The Essential Guide

in case your child ever

To Obtaining

experiences emotional,

Counseling Services

behavioral or substance

For Your Child

abuse difficulties

[A Parent's Handbook]

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To all of the parents who have entrusted me in serving as a coach or therapist to their child. Thank you for allowing me into your family and sharing with me both your triumphs and pain. You have been my greatest teachers in understanding and working with children.

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THE BEST STRATEGY FOR UTILIZING THIS HANDBOOK

This handbook is not intended to be read from cover to cover (although you are welcomed to do so), but rather to be used by parents as a resource at the time of information gathering and decision-making regarding counseling services for their child.

If a school counselor, therapist, family member or friend gives you this handbook at a time when you have no immediate need for it, store it in an easy-to-find location. When you are ready to take action in response to your child's life difficulties, turn to the table of contents and find the section that best matches your situation and area of inquiry. When you have read the selected section, return this handbook back to its easy-to-find location. With emotional, behavioral and/or substance abuse difficulties the road to recovery can be a difficult one. You may need to access this resource again if your child's situation gets worse and additional intervention and treatment strategies need to be considered.

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INTRODUCTION

Most people would agree that parenting is a difficult job under typical parenting conditions (tending to your child's needs, the stress of long hours at work, taking care of your home, getting along with your spouse/partner, etc.). When you have a child who is experiencing emotional, behavioral and/or substance abuse difficulties, it can be overwhelming.

The purpose of this handbook is to provide parents with a general overview of information and strategies that can be helpful in obtaining counseling services. The premise is, by becoming educated consumers, parents give themselves the best chance of finding their child the most effective treatment available. The information and strategies presented are based on my experiences working with parents as a Student Assistant Coordinator in a public school setting and as a clinician in private practice.

This handbook is not in any way intended to be used in the intervention, diagnosis or treatment planning of any individual or as a substitute for a mental health consultation with a qualified professional. If you are a parent of a child experiencing life difficulties, it is crucial that before you act on the information or strategies in this handbook you consult with a mental health professional who can advise you on how to handle your specific situation.

If you find yourself in crisis with your child, I encourage you to take a deep breath, slow down, educate yourself, examine all of your options and prepare for all possible worst-case scenarios. Keep in mind that your child's difficulties probably did not develop overnight, and most certainly will not be resolved overnight. There are absolutely no quick fixes. If you are considering counseling services for your child, I hope that you find this handbook a worthwhile resource.

SECTION 1 - DETERMINING IF YOUR CHILD NEEDS COUNSELING SERVICES

Your child may be in need of counseling services if you or anyone in your child's life (teachers, friends and/or family members) are concerned about ANY of the following symptoms:

- Difficulty concentrating
- Low energy - fatigue
- Sudden change in behavior, mood and/or attitude
- Unusual behavior
- Evidence of alcohol and/or drug involvement
- Academic, behavioral or social difficulties
- Failure to meet school, work and/or family responsibilities
- Extremes in emotion – anger, happiness, sadness, anxiety
- Police involvement
- Change in friends; isolation or withdrawal from friends
- Change in hygiene – poor hygiene
- Change in sleep habits
- Change in eating habits
- Evidence of an eating disorder – preoccupation with body image, binge eating, excessive exercise
- Oppositional behavior toward authority
- Expression of hopeless or suicidal/homicidal thoughts

It is very difficult for parents to be objective about their own children. Many times they see their children through the eyes of unconditional love. If anyone in your child's life ever approaches you to express

concern about your child, it is important that you give him/her serious consideration. You can assume (once your defensiveness passes) that most people would feel anxious about telling a parent something negative about his/her child. If they do so, their concern for the child's well-being is serious enough to override their apprehension about telling the parent. If you are ever approached by such a person, consider that individual an objective set of eyes that may very well be aware of something you are not yet able to recognize.

SECTION 2 - UNDERSTANDING THE DIFFERENT LEVELS OF MENTAL HEALTH SERVICES

In seeking mental health services for your child, you have several options available regarding the philosophy, frequency, intensity and duration of the treatment you choose. Listed in this section are the different levels of treatment in order of intensity (lowest to highest) and typical progression of care. If your child is not a danger to himself or others, I recommend individual outpatient therapy as your starting point. Individual outpatient therapy is the easiest treatment to access and it provides the most personalized care and least restrictive environment. It is important to note that if your child starts with individual outpatient therapy, the treatment provider, upon completing an assessment of your child's difficulties, may refer you to a more intensive level of care if deemed necessary.

Mental health services can be provided by a variety of different professionals including psychiatrists (Medical Doctor, MD), nurse practitioners, psychologists, social workers, family therapists, alcohol and substance abuse counselors and/or a combination of all of the above. Psychiatrists are the only mental health professionals who can prescribe medication. Throughout the remainder of this handbook, the professionals mentioned above will be referred to as "treatment providers".

Outpatient Treatment: Your child attends the treatment session and then returns home.

Individual Outpatient Therapy: Provided by a licensed treatment provider (psychologist, social worker or professional counselor). Approximate duration of treatment varies according to patient's diagnosis and treatment needs. Typical treatment structure is one-on-one counseling, one session per week, one hour per session. I categorize individual outpatient therapy into two subtypes: Individual Talk Therapy – primary focus is the patient, primary treatment strategy is to have the patient talk out his/her problems and emotions, gain insight, problem solve and implement identified solutions. Multi-Strategy Therapy – focus of therapy includes the patient and his/her family members, treatment strategies may include individual talk therapy, group therapy, patient/family education, parent training, behavior modification, and skills training. Session structure often varies with regard to number of sessions per week, length of sessions, strategies for change and who is involved in the treatment along with the patient.

Intensive Outpatient Therapy: Provided by a community or privately operated mental health/substance abuse agency or hospital. Approximate duration and structure of treatment is 2-4 months, 4 days per week, 3-4 hours per day (after-school hours, 4-9 PM). Treatment typically includes a combination of individual, group and family counseling.

Partial Hospitalization: Provided by a community or privately operated mental health/substance abuse agency or hospital. Approximate duration and structure of treatment is 2-4 weeks, 4-5 days per week, 5-8 hours per day (8 AM - 4 PM). Treatment typically includes a combination of medical/psychiatric evaluations and monitoring, individual, group and family counseling and approximately 2-3 hours of academic education (coordinated with the patient's school district).

Inpatient Treatment: Your child stays overnight in the hospital or treatment facility.

Emergency Hospitalization: Provided by a public or private hospital. Length of stay may vary from 2-10 days. Usually occurs following a psychiatric or substance abuse emergency during which an individual is at risk for harming himself/herself or others. The primary goal of hospitalization is to ensure the individual's

safety, stabilize acute physical and/or psychiatric symptoms and educate the patient and his/her family about the nature of the diagnosed condition. Treatment primarily includes medication, medical evaluations/monitoring, psychiatric evaluations/monitoring and patient and family education.

Intensive Inpatient Treatment: Provided by a publicly funded or privately operated inpatient treatment program. Approximate length of stay may be from 5-28 days depending on the treatment program. Usually occurs as a result of failed attempts at less intensive treatments (individual outpatient, intensive outpatient, partial hospitalization) or following an emergency psychiatric hospitalization. The primary goal is to educate and assist the individual in developing a long term plan and strategies for effectively coping with the diagnosed condition. Treatment primarily includes supervised living, academic education (coordinated with patient's school district), medical evaluations/monitoring, psychiatric evaluations/monitoring, behavior modification and individual, group and family counseling.

Extended/Long-Term Treatment: Provided by a publicly funded or privately operated extended/long-term care program. Approximate length of stay may be from 2-18 months. Usually occurs as a result of failed attempt(s) at intensive inpatient treatment and/or when the nature and severity of the psychiatric disorder requires longer treatment. Treatment primarily includes supervised living, academic education (coordinated with patient's school district), medical evaluations/monitoring, psychiatric evaluations/monitoring, behavior modification and one-on-one, group and family therapy.

SECTION 3 - DEALING WITH INSURANCE PROVIDERS

Mental health services can be expensive. While insurance can help offset the cost, it can also be a source of frustration and confusion. To determine which mental health services are available to you under your insurance coverage and to help prevent complications, delays and/or unexpected costs, it is crucial that you read your insurance policy carefully and/or speak to an insurance representative prior to contacting a potential treatment provider. Check your insurance card for a toll-free telephone number that will connect you with an insurance representative who can answer your questions.

There are typically three types of insurance coverage – traditional indemnity, preferred provider (PPO), and managed care (HMO).

Traditional Indemnity Plan: A traditional indemnity plan provides you with the most options. You can see a licensed treatment provider of your choice, pay the fee and submit the claim for reimbursement. The percentage of the fee you are reimbursed may range from 50% - 100% depending on your policy. Some policies require that you pay a deductible prior to being eligible for reimbursement. It is important that you ask your insurance provider what the individual and family deductibles are. The two vary, with the family deductible usually being double the individual deductible.

Managed Care Plan (HMO): A managed care plan requires you to see a treatment provider who is contracted with your insurance company (referred to as an "in-network" provider). With some policies you may need a referral from your primary care physician to initiate treatment. You pay a co-pay ranging from five to twenty-five dollars at the time of service. The treatment provider submits your claim to the insurance company and is paid the balance of the fee directly from the insurance company. Under the HMO plan, initial and ongoing sessions are subject to pre-authorization and review by your insurance provider.

