a doctor suggests another medication it is a good idea to ask more questions. Ask why he or she is not recommending the medication approved by the FDA for this condition, and what research and experience are the basis for the recommendation. You may ask for a second opinion from another doctor if you are not sure this is the best
course of action.

There are three important considerations with the use of antidepressants in children and adolescents:

1. **Suicidal thoughts.** In 2004, the FDA issued a strong "black box" warning about the risk of increased suicidal thoughts and actions in a small percentage of children and adolescents who take antidepressants. While none of the 2200 children and adolescents in antidepressant studies killed themselves, a review of the data determined that the rate of suicidal thoughts was about 4% for those taking the medication, double the rat expected. It is important to have regular care assessments, monitoring and follow-up, particularly in the first months of medication treatment. Please visit the FDA website for more detail.

   In addition, in 2006 the FDA expanded the warning about suicidal thoughts and antidepressants to include adults under the age of 25. All treatment options have risks and benefits. The best strategy is to educate yourself about the choices you can make, to share the decision with your child or teen and to evaluate what is best in the context of a comprehensive care plan.

2. **Bipolar disorder.** Children and adolescents who first experience a major depressive episode may, *over* time, be predisposed to bipolar disorder. Reviewing any family history of bipolar disorder and being mindful of this possibility is a good idea when treating a child or adolescent experiencing a major depressive episode as antidepressants may increase the risk of mania in some youth.

3. **Research on depression in children and adolescents.** Research is ongoing in this

important area, and more needs to be learned. Ask your caregiver about how the latest research studies have influenced the treatment plan. Look through the **NIMH website** for a summary of the latest research. Of future interest are NIMH-funded studies TORDIA (Treatment of SSRI-Resistant Depression in), TASA (Treatment of Adolescent Suicidal Attempters) and ASK (Antidepressant Safety in Kids).

What is the right treatment for my depressed child?

First, be sure that the caregiver has performed an in-depth assessment that looks at the whole person-the environment, school life, medical and family history and current living situation. It is important to have a real understanding of the stresses and strengths a youth brings to the equation. It is also essential to make the youth a part of the emerging plan. There is no "one size fits all" in mental health; interventions need to be tailored to the individual.

Once the diagnosis is made, ask the clinician to collaboratively develop a treatment plan with your child and family. Target symptoms that you and your child are hoping will improve *(e.g.* sleep problems, self-harming statements, school attendance or performance) that will help track your child's progress. Treatment needs to be specific to your child and his or her world. For example, if there is a co-occurring alcohol problem, that must also be addressed. If there is a learning disability or bullying problem at school, that needs attention. Addressing family stresses or conflict may also be part of helping the youth.

If you have concerns about your child's safety, be sure to have a plan for responding to these concerns. This should include how to access resources after hours and on weekends.

In general, the youth, family and clinician should together choose a first treatment or treatments and give that regimen an adequate trial determined in concert with the doctor *(e.g.,* eight to12 weeks). The treatment should be reevaluated at the end of that time if it is not working.

How long should my child stay on treatment?

Treatment duration should be driven by the improvement and severity of the symptoms. Assuming a simple and positive treatment response, medications are typically continued at least six months after response before tapering off. Many therapists will decrease the frequency of psychotherapy sessions but continue some maintenance therapy longer than the initial eight to12 weeks of treatment. Treatment for a first episode of depression is likely to last at least six to 12 months with either treatment but may be longer.

For recurring depression, many clinicians will recommend a person stay on medication for considerably longer periods, sometimes years, to prevent a recurrence. In that case, one key is to help the youth recognize when their symptoms are recurring or worsening so that additional supports can be activated.

The field of depression treatment for youth is continuously evolving and recent research may hold new information to better guide these decisions. The **NIMH** is a good source to summarize these recent findings. The **American Association of Child and Adolescent Psychiatry** is another good resource.

References

Kess!er *et al.* (2001). "Mood Disorders in Children and Adolescents: An Epidemiological Perspective,"
Biological Psychiatry. Volume 49.

Cheung *et al.* (2007). "Guidelines for Adolescent Depression: Treatment and Ongoing Management," Pediatrics, Vol. 120.

Luby, J. (2009). "Early Childhood Depression," American Journal of Psychiatry. 166, 974-979.

The TADS team (2007). "Treatment of Adolescent Depression Study: Long-term Effectiveness and Safety Outcomes," archives of General Psychiatry. 64(10) 1132-1143.

Fristad *et al.* (2009). "Impact of Multifamily Psycho educational Psychotherapy in Treating Children Aged 8 to 12 with Mood Disorders," archives of General Psychiatry. 66 (9) 1013-1021.

www.fda.gov for all medication and antidepressant warnings and indications.

www.clinicaltrials.gov for up-to-date information on relevant research studies.

www.nimh.nih.gov for National Institute of Mental Health summary of research studies.

Reviewed by Ken Duckworth, M.D., July 2010

Early Onset Schizophrenia

What is schizophrenia? Schizophrenia is a major psychiatric illness. Symptoms usually begin in late adolescence or early adulthood. Numerous studies have found that about 1 in every 100 people around the world has the disorder. However, schizophrenia with an onset in adolescence (prior to age 18) is less common, and an onset of the disorder in childhood (before age 13) is exceedingly rare. It is thought that at most one in every 100 adults with schizophrenia develops it in childhood.

Symptoms and Diagnosis In both adults and children, the symptoms of schizophrenia can be divided into two broad categories -- positive symptoms and negative symptoms.

• Positive symptoms include: hallucinations, usually voices which are critical or threatening; delusions, which are firm beliefs that are out of touch with reality and which commonly include the fear that people are watching, harassing, or plotting against the individual; disorganized speech, which is often seen as an inability to maintain a conversation, usually as a result of difficulty staying on topic; or, disorganized or catatonic behavior, which can include behavior that is unusual and bizarre, or can be demonstrated by difficulty planning and completing activities in an organized fashion.
• Negative symptoms include: reduction in emotional expression; lack of motivation and energy; or, loss of enjoyment and interest in activities, including social interaction.

Schizophrenia is diagnosed by the presence of two of the symptoms described above. For a diagnosis of schizophrenia, two of these symptoms must be present for at least 6 months and must be accompanied by increased difficulty in daily living in areas such as school, friendships, and self-care.

Hallucinations or delusions in a child should lead to an evaluation by a mental health professional that has experience working with children and adolescents with mental health disorders.
A diagnosis of schizophrenia is made through an interview with the child and parents using information obtained from them and from school personnel.

Difficulties in diagnosing schizophrenia Many of the symptoms seen in people with schizophrenia are also found in people with depression, bipolar disorder, or other illnesses. As a result, studies have found that misdiagnosis is common. This is particularly true with children and adolescents. As such, it is extremely important to rule-out other diagnoses such as depression, bipolar disorder, and substance use before making a diagnosis of schizophrenia.

An additional difficulty in making a diagnosis in children and adolescents relates to the fact that hallucinations are surprisingly common and, in fact, are most often seen in children and adolescents with diagnoses other than schizophrenia. In a large study at the National Institutes of Health, the great majority of those previously diagnosed with schizophrenia did not receive that diagnosis following careful evaluation. In many children with other conditions, the nature of the hallucinations is different.

While hallucinations in people with schizophrenia are often pervasive when not well treated, many children with other conditions such as mood disorders and dissociative disorders, report auditory hallucinations when they are under stress. These hallucinations tend to be brief and very intermittent (lasting for only a few

minutes). Also, children are very susceptible to leading questions and therefore should be asked about symptoms in a neutral fashion (i.e., not "Do you hear voices?").

Children with pervasive developmental disorders (autism, Asperger's disorder, or an unspecified pervasive developmental disorder) often have social difficulties, disorganized behavior and language impairments. These developmental disorders can be confused with a diagnosis of schizophrenia.

Prognosis of early onset schizophrenia

The outcome for children with schizophrenia varies greatly and some individuals function well with medication. Earlier onset is often associated with a poorer outcome when it interferes with attending school and completing an education. However, because children typically live at home with the combined social environments of family and school, symptoms are often recognized early. This fact is significant because recent studies have suggested that earlier treatment may reduce the decline in functioning and long-term impairments commonly associated with schizophrenia. As such, accurate and early intervention and diagnosis are critical.

Treatment for schizophrenia includes biological, educational, and social interventions. Medication is the cornerstone of the treatment of schizophrenia, but should be viewed as a means to facilitate psychological and social interventions. Treatment with only medication is not as effective as medication therapy combined with other forms of treatment.

The medications used to treat schizophrenia are termed "anti-psychotics" or "neuroleptics". Although these medications are often effective, they have been associated with significant side effects. The last decade has seen the introduction of a number of new anti-psychotics with reduced side effects. The most commonly used medications used now are: risperidone (Risperdal), olanzapine (Zyprexa), and quetiapine (Seroquel). Other medications include haloperidol (Haldol), thioridazine (Mellaril), and chlorpromazine (Thorazine). For individuals who are not responsive to the previous trials of anti-psychotics, including olanzapine, clozapine (Clozaril) is an important option for children and teenagers, but is not used as a first treatment due to significant side-effects (see below). For some children with refractory psychosis, clozapine proves to be the only medication that helps. We have been able, with careful monitoring, to manage side effects in our children on clozapine, should side effects occur. It is also important that associated symptoms be recognized and treated appropriately. For example, individuals with schizophrenia who develop depression or anxiety should be treated for these symptoms.

Children and adolescents with schizophrenia often need adjustments to their educational programs. Typically this would include smaller classrooms with teachers who are experienced with children and adolescents with psychiatric disorders. Their academic work may also need to be modified in order to accommodate problems sometimes associated with schizophrenia such as reduced concentration and attention.

Social difficulties are commonly seen with early onset schizophrenia. These include difficulty making and keeping friends, difficulty with interpersonal interactions, and low frustration tolerance. Activities to develop social skills are integral to the treatment of schizophrenia. In addition, family therapy and education about schizophrenia may help family members to cope with the child's illness.