Preferred Provider Plan (PPO): A preferred provider plan gives you the option of seeing either a contracted (in-network) treatment provider (at the cost of a co-pay) or a treatment provider of your choice. Under the PPO plan, if you choose to see a treatment provider that is "out-of-network", the fee reimbursement is typically lower then it would be with the traditional indemnity plan.

In speaking to your insurance representative, it may be helpful to ask the following questions (I recommend that you document all conversations, dates and names of contact personnel):

- **All Plans**: What type of policy do I have? Traditional Indemnity? Preferred Provider (PPO)? Managed Care (HMO)?
- All Plans: Are mental health services covered?
- All Plans: Are both outpatient and inpatient treatment covered?
- All Plans: Do I need a referral from my primary care physician? If so, what is the best procedure for obtaining one?
- All Plans: Do I have to start with outpatient treatment prior to accessing inpatient treatment?
- All Plans: If the parents or family members of the identified patient need to be seen separately, do specific rules apply? What are those rules? How does the treatment provider need to document those sessions in order for me to be reimbursed?
- All Plans: What is the total amount the insurance will pay on a yearly or a per contract basis for mental health services (e.g., $5000, $10,000, etc.).
- All Plans: If my child is covered by more than one insurance policy, do special rules apply? What are they? What are the steps I need to take in processing the claim and ensuring reimbursement?
- All Plans: Is there anything else I need to know to ensure that I can obtain the type of treatment I am seeking, that my claims are processed expediently and properly and that I receive the correct reimbursement?
- All Plans: What are the steps I need to follow in order to obtain the services that I am seeking?

- **Traditional Indemnity Plan**: If I receive individual outpatient treatment, what credentials does the treatment provider need in order for me to receive reimbursement for the treatment?
- Traditional Indemnity Plan: Is there a limit on how high the professional's charge may be (e.g., $120, $250, etc. per session), what is the maximum fee for which I will be reimbursed?
- Traditional Indemnity Plan: What is the percentage that I will be reimbursed?
- Traditional Indemnity Plan: Do I have to pay a deductible prior to receiving reimbursement? If so, how much is my deductible (e.g., $500, $1000, etc.)

- **HMO Plan**: Do I have to pay a co-payment? If so, how much is my co-payment?
- HMO Plan: Are there out-of-network benefits (PPO option) available? How do I obtain those out-of-network benefits? How do those out-of-network benefits differ from in-network coverage? What is the percentage of reimbursement? Is there a deductible?

If you have an HMO plan, ask your insurance representative for a list of "in-network" providers. When selecting a treatment provider from a list of unknown names, it is strongly recommended that you conduct a telephone consultation (as outlined in section 4) prior to scheduling your first appointment.

If you are on public assistance and you have Medicaid as your insurance, follow the strategies outlined above for an HMO policy.

SECTION 4 – INITIATING TREATMENT, SELECTING ANOUTPATIENT TREATMENT PROVIDER

A good starting point for obtaining counseling services for your child is to consult with your child's pediatrician/primary care physician. Have the doctor do a physical examination to determine if a medical condition is causing or contributing to your child's emotional/behavioral difficulties. Make sure that the physical exam is thorough and includes blood work and, if your child is middle school age or older, a urine drug screen. If your child's symptoms are not related to a medical condition, then mental health or substance abuse treatment may be recommended. If you have an HMO insurance plan, ask your doctor to give you feedback on your list of "in-network" providers. If you have a traditional indemnity or PPO plan,

ask your doctor to provide you with the names and phone numbers of at least two treatment providers that he/she thinks would be a good match for you and your child.

In addition to your doctor, I strongly recommend that you consult with your child's guidance counselor or other member of the school counseling staff (guidance counselor, social worker, psychologist or student assistance coordinator). School counselors are accustomed to working with children experiencing difficulties and can be a great source of support and expertise in connecting you to a treatment provider in your area.

SELECTING A TREATMENT PROVIDER:

To help determine the probability of a good match between you and a potential treatment provider, it is crucial to conduct a telephone consultation and to ask a lot of questions. Consider your first telephone contact and first therapy session as a two-way interview. While the treatment provider assesses you and your child's difficulties and treatment needs, you are assessing the treatment provider's personality, treatment philosophy and skill level.

Ask the treatment provider the following questions:

- Do you accept my insurance _____?
- What are your fees?
- What are your credentials? What is your professional license?
- Do you have experience working with patients my child's age? How many do you have in your total caseload?
- Do you have experience working with my child's presenting difficulty? How many patients with my child's difficulty have you treated?
- What is your treatment philosophy?
- Do you have any specialized training?
- What is the average length of treatment for my child's type of difficulty?
- If my child does not want to come to therapy or is uncooperative with you, how will you handle that?
- Do you communicate and work with school staff if necessary?

If you are still not sure, then ask:

- What are your strengths as a treatment provider?
- Is there anything else you think I need to know as a parent/guardian of a potential patient?

Since most of us do not have ample experience in directly questioning a professional about his/her expertise, it may feel uncomfortable asking these kinds of questions. I urge you to put aside your discomfort. Not asking questions and adequately assessing the compatibility between you and a potential treatment provider increases your risk of wasting your time, money and hope.

The type of responses you get to these questions may vary greatly. What often matters as much as the answers is the openness and sincerity with which they are given. From a credentials standpoint, you want a licensed treatment provider (or someone under the direct supervision of a licensed treatment provider) with both experience and specialized post-masters training.

In making a final decision about a treatment provider, ask yourself the following questions:

- Did the treatment provider sound professional, knowledgeable, warm and considerate?
- Was I comfortable speaking to this treatment provider?

- Did the treatment provider welcome my questions? Did he/she answer the questions fully or did I have to probe for more thorough responses?
- Was the treatment provider patient with me or did I feel rushed?
- If you left a message on the treatment provider's voice mail or answering service – Did the treatment provider return my call within a reasonable amount of time?

SECTION 5 - PREPARING YOUR CHILD FOR THE INITIAL INDIVIDUAL OUTPATIENT THERAPY SESSION

IF YOUR CHILD IS ASKING FOR HELP – MOTIVATED TO ATTEND:

Give your child as much information as possible regarding the treatment providers that are available. Encourage him/her to be part of the selection process. If your child is mature, socially skilled and assertive enough, have him/her participate in the initial telephone consultation described in section 4 of this booklet.

IF YOUR CHILD IS DENYING AND/OR RESISTING THE NEED FOR HELP – NOT MOTIVATED TO ATTEND:

Introduce the idea of seeking professional assistance to your child at a time when emotions are calm. If your child gets angry, denies the need or rejects the idea and you feel strongly that treatment is necessary, then proceed by researching and selecting a treatment provider on your own. Do not include your child in this process and do not keep him/her posted on your progress; to do so may create counterproductive conflict and stress.

Once you have made the initial appointment, inform your child about the appointment and your expectations for him/her to attend. If you anticipate a strong amount of resistance from your child, inform him/her of the appointment shortly before you need to leave your house to attend. Do not allow for a large gap of time between informing your child and leaving for the appointment. To do so may provide your child with the opportunity to argue, challenge and wear you down enough that you find it difficult to follow through with your decision.

Suggestions for informing your resistant child about your expectations for him/her to participate in therapy.

- Sit down with your child (both parents whenever possible) in a private and comfortable place.
- Use a calm, respectful but assertive and directive tone of voice.
- Explain to him/her exactly what is about to take place. Provide as much detail as your child is receptive to hearing regarding the time of the appointment, the treatment provider you have selected, the location of the provider's office and what he/she can expect during the first meeting.
- Take full ownership and responsibility for your decision to seek professional help. A good strategy is to say, "Today we are going to meet with a counselor…I have decided to make the appointment because I am concerned about what is happening in our family…(Be concrete and specific) We have had five "fights" in the last three weeks…" If you must place your concerns directly on your child's behavior, say, "I am concerned because your grades have dropped from B's to C's…you seem real angry, you yell and curse at me and your brother…You were suspended from school and you keep telling me you don't care about school or our family…" Conclude with your expectation for cooperation by saying, "I really need and expect you to cooperate…"
- Avoid blaming comments, "You are going to the counselor because you are doing terrible in school…" Avoid sounding angry or frustrated. To do so will put your child in even a greater defensive state and intensify the resistance and stress of the moment.
- Decide on and tell your child the exact number of sessions you are going to require him/her to participate in. Set the number of sessions at an amount you think your child can accept. The benefit of

providing your child with a "light at the end of the tunnel" is that it usually helps take some of the edge off of his/her resistance and helps get him/her through the front door of the treatment provider's office. Once there, it becomes the treatment provider's responsibility to make a connection with your child that will hopefully lead to your child deciding to voluntarily participate beyond the required number of sessions. If your child does not choose to participate voluntarily beyond the required number of sessions, my experience has been that forcing him/her to do so will have little to no benefit. In fact, it may make things worse by further straining and damaging the relationship between you and your child. If your child participates in no more than the required number of sessions, at the very least the treatment provider will have had the opportunity to complete an assessment and report back to you his/her findings and strategies for addressing your child's difficulties through means other than individual outpatient therapy.

- Inform your child of the following principles he/she can expect in meeting with a treatment provider: Say, "You will be asked questions about school, family, friends, areas of interest and how you are feeling. You do not have to talk about anything you do not want to. If the treatment provider asks you a question that you are not comfortable with, you do not have to answer it. What you discuss with the treatment provider will be confidential with the exception of behavior that might be of danger to you or someone else (includes substance abuse). The main goal of your first meeting (and the first several sessions) is for the treatment provider to get to know you and what's going on with our family". If your child seems receptive, educate him/her as much as possible about the counseling process. The only exception to this is in situations concerning substance abuse treatment. <u>If your concern is substance abuse please read the recommendations below being sure to follow the prescribed precautions</u>.