Common side effects of anti-psychotic medications Every youth will have a different reaction to any medication--be it an antibiotic or an anti-psychotic. Nonetheless, the most common problem that children and adolescents report when taking the new generation of anti-psychotic medications (olanzapine and risperidone, for example) is weight gains. This can be problematic because teens are particularly sensitive about how they look. Common side effects of the older class of antipsychotics, such as the more commonly-used and less expensive haloperidol (Haldol), include drowsiness; and neuroleptic side effects such as acute extrapyramidal side effects and tardive dyskenesia. Approximately 1% of those taking clozapine (Clozaril) will develop a serious side -effect called agranulocytosis; thus, regular monitoring of blood levels is essential.

Research and new treatments. Much research and development of new medications for schizophrenia is underway. Some promising medications have very different mechanisms of action and so may be more effective with fewer side effects. However, the process of drug development and approval is slow and many of these medications are only currently available in research studies. Several centers around the country are involved in research with these new medications.

Reviewed by Julia Tossell, MD September 2003

National Alliance on Mental Illness
page printed from **http://www.nami.org/**
(800) 950-NNIJI; info@nami.org

Dual Diagnosis: Adolescents with Co-occurring Brain Disorders & Substance Abuse Disorders

Adolescents are often referred to treatment for substance abuse, but are not referred to a qualified mental health professional for appropriate diagnosis and treatment of any underlying cause for their drug and alcohol abuse. However, many teens have symptoms of a mood disorder that may in fact have led to self-medicating with street drugs and alcohol.

Families and caregivers know how difficult it is to find treatment for an adolescent who abuses drugs or alcohol, but who also is diagnosed with a brain disorder (mental illness); i.e., ADHD, depression, or bipolar disorder. Traditionally, programs that treat individuals with brain disorders do not treat individuals with active substance abuse problems, and programs for substance abusers are not geared for people with mental illness. Adolescents are often caught in this treatment or services gap.

Is dual diagnosis common?

The combination of mental illness and substance abuse is so common that many clinicians now expect to find it. Studies show that more than half of young persons with a substance abuse diagnosis also have a diagnosable mental illness.

What causes these disorders?

Mental health and addiction counselors increasingly believe that brain disorders and substance abuse disorders are biologically and physiologically based.

What kind of treatment works?

Families and caregivers may feel angry and blame the adolescent for being foolish and weak-willed. They may feel hurt when their child breaks trust by lying and stealing. But it's important to realize that mental illness and often substance abuse are disorders that the adolescent cannot take control of without professional help.

Teens with difficult problems such as concurrent mental illness and substance abuse disorders do not respond to simplistic advice like "just say no" or "snap out of it." Psychotherapy and medication combined with appropriate self-help and other support groups help most, but patients are still highly prone to relapse.

Treatment programs designed primarily for substance abusers are not recommended for individuals who have a diagnosed mental illness. Their reliance on confrontation techniques and discouragement of use of appropriate prescription medications tend to compound the problems of individuals with mental illness. These strategies may produce stress levels that make symptoms worse or cause relapse.

What is a better approach?

Increasingly, the psychiatric and drug counseling communities agree that **both disorders must be treated at the same time.** Early studies show that when mental illness and substance abuse are treated together, suicide attempts and psychotic episodes decrease rapidly.

Since dually diagnosed clients to not fit well into most traditional 12-step programs, special peer groups based on the principle of treating both disorders together should be developed at the community *level*. Individuals who develop positive social networking have a much better chance of controlling their illnesses.

What's the first step in treatment?

The presence of both disorders must first be established by careful assessment. This may be difficult because the symptoms of one disorder can mimic the symptoms of the other. Seek referral to a psychologist or psychiatrist. Local NAMI affiliates are happy to refer families to mental health professionals their members recommend. **(Call the NAMI Helpline at 1-800/950-6264 for a local contact).**

Once a professional assessment has confirmed a dual diagnosis of mental illness and substance abuse, mental health professionals and family members should work together on a strategy for integrating care and motivating the adolescent.

What do model programs for treating mental illness and substance abuse look like?

There are a growing number of model programs. Support groups are an important component of these programs. Adolescents support each other as they learn about the negative role that alcohol and drugs has had on their lives. They learn social skills and how to replace substance use with new thoughts and behaviors. They get help with concrete situations that arise because of their brain disorder (mental illness). Look into programs that have support groups for family members and friends.

If your teen has a substance abuse disorder...

1. **Don't regard it as a family disgrace. Recovery is possible just as it is with other illnesses.**
2. **Encourage and facilitate participation in support groups during and after treatment.**
3. **Don't nag, preach, or lecture.**
4. **Don't use the "if you loved me" approach. It is like saying, "If you loved me, you would not have tuberculosis."**
5. **Establish consequences for behaviors. Don't be afraid to call upon law enforcement if teens engage in underage drinking on your premises. You can be held legally responsible for endangering minors if you do not take timely action.**
6. **Avoid threats unless you think them through carefully and definitely intend to carry them out. Idle threats only make the person with a substance abuse disorder feel you don't mean what you say.**
7. **During recovery, encourage teens to engage in after-school activities with adult supervision. If they cannot participate in sports or other extracurricular** school **activities, part-time employment or volunteer work can build self-esteem.**
8. **Don't expect an immediate, 100-percent recovery. Like any illness, there is a period of convalescence with a brain disorder. There may be relapses and times of tension and resentment among family members.**
9. **Do offer love, support, and understanding during the recovery.**

Reviewed by Patrick C. Friman, Ph.D., A.B.P.P., Director of Clinical Services &r. Research at Father Flanigan's Boys' Home and associate professor, Creighton University School of Medicine.

Eating Disorders

When you become so preoccupied with food and weight issues that you find it harder and harder to focus on other aspects of your life, it may be an early sign of an eating disorder. Studies suggest that 1 in 20 people will

be affected at some point in their lives. Ultimately without treatment, eating disorders can take over a person's life and lead to serious, potentially fatal medical complications. Although eating disorders are commonly associated with women, men can develop them as well.

Symptoms

Eating disorders are a group of related conditions that cause serious emotional and physical problems. Each condition involves extreme food and weight issues; however, each has unique symptoms that separate it from the others.

Anorexia Nervosa. A person with anorexia will deny themselves food to the point of self-starvation as she obsesses about weight loss. With anorexia, a person will deny hunger and refuse to eat, practice binge eating and purging behaviors or exercise to the point of exhaustion as she attempts to limit, eliminate or "burn" calories.

The emotional symptoms of anorexia include irritability, social withdrawal, lack of mood or emotion, not able to understand the seriousness of the situation, fear of eating in public and obsessions with food and exercise. Often food rituals are developed or whole categories of food are eliminated from the person's diet, out of fear of being "fat".

Anorexia can take a heavy physical toll. Very low food intake and inadequate nutrition causes a person to become very thin. The body is forced to slow down to conserve energy causing irregularities or loss of menstruation, constipation and abdominal pain, irregular heart rhythms, low blood pressure, dehydration and trouble sleeping. Some people with anorexia might also use binge eating and purge behaviors, while others only restrict eating.

Bulimia Nervosa. Someone living with bulimia will feel out of control when binging on very large amounts of food during short periods of time, and then desperately try to rid himself of the extra calories using forced vomiting, abusing laxatives or excessive exercise. This becomes a repeating cycle that controls many aspects of the person's life and has a very negative effect both emotionally and physically. People living with bulimia are usually normal weight or even a bit overweight.

The emotional symptoms of bulimia include low self-esteem overly linked to body image, feelings of being out of control, feeling guilty or shameful about eating and withdrawal from friends and family.

Like anorexia, bulimia will inflict physical damage. The binging and purging can severely harm the parts of the body involved in eating and digesting food, teeth are damaged by frequent vomiting, and acid reflux is common. Excessive purging can cause dehydration that effect the body's electrolytes and leads to cardiac arrhythmias, heart failure and even death.

Binge Eating Disorder (BED). A person with BED losses control over his eating and eats a very large amount of food in a short period of time. He may also eat large amounts of food even when he isn't hungry or after he is uncomfortably full. This causes him to feel embarrassed, disgusted, depressed or guilty about his behavior. A person with BED, after an episode of binge eating, does not attempt to purge or exercise excessively like someone living with anorexia or bulimia would. A person with binge eating disorder may be normal weight, overweight or obese.

Causes

Eating disorders are very complex conditions, and scientists are still learning about the causes. Although eating disorders all have food and weight issues in common, most experts now believe that eating disorders are caused

by people attempting to cope with overwhelming feelings and painful emotions by controlling food. Unfortunately, this will eventually damage a person's physical and emotional health, self-esteem and sense of control.

Factors that may be involved in developing an eating disorder include:

- **Genetics.** People with first degree relatives, siblings or parents, with an eating disorder appear to be more at risk of developing an eating disorder, too. This suggests a genetic link. Evidence that the brain chemical, serotonin, is involved also points a contributing genetic and biological factors.
- **Environment.** Cultural pressures that stress "thinness" as beautiful for women and muscular development and body size for men places undue pressure on people of achieve unrealistic standards. Popular culture and media images often tie being thin to popularity, success, beauty and happiness. This creates a strong desire to very thin.
- **Peer Pressure.** With young people, this can be a very powerful force. Pressure can appear in the form of teasing, bullying or ridicule because of size or weight. A history of physical or sexual abuse can also contribute to some people developing an eating disorder.
- **Emotional Health.** Perfectionism, impulsive behavior and difficult relationships can all contribute to lowering a person's self-esteem and make them vulnerable to developing eating disorders.

Eating disorders affect all types of people. However there are certain risk factors that put some people at greater risk for developing an eating disorder.

- **Age.** Eating disorders are much more common during teens and early 20s.
- **Gender.** Statistically, teenage girls and young women are more likely to have eating disorders, but they are more likely to be noticed/treated for one. Teenage boys and men are less likely seek help, but studies show that 1 out of 10 people diagnosed with eating disorders are male.
- **Family history.** Having a parent or sibling with an eating disorder increases the risk.
- **Dieting.** Dieting taken too far can become an eating disorder.
- **Changes.** Times of change like going to college, starting a new job, or getting divorced may be a stressor towards developing an eating disorder.
- **Vocations and activities.** Eating disorders are especially common among gymnasts, runners, wrestlers and dancers.

Diagnosis

A person with an eating disorder will have the best recovery outcome if he or she receives an early diagnosis. If an eating disorder is believed to an issue, a doctor will usually perform a physical examination, conduct an interview and order lab tests. These will help form the diagnosis and check for related medical issues and complications.

In addition, a mental health professional will conduct a psychological evaluation. She may ask questions about eating habits, behaviors and beliefs. There may be questions about a patient's history of dieting, exercise, bingeing and purging.

Symptoms must meet the criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in order to warrant a diagnosis. Each eating disorder has its own diagnostic criteria that a mental health professional will use to determine which disorder is involved. It is not necessary to have all the criteria for a disorder to benefit from working with a mental health professional on food and eating issues.

Often a person with an eating disorder will have symptoms of another mental health condition that requires treatment. Whenever possible, it is best to identified and address all conditions at the same time. This gives a person comprehensive treatment support that helps insure a lasting recovery.

Treatment

Eating disorders are managed using a variety of techniques. Treatments will vary depending on the type of disorder, but will generally include the following.

- **Psychotherapy,** such as talk therapy or behavioral therapy.
- **Medicine,** such as antidepressants and anti-anxiety drugs. Many people living with an eating disorder often have a co-occurring illness like depression or anxiety, and while there is no medication available to treat eating disorders themselves, many patients find that these medicines help with underlying issues.
- **Nutritional counseling and weight restoration monitoring** are also crucial. Family based treatment is especially important for families with children and adolescents because it enlists the families' help to better insure healthy eating patterns, and increases awareness and support.

Related Conditions

People with eating disorders often have additional illnesses:

- Depression
- Anxiety disorders
- Borderline personality disorder
- Obsessive-compulsive disorder
- Substance abuse

Treating these illnesses can help make treating an eating disorder easier. Some of the symptoms of eating disorders may be caused by another illness.

- See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Eating-Disorders#sthash.kgFbLtw4.dpuf

Article taken from 2016 NAMI National webpage LEARN MORE, Mental Health Conditions,.

Self-Harm

People often keep their habit a secret, but the urge to self-harm isn't uncommon, especially in adolescents and young adults. Many overcome it with treatment.

Whether a person has recently started hurting his or herself or has been doing it for a while, there is an opportunity to improve health and reduce behaviors. Talking to a doctor or a trusted friend or family member is the first step towards understanding your behavior and finding relief.

What Is Self-Harm?

Self-harm or self-injury means hurting yourself on purpose. One common method is cutting yourself with a knife. But any time someone deliberately hurts herself is classified as self-harm. Some people feel an impulse to burn themselves, pull out hair or pick at wounds to prevent healing. Extreme injuries can result in broken bones.

Hurting yourself—or thinking about hurting yourself—is a sign of emotional distress. These uncomfortable emotions may grow more intense if a person continues to use self-harm as a coping mechanism. Learning other ways to tolerate the mental pain will make you stronger in the long term.

Self-harm also causes feelings of shame. The scars caused by frequent cutting or burning can be permanent. Drinking alcohol or doing drugs while hurting yourself increases the risk of a more severe injury than intended. And it takes time and energy away from other things you value. Skipping classes to change bandages or avoiding social occasions to prevent people from seeing your scars is a sign that your habit is negatively affecting work and relationships.

Why People Self-Harm

Self-harm is not a mental illness, but a behavior that indicates a lack of coping skills. Several illnesses are associated with it, including borderline personality disorder, depression, eating disorders, anxiety or posttraumatic distress disorder.

Self-harm occurs most often during the teenage and young adult years, though it can also happen later in life. Those at the most risk are people who have experienced trauma, neglect or abuse. For instance, if a person grew up in an unstable family, it might have become a coping mechanism. If a person binge drinks or does drugs, he is also at greater risk of self-injury, because alcohol and drugs lower self-control.

The urge to hurt yourself may start with overwhelming anger, frustration or pain. When a person is not sure how to deal with emotions, or learned as a child to hide emotions, self-harm may feel like a release. Sometimes, injuring yourself stimulates the body's endorphins or pain-killing hormones, thus raising their mood. Or if a person doesn't feel many emotions, he might cause himself pain in order to feel something "real" to replace emotional numbness.

Once a person injures herself, she may experience shame and guilt. If the shame leads to intense negative feelings, that person may hurt herself again. The behavior can thus become a dangerous cycle and a long-time habit. Some people even create rituals around it.

Self-harm isn't the same as attempting suicide. However, it is a symptom of emotional pain that should be taken seriously. If someone is hurting herself, she may be at an increased risk of feeling suicidal. It's important to find treatment for the underlying emotions.

Treatment And Coping

There are effective treatments for self-harm that can allow a person to feel in control again. Psychotherapy is important to any treatment plan. Self-harm may feel necessary to manage emotions, so a person will need to learn new coping mechanisms.

The first step in getting help is talking to a trusted adult, friend or medical professional who is familiar with the subject, ideally a psychiatrist. A psychiatrist will ask that person questions about their health, life history and any injurious behaviors in the past and present. This conversation, called a diagnostic interview, may last an hour or more. Doctors can't use blood tests or physical exams to diagnose mental illness, so they rely on detailed information from the individual. The more information that person can give, the better the treatment plan will be.

Depending on any underlying illness, a doctor may prescribe medication to help with difficult emotions. For someone with depression, for instance, an antidepressant may lessen harmful urges.

A doctor will also recommend therapy to help a person learn new behaviors, if self-injury has become a habit. Several different kinds of therapy can help, depending on the diagnosis.

- **Psychodynamic therapy** focuses on exploring past experiences and emotions
- **Cognitive behavioral therapy** focuses on recognizing negative thought patterns and increasing coping skills
- **Dialectical behavioral therapy** can help a person learn positive coping methods

If your symptoms are overwhelming or severe, your doctor may recommend a short stay in a psychiatric hospital. A hospital offers a safe environment where you can focus your energy on treatment.

What To Do When Someone Self-Harms

Perhaps you have noticed a friend or family member with frequent bruises or bandages. If someone is wearing long sleeves and pants even in hot weather, they may be trying to hide injuries or scarring.

Keep in mind that this is a behavior that might be part of a larger condition and there may be additional signs of emotional distress. He or she might make statements that sound hopeless or worthless, have poor impulse control, or have difficulty getting along with others.

If you're worried a family member or friend might be hurting herself, ask her how she's doing and be prepared to listen to the answer, even if it makes you uncomfortable. This may be a hard subject to understand. One of the best things is tell them that while you may not fully understand, you'll be there to help. Don't dismiss emotions or try to turn it into a joke.

Gently encourage someone to get treatment by stating that self-harm isn't uncommon and doctors and therapists can help. If possible, offer to help find treatment. But don't go on the offensive and don't try to make the person promise to stop, as it takes more than willpower to quit.

- See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Self-harm#sthash.FqyrCRQO.dpuf

Risk of Suicide

If you or someone you know is in an emergency, call The National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or call 911 immediately.

According to the CDC, each year more than 41,000 individuals take their own life, leaving behind thousands of friends and family members to navigate the tragedy of their loss. Suicide is the 10th leading cause of death among adults in the U.S. and the 3rd leading cause of death among people aged 10-24.

Suicidal thoughts or behaviors are both damaging and dangerous and are therefore considered a psychiatric emergency. Someone experiencing these thoughts should seek immediate assistance from a health or mental health care provider. Having suicidal thoughts does not mean someone is weak or flawed.

Know the Warning Signs

- Threats or comments about killing themselves, also known as suicidal ideation, can begin with seemingly harmless thoughts like "I wish I wasn't here" but can become more overt and dangerous
- Increased alcohol and drug use
- Aggressive behavior
- Social withdrawal from friends, family and the community
- Dramatic mood swings
- Talking, writing or thinking about death
- Impulsive or reckless behavior

Is There Imminent Danger?

Any person exhibiting these behaviors should get care immediately:

- Putting their affairs in order and giving away their possessions
- Saying goodbye to friends and family
- Mood shifts from despair to calm
- Planning, possibly by looking around to buy, steal or borrow the tools they need to commit suicide, such as a firearm or prescription medication

If you are unsure, a licensed mental health professional can help assess risk.

Risk Factors for Suicide

Research has found that about 90% of individuals who die by suicide experience mental illness. A number of other things may put a person at risk of suicide, including:

- **A family history of suicide.**
- **Substance abuse.** Drugs and alcohol can result in mental highs and lows that exacerbate suicidal thoughts.
- **Intoxication.** More than one in three people who die from suicide are found to be currently under the influence.
- **Access to firearms.**
- **A serious or chronic medical illness.**
- **Gender.** Although more women than men attempt suicide, men are four times more likely to die by suicide.
- **A history of trauma or abuse.**
- **Prolonged stress.**
- **Isolation.**
- **Age.** People under age 24 or above age 65 are at a higher risk for suicide.
- **A recent tragedy or loss.**
- **Agitation and sleep deprivation.**

Can Thoughts of Suicide Be Prevented?

Mental health professionals are trained to help a person understand their feelings and can improve mental wellness and resiliency. Depending on their training they can provide effective ways to help.

Psychotherapy such as cognitive behavioral therapy and dialectical behavior therapy, can help a person with thoughts of suicide recognize unhealthy patterns of thinking and behavior, validate troubling feelings, and learn coping skills.

Medication can be used if necessary to treat underlying depression and anxiety and can lower a person's risk of hurting themselves. Depending on the person's mental health diagnosis, other medications can be used to alleviate symptoms.

- See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Risk-of-Suicide#sthash.gqSTFwLK.dpuf

Suicide Survivors - Karla Smith Foundation, their survivor meeting follow the successful LOSS program(Loving Outreach to Survivors of Suicide). The purpose of the LOSS program is to provide a healthy and nurturing ,. non-judgmental forum to process the various feelings that result when a death by suicide occurs. We provide a safe environment in which survivors can tell their stories, talk about feelings, express their sadness, ask their questions, and receive support and acceptance from others who have made the same journey.

For more information about the Karla Smith Foundation call 1-888-KSF-Hope and/or visit their website www.KarlaSmithFoundation.org.

Tourette's Syndrome

Tourette's disorder, or Tourette's syndrome (TS) as it is frequently called, is a neurologic syndrome. The \first indication a parent has that their child may have TS. Involuntary sounds, such as throat clearing and sniffing, or tics of the limbs may be an initial sign in other children

Are any other symptoms associated with Tourette's? Approximately 50 percent of patients meet criteria for attention deficit hyperactivity disorder (ADHD) and this may be the more impairing problem. Approximately one-third of patients meets criteria for obsessive-compulsive disorder (OCD) or has other forms of anxiety. Learning disabilities are common as well as developmental stuttering. Social discomfort, self-consciousness and depressed mood frequently occur, especially as children reach adolescence.