<u>WHEN THERE IS A SUBSTANCE ABUSE CONCERN:</u>

If your primary concern with your child is substance abuse, you can probably expect a very high level of denial, resistance and anger from your child when informing him/her of your plan to take him/her to a counselor. Be prepared to handle and not allow your child's resistance to deter you from your planned course of action. If you are a single parent and you do not have the support of your child's other parent, you may want to ask another adult family member to assist and accompany you to your first treatment session.

If you have selected a treatment provider that is qualified and trained in the treatment of substance abuse (it is highly recommended that you do), you can expect that a drug and alcohol urine screen will be collected during the initial meeting. To prepare your child for the first meeting, follow the strategies outlined in the IF YOUR CHILD IS DENYING AND/OR RESISTING THE NEED FOR HELP section of this handbook, with the exception of the following precaution: <u>Do not let your child know that a drug and alcohol urine screen will be part of the evaluation process. This is crucial because young people today have methods for passing drug tests even if they have been using substances. It may also intensify your child's resistance to attending and participating in the counseling session</u>. If your child specifically asks if he/she is going to be tested or evaluated for substance abuse, tell him/her that the first session is part of a comprehensive assessment that includes a substance abuse evaluation and that a urine test <u>might</u> be included. Stress to your child that there is nothing that can be discovered through the assessment that you are not prepared for and ready to deal with by being understanding and supportive.

It is important to note that if your child undergoes a drug and alcohol urine screen and it returns negative, it does not conclusively mean that your child is not using drugs or alcohol or that his/her current difficulties are not being caused or compounded by his/her use.

Facts parents need to know about drug testing:

- Young people today have methods for adulterating and passing drug tests even if they are using drugs and/or alcohol.
- Drug-testing standards vary greatly. "Zero cut-off" means that any level of a substance in the body will be detected by the test. Most drug tests do not have a zero cut off limit, which means that even if the

test comes back negative your child could have a level of drug within his/her system that was not detected by the test. Many physicians do not use a zero cut off test. Their cut-off level might be high relative to typical adolescent drug use patterns. For this reason it is important to know the cut-off level of the drug test being administered. Whenever possible, request that a zero cut-off drug test be administered.

- Many drugs (cocaine, ecstasy, ketamine, LSD, PCP) have a very short half-life in the body, which means that they may be undetectable by a drug test within hours (3-6) after they are last consumed.
- Drug tests only test for specified drugs. If your child is using a drug not specifically being tested for, then the drug test result will be negative.

Because of the numerous variables that impact on the results of a drug test, no one test should be considered 100% conclusive regarding an individual's substance involvement. It is recommended that the drug test be administered as part of a comprehensive mental health/substance abuse evaluation facilitated by a professional trained in the treatment of substance abuse. A professional trained in substance abuse can advise parents on the probability of substance involvement beyond that indicated by the drug test results.

SECTION 6 – IF YOUR CHILD REFUSES TO ATTEND TREATMENT

If your child is experiencing a psychiatric emergency and refuses to go for help, see section 7 of this handbook.

If your child is experiencing mild-moderate emotional difficulties (sadness, anxiety, shyness, social or academic difficulties) but can still meet his/her responsibilities, and refuses to attend treatment, do not try to force him/her to attend. Your best strategy is to be patient, continue providing love and understanding and repeatedly educate your child about the treatment process and its potential benefits. If you maintain your supportive position and your child becomes uncomfortable enough with how he/she feels, there is a good chance that he/she will eventually volunteer to participate in treatment. If your child does not take you up on your offer, then perhaps he/she does not feel as badly as you might think or is deriving some type of benefit from their emotional upset. In the latter case it might be helpful to discuss that possibility with your child.

If your child is involved in destructive and/or illegal behaviors (including substance abuse) and refuses to enter or participate in treatment, you may need to consider taking a "tough love" approach in motivating him/her to do so. Tough love is a parenting philosophy that stresses the accountability of the child to behave in a healthy and responsible way and the accountability of the parent to provide consistent and appropriate punishment for destructive behaviors. The way it works is, when your child is involved in destructive and/or illegal behaviors, you consequence (punish) him/her by imposing logical consequences and/or by allowing natural consequences to occur. Logical consequences are punishments that have a logical link to the behavior that is being disciplined. Logical consequences can include punishments as severe as reporting your child to the police, withholding non-essential support (materials and privileges outside of those necessary for survival - allowances, car, TV or computer in room, rides to friends' houses) and/or making alternative living arrangements for your child. Natural consequences are punishments imposed by society (school suspension, police arrest, etc.). In addition to punishing destructive behaviors, you simultaneously provide logical rewards and encouragement for your child to enter treatment.

In taking a tough love approach, ideally you want to communicate with your child in a non-emotional, assertive yet loving and respectful way. The goal of your communication style is to keep the focus on your child's behavior and not to get drawn into an argument that shifts the focus to you, your parent-child relationship or past unresolved conflicts.

With tough love, as with any disciplinary approach, you need to be patient. There is rarely any one consequence administered at any one time that is going to make the difference. You will only impact on your child by being consistent with your approach over an extended period of time. The following are examples of a tough love response to a child involved in ongoing destructive and/or illegal behaviors.

- Child is being verbally abusive towards you, breaking curfew and refusing to follow house rules. You say: "You are being verbally abusive toward me…you have come home late the past two nights…you have stopped doing school work…at this time you will not receive your allowance and I will not drive you over to your friend's house…you can receive those privileges back when you are able to talk to me about what is going on and improve your attitude and behaviors…"
- Child gets arrested for drinking and driving. Your response is to not hire an attorney to get him/her out of trouble. You explain to your child that if he is going to break the law he has to be prepared to pay the price for it. You allow your child to experience whatever "natural" consequences result from his/her behavior.
- You find drugs in your child's room and confront him/her with it. Child gets angry, pushes you and runs out of the house. Your response is to call the police, report your child for drug possession and assault.
- Child is misbehaving in all of the above ways, you want the child to enter treatment. Your response is to follow through with all of the predetermined consequences. Say to your child, "I don't want things to be this way…if you continue to behave the way you are I will have to continue to hold you accountable…if you go for treatment and show me that you are trying to work at it, we can wipe the slate clean…you can have back all of the privileges you once had…what do you want to do?"
- Child continues to be involved in unhealthy, destructive or illegal behaviors and refuses to enter or participate in treatment despite all of the consequences that have been imposed. You continue to set and follow through with consequences that match the severity of your child destructive and/or illegal behavior.
- One severe consequence is to make alternative living arrangements for your child. You say to your child: "Things continue to get worse…this is not good for either of us…perhaps it would be better if you lived with someone else…here are your options…go to treatment for help in changing your behaviors or plan on living somewhere else by the end of next month."
- Another serious consequence is to work with the police and court system in generating a court order for treatment against your child. To find out more about how to obtain a court order, read Section 8 of this handbook. When reading Section 8, please be aware that the court order is explained in the context of seeking inpatient treatment, but, that it can be used to force a child into any one of the various levels of care (individual outpatient, intensive outpatient, inpatient, etc.)

What makes the tough love approach difficult to institute is that it goes against most parents' natural instinct to protect their child from perceived harm and to avoid the interpersonal pressure inherent in saying no or imposing a consequence. Generally speaking, in some ways it is easier to yell, argue, nag or try to guilt our children into compliance than it is to hold them accountable and impose a consequence that often initially escalates their agitation and anger. Ultimately however, research and my own clinical experience suggest that children (particularly those with behavioral difficulties) learn and are more influenced by our actions in response to their behavior than by our words or emotions. With this principle in mind we move from trying to convince them to change, to giving them leadership and good reasons (logical and natural consequences) to change. For additional information and support in implementing a tough love approach with your child, contact the tough love support program at (800) 333-1069 or visit www.toughlove.org.

SECTION 7 –IF YOUR CHILD IS EXPERIENCING A PSYCHIATRIC EMERGENCY

If your child is experiencing a psychiatric emergency (danger to self and/or others, experiencing delusions, hallucinations, disorganized thoughts and/or exhibiting unusual behaviors) take your child to your local hospital emergency room immediately. If your child is already under the care of a treatment provider, you may want to call the treatment provider first and ask for any special instructions that he/she would like you to follow. If you cannot contact your child's treatment provider immediately, then proceed to the hospital and try to contact him/her later. If your child is emotionally or physically out of control, or has harmed him/herself or someone else, call 911 for assistance.

IF YOUR CHILD IS UNCOOPERATIVE IN GOING TO THE HOSPITAL

Community resources that may be able to help you transport your child to the hospital:

Psychiatric Screening Center: All counties have a psychiatric screening center (see appendix A). The centers are located in designated county hospitals. Some centers serve more than one county. They are staffed by mental health professionals known as "screeners". The role of the screener is to both protect an individual from self-harm in cases of a psychiatric emergency and to advocate for an individual's right against involuntary hospitalization. Screeners intervene in situations when an individual appears to be experiencing a psychiatric emergency but is refusing medical assistance.