What causes these symptoms? Although the cause has not been definitely established, there is considerable evidence that TS arises from abnormal metabolism of dopamine, a neurotransmitter. Other neurotransmitters may be involved.

Can TS be inherited? Genetic studies indicate that TS is inherited as an autonomic dominant gene but different family members may have dissimilar symptoms. A parent has a 50 percent chance of passing the gene to one of his or her children. The range of symptomatology varies from multiple severe tics to very minor tics with varying degrees of attention deficit-disorder and OCD.

Are boys or girls more likely to have TS? The sex of the child can influence the expression of the TS gene. Girls with the gene have a 70 percent chance of displaying symptoms; boys with the gene have a 99 percent chance of displaying symptoms. Ratios of boys with TS to girls with TS are 3:1.

How is Tourette's syndrome diagnosed? No blood analysis, x-ray or other medical test exists to identify TS. Diagnosis is made by observing the signs or symptoms as described above. A doctor may wish to use a CAT scan, EEG, or other tests to rule out other ailments that could be confused with TS. Some medications cause tics, so it is important to inform the professional doing the assessment of any prescribed, over-the-counter, or street drugs to which the patient may have been exposed.

What are the benefits of seeking early treatment of TS symptoms? When a child's behavior is viewed as disruptive, frightening, or bizarre by peers, family, teachers, or friends, it provokes ridicule and rejection. Teachers and other children can feel threatened and exclude the child from activities or interpersonal relationships. A child's socialization difficulties will increase as he reaches adolescence. Therefore, it is very important for the child's self-esteem and emotional well-being that treatment be sought as early as possible.

What treatments are available for TS? Not everyone is disabled by his or her symptoms, so medication may not be necessary. When symptoms interfere with functioning, medication can effectively improve attention span, decrease impulsivity, hyperactivity, tics, and obsessive-compulsive symptomatology. Relaxation techniques and behavior therapy may also be useful for tics, ADD symptoms, and OCD symptoms.

How does TS affect the education of a child or adolescent with TS? TS alone does not affect the IQ of a child. Many children who have TS, however, also have learning disabilities or attention deficits. Frequently, therefore, special education may be needed for a child with TS. Teachers should be given factual information about the disorder and, if learning difficulties appear, the child should be referred to the school system for assessment of other learning problems.

What is the course of TS? Some people with TS show a marked improvement in their late teens or early twenties. However, tics as well as ADD and OCD behavior, may wax and wane over the course of the life span.

1 According to the Diagnostic and Statistical Manual of Mental Disorders (4th Edition), or DSM-IV
2 This is a change from the former edition, DSM-IIIR, that set maximum age of onset at 21 years of age.
3 A biochemical substance that transmits nerve impulses from one nerve cell to another at a synapse.

Reviewed by Charles T. Gordon, III, M.D.

* Internet Resource List for Children's Mental Health *

NAMI
National Alliance on Mental Illness

Internet Resource List For Child and Adolescent Mental Health

Federal Agencies

Center for Mental Health Services (CMHS)
Children, Adolescents and Family Resources
Web address: www.mentalhealth.samhsa.gov/cmhs

CMHS/Systems of Care
A website developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and CMHS dedicated to providing information about the mental health of children, youth and families.
Web address: www.systemsofcare.samhsa.gov

Centers for Disease Control (CDC)
The CDC increasingly has helpful information on mental health related issues and has statistical information on suicide.
Web address: www.cdc.gov

Centers for Medicare & Medicaid Services (CMS)
CMS administers the Medicare, Medicaid and SCHIP (State Children's Health Insurance Program) programs.
Web address: www.cms.hhs.gov

Department of Education (DOE) – Office of Special Education and Rehabilitative Services (OSERS)
OSERS web site includes a wide array of information for families, school districts and states in three main areas: special education, vocational rehabilitation and research.
Web address: www.ed.gov/about/offices/list/osers/index.html

InsureKidsNow
The U.S. Department of Health and Human Services has created a national campaign to link the nation's 10 million uninsured children – from birth to 18 years – to free and low-cost health insurance.

Web address: www.insurekidsnow.gov

National Institute for Mental Health (NIMH)
The mission of NIMH is to diminish the burden of mental illness through research.
Web address: www.nimh.nih.gov

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
OJJDP's mission is to provide national leadership, coordination, and resources to prevent and respond to the needs of individuals in the juvenile justice system. OJJDP supports states and local communities in their efforts to develop and implement effective and coordinated prevention and intervention programs. The agency also works to improve the juvenile justice system.
Web address: www.ojjdp.ncjrs.org

Office of the U.S. Surgeon General
The Surgeon General's office has issued several reports on children's mental health.
Web address: www.surgeongeneral.gov/index.html

President's New Freedom Commission on Mental Health
The Commission was created to examine the current gaps in mental illness treatment services and to make recommendations to the President on ways in which the federal government can help states increase access to care and improve quality in their public programs.
Web address: www.mentalhealthcommission.gov

Children's Mental Health and Advocacy Organizations

About Our Children
A scientifically-based, parent-friendly website of the NYU Child Study Center that includes a wide range of information on child mental health disorders and associated parenting issues. It has over 200 faculty reviewed articles, resources for children and parents, and a publications section that includes newsletters and manuals developed by the faculty of the Child Study Center.
Web address: www.aboutourkids.org

Autism Society of America
Information and resources on autism.
Web address: www.autism-society.org

Bazelon Center for Mental Health Law
The Bazelon Center for Mental Health Law works on a broad array of children's mental health issues. The website includes an array of publications related to children's mental health and related policy issues.
Web address: www.bazelon.org

Child and Adolescent Bipolar Foundation (CABF)
The Child and Adolescent Bipolar Foundation (CABF) is a parent-led, web-based membership organization of families raising children diagnosed with, or at risk for, early-onset bipolar disorder. The web site includes information and resources on early-onset bipolar disorder.
Web address: www.bpkids.org

Children and Adults with Attention-Deficit/Hyperactivity-Disorder (CHADD)
CHADD is a national organization representing individuals with AD/HD in providing education, advocacy and support to individuals and families. The organization is composed of dedicated volunteers

from around the country who play an integral part in the organization by providing resources and encouragement to families, educators and professionals.
Web address: www.chadd.org

Children's Defense Fund (CDF)

CDF's mission is to provide a strong, effective voice for all the children of America who cannot vote, lobby, or speak for themselves. CDF addresses the needs of poor and minority children and those with disabilities. CDF's mission is also to educate the nation about the needs of children and encourages preventive investment before they get sick or into trouble, drop out of school, or suffer family breakdown.
Web address: www.childrensdefense.org

Child Welfare League of America (CWLA)

CWLA is the nation's oldest membership-based child welfare organization committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.
Web address: www.cwla.org/default.htm

Council for Children with Behavioral Disorders (CCBD)

The Council for Children with Behavioral Disorders (CCBD) is the official division of the Council for Exceptional Children (CEC) committed to promoting and facilitating the education and general welfare of children and youth with emotional or behavioral disorders.
Web address: *www.ccbd.net/index.cfm*

Federation of Families for Children's Mental Health

The Federation of Families is dedicated to providing education, resources and information to children with mental health needs and their families.
Web address: www.ffcmh.org

Karla Smith Foundation

KSF provides hope for a balanced life to family and friends of anyone with a mental illness or who lost a loved one to suicide.

National Alliance on Mental Illness (NAMI)

NAMI is the nation's largest grassroots mental health organization dedicated to improving the lives of children and adults living with mental illness and their families. Founded in 1979, NAMI has become the nation's voice on mental illness, a national organization including NAMI organizations in every state and in over 1100 local communities across the country who join together to meet the NAMI mission through advocacy, research, support, and education.
Web address: www.nami.org

National Center for Mental Health and Juvenile Justice (NCMHJJ)

NCMHJJ promotes awareness of the mental health needs of youth in the juvenile justice system and assists the field in developing improved policies and programs based on the best available research and practice.
Web address: *www.ncmhjj.com*

National Child Traumatic Stress Network Center

The National Child Traumatic Stress Network Center works toward raising the standard of care and improve access of services to traumatized children, their families and communities throughout the

United States. They provide valuable resources for parents, caregivers, educators and professionals on child traumatic stress.
Web address: *www.nctsn.org*

National Disability Rights Network (NDRN)

NDRN is a national organization of protection and advocacy and client assistance programs for children and adults with disabilities. These programs provide legally based advocacy services for people with disabilities, including mental illnesses, in the United States.
Web address: www.napas.org

National Health Law Program (NHelp)

The National Health Law Program has a number of excellent publications, resources and information on Medicaid and other important health-related topics.
Web address: www.healthlaw.org

National Mental Health Association (NMHA)

NMHA is an advocacy, education and support organization working to address the needs of people with mental health related needs and mental illnesses.
Web address: www.nmha.org

New Freedom Initiative: State Coalitions to Promote Community-Based Care (Olmstead)
Support for states and territories in their efforts to respond to the goals outlined in the President's New Freedom Commission on Mental Health Report**.** The initiative provides financial assistance, technical assistance and training to promote community-based care.
Web address: www.olmsteadcommunity.org

OCD Resource Center

Information and resources available on obsessive compulsive disorder.
Web address: www.ocdresource.com

Parent to Parent - USA

A national non-profit organization committed to assuring access and quality in Parent to Parent support across the country. Parent to Parent programs provide emotional and informational support to families of children who have special needs most notably by matching parents seeking support with an experienced, trained 'Supporting Parent.'
Web Address: http://www.p2pusa.org

The Trevor Project

An organization dedicated to ending the disproportionately high rates of suicide among lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth.
Web address: www.thetrevorproject.org

Youth Law Center

The Youth Law Center employs staff attorneys that investigate reports of abuse of children in adult jails, juvenile detention facilities, state institutions, and child welfare systems, and uses training, technical assistance and negotiation to bring about needed change. If abusive conditions or practices continue, the Center uses litigation as a last resort to protect children and ensure humane treatment.
Web address: www.ylc.org

Organizations Focused on Special Education and School-Based MH

Centers for School Mental Health -- Technical Assistance Centers

In 1995, two national training and technical assistance centers focused on mental health in schools were established with partial support from the U.S. Department of Health and Human Services and the Center for Mental Health Services. One center is at UCLA and the other is at the University of Maryland at Baltimore. The web sites include information and resources on school-based mental health programs.
Web address: smhp.psych.ucla.edu (UCLA)
Web address: csmha.umaryland.edu (U of MD at Baltimore)

IDEA Partnership

The IDEA Partnership is dedicated to improving outcomes for students and youth with disabilities by joining state agencies and stakeholders through shared work and learning. The web site includes many helpful resources for schools, families and advocates.
Web address: www.ideapartnership.org

Intervention Central

This website offers free tools and resources to help school staff and parents to promote positive classroom behaviors and foster effective learning for all children and youth.
Web address: www.interventioncentral.org

National Information Center for Children and Youth with Disabilities (NICHCY)

NICHCY is an information and referral center that provides information on disabilities and disability-related issues (including mental illnesses) for families, educators, and other professionals, with a special focus on children and youth -- birth to age 22.
Web address: www.nichcy.org

National Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS)

The OSEP-funded National Technical Assistance Center on Positive Behavior and Intervention Supports was established to address the behavioral and discipline systems needed for successful learning and social development of students. The Center provides capacity-building information and technical support about behavioral systems to assist states and districts in the design of effective schools.
Web address: www.pbis.org

SchoolMentalHealth.org

This site offers school mental health resources not only for clinicians, but also for educators, administrators, parents/caregivers, families, and students. The resources included in the site emphasize practical information and skills based on current research, including prominent evidence-based practices, as well as lessons learned from local, state, and national initiatives.
Web address: *www.schoolmentalhealth.org*

School Psychiatry Program and the Mood & Anxiety Disorders Institute (MADI) Resource Center

The School Psychiatry Program and the Mood & Anxiety Disorders Institute (MADI) Resource Center, both part of the Department of Psychiatry at Massachusetts General Hospital (MGH), jointly created Schoolpsychiatry.org. This website is committed to enhancing the education and mental health of every student in every school. The website has resources for parents, educators and clinicians to ensure that each group is working together to support children and teens with mental health conditions.
Web address: www.schoolpsychiatry.org

Technical Assistance Alliance for Parent Centers

The Technical Assistance Alliance for Parent Centers is an innovative project that supports a unified technical assistance system for the purpose of developing, assisting and coordinating Parent Training and Information Projects and Community Parent Resource Centers under the Individuals with Disabilities Education Act (IDEA).
Web address: www.taalliance.org

Wrightslaw: Special Education Law

The Wrightslaw website is designed for families, advocates, educators, and attorneys looking for accurate, up-to-date information about special education law and advocacy for children with disabilities, including those with mental illnesses.
Web address: www.wrightslaw.com

Professional Organizations

American Academy of Child & Adolescent Psychiatry (AACAP)

Web address: www.aacap.org

American Academy of Pediatrics

Web address: www.aap.org

American Psychiatric Association (APA)

Web address: www.psych.org

American Psychological Association (APA)

Web address: www.apa.org

American School Counselors Association (ASCA)

Web address: www.schoolcounselor.org/index.cfm

American School Health Association (ASHA)

Web address: www.ashaweb.org

National Association of Social Workers

Web address: www.naswdc.org

National Association of State Mental Health Program Directors (NASMHPD)

Web address: www.nasmhpd.org

National Association of School Psychologists (NASP)

Web address: www.nasponline.org/index2.html

Academic Centers Focused on Children's Mental Health

Center for the Advancement of Children's Mental Health

Peter Jensen, M.D. directs this center dedicated to a variety of issues related to children and adolescents with mental illnesses. Dr. Jensen's center is located at Columbia University.
W*eb address: www.kidsmentalhealth.org*.

Center for the Promotion of Mental Health in Juvenile Justice

The Center for the Promotion of Mental Health in Juvenile Justice is dedicated to providing expert guidance to juvenile justice settings regarding best practices for mental health assessment and referral. This center is located at Columbia University.
Web address: www.promotementalhealth.org

Florida Mental Health Institute at the University of South Florida -- The Research and Training Center for Children's Mental Health (RTC)

The goal of the RTC is to improve services for children and adolescents with serious emotional disabilities (SED) and their families by strengthening the knowledge base for effective services and systems of care.
Web address: rtckids.fmhi.usf.edu

Georgetown University Child Development Center -- National Technical Assistance Center for Children's Mental Health

Since 1984, the technical assistance center has been dedicated to working in partnership with families and many other leaders across this country to reform services for children and adolescents with mental health treatment needs and their families.
Web address: www.georgetown.edu/research/gucdc/cassp.html

New York University Child Study Center

Web address: www.aboutourkids.org

Portland Research and Training Center, Portland State University

The Center promotes effective community-based, culturally competent, family-centered services for families and their children who are, or may be affected by mental, emotional or behavioral disorders.
Web address: www.rtc.pdx.edu

Yale Child Study Center

The mission of the Center is to understand child development, social, behavioral, and emotional adjustment, and psychiatric disorders and to help children and families in need of care.
Web address: info.med.yale.edu/chldstdy

Organizations Focused on Suicide Prevention

American Foundation for Suicide Prevention (AFSP)

Web address: www.afsp.org

Columbia University TeenScreen Program

Web address: www.teenscreen.org

JED Foundation

The work of the JED Foundation is focused on college students.
Web address: www.jedfoundation.org

National Strategy for Suicide Prevention

Web address: www.mentalhealth.org/suicideprevention

SOS – Signs of Suicide Program
Web address: www.mentalhealthscreening.org/highschool

Suicide Prevention Action Network (SPAN)
Web address: www.spanusa.org

Suicide Prevention Resource Center (SPRC)
Web address: www.sprc.org

Yellow Ribbon Suicide Prevention Program
Web address: www.yellowribbon.org

Youth Suicide Prevention School-Based Guide
Web address: theguide.fmhi.usf.edu

Websites for Children & Teens

KidsHealth
KidsHealth has separate areas for children, teens and parents. Each of these sections includes its own design, age-appropriate content, and tone. There are many in-depth features, articles, animations, games, and resources developed by experts in the health of children and teens. For information for teen mental health, click on "teens" and then click on "Your Mind" to access a broad array of resources for teens.
Web address: www.kidshealth.org

Mindzone – Cope. Care. Deal.
Mindzone is a mental health web site for teens that includes plenty of extremely helpful information. The funding for Mindzone comes from the Annenberg Foundation Trust at Sunnylands with support from the Annenberg Public Policy Center of the University of Pennsylvania.
Web address: www.copecaredeal.org

Reach Out!
This Australian-based website contains valuable information for any teenager to help improve their mental health and wellbeing during the transition-age years. The interactive site includes coping tips, forums, fact sheets, personal stories and resources regarding mental illness, school, employment and relationships.
Web address: www.reachout.com.au/home.asp

Step Out of the Silence
A virtual community where youth can share their experiences with mental illnesses through artwork, prose, poetry, photography, and graphic art. The website also offers information on how youth can participate in anti-stigma campaigns and advocacy efforts regarding mental health.
Web address: www.stepoutofthesilence.org

The Trevor Project
An organization dedicated to ending the disproportionately high rates of suicide among lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth.
Web address: www.thetrevorproject.org

Local Resource Guides/Directories & Assistance

Help – for Special Needs Metro-East Area Agencies, Services and programs. Contact - Southwestern Illinois College, Special Services Center. 618-235-2700 ext. 568

NAMI Southwestern Illinois, Contact 618-798-9788 or www.namiswi.org

St. Louis Times Resource Guide Regional Edition. Contact 636-225-2442 or www.stltimes.com

Connected. Get Answers United Way Illinois. Numbers to know for Clinton Monroe, Randolph, and Saint Clair County. Call 1-800-427-4626

Karla Smith Foundation - Resource Directory. Call 618624-5771 or www.KarlaSmithFoundation.org.

River Bend Head Start & Family Services. Call 618-463-5950 or www.riverbendfamilies.org

Madison County Mental Board, Community Services Guide. Call the Madison County 708 Board Office 618-692-6200 ext. 4357

St. Clair County Community Services Directory published by the St. Clair County Mental Health board (708). Call 618-277-6022 or visit their website www.stc708.org

United Way 2-1-1 2-1-1 is an easy to remember, non-emergency telephone number that connects people with essential community information and services. The 24-hour line makes it easy for the public to navigate the maze of human service providers and help lines. All calls are free, anonymous and confidential.
Callers can get live assistance with needs such as: * Food and shelter * Counseling and mental health services * Income and employments support * help for the elderly and people with disabilities * Resources for children and families.

Contact your County Health Board / Department.

ADDITIONAL RESOURCES

American Academy of Pediatrics.....(847) 981-7667
American Association of Suicidology.....(202) 237-2280
American Mental Health Counselors Association.....(800) 326-2642
American Psychiatric Association.....(202) 682-6220
American Social Health Association.....(919) 361-8400
American Trauma Society.....(800) 556-7890
Autism Society of America.....(800) 3-AUTISM
Brain Aneurysm Foundation.....(617) 723-3870
National Coalition Against Domestic Violence.....(303) 839-1852
National Committee to Prevent Child Abuse.....(312) 663-3520
National Council on Drug and Alcohol Dependence..... (212) 206-6770 EXT. 222
National Mental Health Association.....(800) 969-6642
REFUGE Mental Health Ministry Support Groups.....(618) 622-9812

Information on NAMI Education Courses:
Parents/Caregivers of Children & Adolescents with Brain Disorders

• NAMI BASIC

An educational evidenced based course from the National Alliance on Mental Illness. Basics is for parents/caregivers of children/adolescents who have either been diagnosed with an emotional disorder or show signs or symptoms of the disorder. Brains can get sick like any other part of the body. Evidence has shown that early intervention helps speed recovery. This course is taught by two trained family members with the "lived experience" who understand what you are experiencing.

NAMI Southwestern Illinois is offering this FREE course in both Madison and Saint Clair Counties. There is no charge for the classes as they are funded by the generous support of the Lutheran Foundation of St. Louis and both County Mental Health Boards of Madison and St. Clair counties. The class meets once a week for a total of 6weeks.