In cases when an individual appears to be having a psychiatric emergency, but is uncooperative in going to the hospital, many screening centers have a "mobile unit" that they deploy to the individual's location. The mobile unit consists of 1-3 screeners accompanied by members of the local police department. Upon their arrival they evaluate the individual's mental status. If they believe that a psychiatric emergency exists and that the individual is of danger to him/herself or others, then they exercise their legal authority to have the police bring the individual to the hospital against his/her will. Some screening centers (Morris, Passaic and Warren County) do not deploy their mobile unit in situations involving a minor (any person under the age of 18). If you live in such a county, you may need to get assistance from your local police department (read the Local Police Department section below).

In cases when an individual is already at the hospital and has been recommended for emergency inpatient admission, but refuses to comply, the screening center deploys a screener to the hospital in which the individual is being held. Upon arrival the screener conducts an independent mental health evaluation to determine and make the final decision on whether or not involuntary hospitalization is necessary. Most of the time the screener is in agreement with the hospital evaluation. However, on occasion the hospital is overruled and the individual is released.

Local Police Department: While all counties have a Psychiatric Screening Centers that you can contact in cases of a psychiatric emergency, some screening centers (Morris, Passaic and Warren County) do not deploy their mobile unit in situations involving a minor (any person under the age of 18). If your child is a minor and you live in such a county, you will need to contact your local police department for assistance. In psychiatric emergencies, police departments have the authority to assist parents in transporting a minor to the hospital. Police departments seem to vary in their level of sophistication in dealing with individuals (particularly minors) experiencing a psychiatric and/or substance abuse emergency. When involving your local police department, be prepared for all possible personalities, styles and protocols in how they intervene with your child. Regardless of their approach, remember that the important thing is that your child gets to the hospital where he/she can be further evaluated and treated.

What to do if your child refuses to go to the hospital:

If you attempt to take your child to the hospital and he/she is uncooperative, contact your county's screening center for assistance. During your initial telephone contact with the screening center, be prepared to answer questions regarding your child's current condition and related psychiatric history. Tell them the exact reason you believe your child needs to go to the hospital. Ask them to please intervene. If they inform you that they will be sending their mobile unit to assist, ask them how long it will take for them to arrive and for instructions on what to do until they get there. If for any reason the screening center is unable to deploy it's mobile unit, then contact your local police department for assistance. If the screening center tells you they can't intervene because in their clinical judgement your situation does not constitute a psychiatric emergency, ask them to advise you on how to access and utilize other community resources that can help.

What to do if you want your child admitted into the hospital for emergency hospitalization treatment:

If at the hospital you want your child admitted for emergency hospitalization treatment, communicate your request directly to the evaluating clinician. Tell him/her exactly what your child is doing that makes you believe emergency hospitalization treatment is necessary. Make sure you highlight behaviors that indicate your child may be a danger to him/herself or others. If it appears that the hospital is reluctant to admit your child, ask to fill out a request/application for hospitalization form. Doing so will document your concerns and thus force the hospital to give even greater consideration to your request. Be aware, however, that no matter how strongly and effectively you communicate your request, the hospital can choose not to admit your child for emergency hospitalization.

What to expect at the hospital:

Be prepared to provide the hospital with all pertinent insurance, demographic and medical information. If your child is already involved in some form of psychiatric treatment, remember to bring the treatment provider's telephone number. The hospital might want to contact your child's treatment provider and factor his/her clinical judgement into their evaluation. In preparation for going to the emergency room, remember to bring your child's insurance card and any other information you think you might need to answer the intake questions.

Be prepared for a potentially very (very) long wait. Depending on how busy the hospital is, the recommendation of the evaluator and your child's level of cooperation, your emergency room stay can be anywhere from two to twelve hours. If your child is recommended for inpatient psychiatric treatment, then he/she will be moved from the emergency room to another unit in the hospital or another hospital that has the appropriate type of psychiatric treatment available. In preparation for your potentially long day, it's a good idea to bring some type of busy work (reading materials, crossword puzzles, letter writing, etc.) with you to pass the time. While your state of mind may not be conducive to busy work, emotionally it may be a good idea to force yourself.

Be prepared for a potentially stressful and emotionally draining experience. Depending on the quality of care you receive at the hospital, the length of time you're there, the evaluation results, and your child's emotional state and behavior throughout the process, you may experience an intense roller-coaster ride of fear, sadness, frustration, anger, rage, disappointment and guilt. In preparation for the potential roller coaster of emotion, it may be helpful to have a supportive family member or friend accompany you. Periodically focus on your breathing, step outside to take a walk, and assure yourself that you are strong and that you will endure and handle all possible outcomes.

SECTION 8 - IF YOUR CHILD NEEDS INPATIENT TREATMENT

A QUICK REVIEW OF INPATIENT TREATMENT OPTIONS

Your child stays overnight in the hospital or treatment facility.

Emergency Hospitalization: Provided by a public or private hospital. Approximate length of stay may be from 2-10 days. Usually occurs following a psychiatric or substance abuse emergency during which an individual is at risk for harming oneself or others. The primary goal of hospitalization is to ensure the individual's safety, stabilize acute physical and/or psychiatric symptoms and educate the patient and his/her family about the nature of the diagnosed condition. Treatment primarily includes medication, medical evaluations/monitoring, psychiatric evaluations/monitoring and patient and family education.

Inpatient Treatment: Provided by a publicly funded or privately operated inpatient treatment program. Approximate length of stay may be from 5-28 days depending on the treatment program. Usually occurs as a result of failed attempts at less intensive treatments (individual outpatient, intensive outpatient, partial hospitalization) or following an emergency psychiatric hospitalization. The primary goal is to educate and assist the individual in developing a long-term plan and strategies for effectively coping with the diagnosed condition. Treatment primarily includes supervised living, educational services (coordinated with patient's

school district), medical evaluations/monitoring, psychiatric evaluations/monitoring, behavior modification and individual, group and family counseling.
Extended/Long-Term Treatment: Provided by a publicly funded or privately operated extended/long-term care program. Approximate length of stay may be from 2-18 months. Usually occurs as a result of failed attempt(s) at inpatient treatment and/or when the nature and severity of the psychiatric disorder requires longer treatment. Treatment primarily includes supervised living, educational services (coordinated with patient's school district), medical evaluations/monitoring, psychiatric evaluations/monitoring, behavior modification and one-on-one, group and family therapy.

IF YOUR CHILD IS EXPERIENCING ONGOING PSYCHIATRIC OR SUBSTANCE ABUSE DIFFICULTIES AND YOU ARE CONSIDERING INPATIENT TREATMENT:

Inpatient treatment may be appropriate for ongoing psychiatric or substance abuse difficulties when an individual is experiencing life impairment and/or has had previous treatment attempts that failed to improve his/her condition. The decision to place an individual in inpatient treatment is a serious one that is subject to strict insurance guidelines and mental health legislature. It is not easy to have someone placed in inpatient treatment against his/her will. Inpatient treatment is often the last line of treatment for ongoing psychiatric or substance abuse difficulties typically administered after prior treatment attempts have failed. There are exceptions to this protocol. If an individual is suicidal or homicidal or if there are other serious potentially self-injurious symptoms (including severe drug addiction or dangerously low body weight due to an eating disorder), inpatient treatment may be the first line of treatment.

If you have the financial means to pay for inpatient treatment, you can choose to have your child admitted into a private facility without the approval or guidelines of your insurance provider. In such cases, it is important not to resort to inpatient treatment too quickly out of fear, anger or frustration. The risk is that you will utilize this powerful treatment tool at a time when your child's level of impairment and treatment readiness might not warrant it. In the process you would be expending a limited resource (the cost of inpatient treatment is often so great that even financially secure individuals would have difficulty paying for it multiple times) that will perhaps then not be available to you at a time when it could have the greatest therapeutic impact. To research available private programs, speak to your child's treatment provider, primary physician and/or school counselor.

If you have to depend on your insurance provider to pay for inpatient treatment, you will have to follow their protocol and guidelines for determining when inpatient care is appropriate and which facility to use. Since insurance companies and policies vary so greatly, you will need to speak to your insurance representative to determine how to proceed in getting your child inpatient treatment. If your insurance provider denies your request for inpatient treatment and you believe that it is necessary to your child's wellbeing, you are encouraged to be assertive in advocating for your child. Request to speak to a supervisor and inquire about how to appeal the initial denial of services. Be diligent in asking the names of the insurance representatives to whom you speak, documenting your correspondence and following through with the necessary procedures.

If your child is a minor and is uncooperative in attending an inpatient treatment program the treatment facility you choose may be able to assist you in getting your child to agree to the proposed inpatient admission. In selecting a program and scheduling an admission date, inform the admission counselor of your child's treatment resistance. Ask them to advise you on how you should proceed in getting your child to their facility, how they will handle your child's resistance and how you can best support them in doing so. Admission counselors have a lot of experience in working with resistant individuals. Through the use of "therapeutic leveraging" techniques, they have a good chance of being able to convince your child to enter their program. However, if your child refuses to agree to the inpatient admission, you will not be able to force your child into treatment. In such cases, you may choose to seek an involuntary commitment or court order that mandates your child to enter inpatient treatment.

If your child is of adult age (18 years or older) and is uncooperative in being placed in an inpatient treatment program you can follow the same strategies outlined above, for a minor that is resistant. However, be

aware that treatment facilities are typically less effective in persuading adults into treatment than minors. To give yourself the best chance with an adult child, you may need to utilize other resources. One option is to seek the services of a private therapist who can facilitate a formal "intervention". A formal intervention involves planning and preparing for a meeting during which you and other family members and friends "confront" your child. You prepare for the meeting by working with a therapist who assists you in communicating in the least threatening and most powerful way. Without your child's prior awareness, he/she is brought to the meeting during which time everyone expresses their concern and encourages your child to get "help". At the conclusion of the meeting, you attempt to immediately take your child to a treatment facility that you have pre-selected and scheduled an admission with. If your child refuses, you cannot force him/her into treatment against his/her will. In such cases you may choose to seek an involuntary commitment or court order that mandates that your child enter into inpatient treatment.

An involuntary commitment is when an individual (minor or adult age) is forced by the mental health system to enter inpatient care against his/her will. It is very difficult to have a person "committed". Your best chance of doing so occurs when there is a psychiatric emergency in which your child is overtly expressing thoughts of suicide or homicide, appears psychotic and or is engaging in potentially dangerous behaviors. If your child is experiencing a psychiatric emergency, follow the instructions outlined in Section 7. In addition, inform the evaluating mental health professional that you believe your child is in need of inpatient care and should be involuntarily committed. Another process by which an individual can be involuntarily committed is when a treating psychiatrist determines that inpatient treatment is the most appropriate level of care. In such cases your treatment provider should work with you in making the necessary arrangements for hospitalization and inpatient placement.

A court order for treatment is when an individual (minor or adult age) is mandated by the criminal justice system to enter treatment or face more serious legal consequences. If you want to generate a court order for treatment to be imposed on your child, you will need to follow a "tough love" parenting philosophy. When your child is involved in criminal activity including substance abuse, you notify the police in order to initiate your child's involvement with the criminal justice system. Once your child is involved in the criminal justice system, you work collaboratively with the judge and/or probation officer assigned to your child's case. By informing and/or keeping them abreast of your child's criminal behavior and asking them for help, you will increase the likelihood that the judge and probation officer will impose a court order for treatment (possibly inpatient care).
If you are attempting to generate a court order for treatment and your child is a minor, find some reassurance in knowing that the juvenile justice system is set up to rehabilitate rather than punish. Juvenile records are typically expunged at the age of 21. By getting your child involved with the juvenile justice system, you will be providing him/her with a level of consequences that are mild in comparison to the consequences that may occur as a result of his/her disruptive, dangerous and/or substance abusing behaviors when he/she is older. In the process you will be taking advantage of a window of opportunity that only exists until your child's eighteenth birthday and can possibly give you the leverage needed to motivate him/her to enter and participate in treatment.

If you are attempting to generate a court order for treatment and your child is an adult (18 years or older), the decision to do so will be a very difficult one. The adult criminal justice system is more punitive than the juvenile system. You will have to decide between the lesser of two evils: let your child act out and risk major life catastrophes or death; or generate legal consequence that may result in incarceration and/or a permanent criminal record but could motivate or force your child to get help.

Once you have a plan and are ready to try to get your child into inpatient care, contact the treatment facility you are considering and proceed as follows:

- Ask to speak to an intake/admissions counselor.
- Begin by providing all the necessary insurance information and ask if they accept your coverage.
- Be prepared to spend several minutes on the telephone answering intake questions concerning demographic information and the history and current status of your child's difficulties.

- Ask for their admission criteria and if they will contact your insurance provider to determine treatment eligibility and ongoing case management.
- Ask how any outstanding bills at the end of treatment are handled. Who would be responsible – you or your insurance company?
- Ask how they handle patients who resist admission.
- Ask if they have counselors in your area that can assist you with an "intervention".
- Ask what the average length of inpatient stay is and aftercare options.
- If your child is from 18-21 years of age, ask which unit he/she will be placed in; adolescent or adult.
- Schedule your child's intake. Ask that the intake process be explained to you thoroughly. Ask what you need to bring including any necessary paperwork and personal items your child will need during his/her stay.
- In getting your child to the treatment facility, follow the strategies outlined in section 6. In some cases, particularly with minors, you may not want to inform your child of your plans until you are in the car driving to the treatment facility.

SECTION 9 – UNDERSTANDING YOUR CHILD'S DIFFICULTIES AND RELATED TREATMENT NEEDS

Regardless of the treatment provider you choose or the level of care to be provided, effective treatment should begin with a comprehensive initial assessment/evaluation of your child's difficulties and related treatment needs. The length of time it takes for an initial assessment varies from 2-5 hours (conducted over 1-5 sessions), depending on the treatment provider's professional training and/or treatment philosophy. The goal of the assessment is to determine what is causing and/or maintaining your child's difficulties and how to effectively intervene. In order to have a comprehensive understanding of your child's difficulties, many treatment providers will want to get input from other caretakers, school officials and other agencies or treatment providers working with your child. A treatment provider will need your written consent in order to speak to anyone outside of you and your child.

At the conclusion of the assessment, your treatment provider should report to you what he/she thinks is going on with your child, if there is a diagnosable psychiatric disorder and the best course of treatment. A child's emotional, behavioral and/or social difficulties can be explained many different ways. Remember that it is possible to get varying opinions from different professionals.

DIFFERENT DIAGNOSES AND THEIR IMPLICATION FOR TREATMENT:

Generally, I explain a child's emotional, behavioral and/or relationship difficulties in one of two ways: difficulties caused and maintained by a life stressor or difficulties caused and maintained by a psychiatric disorder.

Difficulties caused and maintained by a life-stressor can be linked to a specific environmental trigger including developmental/physical changes, conflict with family or friends, parents' divorce, illness or death of a family member and/or some other negative life event. A child experiencing difficulties caused and maintained by a life stressor typically responds well to individual outpatient therapy and the experience of being listened to, understood and emotionally supported. Even if therapy is not provided, there is a good chance that the child's difficulties will stabilize and improve as the child matures and/or the life stressor passes.

Difficulties caused and maintained by a psychiatric disorder appear to be independent of a life stressor even though several might be occurring in an individual's life. A child experiencing difficulties caused and maintained by a psychiatric disorder, may or may not respond to individual outpatient therapy. The less motivated a child is to acknowledging and working on his/her life difficulties, the less likely individual outpatient therapy will be effective. Treatment often needs to be augmented by other therapies including family education, family therapy, parent/child management training, group therapy, self-help programs and medication. Having an accurate diagnosis is essential to developing and implementing the most effective

treatment plan possible. An inaccurate diagnosis can result in ineffective treatment and, in the worst-case scenario, an intensification of symptoms. If treatment is not provided, there is a good chance that the child's difficulties will continue to intensify and cause ongoing relationship, school and general life impairment.

The following are categories of disorders for which children and teenagers commonly need treatment:

- Mood Disorders
- Anxiety Disorders
- Disruptive Behavior Disorders
- Eating Disorders
- Substance Abuse Disorders
- Thought Disorders
- Personality Disorders

The table below identifies specific disorders within each category and the most effective treatments as prescribed by a variety of mental health researchers. It is intended to provide you with a general overview that can serve as a starting point for accessing additional information from your child's treatment provider and other credible sources.

Please keep in mind that the table below does not provide a complete list of effective treatments; rather, only treatments backed by consistent research evidence are presented. There are many treatments without consistent research evidence that are considered worthwhile by treatment providers and may be selected as a primary treatment for your child. If you ever have any questions or concerns about the type of treatment that your child is receiving, speak to your child's treatment provider about it. I believe a skilled and effective treatment provider will welcome your inquiry and be willing and able to explain his/her rationale for the treatment being administered.

When it is indicated that there is no consistent evidence of an effective treatment or medication, it does not mean that no treatment exists for a disorder, but rather, that no one treatment has produced consistent positive research findings. In such cases, treatments commonly used with some degree of effectiveness are indicated.

TABLE 1 – CATEGORIES OF DISORDERS & THEIR TREATMENT

MOOD DISORDERS

Diagnosis:	**Most Effective Treatments as Determined by Consistent Research Evidence:**	**Class of Medications Most Often Prescribed:**
Major Depression **Dysthymic Disorder**	1. Individual Talk Therapy ❑ Interpersonal Psychotherapy ❑ Cognitive Behavioral Psychotherapy	1. Selective Serotonin Reuptake Inhibitors (SSRIs)
Bipolar Disorder: Mania & Hypomania	1. No consistent evidence of the effectiveness of psychosocial treatments with adolescents 2. Family Education / Therapy Appears Helpful 3. Medication Therapy is Essential	1. Mood Stabilizers * 2. Antipsychotics 3. Anticonvulsants *There is very limited data on the efficacy and safety of mood stabilizing medications in youths

ANXIETY DISORDERS

Diagnosis:	Most Effective Treatments as Determined by Consistent Research Evidence:	Class of Medications Most Often Prescribed:
Generalized Anxiety **Specific Phobia** **Separation Anxiety** **Social Phobia**	1. Individual Talk Therapy ❑ Systemic Desensitization ❑ Modeling ❑ Contingency Management ❑ Cognitive Behavioral Therapy With or Without Parent Support Component	1. SSRIs
Panic Disorder **Agoraphobia**	1. Individual Talk Therapy ❑ Systemic Desensitization ❑ Modeling ❑ Contingency Management ❑ Cognitive Behavioral Therapy With or Without Parent Support Component	1. No consistent positive trials of medication for Panic Disorder in children and/or adolescents
Obsessive Compulsive Disorder	1. Individual Talk Therapy ❑ Systemic Desensitization ❑ Modeling ❑ Contingency Management ❑ Cognitive Behavioral Therapy With or Without Parent Support Component	1. SSRIs
Post Traumatic Stress Disorder	1. Individual Talk Therapy ❑ Cognitive Behavioral Therapy ❑ Eye Movement Desensitization Reprocessing Therapy	1. No consistent positive trials of medication for Post Traumatic Stress Disorder in children and/or adolescents