• NAMI Parents & Teachers as Allies

Empowering teachers and school personnel to make a lasting difference in the lives of their students, NAMI Parents & Teachers as Allies (PTA) opens the door for schools to make a difference. Our free, on-site presentation is led by a team from your community consisting of a young adult with a mental health condition, a parent and a teacher. Our 90-minute program will share how to: Understand the difference between "bad behavior" and symptoms of a mental health condition. Recognize early warning signs. Communicate and partner with families effectively. Link to community services quickly. Create a supportive learning environment for all students.

• NAMI Ending the Silence

A free 50 minute mental health awareness presentation to junior and high school students typically presented in health, psychology, and science classes. The presentation contains videos, slides, and handouts. The presentation consists of a young adult, parent, and teacher.

To schedule a presentation contact NAMI Southwestern Illinois at (618) 798-9788 or you can email info@namiswi.org. Also, for additional on class information check out our website: www.namiswi.org.

Children's Mental Health Conference

• Piecing It All Together: How Children's Mental Health & Mental Illness Affect Family, School, and Community

Annual Conference held usually the 4th Friday and Saturday of October in Fairview Heights. Parents, Foster Parents, School Professionals and Mental Health Professionals come together to get the latest research, treatment, and information on Children's Mental Health & Mental Illness. NAMI Southwestern IL co-sponsors this 2 day conference with several other agencies that care about kids. Call the NAMI Southwestern IL office for more information or to get a flyer. (618) 798-9788

Federal/National Resources:

Does your child qualify for Social Security and Medicaid?

• Many families do not realize that mental illness qualifies as a disability and that their child may be eligible for income assistance and health care.
There are two federal disability programs; SSI (Supplemental Security Income) and SSDI (Social Security Disability Income). Apply at the local Social Security office. Bring along your child's Social Security number; birth certificate or other proof of age and citizenship; information about the home where he/she lives; possible work history; any sources of financial support; child's Individualized Education Plan and names, addresses and phone numbers of doctors, hospitals, clinics, and institutions where treatment has been received with dates of treatment. If you do not have all of the things listed, apply anyway. For more information or to find the number of your local Social Security office, call 1-800-772-1213. Have the Social Security number with you when you call.

To be eligible for SSI based on disability, the person must:

■Have a physical or mental impairment which prevents the child from performing normal activities of daily living, or which prevents an adult from doing any substantial gainful work, and has lasted or is expected to last at least a year or to result in death.
■Have little or no income or resources, or in the case of a child under 18 living with his family, his or her family has little or no income or resources.

To be eligible for Social Security Disability Income (SSDI), a person must:

■Have worked and paid Social Security taxes (RCA) long enough to be covered under Social Security, or be an unmarried son or daughter (with rare exceptions) who became disabled before age 22, who has a parent Eligible for retirement/disability/death benefits. The disabled child does not have to be dependent or be financially supported by the parent.
■Have a physical or mental impairment that prevents the person from doing any substantial gainful work and has lasted or is expected to last for at least one year.

Since benefits are retroactive only to the day of application, apply as early as possible and follow up persistently. If benefits are denied, the ruling may be appealed by requesting: 1) reconsideration, (2) a hearing before an administrative law judge, (3) a review of the decision by the Appeals Council, or (4) civil action in federal district court. You have 60 days to appeal between each of these steps.
While waiting for a decision on eligibility for SSI or SSDI, a disabled person living in Madison County may qualify for: Township Assistance (contact local township supervisor), food stamps, or assistance with emergency food and shelter through the Crisis Food Center (618-462-820 I), Catholic Charities (618-877-1184 / 618-462-0634) Community Care Center of Protestant Welfare (618-876-8770), or the Salvation Army (618-451-7957 or 618-465-7764).

Medicaid is available for those who qualify for SSI.

Illinois Resources:

NAMI Illinois
217 West Lawrence
Springfield, IL 62704
(217) 533-2403 or (800) 346-4572

http://illinois.nami.org

Encompasses 35 affiliate groups:

Northern Illinois Affiliates:

NAMI Cook County North Suburban 847-683-2371
NAMI DeKalb, Kane South and Kendall Counties 630-896-6264
NAMI DuPage County 630-752-0066
NAMI Elk Grove/Schaumburg 630-529-3037
NAMI Greater Chicago 312-563-0445
NAMI Grundy County 815-942-6323
NAMI Hanover Township 630-736-2823
NAMI Kane County 847-683-2371
NAMI Kankakee 815-933-6871
NAMI Lake County 847-249-1515
NAMI McHenry County 815-444-9991
NAMI Metro Suburban 708-524-2582
NAMI North Central Illinois 815-663-3971
NAMI Northwestern Memorial 773-761-4664
NAMI Northwest Suburban 847-945-8873
NAMI Northern Illinois 815-332-4744
NAMI Rock Island/Mercer Counties 309-793-4993
NAMI Sauk Valley 815-562-7269
NAMI South Suburbs of Chicago 708-798-3862
NAMI Southwest Suburban 708-598-0770

Central Illinois Affiliates:

NAMI Champaign 217-344-4909
NAMI University of Illinois Campus Champaign 630-768-0983
NAMI Decatur 217-420-9338
NAMI Livingston/McLean Counties 309-828-0530
NAMI Quincy 217-222-1124
NAMI Springfield 217-522-0048
NAMI Tri-County (Peoria area) 309-274-2481
NAMI Vermilion County 217-662-2865

Southern Illinois Affiliates:

NAMI Jackson County 800-346-4572
NAMI Southwestern Illinois 618-798-9788
NAMI Mt. Vernon 618-266-7823
NAMI Southeastern Illinois (Harrisburg) 618-252-5400x2370
NAMI Metropolis-Southern Most Illinois 618-638-3080

Health Insurance: All kids Program

All Kids Hotline 1-866-255-5437

All Kids Program is a complete healthcare program for every child in Illinois.

Illinois is the first state in the nation to ensure that every child, regardless of medical conditions or income, has access to healthcare.

What Does All Kids Cover?
All Kids covers all the healthcare a child may need. All Kids pays for doctor visits, hospital visits, dental care, vision care, prescription drugs, medical equipment, mental health services and much more.

How does it Work?
All Kids will cost most families a lot less than private insurance. For instance, a family of four that earns $50,000 a year will pay $40 a month for each child plus a $10 co-pay for each doctor visit. A family of four that earns $29,000 a year has no monthly payment and pays a $2 co-pay for each doctor visit. All Kids has an annual limit on the total co-pays most families have to pay for their children's healthcare. Total costs for each family vary by income.

Who is Eligible?
Children age 18 or younger who live with their families in Illinois and who need health insurance can get All Kids. What if my children have health insurance? If your family has health insurance and your monthly income qualifies for FamilyCare/All Kids Share, Premium Level 1 or Rebate, you can choose the plan that is best for your family. FamilyCare/All Kids Share and All Kids Premium provide a medical card to help cover services for your children that your plan does not cover. FamilyCare/All Kids Rebate reimburses the policyholder for a portion of the premium they pay for health insurance. If you want to apply for the FamilyCare/All Kids Rebate plan, have your employer or insurance agent complete Part B of the Rebate Form.

What about KidCare?
Illinois' KidCare program is now part of All Kids! If you have KidCare, your children will get All Kids automatically. You do not have to reapply.

Can my child get Temporary All Kids Medical Benefits while you review my application?
Your child may get Temporary All Kids Medical Benefits while we review your application. If your child qualifies, you will get a Notice of Temporary All Kids Medical Benefits in the mail.

How do I enroll my Child?

1. You can apply online or download an application.
2. For more information call toll-free 1-866-ALL-KIDS (1-866-255-5437). Persons who use a TTY can call m1-877-204-1012.

The program officially begins on July 1, 2006. This is information is from the State of Illinois website: www.allkidscovered.com/

Local numbers to get information regarding health insurance:

Dept of Human Services; In Madison County, call (618) 258-1660

Need help with prescription drug coverage?

Call the above number for the Dept. of Human Services. You can also check with your local community mental health center. IMPACT in Alton at (618) 462-1411 can also direct you to resources.

Illinois Regional Offices of Education

Illinois State Board of Education
100 North First Street
Springfield, Illinois 62777
1-866-262-6663 Website: www.isbe.state.il.us (see links for your regional office information)
February 2016

Illinois STARNET Regions

Website: www.starnet.org (see links for your regional office information)

Families and communities in Illinois working to develop more effective partnerships and linkages among families, professionals and systems. STARNET provides training and technical assistance to early childhood special education preschool staff and families of young children.

Family Matters Parent Training and Information Center (866) 436-7842 www.fmptic.org

Family Matters offers support, advocacy, information and education to parents to a 26 county region of South Central Illinois. In 2002, they received a grant from the U.S. Department of Education to offer Parent Training and Information which included providing information, referrals, linkages, and training to parents, students with disabilities and special education professionals. This serves the entire state of Illinois outside of the Chicago area.

Family Matters staff and Regional Coordinators provide training for parents and professionals on topics such as: Understanding the Individuals with Disabilities Education Act (IDEA), Individualized Education Program (IEP): Planning and Participation Collaboration: Schools and Families Working Together, Behavior and Discipline for Students Receiving Special Education Services, Understanding IEP Goals, Accommodations & Modifications, Plan, Plan, Plan: Preparing a Working Agenda for Your Child's Next IEP Meeting, Supports at School for Students with ADHD, Educational Services for Students with Emotional or Mental Health Needs, Understanding LRE: Least Restrictive Environment.

IMPACT CIL (Peer Support and Disability Rights)
2735 E. Broadway
Alton, IL 62002
(618) 462-1411
Website: www.impactcil.org

IL Department Of Human Services Mental Health Network Agency List

Helpline 1-800-843-6154
Website: www.dhs.state.il.us (see links for local mental health partners/providers)

Local Resources / Crisis Intervention:

SEEKING TREATMENT

When the need for treatment is evident, family members may be at a loss as to what to say or do in order to succeed in getting the help that is needed. Here are some suggestions:
▪ Understand it is neither your fault nor the fault of the person who is in crisis.
▪ be informed as to what resources are available.
▪ Evaluate the situation, have the person's written medical and behavior information available.