DISRUPTIVE BEHAVIOR DISORDERS

Diagnosis:	Most Effective Treatments as Determined by Consistent Research Evidence:	Class of Medications Most Often Prescribed:
Attention Deficit Hyperactivity Disorders, ADHD	1. Multi-Strategy Therapy ❑ Psycho Educational Therapy for Family Members ❑ Behavior Management Training for Parents	1. Stimulants 2. Antidepressants
Conduct Disorder **Oppositional Defiant Disorder, ODD**	1. Multi-Strategy Therapy ❑ Psycho Educational Therapy for Family Members ❑ Behavior Management Training for Parents ❑ Video Tape Modeling Training for Parents	1. Stimulants 2. SSRIs 3. Mood Stabilizers

EATING DISORDERS

Diagnosis:	Most Effective Treatments as Determined by Consistent Research Evidence:	Class of Medications Most Often Prescribed:
Bulimia	1. No consistent evidence that a single type of therapy is effective when used in isolation 2. Individual Talk Therapy ❑ Cognitive Behavioral therapy 3. Multi Strategy Therapy ❑ Nutritional Counseling & Rehabilitation ❑ Family Therapy ❑ Support Groups ❑ Medications	1. No consistent positive trials of medications for Eating Disorders in children or adolescents 2. A variety of Antidepressants are often tried
Anorexia Nervosa	1. No consistent evidence that a single type of therapy is effective when used in isolation 2. Anorexia Nervosa is a complex, serious and often chronic condition that may require a variety of treatment modalities at different stages of illness and recovery 3. Depending on the stage and severity of illness, more intense levels of care may be necessary including intensive outpatient, partial hospitalization and inpatient treatment 4. Treatment strategies recommended by the American Psychiatric Association include: ❑ Nutritional Rehabilitation ❑ Individual Talk Therapy (Interpersonal, Behavioral, Psychodynamic & Cognitive Behavioral Therapy) ❑ Multi-Strategy Therapy (Family Therapy, Support Groups) ❑ Medications	1. No consistent positive trials of medications for Eating Disorders in children or adolescents 2. A variety of Antidepressants are often tried

SUBSTANCE ABUSE

Diagnosis:	Most Effective Treatments as Determined by Consistent Research Evidence:	Class of Medications Most Often Prescribed:
Alcohol Marijuana Other Substances Abuse & Dependency	1. No consistent evidence that one type of therapy is more effective then others 2. It is uncommon for a single therapy to be effective when used in isolation 3. Depending on the stage and severity of the illness, more intense levels of care may be necessary including intensive outpatient, partial hospitalization and inpatient treatment	1. No consistent positive trials of medications for Substance Abuse Disorders in children or adolescents Medications can be used to: treat intoxication and withdrawal symptoms, decrease the reinforcing effects of abused substances, discourage the use of substances by inducing unpleasant consequences through a adverse drug-drug

	4. Therapies recommended by the American Psychiatric Association include: ❑ Cognitive Behavioral Therapy ❑ Behavioral Therapy ❑ Psychodynamic and Interpersonal Therapy ❑ Group Therapy ❑ Family Therapy ❑ Participation in Self-Help Groups	interaction and to treat co-existing psychiatric conditions

THOUGHT DISORDERS

Diagnosis:	**Most Effective Treatments as Determined by Consistent Research Evidence:**	**Class of Medications Most Often Prescribed:**
Schizophrenia	1. Multi Strategy Therapy ❑ Psycho Educational Therapy for Patient and Family Members ❑ Family Intervention Programs 2. Individual/Group Talk Therapy ❑ Cognitive Behavioral Strategies (if patient is motivated for treatment) ❑ Social Skills Training (if patient is motivated)	1. Antipsychotics (e.g., Clozapine, Risperidone, Olanzapine)

PERSONALITY DISORDERS*

Diagnosis:	**Most Effective Treatments as Determined by Consistent Research Evidence:**	**Class of Medications Most Often Prescribed:**
Paranoid **Schizoid** **Schizotypal** **Antisocial Personality** **Borderline** **Histrionic** **Narcissistic** **Avoidant** **Dependent** **Obsessive-Compulsive**	1. No consistent evidence of the effectiveness of psychosocial treatments with adolescents 2. A therapy that is currently receiving research and showing promise in the treatment of Borderline Personality Disorder is Dialectical Cognitive Behavioral Therapy combined with other multi-strategy therapies 1. No consistent positive trials of medications for Personality Disorders in children or adolescents 2. It is common for a variety of medications to be tried, sometimes in combination *A personality disorder is a condition marked by an enduring pattern of inner experiences and behaviors that are outside of the cultural norm, pervasive and inflexible, consistent over time and lead to distress or life impairment. The onset of a personality disorder occurs during adolescence or young adulthood. Typically an individual with a personality disorder has difficulty building and maintaining healthy relationships (they are often perceived as manipulative), managing stress,	

Personality Disorder Not Otherwise Specified	regulating their emotions and making "good" decisions with regard to school, work and other responsibilities (they often act impulsively). There are several types of personality disorders.

*References supporting the above table appear in the back of this handbook.

Please note that there are a number of disorders that are resistant to individual talk therapy (as defined in section 2 of this handbook). With disorders that are considered biological in nature and/or characterized by a child's unwillingness to acknowledge life difficulties, a lack of motivation for change, blaming others for one's life difficulties and/or a resistance to participating in therapy, the focus of treatment becomes the family dynamics and parenting style. The hope is to assist parents and family members in creating a home environment that serves to reduce stress, teach healthy coping strategies and motivate the child to work on changing maladaptive patterns of thoughts, emotions and behaviors.

If you bring your child to a treatment provider with the hope that he/she will be "fixed", it can feel invalidating and frustrating to hear that the focus of treatment will need to be on your family dynamics or parenting style. The recommendation may seem to imply that you are in some way the cause of your child's difficulties. If you are given the recommendation of parent training or some other family focused intervention, please understand that it is not an indictment of your parenting but rather a reflection of the nature of your child's difficulties and the limitations of standard individual outpatient therapy. Traditional "instinctive parenting" needs to be supplemented by parenting strategies and skills specific to your child's difficulty.

SECTION 10 - IF YOUR CHILD IS PRESCRIBED PSYCHOTROPIC MEDICATIONS

Before providing you with information regarding psychotropic medications, I first want to let you know where I stand on this topic. My wish is that no child (or individual of any age) ever take these medications. The reason I feel this way is because in my 20 plus years of clinical experience I have witnessed first-hand the significant side effects these medications can cause, particularly when used over prolonged periods of time. In addition, it is difficult to fully trust the pharmaceutical companies and their history of bringing to market a number of medications that ultimately proved to cause more harm than good.

With all of that being said, I still support the use of medications in the treatment of mental health disorders. The reason for this is because in addition to witnessing the harmful effects of medications, I have also witnessed the harmful effects of depression, anxiety, ADHD and other psychiatric conditions, which is some cases cause pain, suffering and life impairment far greater then medication side effects. If you considering placing your child on psychotropic medications, it is important that you consider the information that follows, much of which comes directly from the National Institute of Mental Health.

If your child's treatment provider believes that your child could benefit from medication, he/she will refer you to a psychiatrist or your primary care physician. Medications can only be recommended and prescribed by a medical doctor (MD). The decision to accept a doctor's recommendation to medicate your child is often very difficult. You must take many issues into account including your child's age, severity of emotional and/or behavioral difficulties, level of life impairment, degree of cooperation and the potential benefit versus risk of the medications. As parents, you will want to ask your child's doctor many questions, research the recommended medication(s) and carefully think over your final decision.

If you decide to place your child on medication, learn everything you can about the medication(s) in question; know which side effects are tolerable and which may be life threatening, have your child monitored regularly by the prescribing physician, and contact your child's doctor whenever you have any concerns about the presence of side effects or the medication's effectiveness.

There are several major categories of psychotropic medications: stimulants, antidepressants, anti-anxiety agents, anti-psychotics and mood stabilizers.

What follows is a brief explanation of each of the categories. If your child's is ever prescribed any of these medications, it is highly recommended that you research the medication as fully as possible.

Stimulant Medications: There are several stimulant medications approved for use in the treatment of Attention Deficit Hyperactivity Disorder (ADHD), the most common behavioral disorder of childhood. These medications have all been studied and are specifically labeled for pediatric use. Children with ADHD exhibit such symptoms as short attention span, excessive activity, and impulsivity that often causes substantial behavioral, social and academic impairment. Stimulant medication should be prescribed only after a careful evaluation is performed to establish the diagnosis of ADHD and to rule out other disorders or conditions. Medication treatment should be administered and monitored in the context of the overall needs of the child and family, and consideration should be given to combining it with behavioral therapy. If the child is of school age, collaboration with teachers is essential.

Antidepressant and Anti-Anxiety Medications: These medications follow the stimulant medications in prevalence among children and adolescents. They are used for depression, a disorder recognized only in the last twenty years as a problem for children, and for anxiety disorders, including Obsessive-Compulsive Disorder (OCD). The medications most widely prescribed for these disorders are the Selective Serotonin Reuptake Inhibitors (the SSRIs). In the human brain, there are many "neurotransmitters" that affect the way we think, feel and act. Three of these neurotransmitters that antidepressants influence are serotonin, dopamine, and norepinephrine. SSRIs affect mainly serotonin and have been found to be effective in treating depression and anxiety without as many side effects as other antidepressants.