IL WARM LINE (866) 359-7953, from the main menu, select option #2, then #5. Monday through Friday, 8am-5pm. PHONE SUPPORT for persons coping with mental health and/or substance use challenges, their families, Friends, and community members.
Illinois Mental Health Collaborative for access and choice, website: www.illinoismentalcollaborative.com

Contact the nearest NAMI affiliate in your area for additional resources or questions. If a NAMI affiliate is not in your area, please contact the NAMI Illinois state office at (217) 522-1403 or (800) 346-4572

CRISIS INTERVENTION

*** In the Event of a Mental Health Emergency, contact:** In Madison and St. Clair Counties when you dial 911, ask for a CIT (Crisis Intervention Team) officer who is specifically trained to help deal with a mental health emergency.

**Consult ahead of time with the social worker, psychiatrist, and/or your local mental health center or CIT officer so you will know how to obtain services when you need them. You may also call NAMI Southwestern Illinois at 618-798-9788 for assistance with taking these steps.
If you need to call for help in a crisis, have with you written information about the family member's diagnosis, medications and a description of the specific behavior that precipitated the crisis. It may be useful to have several copies to give to the police and to the mental health professionals.

HOTLINE PHONE NUMBERS FOR THE TWELVE COUNTIES WITHIN THE NAMI SOUTHWESTERN ILLINOIS SERVICE AREA

- **BOND COUNTY** – *Prairie Counseling Center* (618)664-1455 8:00a.m.-4:00p.m. After Hours, Call Greenville Hospital (618)664-1234

- **CALHOUN / JERSEY COUNTY** – *Centerstone* (618)639-2016 (Call 24/7)

- **RANDOLPH / WASHINGTON COUNTY** –*Human Services Center* 618-282-6233(8:00a.m.-4:30p.m.)After Hours, Dial 911; police will contact crisis worker
- **CLINTON COUNTY -** *Community Resource Center (618)533-1391 (Call 24/7)*

- **MONROE COUNTY -** *Human Support Services (618)939-4444 (8:00AM -4:30PM) After hours, dial 911; Police will contact crisis worker*

- **GREENE / MACOUPIN COUNTY** – Locust Street Resource Center *Weekdays only - (217)854*-3166 After hours/weekend - (217)854-3135 calls go to Police who will notify a crisis worker

- **WESTERN SAINT CLAIR COUNTY** - Comprehensive *Behavioral Health* (618)482-7330 (Call 24/7)
- **EASTERN SAINT CLAIR COUNTY** – *Chestnut Health Systems* (618)877-0316 (Call 24/7)

- **NORTHERN MADISON COUNTY –** *Centerstone* (618)465-4388 (Call 24/7)

- **SOUTHERN MADISON COUNTY –** *Chestnut Health Systems* (618)877-0316 (Call 24/7)

Local Psychiatric Hospital

▪ Gateway Regional Medical Center, Behavioral Health Services 618-798-3888 Intake Specialist
2100 Madison Ave., Granite City, IL 62040 618-798-3000 http://gatewayregional.net
▪ Touchette Regional Hospital, Inpatient services 618-332-5265 Outpatient services 618-332-5374
5900 Bond Ave., Centreville, IL 62207 618-332-3060

For Children & Adolescents offers:

►Traditional Outpatient Therapy for all ages.
►Partial Hospitalization Program – ages 3 to 17. Offered Monday through Friday
►Inpatient Hospitalization. Have an Adolescent Unit and a Children's Unit

If you need help for your child, contact: The Resource Center (618) 798-3888, Have the following information available: ►Patient Name ►Parent/Legal Guardian's Name ►Patient Address & Phone Number ►Reason for referral ►Medical Insurance

Resource Center will schedule an appointment for an assessment.

School Advocates:

• **CRSA**, Community and Residential Services Authority (877) 541-2712 Call this number to find the representative for your area (statewide). Need to do an intake but service is free. Also, for answers on residential placement.

• **IMPACT, INC.** 2735 East Broadway, Alton, IL (618) 462-1411. Covers several counties.

• **LINC, INC**. #15 Emerald Terrace, Swansea, IL 62220 (618) 235-9988. Covers several counties.

Parent Resources

• **PTIC,** Parent Training and Information Center, (866) 436-7842

• **SASS** (Screening and Assessment Support Services) Call your local community mental health provider and ask for the nearest SASS program.
For Madison County, Centerstone in Alton, Illinois (618) 462-2331.
Parent Resource individual available. Will also help with ICG Grants.

• **STARNET,** (618) 397-8930, Birth to 8 years old. Early Intervention resources

• **Illinois Family Partnership Network** Covers the whole state. Call main number and get local representatives. (312) 516-5559

MADISON COUNTY AND ST. CLAIR COUNTY RESOURCES

ABUSE and NEGLECT:

Child Abuse and Neglect Hotline.....800.252.2873
Court Appointed Special Advocates (CASA).....618.234.4278
IL Dept. of Children and Family Services (Belleville).....618.394.2150

CHILDREN and YOUTH:

Alternatives for AT-Risk Students.....618.398.5280
Belleville Area Special Services Cooperative (BASSC).....618.355.4700
Big Brothers/Big Sisters of St. Clair County.....618.398.3162
Call For Help, Inc (Information and Referrals).....618.397.0963
Children's Center for Behavioral Development.....618.398.1152
Children's Home and Aid Society (C.H.A.S.I.) of Belleville.....618.398.6700
CHASI Child Care Resource & Referral.....800.467.9200
Cahokia Area Joint Agreement for Special Education.....618.332.3700
ESL Area Joint Agreement for Special Education.....618.583.8200
Hoyleton Youth and Family Services (for teen mothers).....618.398.0900
Illinois Center for Autism.....618.398.7500
IL Department of Children and Family Services (East Alton).....618.258.1660
IL Department of Children and Family Services (Belleville).....618.394.2150
IL Department of Human Services (St. Clair County).....618.257.7400
Judevine Center for Autism (St. Louis, MO).....314.849.4440
Lincoln's Challenge (for high school drop-outs).....800.851.2166
Madison Co. Regional Office of Education.....618.692-6200 x 4530
Mamie O. Stookey School 618.234.6876
Promise Center for the Developmentally Disabled.....618.274.3500
Riverbend Head Start.....618.463-5950
School Violence Prevention Hotline (St. Clair County).....877.724.5847
St. Clair County Even Start Program.....618.397.8930 x 179
St. Clair County Regional Office of Education.....618.397.8930
STARNET Region IV Belleville).....618.397.7827
Southwestern Illinois Special Services Cooperative.....618.355.4700
SIUE Head Start Programs.....618.482.6955
Success by 6 Parent Helpline (MO).....314.539.4064
Volunteers of America (foster care/counseling).....618.271.9833
Southern Illinois Healthcare Foundation.....618.236.5800
Youth Crisis Hotline.....800.448.4663

COUNSELING and MEDICAL CARE:

Barnes-Jewish Health Systems (St. Louis, MO).....314.747.3000
BJC Children's Hospital (St. Louis, MO).....314.454.6000

Behavioral Health Alternatives.....618.251.4073
Call For Help, Inc.....618.397.0996
Cardinal Glennon Children's Hospital (St. Louis, MO).....314.577.5600
Catholic Social Services Diocese of Belleville.....618.277.9200
Chestnut Health System (Granite City).....618.877.4420
Chestnut Health System (Belleville).....618.233.0330
C.H.A.S.I.....618.465.4388
Comprehensive Mental Health Center of St. Clair County, Inc.....618.482.7330
Cornell Interventions.....618.271.4542
Depressive-Bipolar Support Alliance.....618.234.0156
East Side Health District (ESL area).....618.271.8722
Family to Family (NAMI).....618.798.3000
GROW in Illinois (support group).....618.332.3664
Hoyleton Youth and Family Services.....618.398.0900
Human Service Center (Red Bud).....618.282.6233
IL Department of Children & Family Services (Belleville).....618.394.2150
IL Department of Public Health – Region IV (Glen Carbon).....618.656.6680
IL Office of Mental Health Help Line.....800.843.6154
IL Office of Rehabilitation Services.....618.466.8409
Lutheran Child & Family Services.....618.234.8904 x21
Memorial Hospital (Belleville).....618.257.5805
Mental Health Center of St. Clair County.....618.274.7154

NAMI SOUTHWESTERN ILLINOIS.....618.798.9788
Obsessive Compulsive Disorders.....800.397.0900
Provident, Inc.....800.782.1008
RAVEN (Rape and Violence End Now).....314.725.6137
Recovery, Inc.....618.632.2601
Scott AFB Medical Center (Family Practice).....618.256.7363
Scott AFB Life Skills Support Center.....618.256.7386
SIUE Community Nursing Services.....618.482.6959
Southwestern Illinois Visiting Nurse Association.....618.236.5800
St. Clair County Health Department.....618.233.7703
St. Elizabeth's Hospital.....618.234.2120
Shiners Hospital for Children (St. Louis, MO).....314.432.3600
Touchette Regional Hospital.....618.332.3060
Violence Prevention Center of Southwestern Illinois.....618.236.2531
Southern Illinois Healthcare Foundation.....618.236.5800

DISABILITY SERVICES and ADAPTATIONS:

Alternative Transportation System (Belleville only).....618.239.0749
Developmental Disability Services of the Metro East.....618.236.7957
Equip for Equality.....800.758.0464
IMPACT (Alton).....618.462.1411
LINC, INC. (Living Independently Now Center) 618.235.9988
Madison County Mental Health Board 708 .....618.692.6200 x 4359
St. Clair Associated Vocational Enterprises, Inc. (SAVE).....618.234.1992
St. Clair County Mental Health Board (708).....618.277.6022
Specialized Living Centers (Swansea).....618.233.6161

SUBSTANCE ABUSE and PREVENTION:

Al-Anon.....618.398-9470
Alcoholics Anonymous.....618.398-9544
ARTS.....618.482-7385
Chestnut Health System (Granite City).....618.877.4420
Emotions Anonymous.....618.345.2167
Gateway East Health Services, Inc.....618.874.0095
Obsessive Compulsive Anonymous.....618.233.0330
Peter's Place (ministry for young men with dual diagnosis)….....618.624.7345
Provident, Inc.....618.235.5656
Recovery, Inc.....618.632.2601
SMARTS (residential services).....618.482.7154
St. Elizabeth's Hospital Chemical Dependence Program.....618.234.2120 x 1555
St. Elizabeth's Hospital Chemical Dependence Hotline.....800.800.9011
T.A.S.C., INC. (Treatment Alternatives to Street Crimes).....800.582.9458
Youth DUI Prevention.....618.397.8930
Southern Illinois Healthcare Foundation.....618.236.5800

Support and Advocacy Groups

for caregivers and individuals living with an mental illness

NAMI Southwestern Illinois, 2100 Madison Avenue, 4th Floor, Granite City, Illinois 62040 (618-798-9788) http://namiswi.org provides support groups for families and friends of persons with mental illness. It is important to share information about mental illness and to understand that serious, long-term mental illness is not caused by the family. Many doctors do not explain the characteristics of the various mental illnesses and the family is left to do its own research. A doctor may carefully explain a blockage in an artery but may not explain biochemical malfunctions of the brain. "We thought it was our fault" is said too many times. Already traumatized families become further traumatized.

Unless they have lived with a family member who has a mental illness, it is difficult for most people to understand the everyday trials and concerns of the rest of the family. It is comforting to know that other people deal with almost exactly the same issues and understand. Sometimes they have suggestions and answers; at other times they can only say, "Yes, I know." And they do. In the support group, information is shared about and loneliness, your own grief and loss, and fear of taking vacations.

Many people drop in at support group meetings for a few months, get some answers and support for the hard times, and then move on. Other people may move from support groups into committee work. Often people make lifelong friends. Many people say "I want to help. I don't want other people to go through what I went through." Some work at making real changes by becoming advocates for better services and care.

The following *support groups* for either family/caregiver members and/or consumers are presently taking place, please contact NAMISWI office to confirm location & timeframe of all meetings (618-798-9788) or contact individual support group leader.

NAMI SWI CONNECTION RECOVERY SUPPORT GROUP

• (GRANITE CITY) First Tuesday of each month, Individuals Living with Mental Illness. Pascal Hall Meeting Room (use ground floor entrance across from Doctor's building parking lot and to right of Emergency Room entrance) at Gateway Regional Medical Center, Granite City, IL 62040, 6:30 - 8:00 PM. Contact Matt G. at magauen@gmail.com

• (WATERLOO) Third Wednesday of each month, Individuals Living with Mental Illness, 7:00pm-8:30pm, at the Human Support Services, 988 IL Route 3, Waterloo, IL 62298. For more information Contact Matt G. at magauen@gmail.com or call NAMIOSWI office 618-77987-9788.

• (BELLEVILLE) Second Friday of each month, Individuals Living with Mental Illness, 3:30-5:00pm, at Chestnut Heath Systems 12 N. 64th Street, Belleville, IL 62223; For more information, contact Matt G. at magauen@gmail.com

NAMI SWI SUPPORT GROUPS

• (BELLEVILLE) Third Tuesday of each month, a support group for family members and Individuals living with a mental illness, St. Matthew's Methodist Church at 7:00PM-8:30PM in the library at 1200 Moreland Drive, Belleville, IL 62220, (Use the Fellowship Hall entrance from the parking lot). Contact Mick or Kathy Janik 618-277-5459

• (EDWARDSVILLE) Fourth Tuesday of each month, a support meeting for Family Members at First Baptist Church, 534 St. Louis St., Edwardsville, IL 62025; use church parking lot entrance, 7:00 - 8:30PM. Contact Pat Rudloff at 618-656-6781

• (GREENVILLE) Third Tuesday of each month, a support meeting for Family Members and caregivers, 7:00 – 8:30PM, St. Lawrence Catholic Church. 512 S. Prairie Street, Greenville, IL 62246. Contact Linda Methvin at (618) 541-2407

• (WATERLOO) Second Monday of each month, a support meeting for Family Members and caregivers, 7:00 – 8:30PM, Immanuel Lutheran Church, 522 S. Church Street, Waterloo, IL 62298. For more information contact Royal Beoder at (618) 340-8825

NAMI SWI CAREGIVERS OF CHILDREN / ADOLESCENTS SUPPORT GROUP

• (EAST ST. LOUIS) Third Monday of each month, a support group meeting for parents/caregivers of children & Adolescents with brain disorders, 6:00-8:00PM at 908 N. 11th St., Emerson Park Metro Statiopn, East St. Louis, IL : For more information contact Kim McCellan at Kimberlyjmcclellan@yahoo.com or phone (618) 407-9081 or log onto namiswi.org .

NAMI SWI MILITARY FAMILIES SUPPORT GROUP

• NAMI Military and veteran family support group, Contact Peter Dodge, JD at (734) 330-6776 or e-mail at vetsupport@namiswi.org for more information.

PLEASE NOTE: NAMI SWI meetings and inclement weather policies are when Southwestern Illinois College classes are canceled, all NAMI SWI support meetings are also cancelled. SWIC cancellation notices will be broadcast on all major TV and radio stations in the St. Louis area. If there is a tornado watch or warning for the area where a support group is to be held during the time frame 6-9PM, that support meeting will be canceled.

OTHER LOCAL SUPPORT MEETINGS

(The support group meetings listed below are not affiliated with NAMISWI. Also, call the support group to verify up to date meeting information.

♦ **St. Louis Obsessive Compulsive Disorder (OCD) Support Group:** 3rd Saturday of each month, 10:00AM to Noon at Missouri Baptist Hospital Auditorium #1, 3015 N. New Ballas Road, Creve Coeur, MO 63141. Contact: Jan at (314) 291-7556.

♦ **DBSA (Depression and Bipolar Support Alliance) of Madison County Meeting**: Every Monday 7:30PM-9:00PM, Anderson Hospital, Maryville, IL, behind the vending area across from the cafeteria on Lower Level B (Basement). Contact**:** Nicole Meyers at (618) 225-7709 or by email at **dbsamcm@yahoo.com** for more information.

♦ **DBSA of Hope - Belleville:** Every Tuesday, 7:00PM and every Saturday at Noon, St. Elizabeth Hospital, 211 S. 3rd St., Belleville, IL, 7th Floor, Room 722. For more information contact: **Lisa Wojick at 618-581-4176 and/or Roger Wegener at 618-444-6927**

♦ **DBSA of Hope - Belleville:** Every Thursday, 6:00PM, at Call For Help-Recovery Support Center, 9400 Lebanon Road , Edgemont, IL, 1st building, use side entrance. For more information contact: John Wuest 618-397-0968 ext. 109.

♦ **Karla Smith Foundation (Dial-In Mental Illness Family Support Group):** 2nd & 4th Month each month @ 7-8pm. Contact Rob Mueller Rob.Mueller@karlsmithfoundation.org or (618) 624-5771. For more information call Tom or Fran Smith at (618) 624-5771 or send email to **ksf@karlasmithfoundation.org.**

♦ **Karla Smith Foundation Suicide Survivor Support Group (Belleville Location)** : 2nd & 4th Thurs-day of each month, 7:00 – 8:30PM, Peace Chapel, 10101 W. Main St., Belleville. For more information call Tom or Fran Smith at (618) 624-5771 or send email to **ksf@karlasmithfoundation.org.**

♦ **Karla Smith Foundation Support Group** for family and friends of anyone with mental illness: 1st & 3rd Thursday of each month, 7:00–8:30PM, Peace Chapel, 10101 W. Main St., Belleville. For more information call Tom or Fran Smith at (618) 624-5771 or send email to **ksf@karlasmithfoundation.org.**

♦ **GROW** meeting for individuals living with mental illness, every Thursday, 7:00PM at St. Elizabeth's Hospital, 211 S. Third St., Room 729, Belleville, IL 62221. Contact Sharon at (**618) 977-1133**.

♦ **GROW** meeting for individuals living with mental illness, every Wednesday, 7:00PM at St. Bartholo-mew's Episcopal Church, 2167 Grand Ave, Granite City, IL 62040. Contact Sharon at **(618) 977-1133**.

♦ **DBSA of Hope - Belleville:** Every Saturday, 12:00PM and every Tuesday at 7:00PM, St. Elizabeth Hospital, 211 S. 3rd St., Belleville, IL, 7th Floor, Room 722. For more information contact: Tod Jurke at (618) 567-0986 or by email at **boeingme@yahoo.com** or Lisa Wojick at **(618) 409-7895.**

♦ **"With Hope in Mind" Support Group**: for family members or caregivers; meets the 4th Tuesday of each month from 7:00-8:30PM at Christian Hospital Northeast (CNE), 11133 Dunn Road, St. Louis, MO, Room 2100. For more information contact Linda Hossin at **(314) 302-2740** or by email at **lhossin57@aol.com.**

♦ **DRA (Dual Recovery Anonymous)** meeting every Wednesday from 1:00 - 2:30PM, at 1218 19th St., Granite City, IL 62040. Contact: John M. at **(618)520-4637**.

♦ ADHD Support **Group:** meets on the 1st Thursday of each month at 5:00PM, at O'Fallon Public Library, 120 Civic Plaza, O'Fallon, IL 62269. For more information contact support group coordinator Kristen Weber at (618)406-0842 or by email at **kristinweberadhdcoach@gmail.com.**

Friday Night Social: for persons living with mental health conditions on the first Friday of each month from 7:00 - 8:30PM, 607 Vandalia, Suite 500, Collinsville, IL . **Contact Jen Gerlach by phone 636-358-1800 or send an email to jgerlac@siue.edu.**

♦ **Family Voices Parent & Caregiver Group:** meets the first Tuesday of each month, 6:00 – 8:00 p.m. at First Baptist Church, 10401 Lincoln Highway, Route 50, Fairview Heights, IL 62208 . Contact Kim Mclellan by email send to **kimberlyjmcclellan@yahoo.com or call her at 618-407-9081**

♦ **Youth M.O.V.E.** meets concurrently with Family Voices Parent & Caregiver Group above, Same time, same location, but separate room, Contacts are Jennifer Johnson at jjohnston@childrenhomeandaid.org and Beverly Watkins at bbwatkins@fanad.net.

♦ **Mental Health Support Group:** a support meeting for Family Members and Individuals Living with Mental Illness, meets the third Tuesday of each month, The Christian Church of Litchfield, 131 Yaeger Lake Trail, Litchfield, IL 62056, 7:00 - 8:30PM. Contact Shirley Ragland at **(217) 313-0165.**

NOTE: These support group meetings are not affiliated with NAMISWI. For questions please call or email the contact person for that particular meeting.

All support group meeting are subject to change. So, always contact the meeting coordinators to verify.