Anti-Psychotic Medications: These medications are used to treat children with schizophrenia, bipolar disorder, autism, Tourette's syndrome and severe conduct disorders. Some of the older anti-psychotic medications have specific indications and dosage guidelines for children. Some of the newer "atypical" anti-psychotics, that have fewer side effects, are also being used for children. Such use requires close monitoring for side effects.

Mood Stabilizing Medications: These medications are used to treat bipolar disorder (manic-depressive illness). However, because there is very limited data on the safety and efficacy of most mood stabilizers in youth, treatment of children and adolescents is based mainly on experience with adults. The most typically used mood stabilizers are lithium and valproate (Depakote), which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes in adults. Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder is ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to compliment medication treatment for this illness in young people. Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer. In addition, using stimulant medications to treat co-occurring ADHD or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

The following Medications Table (Table 2) below shows many of the commonly prescribed medications for children with mood, anxiety (including Obsessive Compulsive Disorder), disruptive behavior and thought disorders. It is intended to provide you with some psychopharmacological terminology that can help you access additional information from your treating medical doctor. It is important to note that it is common practice for doctors to prescribe medications to patients outside the approved age group (see section below titled "What Does Off-Label Mean"). The reason for this is that physician experience and judgement is ahead of the research process. If your child is prescribed a medication that has not been approved for his/her age group, do not assume that the physician made an error in his/her selection. Instead, speak to the physician and find out the appropriateness and potential benefit of the medication plan being recommended.

TABLE 2 – MEDICATIONS:

STIMULANT MEDICATIONS

Brand Name	Generic Name	Approved Age
Adderall	Amphetamines	6 and older
Dexedrine	Dextroamphetamine	6 and older
Dextrostat	Dextroamphetamine	6 and older
Vyvanse	dextroamphetamine	6 and older
Ritalin	Methylphenidate	6 and older
Concerta	Methylphenidate	6 and older
Focalin	methylphenidate	6 and older
* This list includes several of the more commonly prescribed stimulants. Some are available in a time released (XR) pill or capsule. In addition to other stimulants, there are non-stimulate medication		

ANTI-DEPRESSANT AND ANTI-ANXIETY MEDICATIONS

Brand Name	Generic	Approved Age
Anafranil	clomipramine	10 and older (for OCD)
BuSpar	buspirone	18 and older
Effexor	venlafaxine	18 and older
Luvox (SSRI)	fluvoxamine	8 and older (for OCD)
Paxil (SSRI)	paroxetine	18 and older
Prozac (SSRI)	fllioxetine	18 and older
Serzone	nefazodone	18 and older
Sinequan	doxepin	12 and older
Tofranil	imipramine	6 and older
Wellbutrin	bupropion	18 and older
Zoloft (SSRI)	sertraline	6 and older (for OCD)

ANTI-PSYCHOTIC MEDICATIONS

Brand Name	Generic	Approved Age
Clozaril	clozapine	18 and older
Haldol	haloperidol	3 and older
Risperdal	risperindone	18 and older
Seroquel (atypical)	quetiapine	18 and older
(generic only)	thioridazine	2 and older
Zyprexa	olanzapine	18 and older
Orap	pimzide	12 and older (for Tourette's syndrome). Data for age 2 and older indicates similar safety.

MOOD STABILIZING

Brand Name	Generic	Approved Age
Cibalith-S	lithium citrate	12 and older
Eskatith	lithium carbonate	12 and older
Lithobid	lithium carbonate	12 and older
Lamictal	Lamotrigine	2 and older for seizures
Trileptal	oxcarbazepine	4 and older for seizures
Depakote	divalproex	2 and older for seizures
Tegretol	carbamazepine	any age (for seizures)

When your child is being evaluated and considered for psychotropic medication, it is essential that you provide the doctor with a thorough history of your child's medical problems, any medications your child is taking, including over-the-counter medications or vitamin and herbal supplements, and any allergic reactions your child has suffered. If a medication is prescribed for your child, there are certain questions you should ask. It will be helpful to take notes as it is easy to forget exactly what the doctor says.

- What is the name of the medication and how will it help my child? Is the medicine available in both brand name and generic versions, and is it all right to use the less expensive (generic) medication? What is the name of the generic version? Is it all right to switch among brands, or between brand name and generic forms?
- What is the proper dosage for my child? Is the dose likely to change as he/she grows?
- What if my child has a problem with the pill or capsule? Is it available in a chewable tablet or liquid form?
- How many times a day must the medication be given? Should it be taken with meals, or on an empty stomach? Should the school give the medication during the day?
- How long must my child take this medication? If it is discontinued, should it be done all at once or slowly?
- Will my child be monitored while on this medication and, if so, by whom?
- Should my child have any laboratory tests before taking this medication? Will it be necessary to have blood levels checked or have other laboratory tests during the time my child is taking this medication?
- Should my child avoid certain foods, other medications, or activities while using this medication?
- Are there possible side effects? If I notice a side effect—such as unusual sleepiness, agitation, fatigue, and hand tremors—should I notify the doctor at once?
- What if my child misses a dose? Spits it up?
- How well established and accepted is the use of this medication in children or adolescents?

You may think of other questions. Do not be afraid to ask. When you have the prescription filled, be sure the pharmacist gives you a flyer describing the medication, how it should be taken, and any possible side effects it may have. The label on the medication will have a lot of information. Read the label carefully before giving the medication to your child. The label will give the name of the pharmacy, its telephone number, the name of the medication, the dosage, and when it should be taken. It will also tell you how many times the medication can be refilled.

If you want to learn more about your child's medication, you will find helpful books at your public library, or the reference librarian can show you how to look up the medication in the Physicians' Desk Reference

(PDR). Of course you can also access information from the Internet; however, much care is required in distinguishing fact from opinion.

WHAT DOES "OFF-LABEL" MEAN?

Based on clinical experience and medication knowledge, a physician may prescribe to young children a medication that has been approved by the U.S. Food and Drug Administration (FDA) for use in adults or older children. This use of the medication is called "off-label." Most medications prescribed for child mental disorders, including many of the newer medications that are proving helpful, are prescribed off-label because only a few of them have been systematically studied for safety and efficacy in children. Medications that have not undergone such testing are dispensed with the statement that "safety and efficacy have not been established in pediatric patients." The FDA has been urging that products be appropriately studied in children and has offered incentives to drug manufacturers to carry out such testing. The National Institutes of Health and the FDA are examining the issue of pharmacological research in children and are developing new research approaches.

HELPING YOUR CHILD TAKE MEDICATION SAFELY

- Be sure the doctor knows all medications—including over-the-counter medications and herbal and vitamin supplements—that your child takes.
- Read the label before opening the bottle. Make sure you are giving the proper dosage. If the medication is liquid, use a special measure—a cup, a medicine dropper, or a syringe. Often a measure comes with the medicine. If not, ask your pharmacist which measure is most suitable to use with the medication your child is taking.
- Always use child-resistant caps and store all medications in a safe place.
- Never decide to increase or decrease the dosage or stop the medication without consulting the doctor.
- Don't give medication prescribed for one child to another child, even if both appear to have the same problem.
- Keep a chart and mark it each time the child takes the medication. It is easy to forget.

FINAL THOUGHTS

I encourage you, no matter how afraid, angry, frustrated, resentful and/or sad you might be feeling about your child's difficulties and the attempts you have made to get him/her help, don't give up. Don't ever give up. Change is not an event. It is a process. Even if what you are currently doing does not seem to be having an impact, you never know when the cumulative effect of all your efforts will cause something to click and your child to choose a new course in life. Professionally I have been privileged to witness numerous patients make radical changes despite long histories of pain, dysfunction and previous treatment failures. Their successes ensure me that good things are possible for those who stay committed to the change process.

Good luck to you!

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APPENDIX A

NJ PSYCHIATRIC SCREENING CENTERS

Listed by County - Alphabetical Order

Atlantic City Medical Center (Atlantic)
Psychiatric Emergency Screening
1925 Pacific Ave.
Atlantic City, NJ 08401
Telephone: (609) 344-1118
Fax: (609) 348-3910

Care Plus New Jersey (Bergen)
Psychiatric Emergency Screening Program
610 Valley Health Plaza
Paramus, NJ 07652
Telephone: (201) 262-4357
Fax: (201) 265-0366

Lourdes Medical Center (Burlington)
Psychiatric Emergency Screening
212 Sunset Road
Willingboro, NJ 08046
Telephone: (609) 261-8000, Fax: (609) 261-0922

Steininger Center (Our Lady of Lourdes Crisis Center) (Camden)

Psychiatric Emergency Screening
1600 Camden, NJ 08103
Telephone: (856) 541-2222
Fax: (856) 635-1214

Cape Counseling Service (Cape May)
Psychiatric Emergency Screening
128 Cresthaven Road
Cape May Courthouse, NJ 08210
Telephone: (609) 465-4100 – Access Center x134
Emergency - 24 hour access – (609) 465-5999
Fax: (609) 465-2588

Cumberland County Guidance Center (Cumberland)
Psychiatric Emergency
423 Manheim Avenue
Bridgeton, NJ 08302
Telephone: (856) 455-5555
Fax: (856) 455-5405

East Orange General Hospital (Essex)
Psychiatric Emergency - CRISIS/Level G
300 Central Ave.
East Orange, NJ 07018
Telephone: (973) 266-4478
Fax: (973) 266-4445

Newark Beth Israel Medical Center (Essex)
Psychiatric Emergency Screening
201 Lyons Ave.
Newark, NJ 07112
Telephone: (973) 926-7416
Fax: (973) 705-9017

Gloucester County Crisis Center
Psychiatric Emergency
BIdg., #301, Broad St. and Red Bank Avenue
Woodbury, NJ 08096
Telephone: (856) 845-9100
Fax: (856) 845-5745

Jersey City Medical Center (Hudson)
Psych. Emergency Program, (ROOM 27)
50 Baldwin Ave.
Jersey City, NJ 07305
Telephone: (201) 915-2210
Fax: (201) 915-2415

Hunterdon Medical Center CMHC (Hunterdon)
Psychiatric Emergency Screening
2100 Westott Drive, Route 31
Flemington, NJ 08822-9237
Telephone: (908) 788-6401
Fax: (908) 788-6110

Capital Health System (Mercer)
Department of Mental Health (Emergency Screening)
750 Brunswick Ave., Box 64
Trenton, NJ 08638
Telephone: (609) 989-7297
Fax: (609) 396-4832

University of Medicine & Dentistry of NJ (Middlesex)
Univeristy Behavioral Health Care
PO Box 1392
671 Hoes Lane
Piscataway, NJ 08855-1392
Telephone: Primary # (732) 235-5700
Children Weekday Daytime # (732) 235-5705
Fax: (732) 235-4216

Monmouth Medical Center (Monmouth)
Psychiatric Emergency Screening
300 2nd Ave.
Long Branch, NJ 07740
Telephone: (732) 923-6999
Fax: (732) 923-6942

St. Clare's Hospital (Morris)
Psychiatric Emergency Screening
25 Pocono Road
Denville, NJ 07834
Telephone: (973) 625-6150
Fax: (973) 625-6452

Kimball Medical Center (Ocean)
Psychiatric Emergency Screening
600 River Ave.
Lakewood, NJ 08701-5281
Telephone: (732) 886-4475 (Administration), (732) 886 4474 (Crisis)
Fax: (732) 886-4497

St. Mary's Hospital (Passaic)
Psychiatric Emergency Screening
211 Pennington Ave.
Passaic, NJ 07055
Telephone: (973) 470-3025
Fax: (973) 470-3478

Healthcare Commons Incorporated (Salem)
Psychiatric Emergency Screening
500 South Pennsville/Auburn Road
Carney's Point, NJ 08069
Telephone: (856) 299-3200 or (856) 299-3001
Fax: (856) 299-7183

Richard Hall CMHC (Somerset)

Psychiatric Emergency Screening
500 Nt. Bridge St., Box 6877
Bridgewater, NJ 08807
Telephone: (908) 526-4100
Fax: (908) 218-0466

Newton Memorial Hospital Center for Mental Health (Sussex)
Emergency Screening
175 High St.
Newton. NJ 07867
Telephone: (973) 383-0973 or (973) 383-1533
Fax: (973) 383-9309

Trinitas Hospital (Elizabeth General Medical Center) (Union)
Psychiatric Emergency Screening
654 East Jersey St.
Elizabeth. NJ 07206
Telephone: Child (908) 994-7223, Adult (908)994-7556, Fax: (908) 994-7054

Muhlenberg Regional Medical Center (Union)
Psychiatric Emergency Screening
Park Ave. & Randolph Road
Plainfield, NJ 07061
Telephone: (908) 668-2599 or (908) 668-2244, Fax: (908) 226-4558

Family Guidance Center (Warren)
Family Guidance Center of Warren County
Psychiatric Emergency Screening
492 Rt. 57 West
Washington, NJ 07882
Telephone: (908) 689-1000, Fax: (908) 689-4529

APPENDIX B

Psychological Organizations

The organizations listed below are a great starting point for researching your child's difficulties.

In Alphabetical Order:

American Association for Marriage and Family Therapy
112 South Alfred Street
Alexandria, VA 22314
Telephone: (703) 838-9808
Fax: (703) 838-9805
Web Page: http://www.aamft.org/index_nm.asp

American Psychiatric Association
1400 K Street N.W.,
Washington, DC 20005
Telephone: (888) 357-7924
Fax: (202) 682-6850
Web Page: http://www.psych.org/index.cfm

Depression and Bipolar Support Alliance (DBSA)
730 N. Franklin Street, Suite 501
Chicago, IL 60610-7204
Telephone: (800) 826-3632
Fax: (312) 642-7243
Web Page: http://www.ndmda.org/

Educational Resources Information Center (ERIC)
1920 Association Drive
Reston, VA 22091-1589
Telephone: (703) 264-9474
Toll Free: (800) 328-0272
Web Page: http://www.eric.ed.gov/

Learning Disabilities Association of America
4156 Library Road
Pittsburgh, PA 15234
Telephone: (412) 341-1515
Fax: (412) 344-0224
Web Page: http://www.ldaamerica.org/

National Association of Social Workers
750 First Street, NE, Suite 200
Washington, DC 20002-4241
Telephone: (202) 408-8600
Web Page: http://www.naswdc.org/

National Institute on Drug Abuse
National Institutes of Health
6001 Executive Boulevard, Room 5213
Bethesda, MD 20892-9561
Telephone: (301) 443-1124
Email: Information@lists.nida.nih.gov
Web Page: http://www.drugabuse.gov/NIDAHome.html

National Institute of Health (NIH)
9000 Rockville Pike
Bethesda, MD 20892
Telephone: (301) 496-4000
Web Page: http://www.nih.gov/

National Institute of Mental Health
NIMH Public Inquiries
6001 Executive Boulevard, Rm. 8184, MSC 9663
Bethesda, MD 20892-9663
Telephone: (301) 443-4513
Fax: (301) 443-4279
Web Page: http://www.nimh.nih.gov/

U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-0498
Telephone: 1-800-USA-LEARN (1-800-872-5327)
Web Page: http://www.ed.gov/index.jsp

APPENDIX C

A Comprehensive List of Anonymous and No Cost Help Resources
National Listing

Alateen
(ages 12-17), 800-356-9996
www.al-anon-alateen.org

Al-Anon
800-344-2666
www.al-anon-alateen.org

Alcoholics Anonymous
212-870-3400
www.alcoholics-anonymous.org

Anorexia Nervosa and Associated (Eating) Disorders (ANAD)
847-831-3438
www.anad.org

Cocaine Anonymous (CA)
800-347-8998
www.ca.org

Co-Anon (Cocaine Addicts' Family Groups)
520-513-5088
www.co-anon.org

Co-Dependents Anonymous (CODA)
602-277-7991
www.codependents.org

Co-Dependents of Sex Addicts (COSA)
612-537-6904
www.shore.net/~cosa

Debtors Anonymous (DA)
781-453-2743
www.debtorsanonymous.org

Emotions Anonymous (EA)
651-647-9712
www.emotionsanonymous.org

Families Anonymous (FA)
800-736-9805
www.familiesanonymous.org

Gambler's Anonymous (GA)
213-386-8789
www.gamblersanonymous.org

Gam-Anon
718-352-1671
www.gam-anon.org

Marijuana Anonymous (MA)
800-766-6779
www.marijuana-anonymous.org

Mothers Against Drunk Drivers (MADD)
800-438-6233
www.madd.org

Narcotics Anonymous (NA)
818-773-9999
www.wsoinc.com

Nicotine Anonymous
415-750-0328
www.nicotine-anonymous.org

Obsessive-Compulsives Anonymous (OCA)
516-739-0062
www.hometown.aol.com/west24th

Overeaters Anonymous (OA)
505-891-2664
www.oa.org

Recovering Couples Anonymous (RCA)
314-397-0867
www.recovering-couples.org

Sexaholics Anonymous (SA)
615-331-6230
www.sa.org

Sex Addicts Anonymous (SAA)
800-477-8191
www.sexaa.org

Sex & Love Addicts Anonymous (SLAA)
781-255-8825
www.slaafws.org

Students Against Drunk Drivers (SADD)
508-481-3568
www.saddonline.com

Survivors of Incest Anonymous
410-282-3400
www.siawso.org

Tough Love
800-333-1069
www.toughlove.org

Adult Children of Alcoholics
310-534-1815
www.adultchildren.org

Rational Recovery Resource
www.rational.org

BERNARD IVIN, LCSW, CASAC

Bernie Ivin is a Licensed Clinical Social Worker and Certified Cognitive Behavioral Therapist. He has devoted his entire professional career to the service of others. He worked in education for 15 years as a Student Assistant Coordinator, has coached middle school and high school basketball since 1990 and has been the founder and director of Strength for Change (SFC), Cognitive Behavioral Therapy Associates since 1998.

At SFC Bernie has treated over a thousand clients, developed numerous innovative treatment methods, presented hundreds of personal and professional development workshops and self-published a variety of materials including, "A Parent's Handbook: How to Obtain Counseling Services for Your Child", and "The 1-2-3 Succeed Program: A Complete System for Helping The Capable, But Disorganized or Unmotivated Student". Please visit www.123succeed.com for more information about the 1-2-3 Succeed Program.

Bernie wrote A Parent's Handbook: How to Obtain Counseling Services For Your Child in direct response to the many questions and concerns expressed by parents seeking counseling services for their child. The purpose of this handbook is to educate, validate and support parents in the difficult task of obtaining effective mental health or substance abuse treatment for their child.

Strength for Change

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